

ASSEMBLY BILL

No. 1611

Introduced by Assembly Member Chiu
(Principal coauthor: Senator Wiener)

February 22, 2019

An act to amend Section 1317.2a of, and to add Sections 1317.11, 1317.12, 1371.6, 1371.7, and 1385.035 to, the Health and Safety Code, and to add Sections 10112.91, 10112.92, and 10181.35 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1611, as introduced, Chiu. Emergency hospital services: costs.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or health insurer offering a contract or policy to provide coverage for emergency services. Existing law prohibits a hospital from transferring a person needing emergency services and care to another hospital for any nonmedical reason unless prescribed conditions are met and makes a willful violation of this requirement a crime.

This bill would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a

noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment. The bill would require health care service plans and insurers to document cost savings pursuant to these provisions. By expanding the duties of health care services plans and hospitals, this bill would expand existing crimes, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1317.11 is added to the Health and Safety
2 Code, to read:
3 1317.11. (a) A hospital that has a legal obligation, whether
4 imposed by statute or by contract, to the extent of that contractual
5 obligation, to any third-party payor, including, but not limited to,
6 a health maintenance organization, health care service plan,
7 nonprofit hospital service plan, insurer, or preferred hospital
8 organization, a county, or an employer to provide emergency care
9 or poststabilization care as defined in Section 1317.1 for a patient,
10 shall not charge more than the greater of the average contracted
11 rate or 150 percent of the amount Medicare reimburses on a
12 fee-for-service basis for the same or similar services in the general
13 geographic region in which the services were rendered. For the
14 purposes of this section, "average contracted rate" means the
15 average of the contracted commercial rates paid by the health plan
16 or delegated entity for the same or similar services in the
17 geographic region.
18 (b) Notwithstanding this section, the liability of a third-party
19 payor that is licensed by the Insurance Commissioner or the
20 Director of the Department of Managed Health Care and has a
21 contractual obligation to provide or indemnify emergency medical

1 services under a contract which covers a subscriber or an enrollee
2 shall be determined in accordance with the terms of that contract
3 and shall remain under the sole jurisdiction of that licensing
4 agency.

5 (c) A third-party payor shall not be liable for payment for
6 emergency services if the third-party payor reasonably determines
7 that the emergency services and care were never performed,
8 provided that a third-party payor may deny reimbursement to a
9 hospital for a medical screening examination in cases in which the
10 plan enrollee did not require emergency services and care and the
11 enrollee reasonably should have known that an emergency did not
12 exist.

13 SEC. 2. Section 1317.12 is added to the Health and Safety
14 Code, to read:

15 1317.12. (a) (1) A hospital that provides care subject to
16 Section 1317.1 or 1317.2 shall provide that if a patient receives
17 covered services consistent with Section 1317.1 or 1317.2, the
18 patient shall pay no more than the same cost sharing that the patient
19 would pay for the same covered services received from a
20 contracting hospital. This amount shall be referred to as the
21 “in-network cost-sharing amount.”

22 (2) An enrollee shall not owe a hospital that provides emergency
23 or other services consistent with Section 1317.1 or 1317.2 more
24 than the in-network cost-sharing amount for services subject to
25 this section. The hospital shall be provided information on the
26 amount of the in-network cost sharing by the third-party payor.

27 (3) A hospital shall not bill or collect any amount from the
28 patient for services subject to this section except for the in-network
29 cost-sharing amount. Any communication from the noncontracting
30 hospital to the patient shall include a notice in 12-point bold type
31 stating that the communication is not a bill and informing the
32 patient that the patient shall not pay until the patient is informed
33 by the patient’s third-party payor of any applicable cost sharing.

34 (4) (A) If the hospital has received more than the in-network
35 cost-sharing amount from the patient for services subject to this
36 section, the noncontracting hospital shall refund any overpayment
37 to the patient within 30 calendar days after receiving payment from
38 the patient.

39 (B) If the hospital does not refund any overpayment to the
40 patient within 30 calendar days after being informed of the patient’s

1 in-network cost-sharing amount, interest shall accrue at the rate
2 of 15 percent per annum beginning with the date payment was
3 received from the enrollee.

4 (C) A hospital shall automatically include in the refund to the
5 patient all interest that has accrued pursuant to this section without
6 requiring the enrollee to submit a request for the interest amount.

7 (b) If a patient does not have a third-party payor and a hospital
8 determines, consistent with Article 1 (commencing with Section
9 127400) of Chapter 2.5 of Part 2 of Division 107, that a patient is
10 participating in the charity care or discount payment policy
11 provisions of that article, then this section shall not apply to that
12 patient. If a patient does not have a third-party payor and has not
13 yet begun to participate in either the charity care or discount
14 payment policy provisions of Article 1 (commencing with Section
15 127400) of Chapter 2.5 of Part 2 of Division 107, then the hospital
16 shall, consistent with subdivision (b) of Section 127420, provide
17 information on the hospital's charity care and discount payment
18 policies, as well as information on how to apply for Medi-Cal and
19 any other applicable coverage.

20 (c) (1) A hospital may advance to collections only the
21 in-network cost-sharing amount, as determined by the third-party
22 payor pursuant to subdivision (a), that the enrollee has failed to
23 pay.

24 (2) The hospital, or any entity acting on its behalf, including
25 any assignee of the debt, shall not report adverse information to a
26 consumer credit reporting agency or commence civil action against
27 the enrollee for a minimum of 150 days after the initial billing
28 regarding amounts owed by the enrollee under subdivision (a) or
29 (b).

30 (3) With respect to a patient subject to this section, the
31 noncontracting hospital, or any entity acting on its behalf, including
32 any assignee of the debt, shall not use wage garnishments or liens
33 on primary residences as a means of collecting unpaid bills under
34 this section.

35 (d) For purposes of this section, the following definitions shall
36 apply:

37 (1) "Contracting hospital" means a hospital that is contracted
38 with the patient's third-party payor to provide services under the
39 patient's contract.

1 (2) "Cost sharing" includes any copayment, coinsurance, or
2 deductible, or any other form of cost sharing paid by the enrollee
3 other than premium or share of premium.

4 (3) "In-network cost-sharing amount" means an amount no more
5 than the same cost sharing the enrollee would pay for the same
6 covered service received from a contracting health professional.

7 (4) "Third-party payor" means any third-party payor, including,
8 but not limited to, a health maintenance organization, health care
9 service plan, nonprofit hospital service plan, insurer, or preferred
10 hospital organization, a county, or an employer that by statute or
11 contract is required to cover emergency care.

12 (e) This section shall not be construed to require a third-party
13 payor to cover services not required by law or by the terms and
14 conditions of the third-party contract.

15 (f) This section shall not be construed to exempt a plan or
16 hospital from the requirements under Section 1371.4 or 1373.96,
17 nor abrogate the holding in *Prospect Medical Group, Inc. v.*
18 *Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.

19 (g) If a health care service plan delegates payment functions to
20 a contracted entity, including, but not limited to, a medical group
21 or independent practice association, the delegated entity shall
22 comply with this section.

23 (h) This section shall not apply to a Medi-Cal managed health
24 care service plan or any other entity that enters into a contract with
25 the State Department of Health Care Services pursuant to Chapter
26 7 (commencing with Section 14000), Chapter 8 (commencing with
27 Section 14200), and Chapter 8.75 (commencing with Section
28 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

29 SEC. 3. Section 1317.2a of the Health and Safety Code is
30 amended to read:

31 1317.2a. (a) A hospital ~~which~~ *that* has a legal obligation,
32 whether imposed by statute or by contract, to the extent of that
33 contractual obligation, to any third-party payor, including, but not
34 limited to, a health maintenance organization, health care service
35 plan, nonprofit hospital service plan, insurer, or preferred provider
36 organization, a county, or an employer to provide care for a patient
37 under the circumstances specified in Section 1317.2 shall receive
38 that patient to the extent required by the applicable statute or by
39 the terms of the contract, or, when the hospital is unable to accept
40 a patient for whom it has a legal obligation to provide care whose

1 transfer will not create a medical hazard as specified in Section
2 1317.2, it shall make appropriate arrangements for the patient's
3 care.

4 (b) A county hospital shall accept a patient whose transfer will
5 not create a medical hazard as specified in Section 1317.2 and who
6 is determined by the county to be eligible to receive health care
7 services required under Part 5 (commencing with Section 17000)
8 of Division 9 of the Welfare and Institutions Code, unless the
9 hospital does not have appropriate bed capacity, medical personnel,
10 or equipment required to provide care to the patient in accordance
11 with accepted medical practice. When a county hospital is unable
12 to accept a patient whose transfer will not create a medical hazard
13 as specified in Section 1317.2, it shall make appropriate
14 arrangements for the patient's care. The obligation to make
15 appropriate arrangements as set forth in this subdivision does not
16 mandate a level of service or payment, modify the county's
17 obligations under Part 5 (commencing with Section 17000) of
18 Division 9 of the Welfare and Institutions Code, create a cause of
19 action, or limit a county's flexibility to manage county health
20 systems within available resources. However, the county's
21 flexibility shall not diminish a county's responsibilities under Part
22 5 (commencing with Section 17000) of Division 9 of the Welfare
23 and Institutions Code or the requirements contained in Chapter
24 2.5 (commencing with Section 1440).

25 (c) The receiving hospital shall provide personnel and
26 equipment reasonably required in the exercise of good medical
27 practice for the care of the transferred patient.

28 (d) Any third-party payor, including, but not limited to, a health
29 maintenance organization, health care service plan, nonprofit
30 hospital service plan, insurer, or preferred provider organization,
31 or employer ~~which~~ *that* has a statutory or contractual obligation
32 to provide or indemnify emergency medical services on behalf of
33 a patient shall be liable, to the extent of the contractual obligation
34 to the patient, for the reasonable charges of the transferring hospital
35 and the treating physicians for the emergency services provided
36 pursuant to this article, except that the patient shall be responsible
37 for uncovered services, or any deductible or copayment obligation.
38 *Reasonable charges shall not exceed the greater of the average*
39 *contracted rate or 150 percent of the amount Medicare reimburses*
40 *on a fee-for-service basis for the same or similar services in the*

1 *general geographic region in which the services were rendered.*
2 *For the purposes of this section, “average contracted rate” means*
3 *the average of the contracted commercial rates paid by the health*
4 *plan or delegated entity for the same or similar services in the*
5 *geographic region.* Notwithstanding this section, the liability of
6 a third-party payor ~~which~~ *that* has contracted with health care
7 providers for the provision of these emergency services shall be
8 set by the terms of that contract. Notwithstanding this section, the
9 liability of a third-party payor that is licensed by the Insurance
10 Commissioner or the Director of the Department of Managed
11 Health Care and has a contractual obligation to provide or
12 indemnify emergency medical services under a contract ~~which~~
13 *that* covers a subscriber or an enrollee shall be determined in
14 accordance with the terms of that contract and shall remain under
15 the sole jurisdiction of that licensing agency.

16 (e) A hospital ~~which~~ *that* has a legal obligation to provide care
17 for a patient as specified by subdivision (a) of Section 1317.2a to
18 the extent of its legal obligation, imposed by statute or by contract
19 to the extent of that contractual obligation, which does not accept
20 transfers of, or make other appropriate arrangements for, medically
21 stable patients in violation of this article or regulations adopted
22 pursuant thereto shall be liable for the reasonable charges of the
23 transferring hospital and treating physicians for providing services
24 and care ~~which~~ *that* should have been provided by the receiving
25 hospital.

26 (f) Subdivisions (d) and (e) do not apply to county obligations
27 under Section 17000 of the Welfare and Institutions Code.

28 (g) Nothing in this section shall be interpreted to require a
29 hospital to make arrangements for the care of a patient for whom
30 the hospital does not have a legal obligation to provide care.

31 SEC. 4. Section 1371.6 is added to the Health and Safety Code,
32 to read:

33 1371.6. (a) (1) A health care service plan contract issued,
34 amended, or renewed on or after January 1, 2020, shall provide
35 that if an enrollee receives covered services consistent with Section
36 1371.4 or 1371.5 from a noncontracting hospital, the enrollee shall
37 pay no more than the same cost sharing that the enrollee would
38 pay for the same covered services received from a contracting
39 hospital. This amount shall be referred to as the “in-network
40 cost-sharing amount.”

(2) An enrollee shall not owe a noncontracting hospital that provides emergency or other services consistent with Section 1371.4 or 1371.5 more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting hospital, the plan shall inform the enrollee and the noncontracting hospital of the in-network cost-sharing amount owed by the enrollee.

(3) A noncontracting hospital shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount. Any communication from the noncontracting hospital to the enrollee prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the enrollee that the enrollee shall not pay until the enrollee is informed by the enrollee's health care service plan of any applicable cost sharing.

(4) (A) If the noncontracting hospital has received more than the in-network cost-sharing amount from the enrollee for services subject to this section, the noncontracting hospital shall refund any overpayment to the enrollee within 30 calendar days after receiving payment from the enrollee.

(B) If the noncontracting hospital does not refund any overpayment to the enrollee within 30 calendar days after being informed of the enrollee's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the enrollee.

(C) A noncontracting hospital shall automatically include in the refund to the enrollee all interest that has accrued pursuant to this section without requiring the enrollee to submit a request for the interest amount.

(b) The following shall apply:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting hospital.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the

1 health service and shall constitute “applicable cost sharing owed
2 by the enrollee.”

3 (c) (1) A noncontracting hospital may advance to collections
4 only the in-network cost-sharing amount, as determined by the
5 plan pursuant to subdivision (a) that the enrollee has failed to pay.

6 (2) The noncontracting hospital, or any entity acting on its
7 behalf, including any assignee of the debt, shall not report adverse
8 information to a consumer credit reporting agency or commence
9 civil action against the enrollee for a minimum of 150 days after
10 the initial billing regarding amounts owed by the enrollee under
11 subdivision (a) or (b).

12 (3) With respect to an enrollee, the noncontracting hospital, or
13 any entity acting on its behalf, including any assignee of the debt,
14 shall not use wage garnishments or liens on primary residences as
15 a means of collecting unpaid bills under this section.

16 (d) For purposes of this section, the following definitions shall
17 apply:

18 (1) “Contracting hospital” means a hospital that is contracted
19 with the enrollee’s health care service plan to provide services
20 under the enrollee’s plan contract.

21 (2) “Cost sharing” includes any copayment, coinsurance, or
22 deductible, or any other form of cost sharing paid by the enrollee
23 other than premium or share of premium.

24 (3) “In-network cost-sharing amount” means an amount no more
25 than the same cost sharing the enrollee would pay for the same
26 covered service received from a contracting health professional.
27 The in-network cost-sharing amount with respect to an enrollee
28 with coinsurance shall be based on the amount paid by the plan
29 pursuant to paragraph (1) of subdivision (a) of Section 1371.31.

30 (e) This section shall not be construed to require a health care
31 service plan to cover services not required by law or by the terms
32 and conditions of the health care service plan contract.

33 (f) This section shall not be construed to exempt a plan, hospital,
34 any other individual or any other entity from the requirements
35 under Section 1371.4 or 1373.96, nor abrogate the holding in
36 *Prospect Medical Group, Inc. v. Northridge Emergency Medical*
37 *Group* (2009) 45 Cal.4th 497.

38 (g) If a health care service plan delegates payment functions to
39 a contracted entity, including, but not limited to, a medical group

1 or independent practice association, the delegated entity shall
2 comply with this section.

3 (h) This section shall not apply to a Medi-Cal managed health
4 care service plan or any other entity that enters into a contract with
5 the State Department of Health Care Services pursuant to Chapter
6 7 (commencing with Section 14000), Chapter 8 (commencing with
7 Section 14200), and Chapter 8.75 (commencing with Section
8 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

9 SEC. 5. Section 1371.7 is added to the Health and Safety Code,
10 to read:

11 1371.7. A health care service plan contract issued, amended,
12 or renewed on or after January 1, 2020, shall provide that:

13 (a) (1) A noncontracting health facility subject to Section 1371.6
14 shall be paid the greater of the average contracted rate or 150
15 percent of the amount Medicare reimburses on a fee-for-service
16 basis for the same or similar services in the general geographic
17 region in which the services were rendered. For the purposes of
18 this section, “average contracted rate” means the average of the
19 contracted commercial rates paid by the health plan or delegated
20 entity for the same or similar services in the geographic region.

21 (2) To determine the “average contracted rate,” the department
22 shall use the standardized methodology as provided in paragraphs
23 (2) and (3) of subdivision (a) of Section 1371.31.

24 (b) (1) A noncontracting health facility providing emergency
25 services subject to Section 1371.4 may use the independent dispute
26 resolution process established under Section 1371.30. If the
27 noncontracting health facility participates in the independent
28 dispute resolution process, the health care service plan shall also
29 participate.

30 (2) The decision obtained through the department’s independent
31 dispute resolution process shall be binding on both parties. The
32 plan shall implement the decision obtained through the independent
33 dispute resolution process.

34 (c) If dissatisfied, either party may pursue any right, remedy,
35 or penalty established under any other applicable law.

36 SEC. 6. Section 1385.035 is added to the Health and Safety
37 Code, to read:

38 1385.035. (a) For a plan contract subject to Section 1385.03,
39 the plan shall file a separate schedule documenting the cost savings
40 associated with Section 1371.7 and the impact on rates.

1 (b) For a plan contract subject to Section 1385.04, the plan shall
2 file a separate schedule documenting cost savings associated with
3 Section 1371.7 and the impact on rates.

4 SEC. 7. Section 10112.91 is added to the Insurance Code, to
5 read:

6 10112.91. (a) (1) A health insurance policy issued, amended,
7 or renewed on or after January 1, 2020, shall provide that if an
8 insured receives covered services consistent with Section 1371.4
9 or 1371.5 of the Health and Safety Code from a noncontracting
10 hospital, the insured shall pay no more than the same cost sharing
11 that the insured would pay for the same covered services received
12 from a contracting hospital. This amount shall be referred to as
13 the “in-network cost-sharing amount.”

14 (2) An insured shall not owe a noncontracting hospital that
15 provides emergency or other services consistent with Section
16 1371.4 or 1371.5 of the Health and Safety Code more than the
17 in-network cost-sharing amount for services subject to this section.
18 At the time of payment by the insurer to the noncontracting
19 hospital, the insurer shall inform the insured and the noncontracting
20 hospital of the in-network cost-sharing amount owed by the
21 insured.

22 (3) A noncontracting hospital shall not bill or collect any amount
23 from the insured for services subject to this section except for the
24 in-network cost-sharing amount. Any communication from the
25 noncontracting hospital to the insured prior to the receipt of
26 information about the in-network cost-sharing amount pursuant
27 to paragraph (2) shall include a notice in 12-point bold type stating
28 that the communication is not a bill and informing the insured that
29 the insured shall not pay until the insured is informed by the
30 insured’s health insurance policy of any applicable cost sharing.

31 (4) (A) If the noncontracting hospital has received more than
32 the in-network cost-sharing amount from the insured for services
33 subject to this section, the noncontracting hospital shall refund any
34 overpayment to the insured within 30 calendar days after receiving
35 payment from the insured.

36 (B) If the noncontracting hospital does not refund any
37 overpayment to the insured within 30 calendar days after being
38 informed of the insured’s in-network cost-sharing amount, interest
39 shall accrue at the rate of 15 percent per annum beginning with
40 the date payment was received from the insured.

1 (C) A noncontracting hospital shall automatically include in the
2 refund to the insured all interest that has accrued pursuant to this
3 section without requiring the insured to submit a request for the
4 interest amount.

5 (b) The following shall apply:

6 (1) Any cost sharing paid by the insured for the services subject
7 to this section shall count toward the limit on annual out-of-pocket
8 expenses established under Section 10112.28.

9 (2) Cost sharing arising from services subject to this section
10 shall be counted toward any deductible in the same manner as cost
11 sharing would be attributed to a contracting hospital.

12 (3) The cost sharing paid by the insured pursuant to this section
13 shall satisfy the insured's obligation to pay cost sharing for the
14 health service and shall constitute "applicable cost sharing owed
15 by the insured."

16 (c) (1) A noncontracting hospital may advance to collections
17 only the in-network cost-sharing amount, as determined by the
18 plan pursuant to subdivision (a) that the insured has failed to pay.

19 (2) The noncontracting hospital, or any entity acting on its
20 behalf, including any assignee of the debt, shall not report adverse
21 information to a consumer credit reporting agency or commence
22 civil action against the insured for a minimum of 150 days after
23 the initial billing regarding amounts owed by the insured under
24 subdivision (a) or (b).

25 (3) With respect to an insured, the noncontracting hospital, or
26 any entity acting on its behalf, including any assignee of the debt,
27 shall not use wage garnishments or liens on primary residences as
28 a means of collecting unpaid bills under this section.

29 (d) For purposes of this section, the following definitions shall
30 apply:

31 (1) "Contracting hospital" means a hospital that is contracted
32 with the insured's health insurance policy to provide services under
33 the insured's plan contract.

34 (2) "Cost sharing" includes any copayment, coinsurance, or
35 deductible, or any other form of cost sharing paid by the insured
36 other than premium or share of premium.

37 (3) "In-network cost-sharing amount" means an amount no more
38 than the same cost sharing the insured would pay for the same
39 covered service received from a contracting health professional.
40 The in-network cost-sharing amount with respect to an insured

1 with coinsurance shall be based on the amount paid by the plan
2 pursuant to paragraph (1) of subdivision (a) of Section 10112.82.

3 (e) This section shall not be construed to require a health
4 insurance policy to cover services not required by law or by the
5 terms and conditions of the health insurance policy contract.

6 (f) This section shall not be construed to exempt a health care
7 service plan, hospital, any other individual, or any other entity
8 from the requirements under Section 1371.4 or 1373.96 of the
9 Health and Safety Code, nor abrogate the holding in Prospect
10 Medical Group, Inc. v. Northridge Emergency Medical Group
11 (2009) 45 Cal.4th 497.

12 (g) If a health insurance policy delegates payment functions to
13 a contracted entity, including, but not limited to, a medical group
14 or independent practice association, the delegated entity shall
15 comply with this section.

16 SEC. 8. Section 10112.92 is added to the Insurance Code, to
17 read:

18 10112.92. A health insurance policy issued, amended, or
19 renewed on or after January 1, 2020, shall provide that:

20 (a) (1) A noncontracting health facility subject to Section
21 10112.91 shall be paid the greater of the average contracted rate
22 or 150 percent of the amount Medicare reimburses on a
23 fee-for-service basis for the same or similar services in the general
24 geographic region in which the services were rendered. For the
25 purposes of this section, “average contracted rate” means the
26 average of the contracted commercial rates paid by the insurer or
27 delegated entity for the same or similar services in the geographic
28 region.

29 (2) To determine the “average contracted rate,” the department
30 shall use the standardized methodology as provided in paragraphs
31 (2) and (3) of subdivision (a) of Section 10112.82.

32 (b) (1) A noncontracting health facility providing emergency
33 services subject to Section 1371.4 of the Health and Safety Code
34 may use the independent dispute resolution process established
35 under Section 10112.81. If the noncontracting health facility
36 participates in the independent dispute resolution process, the
37 insurer shall also participate.

38 (2) The decision obtained through the department’s independent
39 dispute resolution process shall be binding on both parties. The

1 insurer shall implement the decision obtained through the
2 independent dispute resolution process.

3 (c) If dissatisfied, either party may pursue any right, remedy,
4 or penalty established under any other applicable law.

5 SEC. 9. Section 10181.35 is added to the Insurance Code, to
6 read:

7 10181.35. (a) For a policy subject to Section 10181.3, the
8 insurer shall file a separate schedule documenting the cost savings
9 associated with Section 10112.91 and the impact on rates.

10 (b) For a policy contract subject to Section 10181.4, the insurer
11 shall file a separate schedule documenting cost savings associated
12 with Section 10112.92 and the impact on rates.

13 SEC. 10. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.