II

106TH CONGRESS
1ST SESSION

S. 517

To assure access under group health plans and health insurance coverage to covered emergency medical services.

IN THE SENATE OF THE UNITED STATES

MARCH 3, 1999

Mr. GRAHAM (for himself, Mr. CHAFEE, Ms. MIKULSKI, Mr. DEWINE, and Mr. ROBB) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To assure access under group health plans and health insurance coverage to covered emergency medical services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Access to Emergency Medical Services Act of 1999''.

SEC. 2. EMERGENCY SERVICES.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to

emergency services (as defined in paragraph (2)(B)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider, the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

(D) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act (42 U.S.C. 300gg et seq.), section 701 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)).

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)); and

(ii) within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with the guidelines established under section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)) (relating to

promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), or, in the absence of guidelines under such section, such guidelines as the Secretary shall establish to carry out this subsection), if the services are maintenance care or post-stabilization care covered under such guidelines.

(c) INFORMATION FOR PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this Act, in the case of individuals who are participants and beneficiaries as of such date), at least annually thereafter, and at the beginning of any open enrollment provided under the plan, the information described in paragraph (3) in printed form; and

(B) upon request, make available to participants and beneficiaries, to the applicable authority, and to prospective participants and beneficiaries the information described in paragraph (3) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer, in connection with the provision of health insurance coverage, shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, (and to plan administrators of group health plans in connection with which such coverage is offered) the information described in paragraph (3) in printed form; and

(B) upon request, make available to the applicable authority, to individuals who are prospective enrollees, to plan administrators of group health plans that may obtain such coverage, and to the public the information described in paragraph (3) in printed form.

(3) REQUIRED INFORMATION.—The information described in this paragraph with respect to a group health plan or health insurance coverage offered by a health insurance issuer is information about the coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations

and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services;

(C) any cost-sharing applicable to emergency services; and

(D) the locations of—

(i) emergency departments; and

(ii) other settings in which plan physicians and hospitals provide emergency services and post-stabilization care.

(d) DEFINITIONS.—In this section:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this section, the applicable State authority or the Secretary of Health and Human Services if such Secretary is enforcing such provisions under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act (42 U.S.C. 300gg–22(a)(2), 300gg–61(a)(2)).

(2) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(3) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(4) OTHER TERMS.—The terms ''applicable State authority'', ''beneficiary'', ''group health plan'', ''health insurance coverage'', ''health insurance issuer'', and ''participant'' shall have the meanings given to such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 3. STANDARDS UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following new section:

"SEC. 2707. EMERGENCY SERVICES.

''(a) IN GENERAL.—Each group health plan (and each health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of the Access to Emergency Medical Services Act of 1999, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act with respect to the requirements referred to in subsection (a), and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) INDIVIDUAL MARKET.—Subpart 3 of part B of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following new section:

''SEC. 2753. EMERGENCY SERVICES.

''(a) IN GENERAL.—Each health insurance issuer shall comply with the requirements of the Access to Emergency Medical Services Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

SEC. 4. STANDARDS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following:

''SEC. 714. EMERGENCY SERVICES.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of the Access

to Emergency Medical Services Act of 1999, and such requirements shall be deemed to be incorporated into this subsection.

''(b) SATISFACTION OF REQUIREMENTS.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of the Access to Emergency Medical Services Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.''.

(b) CONFORMING AMENDMENT.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Emergency services.''.

SEC. 5. STANDARDS UNDER THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to emergency services.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO EMERGENCY SERVICES.

''A group health plan shall comply with the requirements of the Access to Emergency Medical Services Act of 1999, and such requirements shall be deemed to be incorporated into this section.''.

SEC. 6. EFFECTIVE DATE.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 3(a), 4, and 5 (and section 2 insofar as it relates to such sections) shall apply to group health plans and health insurance coverage offered in connection with group health plans for plan years beginning on or after January 1, 2000.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of

the enactment of this Act, the amendments made by sections 3(a), 4, and 5 (and section 2 insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act); or

(B) January 1, 2000.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan that amends the plan solely to conform to any requirement of this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL MARKET.—The amendment made by section 3(b) (and section 2 insofar as it relates to such section) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2000.

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