

104TH CONGRESS
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H. R. 2011

To assure equitable coverage and treatment of emergency services under health plans.

IN THE HOUSE OF REPRESENTATIVES

JULY 11, 1995

Mr. CARDIN (for himself, Mrs. ROUKEMA, Mr. McDERMOTT, Mr. TOWNS, Mr. PALLONE, Ms. RIVERS, Mr. NADLER, Mr. WISE, Mr. LEWIS of Georgia, Mr. FAZIO of California, Mr. MORAN, Mr. BEILENSON, and Mr. JOHNSON of South Dakota) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To assure equitable coverage and treatment of emergency services under health plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Access to Emergency Medical Services Act of 1995”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

- Sec. 1. Short title.
- Sec. 2. Findings; purposes.
- Sec. 3. Assuring equitable health plan coverage with respect to emergency services.
- Sec. 4. Requirements for medicare and medicaid managed care.
- Sec. 5. Effect on State law.
- Sec. 6. Enforcement.
- Sec. 7. Regulations.
- Sec. 8. Definitions.
- Sec. 9. Effective dates.
- Sec. 10. Report on application to plans including medical savings accounts.

1 **SEC. 2. FINDINGS; PURPOSES.**

2 (a) FINDINGS.—The Congress finds the following:

3 (1) Federal medicare law requires emergency
4 physicians and other providers to evaluate, treat,
5 and stabilize any individual seeking treatment in a
6 hospital emergency department.

7 (2) This law specifically prohibits emergency
8 physicians from delaying any treatment needed to
9 evaluate or stabilize an individual in order to deter-
10 mine the health insurance status of the individual.

11 (3) Many health plans routinely deny payment
12 for these Federally-required emergency services fur-
13 nished to their enrollees, basing such denials on—

14 (A) failure to obtain prior approval of such
15 services from the plan, or

16 (B) an after-the-fact determination that
17 the medical condition identified through the
18 Federally-required evaluation was not an emer-
19 gency medical condition.

1 (4) These denials by health plans impose sig-
2 nificant financial burdens on—

3 (A) their enrollees who, based on symp-
4 toms that reasonably suggest a medical emer-
5 gency, prudently seek care in a hospital emer-
6 gency department, and

7 (B) emergency physicians, the hospital
8 emergency departments, and others involved in
9 furnishing emergency services to the enrollees.

10 (5) These burdens discourage enrollees from
11 seeking emergency care in cases where it is appro-
12 priate and, ultimately, threaten the financial liveli-
13 hood of hospital emergency departments in providing
14 emergency services to the entire population, includ-
15 ing beneficiaries of the medicare and medicaid pro-
16 grams and of other Federal health care programs.

17 (6) Health plans have engaged in practices that
18 discourage the appropriate use of the 911 emergency
19 telephone number and may adversely impact on the
20 health of enrollees.

21 (b) PURPOSES.—The purposes of this Act are—

22 (1) to require health plans to cover and pay for
23 their fair share for emergency services that hospital
24 emergency departments are required to provide;

1 (2) to protect health plan enrollees by establish-
2 ing a uniform definition of emergency medical condi-
3 tion that is based on the average knowledge of a
4 prudent layperson;

5 (3) to prohibit health plans from requiring prior
6 approval for Federally-required emergency services;
7 and

8 (4) to assure that health plans promote the ap-
9 propriate use of the 911 emergency telephone num-
10 ber.

11 **SEC. 3. ASSURING EQUITABLE HEALTH PLAN COVERAGE**

12 **WITH RESPECT TO EMERGENCY SERVICES.**

13 (a) PROHIBITION OF CONTRACTUAL LIMITATIONS ON
14 COVERAGE OF EMERGENCY SERVICES.—A health plan
15 that provides any coverage with respect to emergency serv-
16 ices shall cover emergency services furnished to an enrollee
17 of the plan—

18 (1) without regard to whether or not the pro-
19 vider furnishing the emergency services has a con-
20 tractual or other arrangement with the plan for the
21 provision of such services to such enrollees, and

22 (2) without regard to prior authorization.

23 (b) PROHIBITION OF DISCRIMINATORY PAYMENT OR
24 COST-SHARING.—

1 (1) IN GENERAL.—A health plan that provides
2 any coverage with respect to emergency services—

3 (A) shall determine and make prompt pay-
4 ment in a reasonable and appropriate amount
5 for such services (including services required to
6 be provided under section 1867 of the Social
7 Security Act), and

8 (B) subject to paragraph (2), may not im-
9 pose cost-sharing for services furnished in a
10 hospital emergency department that is cal-
11 culated in a manner (such as the use of a dif-
12 ferent percentage) that imposes greater cost
13 sharing with respect to such services compared
14 to comparable services furnished in other set-
15 tings.

16 (2) IMPOSITION OF REASONABLE COPAYMENT
17 PERMITTED.—A health plan may impose a reason-
18 able copayment (as determined in accordance with
19 standards established by the Secretary) in lieu of co-
20 insurance to deter inappropriate use of services of
21 hospital emergency departments.

22 (c) ASSURING TIMELINESS OF PRIOR AUTHORIZA-
23 TION DETERMINATION FOR NEEDED CARE IDENTIFIED
24 IN INITIAL EVALUATION.—

25 (1) IN GENERAL.—

1 (A) ACCESS TO PROCESS.—If an enrollee
2 of a health plan receives emergency services
3 from an emergency department pursuant to a
4 screening evaluation conducted by a treating
5 physician or other emergency department per-
6 sonnel and pursuant to the evaluation such phy-
7 sician or personnel identifies items and services
8 (other than emergency services) promptly need-
9 ed by the enrollee, the health plan shall provide
10 access 24 hours a day, 7 days a week, to such
11 persons as may be authorized to make any prior
12 authorization determinations respecting cov-
13 erage of such promptly needed items and serv-
14 ices.

15 (B) DEEMED APPROVAL.—A health plan is
16 deemed to have approved a request for a prior
17 authorization for such promptly needed items
18 and services if such physician or other person-
19 nel—

20 (i) has attempted to contact such a
21 person for authorization—

22 (I) to provide an appropriate re-
23 ferral for the items and services, or

24 (II) to provide the items and
25 services to the enrollee,

1 and access to the person has not been pro-
2 vided (as required under subparagraph
3 (A)), or

4 (ii) has requested such authorization
5 from such a person and the person has not
6 denied the authorization within 30 minutes
7 after the time the request is made.

8 (2) REFERRAL BY PHYSICIAN TO HOSPITAL
9 EMERGENCY DEPARTMENT DEEMED PRIOR AUTHOR-
10 IZATION.—If a physician (or, in the case of a man-
11 aged care plan, a participating physician or other
12 person authorized to make prior authorization deter-
13 minations for the plan) refers an enrollee to a hos-
14 pital emergency department for evaluation or treat-
15 ment, a request for prior authorization of the items
16 and services reasonably furnished the enrollee pursu-
17 ant to such referral shall be deemed to have been
18 made and approved.

19 (3) EFFECT OF APPROVAL.—

20 (A) IN GENERAL.—Approval of a request
21 for a prior authorization determination (includ-
22 ing a deemed approval under paragraph (1) or
23 (2)) shall be treated as approval of any health
24 care items and services required to treat the
25 medical condition identified pursuant to a

1 screening evaluation referred to in paragraph
2 (1)(A).

3 (B) PAYMENT.—A health plan may not
4 subsequently deny or reduce payment for an
5 item or service furnished pursuant to such an
6 approval unless the approval was based on in-
7 formation about the medical condition of an en-
8 rollee that was fraudulent.

9 (d) ENCOURAGING APPROPRIATE USE OF 911 EMER-
10 GENCY TELEPHONE NUMBER.—A health plan—

11 (1) shall include, in any educational materials
12 the plan makes available to its enrollees on the pro-
13 cedures for obtaining emergency services—

14 (A) a statement that it is appropriate for
15 an enrollee to use the 911 emergency telephone
16 number for an emergency medical condition (as
17 defined in section 8(3)), and

18 (B) an explanation of what is an emer-
19 gency medical condition;

20 (2) shall not discourage appropriate use of the
21 911 emergency telephone number by enrollees with
22 emergency medical conditions; and

23 (3) shall not deny coverage or payment for an
24 item or service solely on the basis that an enrollee

1 uses the 911 emergency telephone number to sum-
2 mon treatment for an emergency medical condition.

3 **SEC. 4. REQUIREMENTS FOR MEDICARE AND MEDICAID**
4 **MANAGED CARE.**

5 (a) **MEDICARE.**—Subparagraph (B) of section
6 1876(c)(4) of the Social Security Act (42 U.S.C.
7 1395mm(c)(4)) is amended to read as follows:

8 “(B) meets the requirements of section 3 of the
9 Access to Emergency Medical Care Act of 1995 with
10 respect to enrollees of the plan who are enrolled
11 under this section.”.

12 (b) **MEDICAID.**—Title XIX of the Social Security Act
13 (42 U.S.C. 1396 et seq.) is amended by inserting after
14 section 1908 the following new section:

15 “ACCESS TO EMERGENCY SERVICES FOR INDIVIDUALS
16 ENROLLED IN MANAGED CARE PLAN

17 “SEC. 1909. (a) **IN GENERAL.**—A state plan may not
18 be approved under this title unless the plan requires each
19 managed care plan providing (or arranging for the provi-
20 sion of) health care items and services to individuals who
21 are eligible for medical assistance and enrolled with the
22 managed care plan to comply with the requirements of sec-
23 tion 3 of the Access to Emergency Medical Care Act of
24 1995 with respect to such individuals.

1 “(b) WAIVERS PROHIBITED.—The requirement of
2 subsection (a) may not be waived under section 1115 or
3 section 1915(b).

4 “(c) MANAGED CARE PLAN.—For purposes of this
5 section, the term ‘managed care plan’ means a health plan
6 that provides or arranges for the provision health care
7 items and services to enrollees primarily through partici-
8 pating physicians and providers.”.

9 **SEC. 5. EFFECT ON STATE LAW.**

10 (a) PREEMPTION.—Nothing in this Act shall be con-
11 strued as preempting or otherwise superseding any provi-
12 sion of State law unless such provision directly conflicts
13 with this Act.

14 (b) CONSUMER PROTECTIONS.—A provision of State
15 law shall not be considered to conflict directly with this
16 Act if the provision provides the enrollees of health plans
17 with protections that exceed the protections of this Act.

18 **SEC. 6. ENFORCEMENT.**

19 (a) CIVIL MONEY PENALTIES.—A health plan that
20 violates a requirement of section 3 shall be subject to a
21 civil money penalty of not more than the greatest of—

22 (1) \$10,000 for each such violation;

23 (2) in the case of a violation of section 3, 3
24 times the amount that the health plan would have

1 paid for items and services if the plan had not vio-
2 lated such section; or

3 (3) in the case of a pattern of repeated and
4 substantial violations, \$1,000,000.

5 (b) PROCEDURES.—

6 (1) IN GENERAL.—The provisions of section
7 1128A of the Social Security Act (other than sub-
8 sections (a) and (b)) shall apply to a civil money
9 penalty under this section in the same manner as
10 such provisions apply with respect to a penalty or
11 proceeding under section 1128A(a) of such Act.

12 (2) CORRECTIVE ACTION.—In determining the
13 amount or scope of any civil money penalty under
14 this section, the Secretary shall take into account
15 whether a health plan has taken corrective action,
16 such as—

17 (A) payment for items and services for
18 which coverage or payment has been denied in
19 violation of a requirement of section 3, and

20 (B) establishment of policies and proce-
21 dures to prevent the same type of violation from
22 occurring in the future.

23 (c) INDEMNIFICATION.—The Secretary may, out of
24 any civil money penalty collected pursuant to this section,
25 make a payment to an enrollee or provider (as appro-

1 priate) in an amount equal to the amount a health plan
2 would have paid for an item or service (if any) if the plan
3 had not denied coverage or payment for such item or serv-
4 ice in violation of section 3.

5 (d) VIOLATIONS.—For purposes of subsection (a),
6 the Secretary shall treat at least the following acts or
7 omissions as violations of section 3:

8 (1) COVERAGE OF EMERGENCY SERVICES.—
9 Failure to cover emergency services in violation of
10 section 3(a).

11 (2) FAILURE TO PROVIDE FOR PAYMENT.—
12 Failure to provide for payment for emergency serv-
13 ices in violation of section 3(b)(1)(A).

14 (3) IMPROPER COST SHARING.—Imposition of
15 cost sharing in violation of section 3(b)(1)(B).

16 (4) ACCESS TO PRIOR AUTHORIZATION.—Fail-
17 ure to provide access to prior authorization deter-
18 minations in violation of section 3(c)(1)(A).

19 (4) DEEMED APPROVAL.—Failure to pay for
20 services that are deemed to be approved under sec-
21 tion 3(c).

22 (5) EDUCATIONAL MATERIALS.—Failure to in-
23 clude educational materials as required by section
24 3(d)(1).

1 (6) USE OF 911.—Discouraging the appropriate
2 use of the 911 emergency telephone number or de-
3 nial of payment in violation of paragraph (2) or (3)
4 of section 3(d).

5 **SEC. 7. REGULATIONS.**

6 The Secretary shall issue such rules and regulations
7 as may be necessary to carry out the provisions of this
8 Act.

9 **SEC. 8. DEFINITIONS.**

10 For purposes of this Act:

11 (1) COST-SHARING.—The term “cost-sharing”
12 means any deductible, coinsurance amount,
13 copayment, or other out-of-pocket payment that an
14 enrollee is responsible for paying with respect to a
15 health care item or service covered under a health
16 plan.

17 (2) EMERGENCY DEPARTMENT.—The term
18 “emergency department” includes, with respect to a
19 hospital, a trauma center in the hospital if the cen-
20 ter—

21 (A) is designated under section 1213 of
22 the Public Health Service Act, or

23 (B) is in a State that has not made such
24 designations and is determined by the Secretary

1 to meet the standards under such section for
2 such designation.

3 (3) EMERGENCY MEDICAL CONDITION.—The
4 term “emergency medical condition” means a medi-
5 cal condition, the onset of which is sudden, that
6 manifests itself by symptoms of sufficient severity,
7 including severe pain, that a prudent layperson, who
8 possesses an average knowledge of health and medi-
9 cine, could reasonably expect the absence of imme-
10 diate medical attention to result in—

11 (A) placing the person’s health in serious
12 jeopardy,

13 (B) serious impairment to bodily functions,
14 or

15 (C) serious dysfunction of any bodily organ
16 or part.

17 (4) EMERGENCY SERVICES.—The term “emer-
18 gency services” means—

19 (A) health care items and services fur-
20 nished in the emergency department of a hos-
21 pital, and

22 (B) ancillary services routinely available to
23 such department,

1 to the extent they are required to evaluate and treat
2 an emergency medical condition (as defined in para-
3 graph (3)) until the condition is stabilized.

4 (5) ENROLLEE.—The term “enrollee” means,
5 with respect to a health plan, an individual enrolled
6 with the health plan.

7 (6) HEALTH PLAN.—

8 (A) IN GENERAL.—The term “health plan”
9 refers to any plan or arrangement (other than
10 a plan or arrangement described in subpara-
11 graph (B)) that provides, or pays the cost of,
12 health benefits, whether through insurance, re-
13 imbursement, or otherwise.

14 (B) EXCEPTION.— A plan or arrangement
15 is described in this subparagraph if it is:

16 (i) Coverage only for accidental death
17 or dismemberment.

18 (ii) Coverage providing wages or pay-
19 ments in lieu of wages for any period dur-
20 ing which the employee is absent from
21 work on account of sickness or injury.

22 (iii) A Medicare supplemental policy
23 (as defined in section 1882(g)(1) of the
24 Social Security Act).

1 (iv) Coverage issued as a supplement
2 to liability insurance.

3 (v) Worker's compensation or similar
4 insurance.

5 (vi) Automobile medical-payment in-
6 surance.

7 (vii) Coverage for a specified disease
8 or illness.

9 (viii) A long-term care policy.

10 (ix) A Federally-funded health care
11 program (except when such program con-
12 tracts with a health plan to provide items
13 and services to individuals eligible for ben-
14 efits under the program).

15 (7) MANAGED CARE PLAN.—The term “man-
16 aged care plan” means a health plan that provides
17 or arranges for the provision of health care items
18 and services to enrollees primarily through partici-
19 pating physicians and providers.

20 (8) PARTICIPATING.—The term “participating”
21 means, with respect to a physician or provider, a
22 physician or provider that furnishes health care
23 items and services to enrollees of managed care plan
24 under an agreement with the plan.

1 (9) PRIOR AUTHORIZATION DETERMINATION.—

2 The term “prior authorization determination”
3 means, with respect to health care items and serv-
4 ices for which coverage may be provided under a
5 health plan, a determination, before the provision of
6 the items and services and as a condition of coverage
7 of the items and services under the plan, that cov-
8 erage will be provided for the items and services
9 under the plan.

10 (10) SECRETARY.—The term “Secretary”
11 means the Secretary of Health and Human Services.

12 (11) STABILIZED.—The term “stabilized”
13 means, with respect to an emergency medical condi-
14 tion, that no material deterioration of the condition
15 is likely, within reasonable medical probability, to re-
16 sult or occur before an individual can be transferred
17 in compliance with the requirements of section 1867
18 of the Social Security Act.

19 (12) 911 EMERGENCY TELEPHONE NUMBER.—

20 The term “911 emergency telephone number” in-
21 cludes, in the case of a geographic area where 911
22 is not in use for emergencies, such other telephone
23 number as is in use for emergencies.

1 **SEC. 9. EFFECTIVE DATES.**

2 (a) IN GENERAL.—This Act and the amendments
3 made by this Act shall become effective on the earlier of—

4 (1) 30 days after the date the Secretary issues
5 regulations pursuant to subsection (c), or

6 (2) 210 days after the date of the enactment of
7 this Act (without regard to whether such regulations
8 have been issued by such date).

9 (b) APPLICATION.—The provisions of section 3 (other
10 than paragraphs (1) and (2) of subsection (d)) shall apply
11 to items and services furnished on or after the effective
12 date described in subsection (a).

13 (c) DEADLINE FOR REGULATIONS.—The Secretary
14 shall issue regulations to implement this Act and the
15 amendments made by this Act not later than 6 months
16 after the date of the enactment of this Act. Such regula-
17 tions may take effect on a final basis at the time of publi-
18 cation, subject to revision based on subsequent public com-
19 ment.

20 **SEC. 10. REPORT ON APPLICATION TO PLANS INCLUDING**
21 **MEDICAL SAVINGS ACCOUNTS.**

22 (a) STUDY.—The Secretary shall provide for a study
23 of the application of this Act in the case of health plans
24 composed of a high-deductible, catastrophic health insur-
25 ance policy with a medical savings account. In particular,
26 the study shall evaluate the feasibility and desirability of

1 requiring the application of amounts in such an account
2 toward costs in providing emergency services and in pro-
3 viding promptly needed items and services identified in
4 connection with the provision of emergency services.

5 (b) REPORT.—The Secretary shall submit to Con-
6 gress a report on such study not later than 18 months
7 after the date of the enactment of this Act.

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