

105TH CONGRESS
1ST SESSION

H. R. 815

To amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the Medicare and Medicaid Programs.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 1997

Mr. CARDIN (for himself, Mrs. ROUKEMA, Mr. DINGELL, Mr. SHAYS, Mr. STARK, Mr. DAVIS of Virginia, Mr. WAXMAN, Mr. CONDIT, Mr. BROWN of Ohio, Mr. KENNEDY of Rhode Island, Mr. POMEROY, Mrs. THURMAN, Mr. GEJDENSON, Mrs. MEEK of Florida, Mr. CLEMENT, Mr. DOYLE, Mr. NORWOOD, Mr. LEVIN, Mr. EVANS, Mr. McDERMOTT, Mr. FROST, Mr. CAMPBELL, Mr. CONYERS, Mr. RAHALL, Mr. MCGOVERN, and Mr. GANSKE) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, and Education and the Workforce, 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 amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and titles XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the Medicare and Medicaid Programs.

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 1997”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Amendments to the Internal Revenue Code of 1986.
- Sec. 3. Amendments to the Employee Retirement Income Security Act of 1974.
- Sec. 4. Amendments to the Public Health Service Act relating to the group market.
- Sec. 5. Amendments to the Public Health Service Act relating to the individual market.
- Sec. 6. Application to private coverage for medicare and medicaid beneficiaries.
- Sec. 7. Establishment of guidelines.

8 **SEC. 2. AMENDMENTS TO THE INTERNAL REVENUE CODE**
 9 **OF 1986.**

10 (a) **IN GENERAL.**—Subtitle K of the Internal Reve-
 11 nue Code of 1986 (as added by section 401(a) of the
 12 Health Insurance Portability and Accountability Act of
 13 1996) is amended—

14 (1) by striking all that precedes section 9801
 15 and inserting the following:

16 **“Subtitle K—Group Health Plan**
 17 **Requirements**

“CHAPTER 100. Group health plan requirements.

1 **“CHAPTER 100—GROUP HEALTH PLAN**
 2 **REQUIREMENTS**

“Subchapter A. Requirements relating to portability, access, and renewability.

“Subchapter B. Other requirements.

“Subchapter C. General provisions.

3 **“Subchapter A—Requirements Relating to**
 4 **Portability, Access, and Renewability**

“Sec. 9801. Increased portability through limitation on preexisting condition exclusions.

“Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.”,

5 (2) by redesignating sections 9804, 9805, and
 6 9806 as sections 9831, 9832, and 9833, respectively,

7 (3) by inserting before section 9831 (as so re-
 8 designated) the following:

9 **“Subchapter C—General Provisions**

“Sec. 9831. General exceptions.

“Sec. 9832. Definitions.

“Sec. 9833. Regulations.”, and

10 (4) by inserting after section 9803 the follow-
 11 ing:

12 **“Subchapter B—Other Requirements**

“Sec. 9811. Assuring equitable coverage of emergency services, maintenance care, and post-stabilization care.

1 **“SEC. 9811. ASSURING EQUITABLE COVERAGE OF EMER-**
2 **GENCY SERVICES, MAINTENANCE CARE, AND**
3 **POST-STABILIZATION CARE.**

4 “(a) PROHIBITION OF CERTAIN RESTRICTIONS ON
5 COVERAGE OF EMERGENCY SERVICES.—

6 “(1) IN GENERAL.—If a group health plan pro-
7 vides any benefits with respect to emergency services
8 (as defined in paragraph (2)(B)), the plan (and any
9 health insurance issuer offering health insurance
10 coverage in connection with such a plan) shall cover
11 emergency services furnished to a participant or ben-
12 efiary of the plan—

13 “(A) without the need for any prior au-
14 thorization determination,

15 “(B) subject to paragraph (3), whether or
16 not the physician or provider furnishing such
17 services is a participating physician or provider
18 with respect to such services, and

19 “(C) subject to paragraph (3), without re-
20 gard to any other term or condition of such
21 plan or coverage (other than an exclusion of
22 benefits, or an affiliation or waiting period, per-
23 mitted under section 9801).

24 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-
25 CAL CONDITION.—For purposes of this section—

1 “(A) EMERGENCY MEDICAL CONDITION
2 BASED ON PRUDENT LAYPERSON.—The term
3 ‘emergency medical condition’ means a medical
4 condition manifesting itself by acute symptoms
5 of sufficient severity (including severe pain)
6 such that a prudent layperson, who possesses
7 an average knowledge of health and medicine,
8 could reasonably expect the absence of imme-
9 diate medical attention to result in—

10 “(i) placing the health of the individ-
11 ual (or, with respect to a pregnant woman,
12 the health of the woman or her unborn
13 child) in serious jeopardy,

14 “(ii) serious impairment to bodily
15 functions, or

16 “(iii) serious dysfunction of any bodily
17 organ or part.

18 “(B) EMERGENCY SERVICES.—The term
19 ‘emergency services’ means—

20 “(i) a medical screening examination
21 (as required under section 1867 of the So-
22 cial Security Act) that is within the capa-
23 bility of the emergency department of a

1 hospital, including ancillary services rou-
2 tinely available to the emergency depart-
3 ment, to evaluate an emergency medical
4 condition (as defined in subparagraph
5 (A)), and

6 “(ii) within the capabilities of the
7 staff and facilities available at the hospital,
8 such further medical examination and
9 treatment as are required under section
10 1867 of the Social Security Act to stabilize
11 the patient.

12 “(C) TRAUMA AND BURN CENTERS.—The
13 provisions of clause (ii) of subparagraph (B)
14 apply to a trauma or burn center, in a hospital,
15 that—

16 “(i) is designated by the State, a re-
17 gional authority of the State, or by the
18 designee of the State, or

19 “(ii) is in a State that has not made
20 such designations and meets medically rec-
21 ognized national standards.

22 “(3) APPLICATION OF NETWORK RESTRICTION
23 PERMITTED IN CERTAIN CASES.—

24 “(A) IN GENERAL.—Except as provided in
25 subparagraph (B), if a group health plan (and

1 an issuer of health insurance coverage in con-
2 nection with such a plan) denies, limits, or oth-
3 erwise differentiates in coverage or payment for
4 benefits other than emergency services on the
5 basis that the physician or provider of such
6 services is a nonparticipating physician or pro-
7 vider, the plan and issuer may deny, limit, or
8 differentiate in coverage or payment for emer-
9 gency services on such basis.

10 “(B) NETWORK RESTRICTIONS NOT PER-
11 MITTED IN CERTAIN EXCEPTIONAL CASES.—
12 The denial or limitation of, or differentiation in,
13 coverage or payment of benefits for emergency
14 services under subparagraph (A) shall not apply
15 in the following cases:

16 “(i) CIRCUMSTANCES BEYOND CON-
17 TROL OF PARTICIPANT OR BENEFICIARY.—
18 The participant or beneficiary is unable to
19 go to a participating hospital for such serv-
20 ices due to circumstances beyond the con-
21 trol of the participant or beneficiary (as
22 determined consistent with guidelines and
23 subparagraph (C)).

24 “(ii) LIKELIHOOD OF AN ADVERSE
25 HEALTH CONSEQUENCE BASED ON

1 LAYPERSON'S JUDGMENT.—A prudent
2 layperson possessing an average knowledge
3 of health and medicine could reasonably
4 believe that, under the circumstances and
5 consistent with guidelines, the time re-
6 quired to go to a participating hospital for
7 such services could result in any of the ad-
8 verse health consequences described in a
9 clause of subsection (a)(2)(A).

10 “(iii) PHYSICIAN REFERRAL.—A par-
11 ticipating physician or other person au-
12 thorized by the plan refers the participant
13 or beneficiary to an emergency department
14 of a hospital and does not specify an emer-
15 gency department of a hospital that is a
16 participating hospital with respect to such
17 services.

18 “(C) APPLICATION OF ‘BEYOND CONTROL’
19 STANDARDS.—For purposes of applying sub-
20 paragraph (B)(i), receipt of emergency services
21 from a nonparticipating hospital shall be treat-
22 ed under the guidelines as being ‘due to cir-
23 cumstances beyond the control of the partici-
24 pant or beneficiary’ if any of the following con-
25 ditions are met:

1 “(i) UNCONSCIOUS.—The participant
2 or beneficiary was unconscious or in an
3 otherwise altered mental state at the time
4 of initiation of the services.

5 “(ii) AMBULANCE DELIVERY.—The
6 participant or beneficiary was transported
7 by an ambulance or other emergency vehi-
8 cle directed by a person other than the
9 participant or beneficiary to the non-
10 participating hospital in which the services
11 were provided.

12 “(iii) NATURAL DISASTER.—A natural
13 disaster or civil disturbance prevented the
14 participant or beneficiary from presenting
15 to a participating hospital for the provision
16 of such services.

17 “(iv) NO GOOD FAITH EFFORT TO IN-
18 FORM OF CHANGE IN PARTICIPATION DUR-
19 ING A CONTRACT YEAR.—The status of the
20 hospital changed from a participating hos-
21 pital to a nonparticipating hospital with re-
22 spect to emergency services during a con-
23 tract year and the plan or issuer failed to

1 make a good faith effort to notify the par-
2 ticipant or beneficiary involved of such
3 change.

4 “(v) OTHER CONDITIONS.—There
5 were other factors (such as those identified
6 in guidelines) that prevented the partici-
7 pant or beneficiary from controlling selec-
8 tion of the hospital in which the services
9 were provided.

10 “(b) ASSURING COORDINATED COVERAGE OF MAIN-
11 TENANCE CARE AND POST-STABILIZATION CARE.—

12 “(1) IN GENERAL.—In the case of a participant
13 or beneficiary who is covered under a group health
14 plan (or under health insurance coverage issued by
15 a health insurance issuer offered in connection with
16 such a plan) and who has received emergency serv-
17 ices pursuant to a screening evaluation conducted
18 (or supervised) by a treating physician at a hospital
19 that is a nonparticipating provider with respect to
20 emergency services, if—

21 “(A) pursuant to such evaluation, the phy-
22 sician identifies post-stabilization care (as de-
23 fined in paragraph (3)(B)) that is required by
24 the participant or beneficiary,

1 “(B) the plan or coverage provides benefits
2 with respect to the care so identified and the
3 plan requires (but for this subsection) an af-
4 firmative prior authorization determination as a
5 condition of coverage of such care, and

6 “(C) the treating physician (or another in-
7 dividual acting on behalf of such physician) ini-
8 tiates, not later than 30 minutes after the time
9 the treating physician determines that the con-
10 dition of the participant or beneficiary is sta-
11 bilized, a good faith effort to contact a physi-
12 cian or other person authorized by the plan or
13 issuer (by telephone or other means) to obtain
14 an affirmative prior authorization determination
15 with respect to the care,

16 then, without regard to terms and conditions speci-
17 fied in paragraph (2) the plan or issuer shall cover
18 maintenance care (as defined in paragraph (3)(A))
19 furnished to the participant or beneficiary during
20 the period specified in paragraph (4) and shall cover
21 post-stabilization care furnished to the participant or
22 beneficiary during the period beginning under para-
23 graph (5) and ending under paragraph (6).

1 “(2) TERMS AND CONDITIONS WAIVED.—The
2 terms and conditions (of a plan or coverage) de-
3 scribed in this paragraph that are waived under
4 paragraph (1) are as follows:

5 “(A) The need for any prior authorization
6 determination.

7 “(B) Any limitation on coverage based on
8 whether or not the physician or provider fur-
9 nishing the care is a participating physician or
10 provider with respect to such care.

11 “(C) Any other term or condition of the
12 plan or coverage (other than an exclusion of
13 benefits, or an affiliation or waiting period, per-
14 mitted under section 9801 and other than a re-
15 quirement relating to medical necessity for cov-
16 erage of benefits).

17 “(3) MAINTENANCE CARE AND POST-STA-
18 BILIZATION CARE DEFINED.—In this subsection:

19 “(A) MAINTENANCE CARE.—The term
20 ‘maintenance care’ means, with respect to an
21 individual who is stabilized after provision of
22 emergency services, medically necessary items
23 and services (other than emergency services)
24 that are required by the individual to ensure

1 that the individual remains stabilized during
2 the period described in paragraph (4).

3 “(B) POST-STABILIZATION CARE.—The
4 term ‘post-stabilization care’ means, with re-
5 spect to an individual who is determined to be
6 stable pursuant to a medical screening examina-
7 tion or who is stabilized after provision of emer-
8 gency services, medically necessary items and
9 services (other than emergency services and
10 other than maintenance care) that are required
11 by the individual.

12 “(4) PERIOD OF REQUIRED COVERAGE OF
13 MAINTENANCE CARE.—The period of required cov-
14 erage of maintenance care of an individual under
15 this subsection begins at the time of the request (or
16 the initiation of the good faith effort to make the
17 request) under paragraph (1)(C) and ends when—

18 “(A) the individual is discharged from the
19 hospital;

20 “(B) a physician (designated by the plan
21 or issuer involved) and with privileges at the
22 hospital involved arrives at the emergency de-
23 partment of the hospital and assumes respon-
24 sibility with respect to the treatment of the in-
25 dividual; or

1 “(C) the treating physician and the plan or
2 issuer agree to another arrangement with re-
3 spect to the care of the individual.

4 “(5) WHEN POST-STABILIZATION CARE RE-
5 QUIRED TO BE COVERED.—

6 “(A) WHEN TREATING PHYSICIAN UNABLE
7 TO COMMUNICATE REQUEST.—If the treating
8 physician or other individual makes the good
9 faith effort to request authorization under para-
10 graph (1)(C) but is unable to communicate the
11 request directly with an authorized person re-
12 ferred to in such paragraph within 30 minutes
13 after the time of initiating such effort, then
14 post-stabilization care is required to be covered
15 under this subsection beginning at the end of
16 such 30-minute period.

17 “(B) WHEN ABLE TO COMMUNICATE RE-
18 QUEST, AND NO TIMELY RESPONSE.—

19 “(i) IN GENERAL.—If the treating
20 physician or other individual under para-
21 graph (1)(C) is able to communicate the
22 request within the 30-minute period de-
23 scribed in subparagraph (A), the post-sta-
24 bilization care requested is required to be
25 covered under this subsection beginning 30

1 minutes after the time when the plan or is-
2 suer receives the request unless a person
3 authorized by the plan or issuer involved
4 communicates (or makes a good faith ef-
5 fort to communicate) a denial of the re-
6 quest for the prior authorization deter-
7 mination within 30 minutes of the time
8 when the plan or issuer receives the re-
9 quest and the treating physician does not
10 request under clause (ii) to communicate
11 directly with an authorized physician con-
12 cerning the denial.

13 “(ii) REQUEST FOR DIRECT PHYSI-
14 CIAN-TO-PHYSICIAN COMMUNICATION CON-
15 CERNING DENIAL.—If a denial of a request
16 is communicated under clause (i), the
17 treating physician may request to commu-
18 nicate respecting the denial directly with a
19 physician who is authorized by the plan or
20 issuer to deny or affirm such a denial.

1 “(C) WHEN NO TIMELY RESPONSE TO RE-
2 QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-
3 NICATION.—If a request for physician-to-physi-
4 cian communication is made under subpara-
5 graph (B)(ii), the post-stabilization care re-
6 quested is required to be covered under this
7 subsection beginning 30 minutes after the time
8 when the plan or issuer receives the request
9 from a treating physician unless a physician,
10 who is authorized by the plan or issuer to re-
11 verse or affirm the initial denial of the care,
12 communicates (or makes a good faith effort to
13 communicate) directly with the treating physi-
14 cian within such 30-minute period.

15 “(D) DISAGREEMENTS OVER POST-STA-
16 BILIZATION CARE.—If, after a direct physician-
17 to-physician communication under subpara-
18 graph (C), the denial of the request for the
19 post-stabilization care is not reversed and the
20 treating physician communicates to the plan or
21 issuer involved a disagreement with such deci-
22 sion, the post-stabilization care requested is re-
23 quired to be covered under this subsection be-
24 ginning as follows:

1 “(i) DELAY TO ALLOW FOR PROMPT
2 ARRIVAL OF PHYSICIAN ASSUMING RE-
3 SPONSIBILITY.—If the plan or issuer com-
4 municates that a physician (designated by
5 the plan or issuer) with privileges at the
6 hospital involved will arrive promptly (as
7 determined under guidelines) at the emer-
8 gency department of the hospital in order
9 to assume responsibility with respect to the
10 treatment of the participant or beneficiary
11 involved, the required coverage of the post-
12 stabilization care begins after the passage
13 of such time period as would allow the
14 prompt arrival of such a physician.

15 “(ii) OTHER CASES.—If the plan or
16 issuer does not so communicate, the re-
17 quired coverage of the post-stabilization
18 care begins immediately.

19 “(6) NO REQUIREMENT OF COVERAGE OF POST-
20 STABILIZATION CARE IF ALTERNATE PLAN OF
21 TREATMENT.—

22 “(A) IN GENERAL.—Coverage of post-sta-
23 bilization care is not required under this sub-
24 section with respect to an individual when—

1 “(i) subject to subparagraph (B), a
2 physician (designated by the plan or issuer
3 involved) and with privileges at the hos-
4 pital involved arrives at the emergency de-
5 partment of the hospital and assumes re-
6 sponsibility with respect to the treatment
7 of the individual; or

8 “(ii) the treating physician and the
9 plan or issuer agree to another arrange-
10 ment with respect to the post-stabilization
11 care (such as an appropriate transfer of
12 the individual involved to another facility
13 or an appointment for timely followup
14 treatment for the individual).

15 “(B) SPECIAL RULE WHERE ONCE CARE
16 INITIATED.—Required coverage of requested
17 post-stabilization care shall not end by reason
18 of subparagraph (A)(i) during an episode of
19 care (as determined by guidelines) if the treat-
20 ing physician initiated such care (consistent
21 with a previous paragraph) before the arrival of
22 a physician described in such subparagraph.

23 “(7) CONSTRUCTION.—Nothing in this sub-
24 section shall be construed as—

1 “(A) preventing a plan or issuer from au-
2 thorizing coverage of maintenance care or post-
3 stabilization care in advance or at any time; or

4 “(B) preventing a treating physician or
5 other individual described in paragraph (1)(C)
6 and a plan or issuer from agreeing to modify
7 any of the time periods specified in paragraph
8 (5) as it relates to cases involving such persons.

9 “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-
10 NISHED IN EMERGENCY DEPARTMENTS.—If a group
11 health plan provides any benefits with respect to emer-
12 gency services, the plan (or a health insurance issuer offer-
13 ing health insurance coverage in connection with such a
14 plan) may impose cost sharing with respect to such serv-
15 ices only if the following conditions are met:

16 “(1) LIMITATIONS ON COST-SHARING DIF-
17 FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

18 “(A) NO DIFFERENTIAL FOR CERTAIN
19 SERVICES.—In the case of services furnished
20 under the circumstances described in clause (i),
21 (ii), or (iii) of subsection (a)(3)(B) (relating to
22 circumstances beyond the control of the bene-
23 ficiary, the likelihood of an adverse health con-
24 sequence based on layperson’s judgment, and
25 physician referral), the cost-sharing for such

1 services provided by a nonparticipating provider
2 or physician does not exceed the cost-sharing
3 for such services provided by a participating
4 provider or physician.

5 “(B) ONLY REASONABLE DIFFERENTIAL
6 FOR OTHER SERVICES.—In the case of other
7 emergency services, any differential by which
8 the cost-sharing for such services provided by a
9 nonparticipating provider or physician exceeds
10 the cost-sharing for such services provided by a
11 participating provider or physician is reasonable
12 (as determined under guidelines).

13 “(2) ONLY REASONABLE DIFFERENTIAL BE-
14 TWEEN EMERGENCY SERVICES AND OTHER SERV-
15 ICES.—Any differential by which the cost-sharing for
16 services furnished in an emergency department ex-
17 ceeds the cost-sharing for such services furnished in
18 another setting is reasonable (as determined under
19 guidelines).

20 “(3) CONSTRUCTION.—Nothing in paragraph
21 (1)(B) or (2) shall be construed as authorizing
22 guidelines other than guidelines that establish maxi-
23 mum cost-sharing differentials.

24 “(d) INFORMATION ON ACCESS TO EMERGENCY
25 SERVICES.—A group health plan (or a health insurance

1 issuer, to the extent a health insurance issuer offers group
2 health insurance coverage in connection with such a plan)
3 shall provide education to participants and beneficiaries
4 of the plan on—

5 “(1) coverage of emergency services (as defined
6 in subsection (a)(2)(B)) by the plan in accordance
7 with the provisions of this section,

8 “(2) the appropriate use of emergency services,
9 including use of the 911 telephone system or its
10 local equivalent,

11 “(3) any cost sharing applicable to emergency
12 services,

13 “(4) the process and procedures of the plan for
14 obtaining emergency services, and

15 “(5) the locations of—

16 “(A) emergency departments, and

17 “(B) other settings,

18 in which participating physicians and hospitals pro-
19 vide emergency services and post-stabilization care.

20 “(e) GENERAL DEFINITIONS.—For purposes of this
21 section:

22 “(1) COST SHARING.—The term ‘cost sharing’
23 means any deductible, coinsurance amount, copay-
24 ment or other out-of-pocket payment (other than
25 premiums or enrollment fees) that a group health

1 plan (or a health insurance issuer offering group
2 health insurance issuer in connection with such a
3 plan) imposes on participants and beneficiaries of
4 the plan with respect to the coverage of benefits.

5 “(2) GOOD FAITH EFFORT.—The term ‘good
6 faith effort’ has the meaning given such term in
7 guidelines and requires such appropriate documenta-
8 tion as is specified under such guidelines.

9 “(3) GUIDELINES.—The term ‘guidelines’
10 means guidelines established in accordance with sec-
11 tion 7 of the Access to Emergency Medical Services
12 Act of 1997.

13 “(4) NONPARTICIPATING PHYSICIAN OR PRO-
14 VIDER.—The term ‘nonparticipating physician or
15 provider’ means, with respect to health care items
16 and services furnished to a participant or beneficiary
17 of a group health plan, a physician or provider that
18 is not a participating physician or provider for such
19 services.

20 “(5) PARTICIPATING PHYSICIAN OR PRO-
21 VIDER.—The term ‘participating physician or pro-
22 vider’ means, with respect to health care items and
23 services furnished to a participant or beneficiary of
24 a group health plan, a physician or provider that
25 furnishes such items and services under a contract

1 or other arrangement with such plan (or with a
2 health insurance issuer offering group health insur-
3 ance coverage in connection with such a plan).

4 “(6) PRIOR AUTHORIZATION DETERMINA-
5 TION.—The term ‘prior authorization determination’
6 means, with respect to items and services for which
7 coverage may be provided under a group health plan,
8 a determination (before the provision of the items
9 and services and as a condition of coverage of the
10 items and services under the plan) of whether or not
11 such items and services will be covered under the
12 plan.

13 “(7) STABILIZE.—The term ‘to stabilize’
14 means, with respect to an emergency medical condi-
15 tion, to provide (in complying with section 1867 of
16 the Social Security Act) such medical treatment of
17 the condition as may be necessary to assure, within
18 reasonable medical probability, that no material de-
19 terioration of the condition is likely to result from
20 or occur during the transfer of the individual from
21 the facility.

22 “(8) STABILIZED.—The term ‘stabilized’
23 means, with respect to an emergency medical condi-
24 tion, that no material deterioration of the condition

1 is likely, within reasonable medical probability, to re-
2 sult from or occur before an individual can be trans-
3 ferred from the facility, in compliance with the re-
4 quirements of section 1867 of the Social Security
5 Act.

6 “(9) TREATING PHYSICIAN.—The term ‘treat-
7 ing physician’ includes a treating health care profes-
8 sional who is licensed under State law to provide
9 emergency services other than under the supervision
10 of a physician.”

11 (b) CONFORMING AMENDMENTS.—

12 (1) Chapter 100 of such Code (as added by sec-
13 tion 401 of the Health Insurance Portability and Ac-
14 countability Act of 1996 and as previously amended
15 by this section) is further amended—

16 (A) in the last sentence of section
17 9801(c)(1), by striking “section 9805(c)” and
18 inserting “section 9832(c)”;

19 (B) in section 9831(b), by striking
20 “9805(c)(1)” and inserting “9832(c)(1)”;

21 (C) in section 9831(c)(1), by striking
22 “9805(c)(2)” and inserting “9832(c)(2)”;

23 (D) in section 9831(c)(2), by striking
24 “9805(c)(3)” and inserting “9832(c)(3)”; and

1 (E) in section 9831(c)(3), by striking
2 “9805(c)(4)” and inserting “9832(c)(4)”.

3 (2) Section 4980D of such Code (as added by
4 section 402 of the Health Insurance Portability and
5 Accountability Act of 1996) is amended—

6 (A) in subsection (c)(3)(B)(i)(I), by strik-
7 ing “9805(d)(3)” and inserting “9832(d)(3)”;

8 (B) in subsection (d)(1), by inserting
9 “(other than a failure attributable to section
10 9811)” after “on any failure”;

11 (C) in subsection (d)(3), by striking
12 “9805” and inserting “9832”;

13 (D) in subsection (f)(1), by striking
14 “9805(a)” and inserting “9832(a)”.

15 (3) The table of subtitles for such Code is
16 amended by striking the item relating to subtitle K
17 (as added by section 401(b) of the Health Insurance
18 Portability and Accountability Act of 1996) and in-
19 serting the following new item:

“SUBTITLE K. Group health plan requirements.”

20 (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),
21 the amendments made by this section shall apply to group
22 health plans for plan years beginning on or after 18
23 months after the date of the enactment of this Act.

24 (2) In the case of a group health plan maintained
25 pursuant to 1 or more collective bargaining agreements

1 between employee representatives and 1 or more employ-
2 ers ratified before the date of enactment of this Act, the
3 amendments made by this section shall not apply to plan
4 years beginning before the later of—

5 (A) the date on which the last collective bar-
6 gaining agreements relating to the plan terminates
7 (determined without regard to any extension thereof
8 agreed to after the date of enactment of this Act),
9 or

10 (B) 18 months after the date of the enactment
11 of this Act.

12 For purposes of subparagraph (A), any plan amendment
13 made pursuant to a collective bargaining agreement relat-
14 ing to the plan which amends the plan solely to conform
15 to any requirement added by this section shall not be
16 treated as a termination of such collective bargaining
17 agreement.

18 **SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**

19 **COME SECURITY ACT OF 1974.**

20 (a) IN GENERAL.—Subpart B of part 7 of subtitle
21 B of title I of the Employee Retirement Income Security
22 Act of 1974 is amended by adding at the end the following
23 new section:

1 **“SEC. 713. ASSURING EQUITABLE COVERAGE OF EMER-**
2 **GENCY SERVICES, MAINTENANCE CARE, AND**
3 **POST-STABILIZATION CARE.**

4 “(a) PROHIBITION OF CERTAIN RESTRICTIONS ON
5 COVERAGE OF EMERGENCY SERVICES.—

6 “(1) IN GENERAL.—If a group health plan pro-
7 vides any benefits with respect to emergency services
8 (as defined in paragraph (2)(B)), the plan (and any
9 health insurance issuer offering health insurance
10 coverage in connection with such a plan) shall cover
11 emergency services furnished to a participant or ben-
12 efiary of the plan—

13 “(A) without the need for any prior au-
14 thorization determination,

15 “(B) subject to paragraph (3), whether or
16 not the physician or provider furnishing such
17 services is a participating physician or provider
18 with respect to such services, and

19 “(C) subject to paragraph (3), without re-
20 gard to any other term or condition of such
21 plan or coverage (other than an exclusion of
22 benefits, or an affiliation or waiting period, per-
23 mitted under section 701).

24 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-
25 CAL CONDITION.—For purposes of this section—

1 “(A) EMERGENCY MEDICAL CONDITION
2 BASED ON PRUDENT LAYPERSON.—The term
3 ‘emergency medical condition’ means a medical
4 condition manifesting itself by acute symptoms
5 of sufficient severity (including severe pain)
6 such that a prudent layperson, who possesses
7 an average knowledge of health and medicine,
8 could reasonably expect the absence of imme-
9 diate medical attention to result in—

10 “(i) placing the health of the individ-
11 ual (or, with respect to a pregnant woman,
12 the health of the woman or her unborn
13 child) in serious jeopardy,

14 “(ii) serious impairment to bodily
15 functions, or

16 “(iii) serious dysfunction of any bodily
17 organ or part.

18 “(B) EMERGENCY SERVICES.—The term
19 ‘emergency services’ means—

20 “(i) a medical screening examination
21 (as required under section 1867 of the So-
22 cial Security Act) that is within the capa-
23 bility of the emergency department of a

1 hospital, including ancillary services rou-
2 tinely available to the emergency depart-
3 ment, to evaluate an emergency medical
4 condition (as defined in subparagraph
5 (A)), and

6 “(ii) within the capabilities of the
7 staff and facilities available at the hospital,
8 such further medical examination and
9 treatment as are required under section
10 1867 of the Social Security Act to stabilize
11 the patient.

12 “(C) TRAUMA AND BURN CENTERS.—The
13 provisions of clause (ii) of subparagraph (B)
14 apply to a trauma or burn center, in a hospital,
15 that—

16 “(i) is designated by the State, a re-
17 gional authority of the State, or by the
18 designee of the State, or

19 “(ii) is in a State that has not made
20 such designations and meets medically rec-
21 ognized national standards.

22 “(3) APPLICATION OF NETWORK RESTRICTION
23 PERMITTED IN CERTAIN CASES.—

24 “(A) IN GENERAL.—Except as provided in
25 subparagraph (B), if a group health plan (and

1 an issuer of health insurance coverage in con-
2 nection with such a plan) denies, limits, or oth-
3 erwise differentiates in coverage or payment for
4 benefits other than emergency services on the
5 basis that the physician or provider of such
6 services is a nonparticipating physician or pro-
7 vider, the plan and issuer may deny, limit, or
8 differentiate in coverage or payment for emer-
9 gency services on such basis.

10 “(B) NETWORK RESTRICTIONS NOT PER-
11 MITTED IN CERTAIN EXCEPTIONAL CASES.—
12 The denial or limitation of, or differentiation in,
13 coverage or payment of benefits for emergency
14 services under subparagraph (A) shall not apply
15 in the following cases:

16 “(i) CIRCUMSTANCES BEYOND CON-
17 TROL OF PARTICIPANT OR BENEFICIARY.—
18 The participant or beneficiary is unable to
19 go to a participating hospital for such serv-
20 ices due to circumstances beyond the con-
21 trol of the participant or beneficiary (as
22 determined consistent with guidelines and
23 subparagraph (C)).

24 “(ii) LIKELIHOOD OF AN ADVERSE
25 HEALTH CONSEQUENCE BASED ON

1 LAYPERSON’S JUDGMENT.—A prudent
2 layperson possessing an average knowledge
3 of health and medicine could reasonably
4 believe that, under the circumstances and
5 consistent with guidelines, the time re-
6 quired to go to a participating hospital for
7 such services could result in any of the ad-
8 verse health consequences described in a
9 clause of subsection (a)(2)(A).

10 “(iii) PHYSICIAN REFERRAL.—A par-
11 ticipating physician or other person au-
12 thorized by the plan refers the participant
13 or beneficiary to an emergency department
14 of a hospital and does not specify an emer-
15 gency department of a hospital that is a
16 participating hospital with respect to such
17 services.

18 “(C) APPLICATION OF ‘BEYOND CONTROL’
19 STANDARDS.—For purposes of applying sub-
20 paragraph (B)(i), receipt of emergency services
21 from a nonparticipating hospital shall be treat-
22 ed under the guidelines as being ‘due to cir-
23 cumstances beyond the control of the partici-
24 pant or beneficiary’ if any of the following con-
25 ditions are met:

1 “(i) UNCONSCIOUS.—The participant
2 or beneficiary was unconscious or in an
3 otherwise altered mental state at the time
4 of initiation of the services.

5 “(ii) AMBULANCE DELIVERY.—The
6 participant or beneficiary was transported
7 by an ambulance or other emergency vehi-
8 cle directed by a person other than the
9 participant or beneficiary to the non-
10 participating hospital in which the services
11 were provided.

12 “(iii) NATURAL DISASTER.—A natural
13 disaster or civil disturbance prevented the
14 participant or beneficiary from presenting
15 to a participating hospital for the provision
16 of such services.

17 “(iv) NO GOOD FAITH EFFORT TO IN-
18 FORM OF CHANGE IN PARTICIPATION DUR-
19 ING A CONTRACT YEAR.—The status of the
20 hospital changed from a participating hos-
21 pital to a nonparticipating hospital with re-
22 spect to emergency services during a con-
23 tract year and the plan or issuer failed to

1 make a good faith effort to notify the par-
2 ticipant or beneficiary involved of such
3 change.

4 “(v) OTHER CONDITIONS.—There
5 were other factors (such as those identified
6 in guidelines) that prevented the partici-
7 pant or beneficiary from controlling selec-
8 tion of the hospital in which the services
9 were provided.

10 “(b) ASSURING COORDINATED COVERAGE OF MAIN-
11 TENANCE CARE AND POST-STABILIZATION CARE.—

12 “(1) IN GENERAL.—In the case of a participant
13 or beneficiary who is covered under a group health
14 plan (or under health insurance coverage issued by
15 a health insurance issuer offered in connection with
16 such a plan) and who has received emergency serv-
17 ices pursuant to a screening evaluation conducted
18 (or supervised) by a treating physician at a hospital
19 that is a nonparticipating provider with respect to
20 emergency services, if—

21 “(A) pursuant to such evaluation, the phy-
22 sician identifies post-stabilization care (as de-
23 fined in paragraph (3)(B)) that is required by
24 the participant or beneficiary,

1 “(B) the plan or coverage provides benefits
2 with respect to the care so identified and the
3 plan requires (but for this subsection) an af-
4 firmative prior authorization determination as a
5 condition of coverage of such care, and

6 “(C) the treating physician (or another in-
7 dividual acting on behalf of such physician) ini-
8 tiates, not later than 30 minutes after the time
9 the treating physician determines that the con-
10 dition of the participant or beneficiary is sta-
11 bilized, a good faith effort to contact a physi-
12 cian or other person authorized by the plan or
13 issuer (by telephone or other means) to obtain
14 an affirmative prior authorization determination
15 with respect to the care,

16 then, without regard to terms and conditions speci-
17 fied in paragraph (2) the plan or issuer shall cover
18 maintenance care (as defined in paragraph (3)(A))
19 furnished to the participant or beneficiary during
20 the period specified in paragraph (4) and shall cover
21 post-stabilization care furnished to the participant or
22 beneficiary during the period beginning under para-
23 graph (5) and ending under paragraph (6).

1 “(2) TERMS AND CONDITIONS WAIVED.—The
2 terms and conditions (of a plan or coverage) de-
3 scribed in this paragraph that are waived under
4 paragraph (1) are as follows:

5 “(A) The need for any prior authorization
6 determination.

7 “(B) Any limitation on coverage based on
8 whether or not the physician or provider fur-
9 nishing the care is a participating physician or
10 provider with respect to such care.

11 “(C) Any other term or condition of the
12 plan or coverage (other than an exclusion of
13 benefits, or an affiliation or waiting period, per-
14 mitted under section 701 and other than a re-
15 quirement relating to medical necessity for cov-
16 erage of benefits).

17 “(3) MAINTENANCE CARE AND POST-STA-
18 BILIZATION CARE DEFINED.—In this subsection:

19 “(A) MAINTENANCE CARE.—The term
20 ‘maintenance care’ means, with respect to an
21 individual who is stabilized after provision of
22 emergency services, medically necessary items
23 and services (other than emergency services)
24 that are required by the individual to ensure

1 that the individual remains stabilized during
2 the period described in paragraph (4).

3 “(B) POST-STABILIZATION CARE.—The
4 term ‘post-stabilization care’ means, with re-
5 spect to an individual who is determined to be
6 stable pursuant to a medical screening examina-
7 tion or who is stabilized after provision of emer-
8 gency services, medically necessary items and
9 services (other than emergency services and
10 other than maintenance care) that are required
11 by the individual.

12 “(4) PERIOD OF REQUIRED COVERAGE OF
13 MAINTENANCE CARE.—The period of required cov-
14 erage of maintenance care of an individual under
15 this subsection begins at the time of the request (or
16 the initiation of the good faith effort to make the re-
17 quest) under paragraph (1)(C) and ends when—

18 “(A) the individual is discharged from the
19 hospital;

20 “(B) a physician (designated by the plan
21 or issuer involved) and with privileges at the
22 hospital involved arrives at the emergency de-
23 partment of the hospital and assumes respon-
24 sibility with respect to the treatment of the in-
25 dividual; or

1 “(C) the treating physician and the plan or
2 issuer agree to another arrangement with re-
3 spect to the care of the individual.

4 “(5) WHEN POST-STABILIZATION CARE RE-
5 QUIRED TO BE COVERED.—

6 “(A) WHEN TREATING PHYSICIAN UNABLE
7 TO COMMUNICATE REQUEST.—If the treating
8 physician or other individual makes the good
9 faith effort to request authorization under para-
10 graph (1)(C) but is unable to communicate the
11 request directly with an authorized person re-
12 ferred to in such paragraph within 30 minutes
13 after the time of initiating such effort, then
14 post-stabilization care is required to be covered
15 under this subsection beginning at the end of
16 such 30-minute period.

17 “(B) WHEN ABLE TO COMMUNICATE RE-
18 QUEST, AND NO TIMELY RESPONSE.—

19 “(i) IN GENERAL.—If the treating
20 physician or other individual under para-
21 graph (1)(C) is able to communicate the
22 request within the 30-minute period de-
23 scribed in subparagraph (A), the post-sta-
24 bilization care requested is required to be
25 covered under this subsection beginning 30

1 minutes after the time when the plan or is-
2 suer receives the request unless a person
3 authorized by the plan or issuer involved
4 communicates (or makes a good faith ef-
5 fort to communicate) a denial of the re-
6 quest for the prior authorization deter-
7 mination within 30 minutes of the time
8 when the plan or issuer receives the re-
9 quest and the treating physician does not
10 request under clause (ii) to communicate
11 directly with an authorized physician con-
12 cerning the denial.

13 “(ii) REQUEST FOR DIRECT PHYSI-
14 CIAN-TO-PHYSICIAN COMMUNICATION CON-
15 CERNING DENIAL.—If a denial of a request
16 is communicated under clause (i), the
17 treating physician may request to commu-
18 nicate respecting the denial directly with a
19 physician who is authorized by the plan or
20 issuer to deny or affirm such a denial.

1 “(C) WHEN NO TIMELY RESPONSE TO RE-
2 QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-
3 NICATION.—If a request for physician-to-physi-
4 cian communication is made under subpara-
5 graph (B)(ii), the post-stabilization care re-
6 quested is required to be covered under this
7 subsection beginning 30 minutes after the time
8 when the plan or issuer receives the request
9 from a treating physician unless a physician,
10 who is authorized by the plan or issuer to re-
11 verse or affirm the initial denial of the care,
12 communicates (or makes a good faith effort to
13 communicate) directly with the treating physi-
14 cian within such 30-minute period.

15 “(D) DISAGREEMENTS OVER POST-STA-
16 BILIZATION CARE.—If, after a direct physician-
17 to-physician communication under subpara-
18 graph (C), the denial of the request for the
19 post-stabilization care is not reversed and the
20 treating physician communicates to the plan or
21 issuer involved a disagreement with such deci-
22 sion, the post-stabilization care requested is re-
23 quired to be covered under this subsection be-
24 ginning as follows:

1 “(i) DELAY TO ALLOW FOR PROMPT
2 ARRIVAL OF PHYSICIAN ASSUMING RE-
3 SPONSIBILITY.—If the plan or issuer com-
4 municates that a physician (designated by
5 the plan or issuer) with privileges at the
6 hospital involved will arrive promptly (as
7 determined under guidelines) at the emer-
8 gency department of the hospital in order
9 to assume responsibility with respect to the
10 treatment of the participant or beneficiary
11 involved, the required coverage of the post-
12 stabilization care begins after the passage
13 of such time period as would allow the
14 prompt arrival of such a physician.

15 “(ii) OTHER CASES.—If the plan or
16 issuer does not so communicate, the re-
17 quired coverage of the post-stabilization
18 care begins immediately.

19 “(6) NO REQUIREMENT OF COVERAGE OF POST-
20 STABILIZATION CARE IF ALTERNATE PLAN OF
21 TREATMENT.—

22 “(A) IN GENERAL.—Coverage of post-sta-
23 bilization care is not required under this sub-
24 section with respect to an individual when—

1 “(i) subject to subparagraph (B), a
2 physician (designated by the plan or issuer
3 involved) and with privileges at the hos-
4 pital involved arrives at the emergency de-
5 partment of the hospital and assumes re-
6 sponsibility with respect to the treatment
7 of the individual; or

8 “(ii) the treating physician and the
9 plan or issuer agree to another arrange-
10 ment with respect to the post-stabilization
11 care (such as an appropriate transfer of
12 the individual involved to another facility
13 or an appointment for timely followup
14 treatment for the individual).

15 “(B) SPECIAL RULE WHERE ONCE CARE
16 INITIATED.—Required coverage of requested
17 post-stabilization care shall not end by reason
18 of subparagraph (A)(i) during an episode of
19 care (as determined by guidelines) if the treat-
20 ing physician initiated such care (consistent
21 with a previous paragraph) before the arrival of
22 a physician described in such subparagraph.

23 “(7) CONSTRUCTION.—Nothing in this sub-
24 section shall be construed as—

1 “(A) preventing a plan or issuer from au-
2 thorizing coverage of maintenance care or post-
3 stabilization care in advance or at any time; or

4 “(B) preventing a treating physician or
5 other individual described in paragraph (1)(C)
6 and a plan or issuer from agreeing to modify
7 any of the time periods specified in paragraph
8 (5) as it relates to cases involving such persons.

9 “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-
10 NISHED IN EMERGENCY DEPARTMENTS.—If a group
11 health plan provides any benefits with respect to emer-
12 gency services, the plan (or a health insurance issuer offer-
13 ing health insurance coverage in connection with such a
14 plan) may impose cost sharing with respect to such serv-
15 ices only if the following conditions are met:

16 “(1) LIMITATIONS ON COST-SHARING DIF-
17 FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

18 “(A) NO DIFFERENTIAL FOR CERTAIN
19 SERVICES.—In the case of services furnished
20 under the circumstances described in clause (i),
21 (ii), or (iii) of subsection (a)(3)(B) (relating to
22 circumstances beyond the control of the bene-
23 ficiary, the likelihood of an adverse health con-
24 sequence based on layperson’s judgment, and
25 physician referral), the cost-sharing for such

1 services provided by a nonparticipating provider
2 or physician does not exceed the cost-sharing
3 for such services provided by a participating
4 provider or physician.

5 “(B) ONLY REASONABLE DIFFERENTIAL
6 FOR OTHER SERVICES.—In the case of other
7 emergency services, any differential by which
8 the cost-sharing for such services provided by a
9 nonparticipating provider or physician exceeds
10 the cost-sharing for such services provided by a
11 participating provider or physician is reasonable
12 (as determined under guidelines).

13 “(2) ONLY REASONABLE DIFFERENTIAL BE-
14 TWEEN EMERGENCY SERVICES AND OTHER SERV-
15 ICES.—Any differential by which the cost-sharing for
16 services furnished in an emergency department ex-
17 ceeds the cost-sharing for such services furnished in
18 another setting is reasonable (as determined under
19 guidelines).

20 “(3) CONSTRUCTION.—Nothing in paragraph
21 (1)(B) or (2) shall be construed as authorizing
22 guidelines other than guidelines that establish maxi-
23 mum cost-sharing differentials.

24 “(d) INFORMATION ON ACCESS TO EMERGENCY
25 SERVICES.—A group health plan (or a health insurance

1 issuer, to the extent a health insurance issuer offers group
2 health insurance coverage in connection with such a plan)
3 shall provide education to participants and beneficiaries
4 of the plan on—

5 “(1) coverage of emergency services (as defined
6 in subsection (a)(2)(B)) by the plan in accordance
7 with the provisions of this section,

8 “(2) the appropriate use of emergency services,
9 including use of the 911 telephone system or its
10 local equivalent,

11 “(3) any cost sharing applicable to emergency
12 services,

13 “(4) the process and procedures of the plan for
14 obtaining emergency services, and

15 “(5) the locations of—

16 “(A) emergency departments, and

17 “(B) other settings,

18 in which participating physicians and hospitals pro-
19 vide emergency services and post-stabilization care.

20 “(e) GENERAL DEFINITIONS.—For purposes of this
21 section:

22 “(1) COST SHARING.—The term ‘cost sharing’
23 means any deductible, coinsurance amount, copay-
24 ment or other out-of-pocket payment (other than
25 premiums or enrollment fees) that a group health

1 plan (or a health insurance issuer offering group
2 health insurance issuer in connection with such a
3 plan) imposes on participants and beneficiaries of
4 the plan with respect to the coverage of benefits.

5 “(2) GOOD FAITH EFFORT.—The term ‘good
6 faith effort’ has the meaning given such term in
7 guidelines and requires such appropriate documenta-
8 tion as is specified under such guidelines.

9 “(3) GUIDELINES.—The term ‘guidelines’
10 means guidelines established in accordance with sec-
11 tion 7 of the Access to Emergency Medical Services
12 Act of 1997.

13 “(4) NONPARTICIPATING PHYSICIAN OR PRO-
14 VIDER.—The term ‘nonparticipating physician or
15 provider’ means, with respect to health care items
16 and services furnished to a participant or beneficiary
17 of a group health plan, a physician or provider that
18 is not a participating physician or provider for such
19 services.

20 “(5) PARTICIPATING PHYSICIAN OR PRO-
21 VIDER.—The term ‘participating physician or pro-
22 vider’ means, with respect to health care items and
23 services furnished to a participant or beneficiary of
24 a group health plan, a physician or provider that
25 furnishes such items and services under a contract

1 or other arrangement with such plan (or with a
2 health insurance issuer offering group health insur-
3 ance coverage in connection with such a plan).

4 “(6) PRIOR AUTHORIZATION DETERMINA-
5 TION.—The term ‘prior authorization determination’
6 means, with respect to items and services for which
7 coverage may be provided under a group health plan,
8 a determination (before the provision of the items
9 and services and as a condition of coverage of the
10 items and services under the plan) of whether or not
11 such items and services will be covered under the
12 plan.

13 “(7) STABILIZE.—The term ‘to stabilize’
14 means, with respect to an emergency medical condi-
15 tion, to provide (in complying with section 1867 of
16 the Social Security Act) such medical treatment of
17 the condition as may be necessary to assure, within
18 reasonable medical probability, that no material de-
19 terioration of the condition is likely to result from or
20 occur during the transfer of the individual from the
21 facility.

22 “(8) STABILIZED.—The term ‘stabilized’
23 means, with respect to an emergency medical condi-
24 tion, that no material deterioration of the condition

1 is likely, within reasonable medical probability, to re-
2 sult from or occur before an individual can be trans-
3 ferred from the facility, in compliance with the re-
4 quirements of section 1867 of the Social Security
5 Act.

6 “(9) TREATING PHYSICIAN.—The term ‘treat-
7 ing physician’ includes a treating health care profes-
8 sional who is licensed under State law to provide
9 emergency services other than under the supervision
10 of a physician.

11 “(f) CONTINUED APPLICABILITY OF STATE LAW
12 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The
13 provisions of section 731(a) (relating to State authority
14 to provide for standards and requirements for health in-
15 surance issuers to the extent the standards and require-
16 ments do not prevent the application of a requirement of
17 this part) apply with respect to the requirements of this
18 section.”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) Section 731(c) of such Act (29 U.S.C.
21 1191(c)), as amended by section 603(b)(1) of Public
22 Law 104–204, is amended by striking “section 711”
23 and inserting “sections 711 and 713”.

1 (2) Section 732(a) of such Act (29 U.S.C.
2 1191a(a)), as amended by section 603(b)(2) of Pub-
3 lic Law 104–204, is amended by striking “section
4 711” and inserting “sections 711 and 713”.

5 (3) The table of contents in section 1 of such
6 Act is amended by inserting after the item relating
7 to section 712 the following new item:

 “Sec. 713. Assuring equitable coverage of emergency services, maintenance care,
 and post-stabilization care.”.

8 (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),
9 the amendments made by this section shall apply to group
10 health plans for plan years beginning on or after the date
11 that is 18 months after the date of the enactment of this
12 Act.

13 (2) In the case of a group health plan maintained
14 pursuant to 1 or more collective bargaining agreements
15 between employee representatives and 1 or more employ-
16 ers ratified before the date of enactment of this Act, the
17 amendments made by this section shall not apply to plan
18 years beginning before the later of—

19 (A) the date on which the last collective bar-
20 gaining agreements relating to the plan terminates
21 (determined without regard to any extension thereof
22 agreed to after the date of enactment of this Act),
23 or

1 (B) 18 months after the date of the enactment
2 of this Act.

3 For purposes of subparagraph (A), any plan amendment
4 made pursuant to a collective bargaining agreement relat-
5 ing to the plan which amends the plan solely to conform
6 to any requirement added by this section shall not be
7 treated as a termination of such collective bargaining
8 agreement.

9 **SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

10 **ACT RELATING TO THE GROUP MARKET.**

11 (a) IN GENERAL.—Subpart 2 of part A of title
12 XXVII of the Public Health Service Act is amended by
13 adding at the end the following new section:

14 **“SEC. 2706. ASSURING EQUITABLE COVERAGE OF EMER-**

15 **GENCY SERVICES, MAINTENANCE CARE, AND**

16 **POST-STABILIZATION CARE.**

17 “(a) PROHIBITION OF CERTAIN RESTRICTIONS ON
18 COVERAGE OF EMERGENCY SERVICES.—

19 “(1) IN GENERAL.—If a group health plan pro-
20 vides any benefits with respect to emergency services
21 (as defined in paragraph (2)(B)), the plan (and any
22 health insurance issuer offering health insurance
23 coverage in connection with such a plan) shall cover
24 emergency services furnished to a participant or ben-
25 eficiary of the plan—

1 “(A) without the need for any prior au-
2 thorization determination,

3 “(B) subject to paragraph (3), whether or
4 not the physician or provider furnishing such
5 services is a participating physician or provider
6 with respect to such services, and

7 “(C) subject to paragraph (3), without re-
8 gard to any other term or condition of such
9 plan or coverage (other than an exclusion of
10 benefits, or an affiliation or waiting period, per-
11 mitted under section 2701).

12 “(2) EMERGENCY SERVICES; EMERGENCY MEDI-
13 CAL CONDITION.—For purposes of this section—

14 “(A) EMERGENCY MEDICAL CONDITION
15 BASED ON PRUDENT LAYPERSON.—The term
16 ‘emergency medical condition’ means a medical
17 condition manifesting itself by acute symptoms
18 of sufficient severity (including severe pain)
19 such that a prudent layperson, who possesses
20 an average knowledge of health and medicine,
21 could reasonably expect the absence of imme-
22 diate medical attention to result in—

23 “(i) placing the health of the individ-
24 ual (or, with respect to a pregnant woman,

1 the health of the woman or her unborn
2 child) in serious jeopardy,

3 “(ii) serious impairment to bodily
4 functions, or

5 “(iii) serious dysfunction of any bodily
6 organ or part.

7 “(B) EMERGENCY SERVICES.—The term
8 ‘emergency services’ means—

9 “(i) a medical screening examination
10 (as required under section 1867 of the So-
11 cial Security Act) that is within the capa-
12 bility of the emergency department of a
13 hospital, including ancillary services rou-
14 tinely available to the emergency depart-
15 ment, to evaluate an emergency medical
16 condition (as defined in subparagraph
17 (A)), and

18 “(ii) within the capabilities of the
19 staff and facilities available at the hospital,
20 such further medical examination and
21 treatment as are required under section
22 1867 of the Social Security Act to stabilize
23 the patient.

24 “(C) TRAUMA AND BURN CENTERS.—The
25 provisions of clause (ii) of subparagraph (B)

1 apply to a trauma or burn center, in a hospital,
2 that—

3 “(i) is designated by the State, a re-
4 gional authority of the State, or by the
5 designee of the State, or

6 “(ii) is in a State that has not made
7 such designations and meets medically rec-
8 ognized national standards.

9 “(3) APPLICATION OF NETWORK RESTRICTION
10 PERMITTED IN CERTAIN CASES.—

11 “(A) IN GENERAL.—Except as provided in
12 subparagraph (B), if a group health plan (and
13 an issuer of health insurance coverage in con-
14 nection with such a plan) denies, limits, or oth-
15 erwise differentiates in coverage or payment for
16 benefits other than emergency services on the
17 basis that the physician or provider of such
18 services is a nonparticipating physician or pro-
19 vider, the plan and issuer may deny, limit, or
20 differentiate in coverage or payment for emer-
21 gency services on such basis.

22 “(B) NETWORK RESTRICTIONS NOT PER-
23 MITTED IN CERTAIN EXCEPTIONAL CASES.—
24 The denial or limitation of, or differentiation in,
25 coverage or payment of benefits for emergency

1 services under subparagraph (A) shall not apply
2 in the following cases:

3 “(i) CIRCUMSTANCES BEYOND CON-
4 TROL OF PARTICIPANT OR BENEFICIARY.—

5 The participant or beneficiary is unable to
6 go to a participating hospital for such serv-
7 ices due to circumstances beyond the con-
8 trol of the participant or beneficiary (as
9 determined consistent with guidelines and
10 subparagraph (C)).

11 “(ii) LIKELIHOOD OF AN ADVERSE
12 HEALTH CONSEQUENCE BASED ON
13 LAYPERSON’S JUDGMENT.—A prudent
14 layperson possessing an average knowledge
15 of health and medicine could reasonably
16 believe that, under the circumstances and
17 consistent with guidelines, the time re-
18 quired to go to a participating hospital for
19 such services could result in any of the ad-
20 verse health consequences described in a
21 clause of subsection (a)(2)(A).

22 “(iii) PHYSICIAN REFERRAL.—A par-
23 ticipating physician or other person au-
24 thorized by the plan refers the participant
25 or beneficiary to an emergency department

1 of a hospital and does not specify an emer-
2 gency department of a hospital that is a
3 participating hospital with respect to such
4 services.

5 “(C) APPLICATION OF ‘BEYOND CONTROL’
6 STANDARDS.—For purposes of applying sub-
7 paragraph (B)(i), receipt of emergency services
8 from a nonparticipating hospital shall be treat-
9 ed under the guidelines as being ‘due to cir-
10 cumstances beyond the control of the partici-
11 pant or beneficiary’ if any of the following con-
12 ditions are met:

13 “(i) UNCONSCIOUS.—The participant
14 or beneficiary was unconscious or in an
15 otherwise altered mental state at the time
16 of initiation of the services.

17 “(ii) AMBULANCE DELIVERY.—The
18 participant or beneficiary was transported
19 by an ambulance or other emergency vehi-
20 cle directed by a person other than the
21 participant or beneficiary to the non-
22 participating hospital in which the services
23 were provided.

24 “(iii) NATURAL DISASTER.—A natural
25 disaster or civil disturbance prevented the

1 participant or beneficiary from presenting
2 to a participating hospital for the provision
3 of such services.

4 “(iv) NO GOOD FAITH EFFORT TO IN-
5 FORM OF CHANGE IN PARTICIPATION DUR-
6 ING A CONTRACT YEAR.—The status of the
7 hospital changed from a participating hos-
8 pital to a nonparticipating hospital with re-
9 spect to emergency services during a con-
10 tract year and the plan or issuer failed to
11 make a good faith effort to notify the par-
12 ticipant or beneficiary involved of such
13 change.

14 “(v) OTHER CONDITIONS.—There
15 were other factors (such as those identified
16 in guidelines) that prevented the partici-
17 pant or beneficiary from controlling selec-
18 tion of the hospital in which the services
19 were provided.

20 “(b) ASSURING COORDINATED COVERAGE OF MAIN-
21 TENANCE CARE AND POST-STABILIZATION CARE.—

22 “(1) IN GENERAL.—In the case of a participant
23 or beneficiary who is covered under a group health
24 plan (or under health insurance coverage issued by
25 a health insurance issuer offered in connection with

1 such a plan) and who has received emergency serv-
2 ices pursuant to a screening evaluation conducted
3 (or supervised) by a treating physician at a hospital
4 that is a nonparticipating provider with respect to
5 emergency services, if—

6 “(A) pursuant to such evaluation, the phy-
7 sician identifies post-stabilization care (as de-
8 fined in paragraph (3)(B)) that is required by
9 the participant or beneficiary,

10 “(B) the plan or coverage provides benefits
11 with respect to the care so identified and the
12 plan requires (but for this subsection) an af-
13 firmative prior authorization determination as a
14 condition of coverage of such care, and

15 “(C) the treating physician (or another in-
16 dividual acting on behalf of such physician) ini-
17 tiates, not later than 30 minutes after the time
18 the treating physician determines that the con-
19 dition of the participant or beneficiary is sta-
20 bilized, a good faith effort to contact a physi-
21 cian or other person authorized by the plan or
22 issuer (by telephone or other means) to obtain
23 an affirmative prior authorization determination
24 with respect to the care,

1 then, without regard to terms and conditions speci-
2 fied in paragraph (2) the plan or issuer shall cover
3 maintenance care (as defined in paragraph (3)(A))
4 furnished to the participant or beneficiary during
5 the period specified in paragraph (4) and shall cover
6 post-stabilization care furnished to the participant or
7 beneficiary during the period beginning under para-
8 graph (5) and ending under paragraph (6).

9 “(2) TERMS AND CONDITIONS WAIVED.—The
10 terms and conditions (of a plan or coverage) de-
11 scribed in this paragraph that are waived under
12 paragraph (1) are as follows:

13 “(A) The need for any prior authorization
14 determination.

15 “(B) Any limitation on coverage based on
16 whether or not the physician or provider fur-
17 nishing the care is a participating physician or
18 provider with respect to such care.

19 “(C) Any other term or condition of the
20 plan or coverage (other than an exclusion of
21 benefits, or an affiliation or waiting period, per-
22 mitted under section 2701 and other than a re-
23 quirement relating to medical necessity for cov-
24 erage of benefits).

1 “(3) MAINTENANCE CARE AND POST-STA-
2 BILIZATION CARE DEFINED.—In this subsection:

3 “(A) MAINTENANCE CARE.—The term
4 ‘maintenance care’ means, with respect to an
5 individual who is stabilized after provision of
6 emergency services, medically necessary items
7 and services (other than emergency services)
8 that are required by the individual to ensure
9 that the individual remains stabilized during
10 the period described in paragraph (4).

11 “(B) POST-STABILIZATION CARE.—The
12 term ‘post-stabilization care’ means, with re-
13 spect to an individual who is determined to be
14 stable pursuant to a medical screening examina-
15 tion or who is stabilized after provision of emer-
16 gency services, medically necessary items and
17 services (other than emergency services and
18 other than maintenance care) that are required
19 by the individual.

20 “(4) PERIOD OF REQUIRED COVERAGE OF
21 MAINTENANCE CARE.—The period of required cov-
22 erage of maintenance care of an individual under
23 this subsection begins at the time of the request (or
24 the initiation of the good faith effort to make the re-
25 quest) under paragraph (1)(C) and ends when—

1 “(A) the individual is discharged from the
2 hospital;

3 “(B) a physician (designated by the plan
4 or issuer involved) and with privileges at the
5 hospital involved arrives at the emergency de-
6 partment of the hospital and assumes respon-
7 sibility with respect to the treatment of the in-
8 dividual; or

9 “(C) the treating physician and the plan or
10 issuer agree to another arrangement with re-
11 spect to the care of the individual.

12 “(5) WHEN POST-STABILIZATION CARE RE-
13 QUIRED TO BE COVERED.—

14 “(A) WHEN TREATING PHYSICIAN UNABLE
15 TO COMMUNICATE REQUEST.—If the treating
16 physician or other individual makes the good
17 faith effort to request authorization under para-
18 graph (1)(C) but is unable to communicate the
19 request directly with an authorized person re-
20 ferred to in such paragraph within 30 minutes
21 after the time of initiating such effort, then
22 post-stabilization care is required to be covered
23 under this subsection beginning at the end of
24 such 30-minute period.

1 “(B) WHEN ABLE TO COMMUNICATE RE-
2 QUEST, AND NO TIMELY RESPONSE.—

3 “(i) IN GENERAL.—If the treating
4 physician or other individual under para-
5 graph (1)(C) is able to communicate the
6 request within the 30-minute period de-
7 scribed in subparagraph (A), the post-sta-
8 bilization care requested is required to be
9 covered under this subsection beginning 30
10 minutes after the time when the plan or is-
11 suer receives the request unless a person
12 authorized by the plan or issuer involved
13 communicates (or makes a good faith ef-
14 fort to communicate) a denial of the re-
15 quest for the prior authorization deter-
16 mination within 30 minutes of the time
17 when the plan or issuer receives the re-
18 quest and the treating physician does not
19 request under clause (ii) to communicate
20 directly with an authorized physician con-
21 cerning the denial.

22 “(ii) REQUEST FOR DIRECT PHYSI-
23 CIAN-TO-PHYSICIAN COMMUNICATION CON-
24 CERNING DENIAL.—If a denial of a request
25 is communicated under clause (i), the

1 treating physician may request to commu-
2 nicate respecting the denial directly with a
3 physician who is authorized by the plan or
4 issuer to deny or affirm such a denial.

5 “(C) WHEN NO TIMELY RESPONSE TO RE-
6 QUEST FOR PHYSICIAN-TO-PHYSICIAN COMMU-
7 NICATION.—If a request for physician-to-physi-
8 cian communication is made under subpara-
9 graph (B)(ii), the post-stabilization care re-
10 quested is required to be covered under this
11 subsection beginning 30 minutes after the time
12 when the plan or issuer receives the request
13 from a treating physician unless a physician,
14 who is authorized by the plan or issuer to re-
15 verse or affirm the initial denial of the care,
16 communicates (or makes a good faith effort to
17 communicate) directly with the treating physi-
18 cian within such 30-minute period.

19 “(D) DISAGREEMENTS OVER POST-STA-
20 BILIZATION CARE.—If, after a direct physician-
21 to-physician communication under subpara-
22 graph (C), the denial of the request for the
23 post-stabilization care is not reversed and the
24 treating physician communicates to the plan or

1 issuer involved a disagreement with such deci-
2 sion, the post-stabilization care requested is re-
3 quired to be covered under this subsection be-
4 ginning as follows:

5 “(i) DELAY TO ALLOW FOR PROMPT
6 ARRIVAL OF PHYSICIAN ASSUMING RE-
7 SPONSIBILITY.—If the plan or issuer com-
8 municates that a physician (designated by
9 the plan or issuer) with privileges at the
10 hospital involved will arrive promptly (as
11 determined under guidelines) at the emer-
12 gency department of the hospital in order
13 to assume responsibility with respect to the
14 treatment of the participant or beneficiary
15 involved, the required coverage of the post-
16 stabilization care begins after the passage
17 of such time period as would allow the
18 prompt arrival of such a physician.

19 “(ii) OTHER CASES.—If the plan or
20 issuer does not so communicate, the re-
21 quired coverage of the post-stabilization
22 care begins immediately.

23 “(6) NO REQUIREMENT OF COVERAGE OF POST-
24 STABILIZATION CARE IF ALTERNATE PLAN OF
25 TREATMENT.—

1 “(A) IN GENERAL.—Coverage of post-sta-
2 bilization care is not required under this sub-
3 section with respect to an individual when—

4 “(i) subject to subparagraph (B), a
5 physician (designated by the plan or issuer
6 involved) and with privileges at the hos-
7 pital involved arrives at the emergency de-
8 partment of the hospital and assumes re-
9 sponsibility with respect to the treatment
10 of the individual; or

11 “(ii) the treating physician and the
12 plan or issuer agree to another arrange-
13 ment with respect to the post-stabilization
14 care (such as an appropriate transfer of
15 the individual involved to another facility
16 or an appointment for timely followup
17 treatment for the individual).

18 “(B) SPECIAL RULE WHERE ONCE CARE
19 INITIATED.—Required coverage of requested
20 post-stabilization care shall not end by reason
21 of subparagraph (A)(i) during an episode of
22 care (as determined by guidelines) if the treat-
23 ing physician initiated such care (consistent
24 with a previous paragraph) before the arrival of
25 a physician described in such subparagraph.

1 “(7) CONSTRUCTION.—Nothing in this sub-
2 section shall be construed as—

3 “(A) preventing a plan or issuer from au-
4 thorizing coverage of maintenance care or post-
5 stabilization care in advance or at any time; or

6 “(B) preventing a treating physician or
7 other individual described in paragraph (1)(C)
8 and a plan or issuer from agreeing to modify
9 any of the time periods specified in paragraph
10 (5) as it relates to cases involving such persons.

11 “(c) LIMITS ON COST-SHARING FOR SERVICES FUR-
12 NISHED IN EMERGENCY DEPARTMENTS.—If a group
13 health plan provides any benefits with respect to emer-
14 gency services, the plan (or a health insurance issuer offer-
15 ing health insurance coverage in connection with such a
16 plan) may impose cost sharing with respect to such serv-
17 ices only if the following conditions are met:

18 “(1) LIMITATIONS ON COST-SHARING DIF-
19 FERENTIAL FOR NONPARTICIPATING PROVIDERS.—

20 “(A) NO DIFFERENTIAL FOR CERTAIN
21 SERVICES.—In the case of services furnished
22 under the circumstances described in clause (i),
23 (ii), or (iii) of subsection (a)(3)(B) (relating to

1 circumstances beyond the control of the bene-
2 ficiary, the likelihood of an adverse health con-
3 sequence based on layperson’s judgment, and
4 physician referral), the cost-sharing for such
5 services provided by a nonparticipating provider
6 or physician does not exceed the cost-sharing
7 for such services provided by a participating
8 provider or physician.

9 “(B) ONLY REASONABLE DIFFERENTIAL
10 FOR OTHER SERVICES.—In the case of other
11 emergency services, any differential by which
12 the cost-sharing for such services provided by a
13 nonparticipating provider or physician exceeds
14 the cost-sharing for such services provided by a
15 participating provider or physician is reasonable
16 (as determined under guidelines).

17 “(2) ONLY REASONABLE DIFFERENTIAL BE-
18 TWEEN EMERGENCY SERVICES AND OTHER SERV-
19 ICES.—Any differential by which the cost-sharing for
20 services furnished in an emergency department ex-
21 ceeds the cost-sharing for such services furnished in
22 another setting is reasonable (as determined under
23 guidelines).

24 “(3) CONSTRUCTION.—Nothing in paragraph
25 (1)(B) or (2) shall be construed as authorizing

1 guidelines other than guidelines that establish maxi-
2 mum cost-sharing differentials.

3 “(d) INFORMATION ON ACCESS TO EMERGENCY
4 SERVICES.—A group health plan (or a health insurance
5 issuer, to the extent a health insurance issuer offers group
6 health insurance coverage in connection with such a plan)
7 shall provide education to participants and beneficiaries
8 of the plan on—

9 “(1) coverage of emergency services (as defined
10 in subsection (a)(2)(B)) by the plan in accordance
11 with the provisions of this section,

12 “(2) the appropriate use of emergency services,
13 including use of the 911 telephone system or its
14 local equivalent,

15 “(3) any cost sharing applicable to emergency
16 services,

17 “(4) the process and procedures of the plan for
18 obtaining emergency services, and

19 “(5) the locations of—

20 “(A) emergency departments, and

21 “(B) other settings,

22 in which participating physicians and hospitals pro-
23 vide emergency services and post-stabilization care.

24 “(e) GENERAL DEFINITIONS.—For purposes of this
25 section:

1 “(1) COST SHARING.—The term ‘cost sharing’
2 means any deductible, coinsurance amount, copay-
3 ment or other out-of-pocket payment (other than
4 premiums or enrollment fees) that a group health
5 plan (or a health insurance issuer offering group
6 health insurance issuer in connection with such a
7 plan) imposes on participants and beneficiaries of
8 the plan with respect to the coverage of benefits.

9 “(2) GOOD FAITH EFFORT.—The term ‘good
10 faith effort’ has the meaning given such term in
11 guidelines and requires such appropriate documenta-
12 tion as is specified under such guidelines.

13 “(3) GUIDELINES.—The term ‘guidelines’
14 means guidelines established in accordance with sec-
15 tion 7 of the Access to Emergency Medical Services
16 Act of 1997.

17 “(4) NONPARTICIPATING PHYSICIAN OR PRO-
18 VIDER.—The term ‘nonparticipating physician or
19 provider’ means, with respect to health care items
20 and services furnished to a participant or beneficiary
21 of a group health plan, a physician or provider that
22 is not a participating physician or provider for such
23 services.

1 “(5) PARTICIPATING PHYSICIAN OR PRO-
2 VIDER.—The term ‘participating physician or pro-
3 vider’ means, with respect to health care items and
4 services furnished to a participant or beneficiary of
5 a group health plan, a physician or provider that
6 furnishes such items and services under a contract
7 or other arrangement with such plan (or with a
8 health insurance issuer offering group health insur-
9 ance coverage in connection with such a plan).

10 “(6) PRIOR AUTHORIZATION DETERMINA-
11 TION.—The term ‘prior authorization determination’
12 means, with respect to items and services for which
13 coverage may be provided under a group health plan,
14 a determination (before the provision of the items
15 and services and as a condition of coverage of the
16 items and services under the plan) of whether or not
17 such items and services will be covered under the
18 plan.

19 “(7) STABILIZE.—The term ‘to stabilize’
20 means, with respect to an emergency medical condi-
21 tion, to provide (in complying with section 1867 of
22 the Social Security Act) such medical treatment of
23 the condition as may be necessary to assure, within
24 reasonable medical probability, that no material de-
25 terioration of the condition is likely to result from or

1 occur during the transfer of the individual from the
2 facility.

3 “(8) STABILIZED.—The term ‘stabilized’
4 means, with respect to an emergency medical condi-
5 tion, that no material deterioration of the condition
6 is likely, within reasonable medical probability, to re-
7 sult from or occur before an individual can be trans-
8 ferred from the facility, in compliance with the re-
9 quirements of section 1867 of the Social Security
10 Act.

11 “(9) TREATING PHYSICIAN.—The term ‘treat-
12 ing physician’ includes a treating health care profes-
13 sional who is licensed under State law to provide
14 emergency services other than under the supervision
15 of a physician.

16 “(f) CONTINUED APPLICABILITY OF STATE LAW
17 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The
18 provisions of section 2723(a) (relating to State authority
19 to provide for standards and requirements for health in-
20 surance issuers to the extent the standards and require-
21 ments do not prevent the application of a requirement of
22 this part) apply with respect to the requirements of this
23 section.”.

24 (b) CONFORMING AMENDMENT.—Section 2723(c) of
25 such Act (42 U.S.C. 300gg–23(c)), as amended by section

1 604(b)(2) of Public Law 104–204, is amended by striking
2 “section 2704” and inserting “sections 2704 and 2706”.

3 (c) EFFECTIVE DATE.—(1) Subject to paragraph (2),
4 the amendments made by this section shall apply to group
5 health plans for plan years beginning on or after the date
6 that is 18 months after the date of the enactment of this
7 Act.

8 (2) In the case of a group health plan maintained
9 pursuant to 1 or more collective bargaining agreements
10 between employee representatives and 1 or more employ-
11 ers ratified before the date of enactment of this Act, the
12 amendments made by this section shall not apply to plan
13 years beginning before the later of—

14 (A) the date on which the last collective bar-
15 gaining agreements relating to the plan terminates
16 (determined without regard to any extension thereof
17 agreed to after the date of enactment of this Act),
18 or

19 (B) 18 months after the date of the enactment
20 of this Act.

21 For purposes of subparagraph (A), any plan amendment
22 made pursuant to a collective bargaining agreement relat-
23 ing to the plan which amends the plan solely to conform
24 to any requirement added by this section shall not be

1 treated as a termination of such collective bargaining
2 agreement.

3 **SEC. 5. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

4 **ACT RELATING TO THE INDIVIDUAL MARKET.**

5 (a) IN GENERAL.—Part B of title XXVII of the Pub-
6 lic Health Service Act is amended—

7 (1) by redesignating the subpart 3 relating to
8 other requirements as subpart 2, and

9 (2) by adding at the end of such subpart the
10 following new section:

11 **“SEC. 2752. ASSURING EQUITABLE COVERAGE OF EMER-**

12 **GENCY SERVICES, MAINTENANCE CARE, AND**

13 **POST-STABILIZATION CARE.**

14 “(a) IN GENERAL.—The provisions of section 2706
15 shall apply to health insurance coverage offered by a
16 health insurance issuer in the individual market in the
17 same manner as it applies to health insurance coverage
18 offered by a health insurance issuer in connection with a
19 group plan. In applying the previous sentence, the ref-
20 erence in section 2706(b)(2)(C) to section 2701 is deemed
21 a reference to subpart 1 of this part.

22 “(b) CONTINUED APPLICABILITY OF STATE LAW
23 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—The
24 provisions of section 2762 (relating to State authority to

1 provide for standards and requirements for health insur-
2 ance issuers to the extent the standards and requirements
3 do not prevent the application of a requirement of this
4 part) apply with respect to the requirements of this sec-
5 tion.”.

6 (b) CONFORMING AMENDMENT.—Section 2763(b)(2)
7 of such Act (42 U.S.C. 300gg–63(b)(2)), as added by sec-
8 tion 605(b)(3)(B) of Public Law 104–204, is amended by
9 striking “section 2751” and inserting “sections 2751 and
10 2752”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply with respect to health insurance
13 coverage offered, sold, issued, renewed, in effect, or oper-
14 ated in the individual market on or after the date that
15 is 18 months after the date of the enactment of this Act.

16 **SEC. 6. APPLICATION TO PRIVATE COVERAGE FOR MEDI-**
17 **CARE AND MEDICAID BENEFICIARIES.**

18 (a) MEDICARE.—Subparagraph (B) of section
19 1876(c)(4) of the Social Security Act (42 U.S.C.
20 1395mm(c)(4)) is amended to read as follows:

21 “(B) meets the requirements of section 2706 of
22 the Public Health Service Act with respect to indi-
23 viduals enrolled with the organization under this sec-
24 tion.”.

1 (b) MEDICAID.—Title XIX of such Act (42 U.S.C.
2 1396 et seq.) is amended by inserting after section 1908
3 the following new section:

4 “ACCESS TO EMERGENCY SERVICES FOR BENEFICIARIES
5 ENROLLED IN PRIVATE HEALTH PLANS

6 “SEC. 1909. (a) IN GENERAL.—A state plan may not
7 be approved under this title unless the plan requires each
8 health insurance issuer or other entity with a contract
9 with such plan to provide coverage or benefits to individ-
10 uals eligible for medical assistance under the plan to com-
11 ply with the provisions of section 2706 of the Public
12 Health Service Act with respect to such coverage or bene-
13 fits.

14 “(b) COST SHARING.—Nothing in this section or sec-
15 tion 2706(c) of the Public Health Service Act shall be con-
16 strued as authorizing a health insurance issuer or entity
17 to impose cost sharing with respect to the coverage or ben-
18 efits described in subsection (a) that is inconsistent with
19 the cost sharing that is otherwise permitted under this
20 title.

21 “(c) WAIVERS PROHIBITED.—The requirement of
22 subsection (a) may not be waived under section 1115 or
23 section 1915(b) of the Social Security Act.”.

24 (c) MEDICARE SELECT POLICIES.—Section
25 1882(t)(1) of such Act (42 U.S.C. 1395ss(t)(1)) is amend-
26 ed—

1 (1) in subparagraph (B), by inserting “subject
2 to subparagraph (G),” after “(B)”,

3 (2) by striking “and” at the end of subpara-
4 graph (E),

5 (3) by striking the period at the end of sub-
6 paragraph (F) and inserting “; and”, and

7 (4) by adding at the end the following new sub-
8 paragraph:

9 “(G) the issuer of the policy complies with the
10 requirements of section 2752 of the Public Health
11 Service Act with respect to enrollees under this sub-
12 section.”.

13 (d) EFFECTIVE DATES.—

14 (1) MEDICARE.—The amendment made by sub-
15 section (a) shall apply to eligible organizations under
16 section 1876 of the Social Security Act for contract
17 years beginning on or after the date that is 18
18 months after the date of the enactment of this Act.

19 (2) MEDICAID.—The amendment made by sub-
20 section (b) shall apply to State plans under title
21 XIX of the Social Security Act for contract years be-
22 ginning on or after the date that is 18 months after
23 the date of the enactment of this Act.

24 (3) MEDICARE SELECT.—The amendments
25 made by subsection (c) shall apply to policies for

1 contract years beginning on or after the date that is
2 18 months after the date of the enactment of this
3 Act.

4 **SEC. 7. ESTABLISHMENT OF GUIDELINES.**

5 (a) IN GENERAL.—The Secretary of Labor, the Sec-
6 retary of Health and Human Services, and the Secretary
7 of the Treasury (in this section referred to as “the Sec-
8 retaries”) shall, in accordance with the process described
9 in subsection (b), jointly establish guidelines to carry out
10 section 9811 of the Internal Revenue Code of 1986, sec-
11 tion 713 of the Employee Retirement Income Security Act
12 of 1974, and sections 2706 and 2752 of the Public Health
13 Service Act, including all such guidelines as may be re-
14 ferred to in such sections.

15 (b) PROCESS.—

16 (1) ADVISORY PANEL.—Not later than 90 days
17 after the date of the enactment of this Act, the Sec-
18 retaries shall jointly establish an advisory panel to
19 assist in the development of the guidelines referred
20 to in subsection (a). The members of the panel shall
21 include individuals representing—

22 (A) emergency medical personnel, includ-
23 ing emergency physicians, emergency nurses,
24 and other appropriate emergency health care
25 professionals;

- 1 (B) health insurance issuers, including at
2 least one health maintenance organization;
3 (C) hospitals;
4 (D) employers;
5 (E) the States; and
6 (F) consumers.

7 (2) NOTICE AND COMMENT.—Not later than
8 180 days after the date of the enactment of this Act,
9 the Secretaries shall jointly cause to have published
10 in the Federal Register notice of proposed rule-
11 making on the guidelines referred to in subsection
12 (a). Not later than 60 days after the close of the pe-
13 riod for public comment on such guidelines, the Sec-
14 retaries shall jointly cause to have published in the
15 Federal Register a final rule establishing such guide-
16 lines.

○