Prudent Layperson Standard Background

The Prudent Layperson Standard (PLS) grew out of the insurance environment of the early 1980s. In 1986, the U.S. Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA), setting the standard that hospitals must provide care to anyone needing emergency treatment. However, private insurers routinely would require prior authorization for emergency department visits or deny payments for visits that they deemed inappropriate for that care setting, often based on a retrospective review or discharge diagnosis. If an individual wanted insurance to cover an emergency treatment, the patient was expected to contact his or her insurer for approval *prior* to the emergency department (ED) visit. If an individual sought care in the ED and his or her insurer later deemed that the visit was not a medical emergency – based on the final diagnosis, not the presenting symptoms – then the insurer would refuse to pay for the visit.

In response to such potentially dangerous and unfair requirements, many states enacted PLS laws. In 1993, Maryland was the first to do so and, ultimately, 47 states passed legislation that supported a patient's right to seek care in the ED. The federal Balanced Budget Act (BBA) of 1997 extended the PLS to Medicare and Medicaid *managed care plans*. The language from the BBA eloquently states what, at its core, is a simple concept:

"The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part."

President Bill Clinton extended the PLS to all federal health plans by executive order in 1998.

Group and individual market health insurance plans, which are regulated by the federal Employee Retirement Income Security Act (ERISA), were finally required to comply with the PLS in the Patient Protection and Affordable Care Act of 2010.

The only segment of insured individuals who are not currently covered by the PLS is Medicaid Fee-for-Service, which accounts for about 20-30% of Medicaid beneficiaries.

However, there have been, and continue to be, attempts by insurance providers at the state level to curtail patient access to emergency department care in violation of the PLS. These efforts focus on increasing the burden (either financial or otherwise) on the patient/beneficiary. Some policies achieve this objective by denying coverage for any non-emergency services to the ED beyond the first few visits while others retroactively reimburse claims based on the discharge diagnosis.