THE PRUDENT LAYPERSON STANDARD—Bridging the Gap Between EMTALA and MCO Review of Emergency Utilization

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I. INTRODUCTION.

The past 50 years have seen a dramatic and widespread democratization in the availability of healthcare in the United States. Nonetheless, this process has been fraught with public dissatisfaction and outcry. For the past ten years public controversy has focused on the issues of (1) access to emergency medical care, and (2) accountability of the new delivery systems, managed care organizations (MCOs). As will be shown, these controversies have grown directly out of the legislative solutions of yesterday, interacting within a new healthcare finance economy. Worse, the solutions of yesterday have stymied further reform by freezing a distortive status quo that allows insurers, especially MCOs, to escape liability and accountability.

As a brief example of the interplay between healthcare legislation and the changing healthcare finance market, consider the following. The last call for major legislative reform of healthcare began as recently as the late 1960s. Then the problem was escalating healthcare costs. Consumers, i.e. patients, initially appeared to have “won” with such legislation as The Federal HMO Act of 1973, and the Employment Retirement Income Security Act of 1974 (ERISA).

The Federal HMO Act sought to encourage the growth and development of health maintenance organizations (HMOs), a type of MCO, on the MCO promise to increase access to basic care and decrease costs by preventing over-treatment. ERISA encouraged large multi-state employers to provide health and welfare benefits to employees (for

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1 42 U.S.C. § 300e to e-17.

example through the new, low-cost delivery system being formulated) by preempting conflicting state administration requirements.\(^3\) That these tended to create new problems of their own upon interaction, however, become clear with the 1985 passage of the Emergency Medical Treatment and Labor Act (EMTALA),\(^4\) and the tortuous evolution MCO-related jurisprudence during the same time.

In replacing the fee-for-service model with a model that contracts for minimum care and shifts the risk of excess care unto providers, the widespread use of HMOs decreased the ability of healthcare providers to subsidize the care of indigents, uninsureds and underinsureds by increasing prices paid by insured patients. Because the cost of treating such patients could no longer be subsidized by insured patients, an emergent practice developed among emergency facilities to “dump” indigent patients onto other facilities, or simply deny emergency medical treatment to such patients. Accordingly, EMTALA was passed to provide that emergency facilities must provide appropriate screening and stabilization to any patient presenting to the facility with an emergency medical condition.

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3 ERISA includes two separate types of preemption:
   a. Complete preemption: § 502 (29 U.S.C. § 1132(a)), ERISA’s civil enforcement scheme, has been interpreted by the Supreme Court to provide the exclusive remedy for actions based on the improper processing of claims for benefits, and to thus provide for complete preemption and removal to federal court. See e.g. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51-54 (1987).

   b. Conflict preemption: § 514(a) (29 U.S.C. §1144(a)) provides for the preemption and dismissal of “any and all State laws insofar as they may now or hereafter relate to any employee benefits plan...” “Relate to” has been interpreted very broadly by the Supreme Court, on the basis of plain meaning and legislative history, see infra. See e.g. Shaw v. Delta Airlines, 463 U.S. 85 (1983).

   c. 42 U.S.C. § 1395 et seq. EMTALA was one part of a larger Act, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), having a number of provisions relating to health care access.
Meanwhile, federal and state courts grappled with the legal obligations of the new entities, MCOs generally as well as HMOs, in the context of EMTALA and ERISA. Early on it was held that EMTALA only imposed an obligation upon emergency care facilities or hospitals, not upon MCOs. At the same time, ERISA’s preemption provisions were interpreted broadly by the courts. As a general rule, any state legislation attempting to secure minimum healthcare benefits is potentially threatened with ERISA preemption, while ERISA has no substantive provisions regarding healthcare as an employee benefit.

As the foregoing example indicates, the problems seen in healthcare today are best understood as having arisen as unintended consequences of competing legislative solutions conceived in the early 1970s, whose implications are only now being fully understood. This paper will begin by examining the shift from indemnification health insurance to managed care organizations. The new federal regulatory regimes regarding healthcare created two “regulatory vacuums” in the context of an industry-wide shift in the economic market of healthcare finance.

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7 See Davidson, supra note 6, at 204 and n. 12. Davidson notes that this term was coined by one of the original drafters of ERISA, regarding ERISA’s preemptive effect on health care law.
The first vacuum created was that between the requirements of EMTALA and the obligation of MCOs. On one hand, EMTALA imposes an obligation on emergency facilities to appropriately screen and stabilize any presenting patient. On the other hand, as noted, no parallel obligation is imposed on MCOs. The structure of the MCO, based on cost-containment and utilization review, operates to take advantage of this gap. Accordingly, MCOs have denied emergency care reimbursement when laypersons misdiagnosed the severity of their condition, or where they suffered an emergency medical condition but failed to get prior authorization for emergency services.

A common response by states to this gap has been to institute a “prudent layperson” (PLP) standard, which provides that an emergency medical condition is one that,

"manifests itself by acute symptoms of sufficient severity (including severe pain) such that the average 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."

This paper will examine the consensus that has emerged behind the prudent layperson standard, whether the standard is intended to represent our old friend, the objective “reasonable person” standard, and the economic implications and consequences of the prudent layperson standard.

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8 See In Re Baby K, 16 F.3d 590 (4th Cir. 1993) (held EMTALA applies to any patient, in context of anencephalic infant).

9 See e.g. M.D. Code Ann. Health-General II, § 19-701(d)(1996), the first state PLP statute, and 42 U.S.C. § 1395w-22(d)(3)(B) and § 1395u-2, the federal Balanced Budget Act of 1997 regarding Medicare+ Choice, which was based on the Maryland statute.
Unfortunately, the second vacuum created, that between ERISA preemption and substantive ERISA provisions, today threatens any state law seeking to regulate MCOs. MCOs have come to provide insurance to 75-80% of Americans and today half of all Americans have health benefits through ERISA-governed employee benefit plans. However, ERISA's substantive provisions only deal with retirement income, while it has been broadly interpreted by the U.S. Supreme Court to preempt any state law related, even indirectly, to employee benefit plans. Accordingly, this paper will also analyze ERISA preemption jurisprudence to date, to determine the likelihood of federal preemption of state prudent layperson laws. Analysis will demonstrate that no state effort can be clearly secure from federal preemption in today's confused legal environment.

Thus, I will conclude by forecasting that only uniform, nationally mandated benefits or an amendment to ERISA permitting state health care standards or causes of action can correct the problems of MCO accountability regarding emergency medical care and federal preemption.

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11 See Richardson, supra note 6, at 689-90.

12 Although the Supreme Court, in Shaw, supra note 3, at 91, has found ERISA to be comprehensive as to both employee pension plans and employee benefit plans, this is plainly not so, as evidenced by the Court's own description of ERISA: "The statute imposes participation, funding, and vesting requirements on pension plans...It also sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans." (cites omitted, emphasis added). The standards described simply provide no recourse for the problems seen today with MCOs.

13 See Shaw, id. See also Metropolitan Life Ins Co. v. Mass., 471 U.S. 724, 739 (1985), incorporating the rule of Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 525 (1981), that even indirect impact "relates to" and is preempted. However, it is not clear that that was an appropriate incorporation. Alessi concerned pensions and direct conflict with federal objectives by outlawing a method of calculation legal under the
II. A BRIEF HISTORY OF THE HEALTH INSURANCE INDUSTRY—The shift from an indemnification model to the MCO model.

Health insurance arose during the 1930s, in response to the Great Depression. During this time physicians and hospitals were forced by dwindling receipts to solicit sales more actively, by organizing health maintenance programs to provide basic healthcare for a small monthly premium.\(^{14}\) Concurrently, New Deal legislation created the legal environment for improved employment stability, and hence better labor bargaining power and increased employee benefits, such as healthcare insurance. Shortly thereafter, encouraged by this new lucrative market, private insurance companies began to enter the field and health insurance as we know it arose.\(^{15}\) The industry advanced along with the rest of the American economy through the wartime manufacturing boom of the second quarter of the century. Between 1930 and post-World War II, insured Americans had increased from near 0 to 63%.\(^{16}\) At this time, healthcare was provided on a fee-for-service basis and the patient sought reimbursement from his or her insurance.

Despite the general democratization of health insurance, considerable complaint and dissatisfaction with the healthcare industry arose by late 1960s. Costs were escalating rapidly due to increased insurance utilization, increased technological

\[^{14}\text{See}\ \text{Richardson, supra note 6, at 681-683. For example the Farmer's Union in Oklahoma formed the Co-op Health Association in 1929. At about the same, the American Hospital Association developed Blue Cross plans.}\]

\[^{15}\text{Id., at 683.}\]

\[^{16}\text{Id.}\]
sophistication, longer longevity, and the general economic inflation of the period. By the 1970s there was considerable call for reform and managed care was embraced because of its cost-containment principles.

Managed care is a type of healthcare delivery system where attempt is made to control costs by controlling the provision of services. By controlling enrollees' access to services, MCOs can offer broader access to healthcare. This creates further economic incentives independent of cost-containment. Employers are more willing to contract with MCOs for the provision of employee welfare benefit plans because all their employees will be accepted. This eases administration and lowers costs. Additionally, healthcare providers are more willing to contract with MCOs because MCOs can guarantee them a large consumer base from which to determine compensation.

The two main types of managed care organizations are Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs). PPOs are an offshoot of the traditional health indemnity model, operating on a traditional fee-for-service basis. The insurance company contracts with physicians and/or hospitals for lower rates. Then, both physician and insurance are paid on the basis of the number of services performed and amount of each. Patients do not have to use a particular

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17 Id., at 683-684. For example, “[n]ational spending for health care increased from $12.7 billion to $41.9 billion in 1965 to $647 billion in 1990. Likewise, per capita spending for medical services skyrocketed from $82 per year in 1950 to $211 in 1965 to $2511 in 1990.” Id., at 683.


19 The following descriptions are gotten from Richardson, supra note 6, at 685-687, except where otherwise noted.
physician, but are encouraged to. Although there is some controversy as to the legal responsibility of PPOs, there is not near so much as with HMOs.

HMOs are the most prevalent and controversial form of managed care organizations. They are marked by a controlled structure based on the essential goal of cost-containment. First, HMOs eliminate physician incentives to over-treat by shifting the risk to the medical provider, through incentives such as withholds\textsuperscript{20} and capitation.\textsuperscript{21} Second, the patient’s assigned primary care physician acts as a gatekeeper to restrict the patient’s freedom to self-select certain forms of treatment and services.

While MCOs appear to have been regarded with some suspicion initially,\textsuperscript{22} managed care’s market share grew dramatically through the 1980s and 1990s. Today 75-80\% of Americans are covered by MCOs\textsuperscript{23} and on third of all Americans are covered by HMOs.\textsuperscript{24}

\section*{III. THE IMPETUS TOWARDS REFORM OF MANAGED CARE.}

\textsuperscript{20} Where the HMO holds a percentage (usually 10-15\%) of the provider’s payment and uses it to cover “excess” referrals. Alternately, any balance will be returned to the provider.

\textsuperscript{21} Where payment per contract depends on the number of members that \textit{can be} enrolled (the provider’s defined population) for the provider’s services.

\textsuperscript{22} See e.g. Brown and Hartung, \textit{supra} note 10, at 26. Despite the perceived market failure of fee-for-service and the Federal HMO Act, MCO and HMO enrollment continued to be low until early 1980s. For example, by 1979, only 5\% of Americans were enrolled in HMOs.

\textsuperscript{23} See note 10, \textit{supra}, and accompanying text.

\textsuperscript{24} See Richardson, \textit{supra}, note 6, at 688; furthermore, enrollment has increased by 60\% just since 1991.
Despite, the economic success of managed care, it has now come under public fire in its own turn. The major complaints against managed care are twofold: (1) their aggressive and inappropriate cost-containment; and (2) their ability to escape accountability for mandating healthcare decisions through ERISA’s preemption provisions.

First, consumers have come to question the wisdom of the very thing that gave MCOs a market edge, namely their emphasis on the bottom line and aggressive cost-containment. Without legislative restraint, MCOs have become “tyrannical” in their cost-containment. The objectionable practices are legion. Lump sum payments to physicians, regardless of the number of patients seen or the cost of care/treatment, encourage physicians to limit treatment. Requirements of specialty referral and emergency/urgent care pre-authorization, as well as physician incentives for limiting referral quotas, all tend to discourage referrals for care that the primary care doctor cannot provide. The policy of “gagging” physicians prevents them from speaking of alternate procedures not offered by the MCO. Finally, clinical rules such as utilization review, treatment protocols, and practice guidelines allow MCOs to actually dictate modes of treatment.

The second source of the public resentment toward managed care is the unintended reaction between managed care and ERISA. While the issue of cost-containment concerns a direct structural characteristic of managed care, ERISA was not

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25 See Misocky, supra note 18, at 57. But see Hyman, supra note 18, at 457. Hyman warns that most of the calls for reform are based on “anecdotal evidence,” and hence unreliable. However, dissatisfaction with MCOs is also based on verifiable contract provisions, and more than twenty years of judicial, administrative and legislative hearings regarding managed health care.
written with managed care in mind and its impact within a new healthcare economy was completely accidental.

ERISA has aggravated consumer frustration with managed care in three ways. First, § 502 provides an exclusive remedy that is ineffectual in the context of managed care. Second, ERISA’s substantive provisions do not address healthcare. Finally, ERISA preemption through § 502 and § 514(a) acts as a barrier to state reform efforts.

The only causes of action that § 502 of ERISA provides beneficiaries is to “recover benefits due...under the terms of [the] plan” or “to enforce...rights under the terms of the plan.” This limited remedy is a result of ERISA having been written in light of the old fee-for-service model. When ERISA was enacted, patients paid for medical services and were then reimbursed by insurer. Because a patient was to seek medical treatment first, and then reimbursement, there was never any danger of damages greater than reimbursement. Accordingly, an exclusive remedy of reimbursement of the cost of service was adequate at that time.

Today, however, the fee-for-service model no longer represents the majority of health insurance relationships. As noted above, 75-80% of Americans are covered by MCOs, a third are covered by HMOs, and half have healthcare benefits through ERISA governed employee benefit plans. In light of the attractiveness of managed care to employers, also noted above, the overlap between managed care plans and ERISA-covered plans could be near complete.


Thus, the healthcare finance industry has reshaped itself almost entirely, so that the structure and nature\(^{29}\) of the most prevalent type of health insurance model requires insurers to decide prospectively whether to pay for medical care. Now, incorrect assessment can lead to further injury or even death, since medical care is being denied beforehand.\(^{30}\) Section § 502 remedies, however, are useless in the case of injury or death as an enrollee can only sue for cost of services denied, not the resulting injury, death, or economic loss caused by the denial.\(^{31}\)

Furthermore, the substantive provisions of ERISA do not deal with healthcare so that, in addition to the lack of remedy, there are no federal laws governing employee health benefit plans. The purpose of ERISA was to provide for uniformity in the administration of pension plans and the payment of benefits.\(^{32}\) Accordingly, substantive provisions are directed to pension administration and concomitant fiduciary obligations of plan administrators. In the absence of regulation or penalty, most MCOs have rationally chosen to continue to contain costs aggressively.

In response to this gap in the federal regulatory scheme and rising consumer dissatisfaction, most states have recently sought to reform the regulation of health insurance to make MCOs more accountable, and to improve access to the contracted for

\(^{28}\) See 10, 11 and 214, supra, and accompanying text.

\(^{29}\) Through use of prior authorization, pre-certification, the limiting of referrals, etc.

\(^{30}\) See Otterson, supra note 27, at 840.

\(^{31}\) See Michael Higgins, Texas Law Allow Patients to Sue—HMO Waging Preemption Battle, 83 ABA J 24(1) (Sep 1997). See also Pilot Life, supra note 3, at 50 (that § 502 does not provide express or implied authority for an award of punitive damages).

medical care. Forty-five (45) states have enacted 56 laws from over 1,000 bills, providing for some type of "consumer protection" targeting MCOs.\textsuperscript{33} Most of the state laws have been geared toward mandating minimum benefits, patient protection mechanisms, or claims processing protocols. A number have also been directed toward creating a statutory causes of action against MCOs.\textsuperscript{34} The need for reform has also been recognized at the federal level, as seen in the Balanced Budget Act of 1997 regarding Medicare,\textsuperscript{35} and a flurry of legislative proposals.\textsuperscript{36}

Despite this consensus, however, both state legislative efforts and state common law tort and breach of contract causes of action have often been held to be preempted under ERISA, bringing us to the third way in which ERISA frustrates the goal of MCO accountability.

The U.S. Supreme Court has determined that Congress intended ERISA to preempt the entire field of employee benefit plans,\textsuperscript{37} including employee health benefit

\textsuperscript{33} See Brown and Hartung, supra note 10, at 31; Hyman, supra note 19, at 426; Michele Bitoun Blecher, et al., comp., Hospitals & Health Networks 1998; 72(16): 12-14, 16.

\textsuperscript{34} See e.g. Texas Civ. Prac. & Rem. Code Ann. § 88.002(a) (that an enrollee can sue an MCO if it does not exercise the degree of care that an MCO of ordinary prudence would exercise) (upheld as not preempted in 12 F.Supp.2d 597 (S.D. Tex. 1998)); New Mexico Stat. Ann. § 59(A)-57-9(c) (codifying common law right of enrollees to sue MCOs for breach of contract, if MCO violated a provision of New Mexico’s Patient Protection Act). See also Missouri Ann. Stat. § 354.505 (repealed state law providing that MCOs do not practice medicine, which facilitates medical malpractice claims against MCOs).

\textsuperscript{35} See note 9, supra, and accompanying text. The prudent layperson standard defines medical emergency conditions in terms of the prudent layperson perspective and usually forbids prior authorization requirements.

\textsuperscript{36} See e.g. S. 356 §981 (Access to Emergency Medical Service Act; Norwood I); S. 373/H.R. 820 (Kennedy/Dingell); S. 1712 (Jeffords/Lieberman); H.R. 1415 (Patient Access to Responsible Care Act); HR 3605 § 101. See also President Clinton’s Commission’s Patient Bill of Rights, from 1998.

\textsuperscript{37} See notes 3, 12 and 13, supra. However, these earlier holdings may be relaxing today, as the Court moves away from its original, strict textual interpretation of ERISA, and begins to consider the actual impact of state law on the purposes of ERISA. See e.g. Fort Halifax v. Coyle, 482 U.S. 1 (1987), and N.Y. State Conference of BCBS v. Travelers Ins, 115 S. Ct. 1671 (1995), which direct courts to look to the objectives
plans such as MCOs and HMOs. Since the early 1980s, federal courts have held a number of state law claims directed against MCOs to be so preempted. The majority of healthcare-related cases have dealt with state laws seeking to hold MCOs liable for injuries caused by denial of medical care, such as breach of contract, fraud and/or misrepresentation, breach of fiduciary care, tortious interference with contractual relations, negligence, and malpractice. Federal courts have also held that state “any willing provider statutes” are preempted under ERISA.

Because ERISA is likely to be found to preempt both legislative and common law causes of action or remedies, commentators argue that a complete legal vacuum exists today as regards the duties and liabilities of MCOs.

IV. THE PRUDENT LAYPERSON STANDARD—A case study on the practical difficulties created by EMTALA and ERISA.

of the state law and ERISA to determine if there is true conflict. The final result is not clear as of yet, though, as evidenced in subsequent confusion in lower courts, discussed infra, Part IV.D.

38 See Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993).


41 See Kuhl, supra note 38, at 302.

42 See Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992)


44 See CIGNA Health Plan, Inc. v. Louisiana, 82 F.3d 642 (5th Cir. 1996); Texas Pharmacy Ass'n v. Prudential Ins. Co., 105 F.3d 1035 (5th Cir. 1997).

45 See e.g. Davidson, supra note 6, and note 7.
A. Impetus Toward Reform of Emergency Care Utilization Review.

The prudent layperson standard has been the second most popular state patient protection measure enacted by states recently.\(^{46}\) Thirty-one (31) states and the District of Columbia provide for use of the PLP standard in some situations. Eight of these states have passed laws ensuring coverage for all emergency services defined by the prudent layperson standard.\(^{47}\) The remaining states and the District of Columbia have passed laws providing for the use of the prudent layperson standard under certain conditions, such as for reimbursement of out-of-area emergency services, or when prior authorization is not required. Additionally, electronic research reveals that 29 federal bills proposing a prudent layperson standard were introduced in the 105\(^{th}\) Congress,\(^{48}\) and 13 bills have been introduced in the 106\(^{th}\) Congress to date.\(^{49}\) Finally, the prudent layperson standard is included in the AMA's model contract.\(^{50}\)

This broad consensus is not surprising when it is estimated that as much as 60% of managed care coverage disputes may involve emergency medical care.\(^{51}\) The reason

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\(^{46}\) See Blecher et al, supra note 33 (bans on physician gag rules are the most popular measure, enacted in 45 states and D.C.).


\(^{48}\) See note 36, supra, for the most well-known.

\(^{49}\) See S. 517; H.R. 904; S. 636; H.R. 1133; H.R. 448; H.R. 719; S.240; S.6; H.R. 358; S.326; S.374; S.300; H.R.216.


coverage for emergency services is so hotly contested appears to stem from the
divergence between the standard imposed on emergency facilities by EMTALA, and the
definitions used by MCOs in after-the-fact review.52

Imagine two common instances in which emergency service coverage is denied by
MCOs. In the first situation, an older, high-risk patient has severe chest pains and thinks
he is having a heart attack. At the emergency room, he is diagnosed with indigestion.
Later, the MCO refuses to pay for the emergency services provided because it was
determined, after the fact, to not be an emergency. In the second situation, a patient is in
a severe car crash and an ambulance rushes her to the nearest emergency room where she
is admitted for surgery without first obtaining prior authorization. Later, the insurance
refuses to pay $40,000.00 of the bill because the patient didn’t first obtain prior
authorization.

EMTALA provides that emergency facilities receiving Medicare funding are to
provide appropriate screening and stabilization to patients presenting to the facility with
an “emergency medical condition,” defined as one,

“manifesting itself by acute symptoms of sufficient severity (including severe
pain) such that the absence of medical attentions could reasonably be expected 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…”53

about the problems concerning emergency medical care in the age of managed care, [Dr. Aghababian
stated] that 40% of the disputes of Medicare involved “in-area” emergency care, while another 20% were
for “out-of-area” emergency care.”

52 See e.g. Diane E. Hoffmann, Emergency Care and Managed Care—A Dangerous Combination, 72
Wash. L. Rev. 315 (1997); Joan Stieber and Linda J. Spar, EMTALA in the ’90s—Enforcement Challenges,

53 42 USC 1395dd(e)(1).
EMTALA was intended to ensure universal access to emergency medical care by providing that emergency facilities cannot deny treatment to indigent or uninsured emergency patients, or endanger an emergency patient’s health by requiring prior-authorization before treatment. However, the Act only speaks to the responsibility of emergency service providers. Accordingly, MCOs can shift risk and costs to medical providers by denying payment to hospital when the medical condition is later found not to be an emergency.\(^{54}\)

As with ERISA, this appears to be another unintended consequence of legislation passed before the full implications of managed care were assessed. It is unlikely that Congress intended to implicitly shift costs to public service providers and reward MCOs for the breach of their contractual obligations.

In response, a number of states have passed similar legislation defining a “medical emergency condition” as one which,

“manifest[s] itself by acute symptoms of severity (including severe pain) such that the average 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.”\(^{55}\)

Because EMTALA spoke in terms of “appropriate” screening and stabilization, it is clear that emergency service providers cannot abdicate all medical evaluation authority.

\(^{54}\) See e.g. Dearmas, supra note 5, at 1108.
Nonetheless, physicians are constrained by their necessary reliance on second hand information, and must screen and stabilize according to symptoms relayed to them. Accordingly, the language "such that the average prudent...could reasonably expect the absence of immediate medical attention to result in..." simply emphasizes that the determination of whether a patient should have presented himself to an emergency department for appropriate screening and stabilization shall be made from the patient’s perspective. The AMA model contract is in accord with this interpretation, as it provides that “a reasonably prudent lay person’ should initially determine what constitutes an emergency. Once the patient is screened, the standard shifts to how the condition would be classified by a reasonably prudent doctor."  

Similarly, the language “who possesses an average knowledge of health and medicine” reemphasizes whose perspective is critical to this inquiry. It further guarantees that patients are not to be held to the knowledge of medical professionals, in deciding to seek emergency service.

For these reasons, commentators argue persuasively that the prudent layperson standard was intended to "bridge the gap" between medical screening obligations imposed by EMTALA and MCOs’ contractual obligations to providers.  

55 See Stieber and Spar, supra note 52, at 76 (emphasis added). All the statutes, including the federal B.B.A., and the federal bills cited in note 45 supra, track this language consistently, which in turn tracks the language in EMTALA itself but for the addition in italics.

56 See Hospital & Health, supra note 50.

57 See e.g. Stieber and Spar, supra note 52, at 76 (that such provisions are “clearly intended to bridge the gap” between those services required under EMTALA, and those which MCOs are obligated to pay).
B. Is the PLP Standard a Restatement of the Objective “Reasonable Person” Legal Standard?

Upon reading the prudent layperson standard, the first question that presents itself is whether it is simply a restatement of our old friend, the objective “reasonable person” legal standard. This is a difficult question. No prudent layperson standard has been adjudicated yet so it is unclear how courts will interpret it. However, analysis of the plain language, legislative and administrative history, and other factors indicates that the PLP would probably be as an objective standard.

The plain language of the provision, when read in its entirety, indicates an objective standard. It could be argued that lawmakers intended all prudent and reasonable persons to monitor their health and seek emergency care if they believe the acuteness of their symptoms, including pain,\(^{58}\) indicate a potentially serious threat to their health. The policy behind such an interpretation would be that health care costs are mitigated with timely care. However, this is an admittedly tortured reading of the statute. First, the standard clearly speaks of “the average... layperson, who possesses an average knowledge of health and medicine.” Second, it expressly refers to reasonable expectations.

Legislative and administrative history also indicates an objective standard. Although interpretations of the Medicare agency, the Health Care Finance Administration (HCFA), and state legislatures could be said to point to a subjective standard, these arguments are easily rebutted. First, the HCFA sought to add “from patient’s

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\(^{58}\) As an interesting side note, MCOs fought the inclusion of pain, even qualified by “severe” for fear of over-utilization. They argued that patients would seek emergency care for “stubbed toes” if pain was included. However, commentators have pointed out that MCOs are particularly insensitive to the issue of patient pain. For example, MCOs tend to under-prescribe pain meds for terminally ill patients.
perspective” to the Balanced Budget Act of 1997 and later to the Presidents administrative bill, The Patients’ Bill of Rights, to avoid confusion with the legal standard.\(^5\) That the attempted amendment was unsuccessful, however, undercuts the argument.

Second, it can be argued that HCFA regulations cumulatively give the impression that claims reviewers are to look to the subjective determination of the patient, and direct reviewers to look for evidence of the patient’s subjective assessment.\(^6\) HCFA regulations specify that the determination of whether or not an emergency existed is to be made at the time of service, to avoid putting enrollees in the unreasonable position of making quasi-clinical evaluations. It is also recommended that evaluation consider statements by the members that imply his or her lay assessment of an emergency medical condition. This is a better argument than the first, but the regulations are probably still better understood as specifying the type of proof of objective lay assessment preferred.

Finally, legislative history of the New York Health Care Coverage Protection Act provides that the prudent layperson was intended to “allow for more reasonable errors” in patients’ assessments.\(^6\) However, the New York legislature also intended a “more objective standard” to prevent MCOs from using their own, stricter definition of

\(^5\) See e.g. Stieber and Spar, supra note 52, at 78.

\(^6\) See Hoffman, supra note 52, at 407, n. 222, n. 238, and n. 241, citing the following: David Richardson, Network Design Group, HCFA Coop Agreement No. 17-C.90070/2-01, Study, Sep 1993, pg. 3-4 (agency wanted to avoid putting enrollee in unreasonable position of making quasi-clinical evaluations of condition); CCH Medicare & Medicaid Guide, P13,960.22, at 5842 (HCFA regulations amended so that emergency is determined at time of service, and claims are not to be retrospectively denied simply because condition turned out to not be an emergency); June 1994 at 2, Reconsideration Notes, NDG (to consider statements where member clearly indicated or implied his lay assessment).

\(^6\) See Everhart, supra note 18, at 532.
emergency. It would follow that, if the legislature intended to cabin subjective determinations by MCOs, the same standard should apply to patients.

The remaining factors, the PLP's origin and its likely effects, provide mixed support for an objective interpretation. As to origin, the Balanced Budget Act of 1997 and the various state statutes are all based on the first prudent layperson standard, that of Maryland. Maryland observes a strictly objective standard which it often calls the 'prudent layperson standard,' in its general contract law. This suggests that the PLP is not a new subjective standard. Furthermore, as the originator of the prudent layperson medical emergency standard, Maryland's interpretation should be extremely persuasive. However, this argument is weak if all the acts, including the Maryland law, are really based on EMTALA. The better argument is that the objective standard was selected to avoid subjective determinations on part of MCOs.

As to effects, some commentators have argued that the prudent layperson standard tends to be too subjective as it is, and many or even most visits to an emergency department are inappropriate. However, as will be explained below, the data is not conclusive on this issue and statistics of inappropriate utilization actually range from 10.2% to 46%.

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62 Id.

63 See Scott A. Conwell, Recent Decisions in the Maryland Court of Appeals, 57 Maryland. L. Rev. 706, 728, n. 50.

64 Compare the influence of Illinois jurisprudence regarding Long Arm Statutes.

65 See Hyman, supra note 18, at 441-442.

66 Id., at 432.
On balance, prudent layperson legislation will probably be interpreted as an objective standard. This conclusion is supported by plain language, history of the act, logic and equitable considerations. However, this should not make an enormous difference from the average patient’s perspective. Today, medical care is so complicated and specialized that the “average knowledge of health and medicine” is pretty minimal and inaccurate. Thus, there is a “dumbing-down” of a standard based on the “average” person, in the case of healthcare.

C. Economic Implications of the Prudent Layperson Standard.

As a general economic proposition it is clear that, all else being equal, increased medical benefits and flexibility of use translates to greater insurance cost. This is particularly significant in light of fact that MCOs had been popularized precisely for their cost-containment abilities. However, it has not been established that the use of a prudent layperson standard will dramatically increase costs, or the risk of inappropriate and over-utilization of emergency facilities.

There are three separate factors that indicate that the prudent layperson standard will not increase the healthcare costs of patients substantially, and further, will promote economic efficiency.

First, there is no evidence that the use of the prudent layperson standard will translate to a direct and substantial increase in insurance costs. When Medicare instituted the prudent layperson standard under the Balanced Budget Act of 1997, it did not appear to have a significant effect on claims, as 78% of denials have been upheld under the new
standard. Furthermore, a study by the health care finance organization Kaiser Prominente projects that the use of the prudent layperson standard will increase costs by less than 1%, raising premiums by an additional $1.20 a year per insured person. Finally, there is criticism that the savings due from restricted access to emergency services has not materialized, while patients are exposed to unnecessary risk. In terms of industrial organizational economics, this is not surprising—large industries with concentrated market power often simply absorb savings derived from economies of scale as profits, because they can.

Second, the prudent layperson standard simply corrects inadvertent cost-shifting effected by EMTALA. In so far as cost-shifting creates distortion, and restricts the inability to determine the ideal allocation of resources and preferences, this must be recognized as an economic benefit despite its intangible nature.

Finally, there is empirical data that suggests that the threat of inappropriate or over-utilization has been exaggerated. First, while some studies posit that 43% to 46% of the visits to emergency rooms are inappropriate, these figures include undisclosed statistical outliers that should not be considered in evaluating the economic impact of the prudent layperson standard. For example, omitting marginal or hard-to-

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67 See Hoffmann, supra note 52, at 365.
distinguish cases reduces the value to 25 to 30%. These cases should rightly be excluded from the sample because the prudent layperson standard seeks to minimize the risk of forcing laypersons to make exactly this sort of quasi-clinical evaluations. Similarly, omitting "sub-variations," or those classes of people lacking average knowledge of health and medicine, drops the value to 10.2%. Since we have concluded that the prudent layperson is intended as an objective standard, these cases should also be excluded from the sample because they would not be covered under the prudent layperson standard.

Second, inappropriate utilization has not stemmed solely from irascible patients. A study of emergency room utilization in Tennessee over the course of two summers suggests that problems have stemmed from flaws in MCO prior-authorization procedures as well. The study demonstrated that 37% of the emergency room patients did not have a primary care doctor, or did not know his or her name, and that 40% of those who tried to contact their primary care physician or other prior-authorization point-of-contact were unsuccessful.

In conclusion, I submit that MCOs' mantra of "rising prices" is largely empty rhetoric designed to frighten consumers and critics. While premiums will increase somewhat, it looks to be by only a nominal amount. Furthermore, the risk of cost...

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72 See Williams, supra note 70.

73 See e.g., HCFA Cooperative Agreement No. 17-6.90070/2-01, Sep 1993, p. 3-4, cited in Hoffman, supra note 63, at 407 n. 222 (that the agency wanted to avoid putting enrollee in the unreasonable position of making a quasi-clinical evaluation of his condition).


increases due to over-utilization appears to be equally inflated, and controllable by improved prior-authorization protocols. Contraposed to these arguments by MCOs is the undisputed facts of distortive and hence inefficient cost-shifting to providers and patients.

D. Will ERISA Preempt State PLP Acts?

Despite the clear need for a prudent layperson standard, today such a standard initiated by states is in danger of preemption under § 502 and § 514(a) of ERISA. The basic ERISA preemption analysis that has evolved is not favorable to the prudent layperson standard because it is directed to MCOs, while ERISA was written and has been largely interpreted in the context of traditional insurance. Some of the problems could be overcome if courts were to commit themselves to being more careful with the language they use, and to keeping in mind the prevalence of the managed care model. However, it is unlikely that such a change could occur in time under the present state of law, because lower court confusion has continued even when the Supreme Court has laid down relatively clear rules.

1. Basic ERISA Preemption Analysis.

ERISA preemption analysis appears fairly straightforward and devastating to the prudent layperson standard, providing four separate opportunities to find preemption. First, under established reasoning, the prudent layperson standard is preempted because it “relates to” employee benefit plans. Second, the PLP is unlikely to be “saved,” at least in some jurisdictions, as traditional state regulation of insurance because it is directed

76 § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), Savings Clause (provides that “nothing in this subchapter shall be construed to exempt or relieve any person from any State which regulates insurance, banking, or securities”).
toward MCOs rather than towards the "insurance industry." Third, assuming the FLP is saved, the language of a number of cases suggests that it could be preempted under the "deemer" clause. Finally, if claims brought under a prudent layperson standard are viewed as claims based on improper processing, they will still be preempted under § 502.

Section 514(a) provides for the preemption of "any and all State laws insofar as they now or hereafer relate to any employee benefit plan." Under Shaw "relate to" has been broadly interpreted on the basis of plain language and legislative history to mean only that the law has a connection with or reference to such a plan. The reasoning behind such extraordinarily expansive preemption power was that Congress was seeking to "eliminate the threat of conflicting and inconsistent State and local regulation," and had expressly rejected earlier bills that provided for preemption only of those state laws conflicting with substantive provisions of ERISA.

77 § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), Deemer Clause (provides that "[a]either an employee benefit plan...nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer,...or to be engaged in the business of insurance for purposes of any law of any State purporting to regulate insurance companies [and] insurance contracts").

78 See note 3, supra, at 96. But see Richardson, supra note 6, at 694. While the Supreme Court read the legislative record to provide unconditional support for broad preemption, Richardson informs us that "[a]fter passage, House and Senate Members disagreed on the desirability of the preemption clause." While the House sponsor, Representative Dent, called the clause ERISA'a "crowning achievement" (120 Cong. Rec., 29,197 (1974)), other members viewed it differently. For example, its sponsor in the Senate, Senator Javits, suggested that the "desirability of further [state] regulation" necessitated that § 514(a) be refined (120 Cong. Rec., 29,942). Additionally, Senator Harrison Williams, a co-sponsor, "suggested in no uncertain terms that the preemption clause was obviously the result of interest group politics" (120 Cong. Rec., 29,933).

79 See e.g. 120 Cong. Rec. 29,197 (1974) (Statements by Representative Dent), cited in Shaw.
This broad interpretation of “relate to” has since been restricted in *N.Y. State Conf. Of BCBS v. Travelers Ins. Co.* 80 However, the prudent layperson standard does clearly relate to employee benefit plans, as it seeks to impose minimum standards of access and administrative review on MCOs and HMOs, the vehicle of most ERISA-covered employment health benefit plans today.

Meanwhile, there are a number of problems in applying ERISA’s savings clause to state prudent layperson acts to avoid ERISA preemption, because such laws are directed to MCOs as opposed to traditional insurers. As interpreted by the U.S. Supreme Court in *Metropolitan Life*, the savings clause requires that state legislation meet the following requirements. 81 First, the legislation must regulate insurance in a “common-sense view.” For example, *Pilot Life* found that bad faith claims did not meet this threshold requirement, because the cause of action had its roots in common law tort and contract law, despite its formal identification with insurance. In contrast, *Metropolitan Life* found that state laws mandating minimum benefits did meet the “common sense” test. It is not inconceivable, though, that some jurisdictions could find that the prudent layperson standard fails on this account because it is directed to MCOs in particular, 82 or because it is in reality a health law. 83

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80 514 U.S. 645 (1995) (holding that simple increase in the cost of administration alone, applicable whether or not commercial insurance is obtained through an ERISA governed plan, does not constitute sufficient “relation to” ERISA plans).

81 See note 13, supra, at 740-743.

82 For example, *Pilot Life*, supra note 3, at 50, specified that “a law must not only have an impact on the insurance industry, but must be specifically directed toward that industry.”

83 Although this latter distinction was supposedly disposed of by the Supreme Court in *Metropolitan Life*, supra note 13, at 741, lower court confusion as to more clearly stated principles should warn us from being too quick in presuming that an ERISA preemption question has been settled. See infra, Part IV.D.3.
Second, the legislation must regulate the "business of insurance," according to the three factors enumerated in *Union Labor Life Ins. Co. v. Pireno*.

84 The law must be regarding the spreading of risk, be related to the contract or policy between the parties, and its application must be limited to entities within the insurance industry.

85 The only *Pireno* factor that the prudent layperson standard clearly meets is that of relating to the contract between parties, by specifying a statutory definition of "emergency medical condition." The standard only spreads the risk of inaccurate layperson emergency evaluation, rather than foreseeable risks of injury as envisioned in *Pireno*. Furthermore, the PLP standard is not limited to traditional insurers, and is in fact directed toward MCOs. This factor in particular, has been the death of state reform efforts in the Fifth Circuit.

86 Even assuming the prudent layperson standard is saved, it could still be found to regulate employee benefit plans "deemed" to be insurance companies or contracts for the purpose of state regulation. To date, the U.S. Supreme Court has only interpreted the deemer clause to prohibit state regulation of self-funded employee benefit plans.

87 However, the language of both the deemer clause and the Supreme Court's opinions could support a broader rule.

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85 The factors have generally been understood in the conjunctive. However, both the Sixth and the Ninth Circuits have rejected the requirement that all three *Pireno* factors be met. See Davies v. Centennial Life Ins. Co., 128 F.3d 934, 940 (6th Cir. 1997); Cisneros v. UNUM Life Ins. Co., 134 F.3d 939, 946 (9th Cir. 1998).

86 See e.g. CIGNA, supra note 55, and Texas Pharmacy, supra note 55, regarding any willing provider statutes.

The clause specifies that "an employee benefit plan...shall [not] be deemed to be an insurance company, or other insurer...or to be engaged in the business of insurance for purposes of any law of any State purporting to regulate insurance companies [and] insurance contracts." In Metropolitan Life & Holliday, the Supreme Court noted that this clause prevents states from regulating employee benefit plans directly, and that such plans can only be regulated indirectly through the regulation of insurance. This raises the question of whether mandating minimum benefits to be provided by MCOs constitutes regulation of insurance contracts or regulation of employee benefit plans.

Finally, assuming the prudent layperson standard is saved and not then preempted under the deemer clause, it may still be preempted under § 502 if claims brought under a prudent layperson standard are viewed as claims based on improper processing. For example, in Pilot Life the Court found that a bad faith breach of contract claim was in reality based on a claim of improper processing, despite its formal identification with state insurance law. A claim under the prudent layperson could easily be re-characterized in a similar manner, because it is at bottom based on a claim of improper denial of benefits.

2. Particular Problems Associated with Applying ERISA Preemption

Analysis to MCOs.

As the foregoing analysis has demonstrated, a number of questions related to MCOs remain unaddressed by the courts. Because of this, the typical ERISA preemption

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88 See Pilot Life, supra note 3, at 52.

89 See Richardson, supra note 6, at 705 (that the essential goal of HMOs, cost-containment, requires HMOs to retain a certain degree of control over the provision of medical care, and that § 502 complete preemption
analysis becomes swamped in uncertainty when it begins with recognition of MCOs' dual roles as healthcare insurers and providers.

First, it is unclear whether MCOs will ultimately be held to be insurers or entities outside of the insurance industry. For example, the Fifth Circuit has twice preempted any willing provider statutes because they applied to MCOs. In each case the statute was held to fail the third prong of the *Pireno* test under the savings clause, because the statute was not directed exclusively to the insurance industry. In contrast, the Fourth Circuit and a federal district court within the Sixth Circuit have held that such a statute is saved, even though it is directed to MCOs.

In particular, the district court in *Ex rel. George Nichols II* noted that the differences between traditional insurers and HMOs are insufficient to establish that a statute regulating both is not limited to entities within the insurance industry. Citing *SEC v. Variable Annuity Life Ins.*, the court warned that insurance is an evolving institution, and that courts should not undertake to freeze the concept of insurance.

Second, it is unclear whether MCOs will eventually be held to be employment benefit plans. As discussed above, the deemer clause prevents states from regulating employee benefit plans, as opposed to the insurer providing the plan. Thus, a finding that

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would apply to state law claims challenging the ability of HMOs to contain costs through its structural characteristics such as utilization review).

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90 See *CIGNA Health Plan*, supra note 55; *Texas Pharmacy Ass'n*, supra note 55.


MCOs are insurers rather than employment benefit plans, would remove the danger of preemption under the deemer clause.

Because of their dual role, MCOs can be termed both a plan for the provision of health benefits, and the insurer providing the plan. ERISA itself is not particularly helpful on this point, only defining employment benefit plans as the “provision of benefits for contingencies such as illness, accident, disability, death, or unemployment.”

Brooks Richardson argues persuasively that MCOs are not employment benefit plans, but rather simply the means by which employee benefit plans provide the benefit of affordable healthcare coverage. In Travelers, the U.S. Supreme Court also appears to have implicitly recognized that HMOs are not employment benefit plans, since it noted that employee benefit plans could choose to “purchase insurance policies or HMO memberships.” If lower courts take notice of this language, this question, at least should be resolved.

Third, it is unclear whether mandated minimum benefits imposed on MCOs constitute a regulation of benefits, or a regulation of benefit plans. A finding that mandated minimum benefits such as the prudent layperson standard are regulation of benefits could hypothetically cut the Gordian knot of ERISA preemption, under Halifax.

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94 § 3(1), 29 U.S.C. § 1002(1).
95 See Richardson, supra note 6, at 702-704.
96 Supra, note 37, at 1679. However, it does need to be kept in mind that these statements were made in the context of "relate-to" analysis. The lower courts may decline to apply the principle in the context of savings or deemer analysis. Additionally, the Court's reference to insurance and HMOs as two separate entities further complicate analysis. Ideally, the Court should have made it clear that MCOs and HMOs are the "other insurers" referred to in § 514(b)(2)(B) (deemer clause).
In that case the Supreme Court held that only laws relating to employee benefit plans, not those relating to employee benefits, are preempted.\textsuperscript{97}

However, these analytical difficulties are not likely to be resolved by the courts soon. Confusion has continued in the lower courts even as to those issues that have been clearly resolved by the Supreme Court. For example, the Court indicated in 1988 that “run of the mill torts” such as medical malpractice would not be preempted.\textsuperscript{98} Nonetheless, a number of courts have held a variety of such torts to be preempted since then.\textsuperscript{99} Furthermore, there are a number of questions that have not yet reached the Supreme Court that have given rise to conflicting circuit interpretations, such as the case of the any willing provider statute described above. Accordingly, it is not realistic to expect the lower courts to resolve these issues, at least not in the prompt, systematic and comprehensive fashion which an issue as prominent as healthcare demands.

V. CONCLUSION AND FORECASTING.

On the basis of the foregoing, it is clear that the U.S. Congress has to confront this issue squarely. Analysis has demonstrated that no state healthcare reform effort can be clearly secure from federal preemption in today’s confused legal environment. Furthermore, even if the courts were inclined to radically revamp preemption analysis as

\textsuperscript{97} See \textit{Ft. Halifax}, supra note 37, at 7. \textbf{But see} note 89, supra (that regulation of an HMO’s cost containment mechanism could be preempted § 502).


\textsuperscript{99} See \textit{e.g. Settles}, supra note 39 (fraud and misrepresentation); \textit{Elsesser}, supra note 39 (fraud and misrepresentation); \textit{Sanilotoro}, supra note 40 (breach of fiduciary care); \textit{Kuhl}, supra note 38 (tortious interference with contractual relations); \textit{Corcoran}, supra note 42 (negligence); \textit{Jass}, supra note 43 (medical malpractice); \textit{Dukes}, supra note 43 (medical malpractice).
to MCOs, it would necessarily be done on a piecemeal basis, as appropriate issues were presented.

That the courts themselves are frustrated by the impasse of legislative inaction is evidenced in the memorandum opinion of *Andrews-Clark v. Travelers.* The judge there acknowledged that ERISA remedies were inadequate in a day where 75% of Americans are insured through MCOs, and he clearly wanted to find for the plaintiff. Nevertheless, he took judicial notice of all the federal bills pending regarding patient protection, and concluded that Congress was aware of the problem and that it was their lack of action causing the problem. He ended his opinion with, “WHO CARES? DO YOU?”

The only viable solution to today’s impasse is legislative action. Such legislation could go one of several routes. First, Congress could institute nationally mandated minimum benefits and patient protections, such as the prudent layperson standard among others. This would have the benefit of prohibiting the multiplicity of conflicting legislation that ERISA preemption ultimately seeks to prohibit. However, there is considerable resistance to federal encroachment onto areas of traditional state police power such as insurance regulation and health and welfare laws. This is evidenced by the failure to mandate such benefits to date, despite widespread recognition of its necessity.

Alternatively, Congress could amend ERISA to permit state law actions for injury or death, and to provide that no state law will be preempted so long as the state law

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101 See *Travelers,* supra note 37, at 1677.

102 See e.g. 1998 H.R. 1415, Patients’ Access to Responsible Care Act, § 4(a).
does not actually prohibit the application of ERISA's substantive provisions. The problem with this is that it would permit employee benefit plans to purchase different benefits according to varying state law.

Despite their problems however, such legislation is the only thing that will permit future MCO regulation, in a day when such regulation is sorely needed. Absent some kind of reform along these lines, the public cannot be guaranteed access to reasonable emergency care without fear of preemption under ERISA jurisprudence.

103 See e.g. 1998 S. 356, Access to Emergency Medical Service Act, § 3(f).