

# The Impact and Enforcement of Prudent Layperson Laws

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**Study objective:** Almost every state has enacted a “prudent layperson” standard for determining insurance coverage for emergency department (ED) services. This study evaluates whether these laws are achieving their goals or causing unintended side effects.

**Methods:** Six states were selected for in-depth case studies to represent a range of market, demographic, and legal conditions. In each state, 11 to 15 interviews were conducted with insurers, regulators, providers, employers, patient advocates, and industry observers, for a total of 87 interviews. In addition, regulators in all 50 states completed a written survey about likely enforcement responses for hypothetical violations of these laws.

**Results:** Basic compliance with prudent layperson laws appears to be widespread. Regulators actively enforce these laws, and most subjects reported no systematic violations. Insurers explained that it is difficult to operationalize a coverage standard that relies on patients’ experience of symptoms rather than on providers’ assignment of diagnostic and procedure codes. No strong evidence was found that these laws have significantly increased insurance costs, which is due in part to various strategies insurers have adopted to reduce payments to providers for ED services and to greatly increase patients’ copayments. Accordingly, few subjects believe these laws have increased inappropriate ED use.

**Conclusion:** Prudent layperson laws have helped to catalyze industry-wide changes in how health insurers review ED claims and how they manage ED costs. Whether these changes, on balance, are beneficial to patients and to society requires further study focused on outcomes and system-wide costs.

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## INTRODUCTION

Since 1997, 48 states have implemented a package of managed care “patient protection” laws or a “patients’ bill of rights” to protect against abuses by managed care organizations.<sup>1</sup> Prominent among these protections is a provision, known as a “prudent layperson” law, that affects coverage for hospital emergency department (ED) services.<sup>2</sup> Prudent layperson laws have been adopted by 47 states, and this is one of the managed care protections required by Medicare and Medicaid and by the Federal Employees Health Benefits Program, among others.

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**Editor's Capsule Summary*****What is already known on this topic***

Despite widespread adoption of prudent layperson laws defining an emergency medical condition, disagreement persists about their impact on emergency department (ED) use and about the definition of "prudent."

***What question this study addressed***

In this qualitative study, researchers interviewed 87 insurers, regulators, providers, employers, patient advocates, and industry observers, representing a wide range of stakeholders in 6 selected states, to determine their assessment of prudent layperson laws.

***What this study adds to our knowledge***

Most respondents in this qualitative study believed that basic compliance with the standard is widespread and that prudent layperson laws have not led to an increase in inappropriate ED use. Some compliance problems were noted, including a subgroup of insurers that initially deny claims but then quickly reverse their decision when the denial is challenged. Insurer costs appear to have been passed on to the patient in the form of higher copayments for emergency visits.

***How this might change clinical practice***

Although the insurance industry appears to have made significant changes in how it reviews ED claims and manages ED costs, it is not clear whether these changes are primarily a result of prudent layperson laws or if they reflect a much broader trend away from utilization control. The findings highlight the challenges of implementing a standard based on a patient's perception of symptoms, as well as designing legislation to achieve a particular goal.

Although prudent layperson laws are not worded identically, in essence they all require that the urgent or emergency nature of a patient's condition be judged according to the patient's presenting symptoms rather than on the eventual diagnosis of the patient's problem. Moreover, whether the symptoms reasonably warranted immediate attention is to be judged from the perspective of an ordinary person.<sup>3,4</sup> Thus, for instance, chest pain is still an emergency even if it turns out to be due to indigestion, and ED visits may be justified for an upset stomach that turns out not to be food poisoning or for a baby with an elevated temperature that quickly resolves.

These laws are intended to address the concern that some, perhaps many, health insurers were refusing to pay for ED visits they judged to be unnecessary under managed care provisions that require previous authorization for nonurgent treatment or that restrict coverage to only facilities within a contracted network in the absence of an emergency.<sup>5</sup> Restricting access to emergency services was one of the most prominent complaints made in the backlash against managed care.<sup>6</sup>

Therefore, these laws had broad support in legislative initiatives to protect patients. For instance, they were contained in all of the competing versions of the federal patient bill of rights legislation that has been debated during the past several years (but not enacted). Even the managed care industry did not oppose these laws.<sup>7</sup>

Despite this consensus, questions remain on a number of fronts. Some critics thought that these laws were unneeded because the perceived problem was overstated or the industry was reforming itself. Others believed that these laws would cause an unjustified increase in costs by accelerating the inappropriate use of EDs for ordinary primary care, and concerns were raised about whether a standard as vague as "reasonable" or "prudent" could be administered adequately.<sup>7</sup> To date, no systematic evaluation has been reported of the enforcement and impact of these laws across the country, so it is unknown whether, and to what extent, these concerns might be valid.

**MATERIALS AND METHODS**

This article reports on one aspect of a larger study of the effects of state managed care patient protection laws, such as prudent layperson laws, but also including external review, access to specialists, managed care liability, restrictions on gatekeeping, and other provisions. The focus was on laws affecting private insurers, but the findings may also be relevant to similar laws affecting public insurance. After a review of all 50 states, 6 states were selected in 2002 for in-depth case study interviews—Iowa, Louisiana, Michigan, New Jersey, Texas, and Virginia—to reflect a range of market, demographic, and legal characteristics. Each state has a prudent layperson law, but they were enacted at different times, ranging from 1995 (Virginia), to 1997 (Louisiana, New Jersey, Texas), to 1999 (Iowa) and 2000 (Michigan). These states reflect geographic and demographic diversity and a range of market conditions from heavier (Michigan, New Jersey) to lighter (Iowa, Louisiana) penetration of managed care.

In each state, 11 to 15 confidential interviews were conducted with key informants, including health plan managers, providers, regulators, patient advocates, employers, insurance agents, and various industry observers (Table). In addition, 8 interviews were conducted at the home office of 5 national health plans, including 3 of the country's 5 largest plans. Interview subjects were purposefully selected to represent a wide range of views but also to capture the representative or typical views for their particular sectors and markets.

The principal investigator (MAH) compiled a list of potential subjects through various sources, such as the existing lists noted below and independent research in newspapers and the trade press. If the person identified at an institution did not believe he or she was the best source for this study, a recommendation was sought for an alternate person, who was contacted instead. Interviews often were held with more than 1 person at once from the same institution.

Subjects were recruited by telephone or e-mail. The study was described as an in-depth investigation of the effects of state managed care patient protection regulation, funded by the Robert Wood Johnson Foundation but directed independently by the author at Wake Forest University. To enhance recruitment, endorsements of the study were obtained from various organizations, and the endorsements that were most relevant were mentioned to subjects. These endorsements came from the Medical Group Management Association, the National Association of Managed Care Regulators, the American Health Lawyers Association, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. (However, these organizations do not necessarily endorse the findings or conclusions reached in this study.)

The Table summarizes the composition of interview subjects who addressed issues relating to prudent

layperson laws. In each state, the Blue Cross plan participated, along with 2 or 3 of the larger local or regional health maintenance organizations (HMOs) in all states except New Jersey (although there, interviews were held with 2 national plans active in the market). Also, the medical society participated in each state, and the patient advocates and industry observers were recruited from among the leaders or experts identified by other subjects in each state. Regulators were those with primary authority for enforcing these laws. A convenience sample of interview subjects from other groups, such as insurance agents, physician group managers, and health benefit managers, was selected using directories from professional or trade organizations.

Interviews were semistructured, following interview guides that were developed through consultation with a panel of expert reviewers, and then field tested. (These are available as an Appendix at <http://www.mosby.com/AnnEmergMed>.) Interviews were conducted by 3 investigators with expertise in managed care regulation. More than half of the interviews were conducted by the principal investigator (MAH). About one fifth were conducted by Janice S. Lawlor, MPH, a research associate working directly under the principal investigator's supervision, and approximately one fourth were conducted by Elliot Wicks, PhD, a health economist at the Economic and Social Research Institute in Washington, DC, who func-

**Table.**  
*Location and type of interviews.*

Type of Subject	Location							Total
	Iowa	Louisiana	Michigan	New Jersey	Texas	Virginia	Other	
<b>Regulators</b>	1	1	1	2	1	1		7
<b>Health plans</b>								
Blue Cross	1	1	1	1	1	1	1	7
Local/regional HMO	2	1	1		3	1		8
National health plan	1						7	8
<b>Medical practices</b>								
Primary care		1	1	1	1			4
Specialty	1				1	1		3
Multispecialty	1	1	2	1		1		6
<b>Professional associations</b>								
State medical society	1	1	1	1	1	1		6
Hospital association				1	1			2
<b>Employer health benefits manager</b>								
Fully insured plans only	1	1	1	2	1	1		7
Self-insured plans only		1	2		1	1		5
Insured and self-insured plans	5	2	1			1		9
<b>Independent insurance agents</b>	1	1	2		1	2		7
<b>Patient advocates</b>		1	1	2	1			5
<b>Observer/other</b>			2			1		3
<b>Total</b>	15	12	16	11	13	12	8	87

tioned as an independent research colleague. There was substantial variation among interviews in the depth and breadth of discussion of different topics to focus on the topics of particular relevance to different interview subjects. Interviews lasted from 30 to 60 minutes, but only 2 to 10 minutes were devoted to prudent layperson laws.

Interviews were not transcribed. Instead, the expert interviewers wrote detailed notes that were coded systematically by the study's lead investigator (MAH) to identify relevant themes. These coded notes were entered into the software program NUD\*IST (QSR International, Melbourne, Victoria, Australia) for qualitative analysis by this article's author, using standard qualitative techniques.<sup>8-10</sup>

This report is based on 87 interviews that included some discussion of prudent layperson laws (Table). These consisted of 23 interviews with health insurers, including 8 with national insurers; 21 interviews with providers (hospitals and physicians) or their representatives (such as trade associations or lawyers); 28 interviews with human resource benefit managers, insurance agents, or employer representatives; and 15 interviews with regulators, patient advocates, and industry observers. For convenience, these 4 groups will be referred to as insurers, providers, employers, and observers. All interview notes referring to prudent layperson laws or to coverage of emergency services were extracted from the database and sorted into these 4 categories of interview subjects. Responses were tabulated within each group for each of several themes discussed below that emerged as significant to determine the extent of agreement or disagreement within each theme and among these groups of subjects. For each theme, opinions and reported behaviors within each group and each state were compared with those noted in other groups and other states to determine the extent of convergence or divergence in views and reported behaviors.

In addition, a written survey (with telephone follow-up as needed) was conducted in the second half of 2001 of regulators in all 50 states with relevant authority over the enforcement of these laws. Regulators were asked how likely they would be to detect a "health plan that repeatedly was unreasonable in refusing to pay for emergency room care" (almost certain, very likely, somewhat likely, 50/50, unlikely) and what the "most likely" enforcement response would be if such a repeated practice were detected (only order that the practice cease or issue a fine or penalty).

Institutional review board approval was obtained for the interviews and the regulator survey. Verbal assent

was obtained from all interview subjects, and subjects were promised anonymity.

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## RESULTS

Overall, prudent layperson laws have had a significant impact on how managed care insurers determine coverage for emergency services. Most subjects, from all perspectives, thought that coverage for emergency services was being denied at some point before these laws more on the basis of ultimate diagnosis than on presenting symptoms and that these laws have largely corrected such practices. Most insurers (16 of 20) said they had changed their practices because of these laws, and the rest said they had previously changed in response to the public and provider pressures noted below. Almost all providers, regulators, employers, and observers said that now they experience or hear about few or no denials for emergency care according to lack of medical appropriateness or failure to obtain referrals. Any differences in these views did not vary noticeably by state or according to whether coverage is insured versus self-insured.

Dissenting views were heard from only about one quarter of the interviews with employers and providers (spread across 5 states), who said this is still a problem area that generates a significant number of complaints or appeals. Similar views were not shared by any regulators, patient advocates, or other industry observers. However, 2 patient advocates commented that the prudent layperson standard, by its nature, does not work well to resolve issues about emergency mental health care because the mentally ill, by definition, tend not to be "prudent," and mental health crises involve a different kind of urgency than physical ailments.

Among the 6 employers who saw ED claims as a continuing problem area, 2 attributed the source of the problem to insurers who made it a policy to first deny coverage but then agree to coverage only after the claim is refiled or a request is made for reconsideration. This practice was admitted to by only one insurer, however. Another insurer said that it still denies coverage about as often as before, only for reasons that are more "focused" on the new statutory language, such as the absence of a "sudden onset" when symptoms have been present for several days or for failing to notify the primary care physician within 48 hours after admission. The rest of the insurers said they routinely "just pay" everything that plausibly appears to be urgent.

This level of compliance may be the result of the active regulatory oversight that was reported in the sur-

vey of state regulators. Regulators in 40 states (80%) thought they would be “almost certain” or “very likely” to detect a repeated violation of this law, and 27 (59% of those responding) said they would impose a fine rather than merely order the health plan to cease the practice. Although regulators may have a bias toward overestimating their likely enforcement response, these projections are confirmed by the actual enforcement activity for related laws such as “prompt payment statutes.” In the same survey, regulators in 23 states reported fining insurers that violated some aspect of managed care patient protection laws, usually prompt payment laws, and some of these fines have been very large, amounting to several hundred thousand dollars.<sup>1</sup> However, no relevant fines were reported in 17 states, and no state reported fines directed toward prudent layperson laws.

Although most interview subjects agreed that coverage denials for emergency care are no longer a significant problem, several subjects disagreed with the view that prudent layperson laws are primarily responsible for this improvement. A few (5) providers and observers thought there was not a significant problem before the law changed or that the problem was correcting itself. Four insurers (2 national and 2 local) said that they have always used a prudent layperson approach, and so these laws simply “codified existing practices.” A large, national insurer that changed its practices said it did so partly because of the threat of lawsuits with large punitive damages, rather than simply the change in regulatory law. Also, this insurer noted that it changed its practices uniformly across the country when coverage of emergency care first became an issue, rather than one state at a time, only as particular laws were adopted.

Five employers that believed the situation had improved attributed the improvement more to efforts to educate employees about managed care rules than to any legal changes. Two other employers thought improvement came from providing better access to urgent care through primary care clinics. Several insurers reinforced this view by noting that excess use of emergency services is often due to inadequate after-hours call service or the lack of urgent care alternatives from primary care physicians. Therefore, rather than deny coverage, they profile physician practices for patterns of excess ED use so they can intervene with certain physicians to improve their after-hours coverage. Some insurers also noted using financial incentives such as capitation or risk pools to reinforce primary care physicians’ motivation for reducing ED costs.

Another qualifying view about the effect of these laws was heard from several providers (5), who noted that the prudent layperson standard does not promote access per se, only payment. These subjects explained that, under the federal Emergency Medical Treatment and Active Labor Act (or “patient anti-dumping law”), hospital EDs were already required to at least screen everyone who presents. Therefore, there was not a problem with denial of care by EDs; the only issue was who is responsible for paying after treatment is rendered. Under this view, hospitals previously were put in the difficult situation of having to treat patients and then being denied payment by insurers and also being unwilling or unable to collect from many patients directly. Hospitals noted, however, that this payment problem is only partially alleviated by these laws because disputes still remain about the amount of payment. For instance, some hospital subjects complained bitterly about the practice of insurers paying only a small amount, such as \$50, intended only to cover initial triage or screening, rather than paying for the full battery of tests and treatment that was performed.

Several insurers confirmed these and related practices. One insurer thought that the law requires coverage only through screening, but once it is determined a condition is not urgent, then further treatment costs are not covered, even if performed during an ED visit that initially was prudent because of presenting symptoms. However, this insurer noted that it is difficult to make this determination without reviewing actual medical records, which is expensive, so it takes this stance only in certain cases. Other insurers said that, in response to these laws, they now are “more aggressive” about negotiating fixed or bundled rates with network hospitals for different levels of ED care, and they conceded that this practice produces disputes about which levels apply to which patients and treatments. Payment disputes also arise when emergency care is rendered by nonnetwork providers. Contrary to the assumption that such care must be paid at 100% of billed charges, some insurers said they refuse to pay any more than their normal negotiated rates, claiming that anything more is not “usual, customary, and reasonable.” When hospitals appeal, the parties typically settle on a payment that is negotiated case by case.

Regarding the appropriate utilization of ED services, most insurers believed that an increase in costs because of inappropriate use is an inevitable result of these laws. However, none was able to document whether or to what extent this increase might have occurred, and one

said it is only a “blip on the radar screen.” One way insurers might contain costs is to review carefully when emergency services are in fact “prudent” according to the patient’s experience of symptoms. A number of insurers said they attempt to operationalize the prudent layperson standard at least to some degree with computerized lists of particular symptoms that identify claims meriting more detailed review. For instance, one large insurer said they might flag a claim for review according to symptoms of a common cold, but it would not automatically deny the claim. In fact, it would automatically pay ED claims for an earache or for chest pain that turned out to be heartburn, rather than attempting to determine which of these is and is not severe enough to warrant immediate attention.

Likewise, most of these insurers said they have greatly reduced or eliminated their efforts to conduct this type of review. They noted that it is difficult to construct an efficient, automated claims processing system according to symptoms rather than diagnoses. As one insurer noted, these laws are passed with the assumption that each claim is reviewed individually, but this is not the case for the vast majority of claims. Conducting a detailed review is costly, involving a request for the full medical record, which is feasible only for more expensive claims and only if such reviews produce a fair number of denials. However, the experience of most insurers has been that they are seldom able to document in a manner that will withstand legal challenge that an ED encounter was imprudent from the patient’s perspective. As one insurer said, there is “no way to get into the head” of each person to determine whether he or she acted reasonably. One insurer even created a committee composed in part of laypeople to apply the prudent layperson standard to cases selected for review, but this committee proved to be too cumbersome.

Therefore, most insurers said they now seldom deny claims for emergency care, or they do so much less often than before. In the words of one, “it’s not really a ‘prudent layperson’ standard; it’s an ‘any emergency room’ standard.” However, as one HMO noted, they do not tell patients this. Instead, classic HMOs still stress the standard gatekeeping and network requirements, including the need to notify the primary care physician within 48 hours after receiving emergency care.

Among other groups of subjects (eg, providers, employers, regulators), views were almost equally split about whether these laws have increased costs and inappropriate ED use, but again no documentation was offered for any of negative views. Among those who

thought these laws have not had negative effects, subjects noted that most people would prefer not to go to hospital EDs. Therefore, they thought that most inappropriate use is the result of problems with access to primary care, and not to any leniency in the law or in insurers’ coverage decisions.

Many subjects noted that one factor that controls costs is the sharp increase in copayments for hospital emergency care. These copayments now typically range from \$50 to \$100, at least twice what they were a few years ago. Many subjects directly attributed this increase to employers’ and insurers’ concerns about controlling ED use in light of the prudent layperson laws. Most subjects also thought copayments were largely effective in this regard, which may account for the absence of any documented increase in utilization or insurance costs because of these laws.

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## LIMITATIONS

This study is limited by factors that affect most qualitative studies. Although the interview subjects were selected to reflect a broad range of views and to reflect the views that are typical for each group, it was impossible to capture conditions that prevail in all markets. In particular, California, the largest state with heavy managed care penetration, was not included. Also, there was only limited ability to confirm or refute reported behaviors with objective evidence or observation. Finally, interpretation of these qualitative data depends to some extent on the author’s and interviewers’ subjective impressions. The potential for bias was reduced by probing questions that asked interview subjects to support their views by comparing information from one source with information from others and by using computerized analysis to identify commonalities and differences among states, groups of subjects, and particular subjects.

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## DISCUSSION

Overall, this study finds that the prudent layperson laws have been effective in changing health insurers’ practices about coverage of emergency services. Before these laws, many or most managed care plans would determine the necessity for emergency care more according to ultimate diagnoses than presenting symptoms. After implementation of these laws, such practices appear to have been vastly reduced or have disappeared, according to most informed views. Also, regulatory enforcement appears to be active and effective.

tive. Two single-state studies report greater levels of noncompliance.<sup>11,12</sup> However, these studies were done immediately after these laws took effect, when insurers may not yet have had time to adjust their claims systems or perhaps when the laws were not yet fully in force, because they often apply only after existing insurance policies are renewed. A third study found a significant decrease in the proportion of ED claims denied immediately after adoption of the new law in Florida, although it also found some initial level of noncompliance.<sup>13</sup>

It is debatable, however, whether this change in practices is entirely due to these laws. All of the large national insurers that were interviewed in this study had adopted a prudent layperson standard before the enactment of most state laws, and there were other considerable market, public, and liability pressures to make this change. However, these state laws clearly were major catalysts for industry-wide change.

Although these laws prompted insurers to change, most said they were not especially reluctant to do so, and many reported changing their practices in all states at once even when the laws were in force in only some states. Therefore, this is not an area of patient protection regulation where a strong case can be made, according to this study, that federal legislation is needed. Almost every state now has a prudent layperson law, national insurers appear to have changed their practices regardless of particular state laws, and compliance problems do not appear deep-seated or widespread.

This is not to say, however, that no problems remain. Several continuing problem areas were noted, such as how the prudent layperson concept should apply to mental health crises. There were also indications that some insurers continue to deny a significant number of claims for emergency care initially and adopt a more permissive approach only if patients or providers request reconsideration or appeal. This view is supported by another study that reported that 2 North Carolina insurers denied a substantial number of ED claims shortly after the new prudent layperson law took effect but reversed almost all of these denials that were challenged as meeting this standard.<sup>11</sup> However, the study also reported that one of these insurers appeared to make permanent changes in its coverage criteria.

Also of interest is a study of 2 large capitated physician groups in California, which perform their own initial claims review under a “delegated” model. This study found that emergency care produces one of the highest rates of denial at both groups (17%).<sup>14</sup> However, when these denials were appealed to the health

plans, they were reversed more than 90% of the time,<sup>15,16</sup> which suggests that physicians who bear financial risk for primary care may take a more stringent view of prudence than do health insurers. One reason for the health plans’ leniency may be the difficulty in documenting and defending a denial according to differing views of reasonableness. Consistent with the explanations we received from insurers that it is usually not worth the effort and cost to investigate ED claims in depth, 1 of the 2 health plans in this California study reported paying 65% of its ED appeals on the basis of maintaining “goodwill” rather than based on the merits of the claim.<sup>16</sup>

Another problem area that remains is the appropriate level of payment for emergency services that are covered. Insurers remain reluctant to pay full list charges to nonnetwork hospitals, and they increasingly seek to negotiate bundled payment rates with network hospitals. This practice is reflected in another study that found that, during the 1996 to 1998 period when these laws were taking effect, the proportion of ED charges paid by private insurance dropped from 75.1% to 63.4%.<sup>17</sup> Payment issues also produce ongoing disputes about what rates are “usual, customary, and reasonable” and which parts of an ED encounter are and are not included within a bundled rate.

Whether on balance these laws have been beneficial to patients and society depends in part on whether they result in inappropriate use of emergency services. There is no clear indication from these interviews that inappropriate use has occurred to a substantial extent overall. This qualitative impression is supported by the unreported results of a statistical analysis of 3 rounds (covering 1996 to 2001) of the Community Tracking Household Survey, performed as part of this study by the Duke University Center for Health Policy, Law and Management (details available on request). This analysis found no statistical association between enactment of prudent layperson laws and the number of self-reported ED visits among privately insured people, controlling for demographics, self-reported health status, date of enactment, and other parts of these patient protection laws (such as liability statutes, the availability of external review, and restrictions on the use of financial incentives). Overall, ED use nationwide has increased sharply throughout the time span covered by these laws, but increased usage by the privately insured has been in proportion to increases in all types of ambulatory care.<sup>18</sup>

Interview subjects offered several reasons why more lenient coverage policies may not have led to increased

ED use. Most subjects who commented on this issue thought that inappropriate use results more from barriers of access to primary care rather than from an excessively permissive coverage standard. This position is supported by various empirical studies.<sup>16,19,20</sup> Subjects also noted increased efforts by insurers to control ED use by encouraging physicians or providing incentive to them to improve after-hours primary care access.

Still, studies indicate that appropriate ED use continues to be a concern even if appropriateness is defined from a layperson's perspective.<sup>21</sup> For instance, one systematic national study found that only 45% of ED patients themselves consider their condition urgent,<sup>19</sup> although this and other studies also indicate that patients do not have an accurate view of urgency.<sup>22</sup> It is impossible, however, to determine from the present investigation whether prudent layperson laws have affected inappropriate ED use. That determination would require a more systematic sampling, with expert reviews of medical records and better agreement about what constitutes appropriate use.

In contrast with earlier reports before widespread enactment of prudent layperson laws,<sup>23</sup> it does not appear from this study that most insurers now are controlling ED costs by trying to define and monitor which symptoms are and are not reasonable indications to laypeople of a possible medical emergency. Instead, under the prudent layperson standard, most insurers appear to approve the vast majority of emergency claims either initially or after an appeal or request for reconsideration. In part, this approval is because of the difficulty, recognized in these interviews and by other authors,<sup>11,16,24,25</sup> of defining and operationalizing the prudent layperson concept. For instance, one study found that laypeople themselves have great difficulty coming to agreement on ED case vignettes because their views remain "heterogeneous and quite polarized" even after group discussion.<sup>26</sup>

Despite the difficulties in operationalizing the prudent layperson standard, there is no strong evidence from these interviews that overall insurance costs have increased significantly as a result of these laws. This evidence is consistent with initial cost impact estimates, which projected that prudent layperson laws would increase premiums only a small or negligible amount, from 0.1% to 0.4%.<sup>27,28</sup> Although a more definitive account of the cost impacts would require a quantitative study, the lack of observable cost impacts so far may be explained by the fact that insurers have other cost-control mechanisms at their disposal besides claims review. Most notably, they have greatly

increased copayments for emergency care to deter inappropriate demand by patients.

How effective increased copayments are in reducing costs without harming care remains an open research question.<sup>29</sup> Regardless, this shift in insurers' approach to emergency care is a harbinger of the more fundamental changes that are occurring in health insurance generally under the banner of "consumer-driven" health care.<sup>30</sup> Across the board, health insurers are replacing managed care techniques with increased cost sharing to manage patients' demand for care rather than providers' supply of care. Whether the health care delivery system now operates more fairly and efficiently is a question that merits ongoing study.

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