What is the Prudent Layperson Standard and what does it mean?

The Prudent Layperson Standard (PLP) emerged in the 1990s when a Maryland-based emergency physician, while pursuing his law degree, learned how it protected consumers. He took the concept to the Maryland legislature in 1993 and applied it to emergency care to protect patients presenting with severe symptoms in the emergency department (ED). Now, anyone with commercial or government insurance is covered under the PLP. The law is premised on a simple concept: prudent laypersons do not have the level of medical knowledge needed to diagnose themselves and should not be expected to look at a diagnosis list and know with certainty whether they will be diagnosed with one of the listed conditions.

Why is the PLP significant?

In 1986, the U.S. Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA), setting the standard that hospitals must provide care to anyone needing emergency treatment. However, that didn't mean insurance companies paid for that emergency care and this is where the PLP comes in. Prior to the PLP, if an individual wanted insurance to cover emergency treatment, the patient was expected to contact their insurer for approval from their primary care physician (PCP) prior to the ED visit. This is known as "prior authorization" and if an individual sought care in the ED without it, and their insurer later deemed the visit was not a medical emergency – based on the final diagnosis, not the presenting symptoms – then the insurer would refuse to pay for the ED visit.

The PLP ensures American consumers have appropriate access to emergency care and are not expected to diagnose themselves before consulting a medical professional. The complexity of care is not dependent on the final diagnosis, it is based on the complexity of medical decision-making, which is impacted by presenting symptoms, comorbidities, and more.

How does the PLP redefine emergency medical conditions?

The PLP defines an "emergency medical condition" (EMC) as one that manifests itself by acute symptoms of sufficient severity—including severe pain—such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.

While health plans objected strongly to "severe pain" being part of the definition, their fears of run-a-way overutilization have been overblown. Imagine if severe pain had not been part of the PLP definition when the COVID-19 pandemic first became a pandemic. Clinicians often did not know what the source of severe pain and inflammation was in their patients, but the law protected the clinicians and patients while the clinicians discovered how the COVID virus worked against major organs.

What challenges face the PLP today?

Recent efforts by insurers and plan and benefit managers have eroded the PLP by leaving the patient lacking benefit coverage for certain conditions where the insurers and plan benefit administrators retrospectively determine the visit to be 'non-emergent' by the insurer's own standard. The plans usually achieve these results through the deployment of diagnosis lists.

In a recent decision, the Roberts' federal court (April 27, 2023) described the 800+ final diagnosis list, also called "the Downcoding List" in which VA Medicaid would take the final diagnosis, and if the diagnosis was on the list, would reimburse the services at a "non-emergent" (lower) rate. This is a direct violation of the PLP and only serves to discourage appropriate access to emergency care, and the Roberts' court found that the Downcoding List violated federal PLP.

How does this affect patients?

The PLP ensures that enrollees have unfettered access to health care for emergency medical conditions and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens. This standard iterates that the final determination of coverage and payment must be made considering the presenting symptoms rather than the final diagnosis.

Timeline of the PLP

Year	Event
1986	The U.S. Congress enacts EMTALA which set the standard that hospitals must provide care to anyone needing emergency treatment. It requires that hospitals and physicians as their agents provide medical screening exams to any patient who presents to a dedicated ED. Then patients with emergency medical conditions (EMCs) must be provided stabilizing care to the extent that the facility is able to render care.
Early 1990's	The Prudent Layperson Standard (PLP) emerges in the insurance environment after they roll out policies requiring prior authorization for ED visits or deny payments for visits, they deemed inappropriate.
1993	Maryland is the first state to enact a PLP law in response to the unfair and dangerous requirements from private insurers; 46 other states soon follow suit.
1997	Congress enacts the PLP for Medicare and Medicaid managed care plans via the federal Balance Budget Act of 1997 (BBA '97), ensuring that emergency services would be covered if a prudent layperson acting reasonably would have believed that an emergency medical condition existed, for Medicare and Medicaid plans. The BBA also defined an "emergency medical condition" as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.
1998	The PLP extends to cover all federally insured employees in the Federal Health Benefits Program, also known as "Federal BCBS".
2010	The Affordable Care Act extended the PLP to individual and small-group health plans, as well as self-funded employer plans under ERISA. Medicaid managed care plans, like Centene, and commercial health plans, like Anthem and BCBS in GA, deploy downcoding lists, algorithms, and policies that attempt to cut back on federal and state PLP protections. ACEP, state chapters, and EDPMA respond with litigation.
2023	On April 27, the *Roberts* decision strikes down the VA Medicaid Downcoding Provision in part for violating the federal PLP standard, citing that the Provision impermissibly "downcoded" claims based on the final diagnosis.
Present	The PLP remains an important patient protection and a bedrock principle of emergency medicine, alongside EMTALA. It provides assurance that anyone can receive emergency care regardless of insurance status or ability to pay.

Thanks to the implementation of the Prudent Layperson Standard, all patients who believe their symptoms merit a visit to the ED can be assured of the following protections:

- No need for prior authorization or approval from their insurance company.
- The patient can choose where to receive care, even if the hospital is out-of-network.
- Insurance companies cannot charge out-out-network fees if they visit an ED out-of-network.
- Insurance companies cannot deny or overcharge if the diagnosis is milder than initially thought.