

## Investigations &amp; Enforcement

# Health Plan Investigations: Prudent Layperson Rule

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There has been a significant uptick in Department of Labor (“DOL”) investigations of group health plans and health insurers over the past few years. Those investigations focus generally on compliance with a host of laws, and there has been particular focus on the “prudent layperson” standard under the Affordable Care Act (the “ACA”).

The ACA generally requires that, if a group health plan or health insurance issuer provides or covers any benefits with respect to services in the emergency department of a hospital, then cost-sharing requirements imposed for out-of-network emergency services cannot exceed cost-sharing requirements imposed for in-network emergency services. This requirement is triggered by a “prudent layperson” standard. In other words, an emergency medical condition is evidenced by acute symptoms of sufficient severity so that a “prudent layperson” with average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would place the individual’s health in serious jeopardy, or seriously impair bodily functions, organs, or parts.

In a complaint and subsequent consent order in *Perez v. MagnaCare Admin. Sys., LLC, et al.* (the “MagnaCare Consent Order”), DOL asserted that a third-party administrator’s use of an internal listing of diagnostic codes (“True ER List”) to adjudicate emergency room services claims violated the emergency services rule’s prudent layperson standard because such a list could not account for a prudent layperson’s perspective as to whether he or she was experiencing a medical emergency. DOL has been relying on its result in the MagnaCare Consent Order to cite group health plans and health insurance issuers that utilize a True ER List to adjudicate emergency room services despite the previous lack of binding regulations or guidance in this area.

Recently, in the preamble to the interim final rule “Requirements Related to Surprise Billing; Part I,” DOL, Health and Human Services (“HHS”), and Treasury explained that denials for emergency services cannot be based solely on diagnosis code and must instead be evaluated under the prudent layperson standard. This conclusion is also included in the regulatory text. The practical effect is that the agencies have codified DOL’s enforcement position under the ACA’s emergency services rule that the use of a True ER List is impermissible as a sole basis to deny claims.

Given the codification, we will likely see continued investigative activity in this area as well as more of a focus on participant disclosures regarding emergency services, the plan or issuer's policies and procedures for adjudicating emergency services claims in light of the expanded definition of emergency services, and a review of claims involving emergency services to confirm they were processed in accordance with the Consolidated Appropriations Act, 2021's surprise billing requirements and the regulations implemented thereunder.