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EMERGENCY CARE AND MANAGED CARE— A DANGEROUS COMBINATION

Diane E. Hoffmann*

Abstract: Managed care plan subscribers in need of emergency medical treatment often face unduly restrictive plan practices. These practices may result in life-threatening injury or significant financial obligations on the part of plan subscribers. They are the result of a managed health care system that is inadequately regulated and overly concerned with cost control. Economic incentives lead plans to deny approval for emergency medical treatment or to deny retroactively coverage for such treatment. Emergency medical providers also are harmed by these practices, often forced to treat patients under federal law but denied payment for their services. This Article describes this problem in more detail and argues that the existing legal framework for preventing and addressing harms to managed care subscribers due to denial of emergency medical care or coverage is wholly insufficient. Moreover, the author argues that current law leads to an unjust apportionment of the cost of emergency care among providers, subscribers, and plans and that federal legislation to address these injustices is necessary. The Article critically examines the ability of the proposed Federal Access to Emergency Medical Services Act to protect consumers from harms due to plan denial of approval for emergency medical treatment and fairly apportion the cost of emergency care among the relevant stakeholders without significantly increasing health care costs. It advocates the passage of the Act with minor revisions.

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Dear Doctor:

I'm writing to you because of my experience with my HMO. Let me start with a history of my situation I have a blood disorder called anticoagulant lupus. This causes my blood to clot easily. I have had about 6 clots in my legs. I am 24 and have been on coumadin since I was 18. One evening [two months ago] I was experiencing some numbness and loss of circulation in my wrist and hand. Considering my particular problems I was concerned and called my HMO. Because it was after hours I talked with the [physician] on call. I told him my history and explained the problem. He told me that it probably was not a blood clot and to follow-up with my regular doctor in the morning. After discussing it with my family, we decided not to risk it and went to the emergency room at [a nearby hospital]. When I got there, I filled out the usual paperwork. When the hospital called my HMO to get approval, the doctor on call asked to speak with me. He said he thought he had explained to me that he did not feel it was a clot. I asked him if he was positive it wasn't a clot. He said no he was not, but he really felt it probably wasn't. He also told me that the only way he would approve this emergency visit was if it turned out to be a clot. If not, it was up to me to pay the bill. Fortunately, it was not a clot, but now I have a medical bill which I feel my HMO should pay for. Why was that doctor willing to risk my health? Isn't it better to be safe than sorry? I am very disturbed by this practice. I work and pay for my insurance. I feel I am entitled to the best care that they can [provide].

A Dissatisfied HMO Member¹

I. INTRODUCTION: THE PROBLEM

In an effort to control costs, many managed health care plans require that their members obtain authorization before seeking care in a hospital emergency department (ED). Some members claim they have been unable to reach their plans during emergencies² or have been denied

1. Letter from HMO patient to David S. Davis, M.D., J.D., Chair, Public Policy Committee, Maryland Chapter of the American College of Emergency Physicians (Sept. 6, 1993) (punctuation altered) (on file with *Washington Law Review*).

2. See *infra* note 63 and accompanying text.

prior authorization inappropriately.³ Others claim their plans have retroactively denied coverage for emergency care.⁴ These practices may be endangering the lives and health of managed care subscribers as well as inappropriately shifting costs of emergency care from plans to patients or, more often, to EDs.

Administrators of managed care plans argue that the cost of emergency care is very high and that the services provided are often unnecessary.⁵ In many cases, they say, patients can wait to see a plan physician for treatment.⁶ Emergency care providers and some consumer groups counter that managed care plans are taking advantage of hospital EDs.⁷ The plan managers know that, under the Federal Emergency Medical Treatment and Labor Act (EMTALA),⁸ all hospitals offering emergency services must screen all persons who come to the hospital to determine if an emergency exists and, if so, must provide them with treatment until they are stabilized, whether or not they can pay for the treatment.⁹ Therefore, a plan member who goes to a hospital offering emergency services must be screened and stabilized, even if the member could not obtain prior plan authorization for the emergency care.¹⁰

These practices create significant dilemmas for both patients and ED providers. For example, consider the patient who experiences chest pain in the middle of the night and cannot reach his or her managed care plan

3. See, e.g., Loren A. Johnson & Robert W. Derlet, *Conflicts Between Managed Care Organizations and Emergency Departments in California*, 164 W. J. Med. 137, 139 (1996) (“Using the rationale that the claim can always be reviewed and paid later, if necessary, [managed care plans] have been known to publish policies advocating the routine denial of ‘treatment authorization,’ and, in some instances, patients with obvious life-threatening conditions have been denied authorization.”).

4. *Id.*

5. See *infra* note 45 and accompanying text.

6. See *infra* note 76.

7. See, e.g., Letter from David S. Davis, M.D., J.D., Chair, Public Policy Committee, Maryland Chapter of the American College of Emergency Physicians, to Governor Parris Glendening (May 9, 1995) (regarding “HMOs—Reimbursement—Services in Hospital Emergency Facilities,” H.B. 615, Reg. Sess. (Md. 1995)) (on file with *Washington Law Review*). Plans often send their members (or desire that their members go) to the ED even when their condition is not of an emergency nature. Reasons why this might be done are convenience to HMO providers who have abbreviated hours, financial incentives to physicians paid on a capitation basis, lack of specialists within the HMO network, fear of misdiagnosis of high risk cases, and cost shifting to patient and ED. *Id.* at 1–2.

8. 42 U.S.C. §§ 1395cc, dd (1994).

9. § 1395dd(a), (b).

10. See 42 U.S.C. § 1395dd(h); see also Helen Lippman, *The Games Plans Play with ER Bills*, 14 Bus. & Health 20, 21 (June 1996) (quoting Lauren Dame, attorney and co-author of report on patient dumping for Public Citizen Health Research Group, as stating that federal mandate is “one of the reasons HMOs can get away with refusing to pay” for ED visits).

for “preapproval” for out-of-network care. The patient, uncertain as to whether the pain is indigestion or a heart attack, must choose between waiting perhaps an hour or more trying to contact the managed care plan, potentially risking health or life, or going immediately to the closest emergency facility. At the ED, the physician may attempt to reach the patient’s plan again and, if the plan does not respond, the patient may still be reluctant to be treated, concerned that the plan may not pay the bill if the condition is not determined to be an emergency.¹¹ Emergency physicians feel torn because, on the one hand, EMTALA and their own professional ethics require them to perform the diagnostic exam and tests needed to rule out heart trouble.¹² On the other hand, emergency physicians also are sensitive both to a patient’s reluctance to be strapped with a large ED bill for tests that will not be covered by insurance, and to the possibility that if the patient cannot pay the bill, they and the hospital will incur the costs of the patient’s care.¹³

At least twelve states recently have enacted legislation that attempts to remedy this situation by eliminating some of the obstacles managed care plans have placed in the way of members seeking emergency care, and/or by making it more likely that plans will reimburse patients or providers for ED treatment.¹⁴ Bills attempting to address this issue also have been introduced in Congress.¹⁵

11. Other examples of conditions that may appear to a layperson to be an emergency, but on retrospective review may not be, include:

1. A young woman with pelvic pain, who fears she may have a miscarriage, bleeding ovarian cyst, tubal pregnancy or infection.
2. A patient with an unusual and severe headache, with vomiting and arm numbness.
3. A patient with 12 hours of vomiting, diarrhea and abdominal cramps, not better despite the phone advice of the HMO.
4. A patient who fell and cannot use her arm.
5. A middle-aged patient with chest pain and trouble breathing, whose father died of a heart attack.

Maryland Chapter of the Am. College of Emergency Physicians, *Fact Sheet on H.B. 1203 and S.B. 701* (Aug. 23, 1993). If, on ultimate diagnosis, these conditions respectively turn out to be (1) a urinary tract infection; (2) a migraine headache; (3) viral gastroenteritis or food poisoning; (4) a wrist sprain; or (5) chest wall pain or esophageal reflux, they may not be covered by the HMO. *Id.*

12. See Public Citizen Health Research Group, *Emergency Doctors Faced with Catch-22 as HMOs Impede Access to Emergency Care*, 11 Health Letter 1 (Dr. Sidney M. Wolfe ed., Feb. 1995) [hereinafter Health Letter].

13. *Id.* at 2.

14. See Ariz. Rev. Stat. Ann. §§ 20-821, -923, -1068, -1137, -2801 to -2804 (West Supp. 1996); Ark. Code Ann. § 20-9-309 (Michie Supp. 1996); Cal. Health & Safety Code § 1371.4 (Deering Supp. 1996); Fla. Stat. Ann. § 641.513 (West Supp. 1997); Ga. Code Ann. §§ 31-11-80 to -82 (1996); Ga. Code Ann. §§ 33-20A-1 to -10, 33-21-1, -13, -18 (Supp. 1996); La. Rev. Stat. Ann. § 22:2018(D)(1) (West 1995); Md. Code Ann., Health-Gen. II §§ 19-705.1(b), -712.5, -716 (Supp. 1996); Va. Code Ann. § 38.2-4300 (Michie Supp. 1996); W. Va. Code § 33-25A-8d (Supp. 1996);

This Article explores the conflict between managed care and emergency care in detail, first analyzing it from the perspective of the various stakeholders—the managed care industry, the consumer, and the ED provider. In Part III, the Article examines the root causes of the conflict, focusing on (1) the clash between managed care philosophy and the nature of emergency care and (2) the allegation of “inappropriate” ED use. Part IV describes and analyzes the limitations of proposed solutions to the problem, including the limitations of reliance on the market, the courts, and recent state statutes. The last section of the Article, Part V, argues for a federal solution to the conflict¹⁶ and critiques the ability of proposed federal legislation to address adequately the problem in a way that discourages unnecessary emergency care but does not significantly increase health care costs or penalize patients who are truly in need of emergency services.

II. THE PERSPECTIVES OF THE STAKEHOLDERS

A. *The Managed Care Industry*

1. *An Overview*

With an eye toward controlling the rising cost of health care, this country has boldly embraced the concept of managed care.¹⁷ Employers

Act of Apr. 14, 1996, § 13, 1995 Kan. Sess. Laws 169; New York Regulation of the Delivery of Managed Care Act, S. 7553, 219th Leg., 2d Sess. (N.Y. Oct. 9, 1996); Pennsylvania Hospital Emergency Insurer Reimbursement Act, 1996 Pa. Legis. Serv. 112 (West). Some states, such as Minnesota and Texas, have attempted to address the issue through regulations. See Minn. R. 4685.1010 (1996); 25 Tex. Admin. Code, tit. 28, §§ 119.51, 119.52, 28 Tex. Admin. Code § 3.3704 (1996). Another half dozen states are considering legislation to address the problem. See Milt Freudenheim, *HMO's Cope With a Backlash on Cost Cutting*, N.Y. Times, May 19, 1996, at A1.

15. Access to Emergency Medical Services Act of 1997, H.R. 815, 105th Cong. (1997); Access to Emergency Medical Services Act of 1997, S. 356, 105th Cong. (1997); Access to Emergency Medical Services Act of 1995, H.R. 2011, 104th Cong. (1995); Access to Emergency Medical Services Act of 1995, S. 1233, 104th Cong. (1995); Graham Amendment No. 3014 to S. 1357, 104th Cong., 141 Cong. Rec. S16,007, S16,130 (daily ed. Oct. 27, 1995); see *infra* note 249.

16. The argument assumes that existing relevant federal statutes—EMTALA, 42 U.S.C. §§ 1395cc, dd (1994), and the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144 (1994)—will not be repealed or amended in the near future.

17. Studies have shown that managed care has slowed the growth of health care costs in the private market. See, e.g., Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 Cornell L. Rev. 1507, 1514 (1994) (“There is widely-accepted evidence that associates managed care with significant cost savings as compared to fee-for-service or traditional indemnity insurance.”). Greaney cites numerous reports confirming this statement but also qualifies the statement by clarifying that different managed care organization forms “vary significantly in their capacity to control costs.” *Id.* at 1514. For example, empirical studies reveal that HMOs and

and states (through their Medicaid programs)¹⁸ are rapidly moving individuals into managed care plans. In addition, over four million Medicare patients (twelve percent of the Medicare population) have joined managed care plans.¹⁹

Although managed care has no precise definition, it refers to “programs that attempt to control the utilization as well as the pricing of health care services.”²⁰ In doing so, managed care plans often limit the

independent practice associations (IPAs) achieve appreciably greater cost reductions than preferred provider organizations (PPOs) and IPA point-of-service systems. *Id.*; see also Editorial, *Managed Care Beats Medicare Any Day*, Bus. Wk., Feb. 27, 1995, at 136.

18. As of March 1996, 71% of the nation’s employees in companies with 10 or more workers were enrolled in managed care plans. Steven Findlay & Wendy J. Meyeroff, *Health Costs: Why Employers Won Another Round*, Bus. & Health, Mar. 1996, at 49, 49–50. As of mid-1995, approximately 28% of the Medicaid population nationwide was enrolled in managed care plans. Office of Managed Care, Health Care Fin. Admin., *National Summary of Medicaid Managed Care Programs and Enrollment*, tbl. 11 (Sept. 20, 1996) (listing percentage as of June 20, 1995) (on file with *Washington Law Review*). Most state efforts to move their Medicaid population into managed care plans have involved only a portion of the state’s Medicaid population and are considered regional “demonstration projects.” See The Nat’l Inst. of Health Care Management, *States as Payors: Managed Care for Medicaid Populations*, at ES-4 (Feb. 1995). However, at least 14 states have received approval from the Health Care Financing Administration (HCFA) for a state-wide demonstration project to move most of their Medicaid population (with the exception of the disabled and long-term care population) into managed care. See Peter MacPherson, *Measure by measures: A Commercial Version of HEDIS Has Been Adapted for Use by Medicaid, but It’s Weaknesses May Outweigh—And Outlast*, Hosp. & Health Networks, Mar. 20, 1996, at 53, 53.

A recent study synthesizing over 100 reports, studies, and articles on Medicaid managed care found that Medicaid managed care plans can produce savings of between 5% and 15% over fee-for-service plans. The Kaiser Comm’n on the Future of Medicaid, *News Release: Study Finds That Medicaid Managed Care Can Save Money and Improve Access but Big Cost Savings are Unlikely* (May 31, 1995) (on file with *Washington Law Review*). However, the study also found that the overall savings potential from Medicaid managed care is limited because managed care enrollment in most states is restricted to the least costly of the Medicaid population groups—children and low income adults who account for only 23% of total Medicaid spending. *Id.*; see also Fred Schulte & Jenni Bergal, *Doubts Raised About HMO Savings*, Sun Sentinel (Fort Lauderdale, Fla.), Nov. 26, 1995, at 7A (casting doubt on state health officials’ claim that Florida has saved as much as \$50 million per year in Medicaid costs by shifting beneficiaries to HMOs).

19. Health Care Fin. Admin., *Monthly Medicare Managed Care Contract Report 1* (Sept. 1, 1996) (stating that actual number of enrollees as of Sept. 1, 1996 was 4,548,113) (on file with *Washington Law Review*).

20. Michael G. MacDonald et al., *Health Care Law: A Practical Guide* § 6.05[3][c][iii], at 6-36 (1994); see also George W. Rimler & Richard D. Morrison, *The Ethical Impacts of Managed Care*, 12 J. Bus. Ethics 493, 493 (1993) (“Managed care is a term in common use—but often used without precision—to refer to forms of health benefits coverage and health service delivery that are alternatives to traditional fee-for-service medicine.”). Rimler and Morrison compiled other definitions of managed health care from several authoritative sources:

Managed care is a comprehensive approach to health care delivery that encompasses planning, education, monitoring, coordinating, and controlling quality, access, and cost considering the interests of patients, providers, and payors. *American Managed Care and Review Association*.

number of providers who service beneficiaries, negotiate favorable prices from those providers for the right to participate in the managed care plan, and require each beneficiary to have his or her health care needs screened by a primary care physician (PCP), often called a gatekeeper.²¹ "Capitation" is often a primary feature of managed care plans. Under a capitation arrangement, a health care facility or physician agrees to provide all or nearly all of the health care needs of a defined patient population for a flat amount that is fixed in advance. By limiting or fixing total revenues in relation to the total health care needs of a specific group of beneficiaries, the facility has a great economic incentive to limit utilization and the content of the health care product.²²

Managed care plans vary greatly. A number of authors have described them as existing along a continuum from "least managed" to "most managed."²³ On the "most managed" end are closed panel or staff model health maintenance organizations (HMOs) in which members must see plan physicians who typically are salaried and operate out of a central facility.²⁴ On the "least managed" end are traditional indemnity plans with a few managed care features, as well as preferred provider

. . . A variety of interventions in health care delivery and financing intended to eliminate unnecessary and inappropriate care and to reduce cost, including: reviewing and intervening in decisions about health services to be provided, either prospectively or retrospectively; limiting or influencing patients' choice of providers; and negotiating different payment terms or levels with providers. *Congressional Budget Office*.

....

Managed care is a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness of care prior to its provision. *Institute of Medicine/National Academy of Sciences*.

Id. at 494 (footnotes omitted).

21. MacDonald et al., *supra* note 20.

22. *Id.* § 7.02(2)(f), at 7-15; see also David Segal, *A Closer Look at Plan English, Fine Print in HMO Contracts Spurs Lawsuits, Legislation Requiring Clarity on What's Covered*, Wash. Post, Mar. 27, 1996, at F1.

23. See, e.g., Peter R. Kongstvedt, *Essentials of Managed Care* 25 (1995); R. Danielle Federa & Tracey L. Camp, *The Changing Managed Care Market*, in *Managed Care* 3, 3 (Seth B. Goldsmith ed., 1995).

24. See Kongstvedt, *supra* note 23, at 25. According to Federa and Camp:

[These more "managed" models are more likely to have] formalized utilization review monitoring procedures, provider utilization profiling, and peer review; more selective provider subpanels, frequently including a group setting of physicians or staff providers; less freedom or no freedom in consumer choice of providers . . . ; more comprehensive coverage, including preventive care with little consumer out-of-pocket expense; and more shifting of risk to the provider (e.g., capitation) or salaried arrangements rather than fee-for-service.

Federa & Camp, *supra* note 23, at 3.

organizations (PPOs). In a PPO, the plan provides its members with incentives to use designated health care providers (preferred providers). Members also may use non-preferred providers but typically must pay a higher cost for their services.²⁵ In general, all models share a number of common cost containment features including provider selection,²⁶ access procedures, physician financial incentives, and peer and utilization review.²⁷ However, the specifics of each of these features differ from plan to plan.

2. *Competitive Pressures*

The competitive environment in which managed care plans operate has intensified dramatically in many regions of the country in the last few years.²⁸ In the market for employer contracts, where the competition is most fierce, plans are competing primarily on the basis of price.²⁹ This means that plans must cut premiums and, to remain profitable, must operate more efficiently, negotiate favorable contracts with providers, and cut unnecessary costs where possible. The most important factors cited by managed care administrators for turning a profit include low hospital utilization, favorable contracts with hospitals, control of administrative costs, and increased enrollment.³⁰ For many plans, however, the intense nature of the competition has meant profit declines, and survival has required a store of capital, typically available only to the larger and for-profit plans.³¹ Thus, competitive pressures are forcing plans to become bigger and, if they have not done so already, to switch to for-profit status.³² Incentives to cut costs created by the excessive competition within the industry also have created a backlash among

25. See Kongstvedt, *supra* note 23, at 25.

26. Provider selection means that plans rather than members choose the physicians that members can see. These physicians are part of a "provider panel" or "network" and are selected, in part, for their ability to limit unnecessary health care expenditures. See Linda J. Havlin & Larry J. Tucker, *Managed Care Benefit Design*, in *Making Managed Health Care Work* 265, 270 (Peter Boland ed., 1993).

27. See *infra* Part II.A.3.a.

28. See John Lombardo, *Fever Pitch Competition has Managed-Care Companies Fighting to Stay on Top*, Wash. Bus. J., May 31, 1996, at 19.

29. William H. Nelson, *Customers Demand Managed Care*, 49 *Healthcare Fin. Mgmt.* 10, 10 (1995).

30. Michael Pretzer, *The Managed-Care Juggernaut: Explosive Growth Nationwide*, *Med. Econ.*, Apr. 15, 1996, at 64, 69.

31. Lombardo, *supra* note 28.

32. Pretzer, *supra* note 30, at 74. A number of analysts predict that ultimately the market will consist of only a "handful of large regional managed-care players." Lombardo, *supra* note 28.

consumers and state legislators in favor of consumer protections from managed care plans.³³

3. *Keeping the Lid on Expenditures*

Internally, plans attempt to control costs in large part by managing or controlling provider behavior so that providers will make cost-effective decisions in the care and treatment of the plan's members. Perhaps one of the most controversial aspects of some managed care models are financial incentives to member physicians to increase efficiency and productivity. These incentives take the form of bonuses or "salary withholds."³⁴ For example, in some plans, physicians may receive bonuses for keeping patients out of the hospital, ordering fewer tests and procedures for their patients, and lowering the use of expensive specialists.³⁵

a. *Utilization Review*

Another mechanism common to managed care plans to ensure that care provided is cost-effective is utilization review (UR). UR consists of an evaluation of "the necessity and appropriateness of medical care."³⁶ It is based, in part, on the assumption that "careful review of medical care can eliminate wasteful, unnecessary . . . or harmful care."³⁷ Although UR has been used in traditional indemnity plans, its use in the managed care setting is distinctive:

In contrast to traditional insurance plans and Medicare, which generally rely on retrospective review, [many managed care plans] decide whether to reimburse care prospectively and concurrently. The reviewer may be the [plan] itself or a third party contractor (commonly a for-profit company). First-level reviewers are usually

33. See Thomas Bodenheimer, *The HMO Backlash—Righteous or Reactionary?*, 335 *New Eng. J. Med.* 1601, 1601 (1996) ("In 1996 alone, 1000 pieces of legislation attempting to regulate or weaken HMOs were introduced in state legislatures, and 56 laws were passed in 35 states.").

34. See Segal, *supra* note 22.

35. See Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 *J. L. Med. & Ethics* 223, 224 (1995); see also Bodenheimer, *supra* note 33, at 1602 ("The trend in managed care is toward the 'capitation-plus-bonus' method of paying physicians. High-profile managed-care consultants suggest that physicians, whose use of hospitals and expensive ambulatory care services is low receive 30 to 50 percent of their income in bonuses.") (footnotes omitted).

36. Barry R. Furrow et al., *Health Law* 322 (1995).

37. *Id.*

non-physicians who apply plan-specific criteria for medical necessity and determine whether to authorize a particular procedure ordered by the treating physician.³⁸

If the first level reviewers are uncertain as to how to rule on a request for coverage, they “may refer a case to a physician advisor before denying authorization for treatment.”³⁹

b. The Gatekeeper and Prior Approval

In addition to the UR process, many plans also procedurally limit access to care by requiring physician or plan preauthorization for certain kinds of care or treatment. Typically care or treatment subject to preauthorization includes hospitalization, specialty care, and use of ancillary services. Without preauthorization from a primary care physician (PCP) or other plan representative, the plan will not pay for the services or will reimburse at a substantially reduced rate.⁴⁰ A preauthorization system is considered key to managing costs in most managed care plans. Authorities on managed care assert that there are many reasons for an authorization requirement:

One is to allow the medical management function of the plan to review a case for medical necessity. A second reason is to channel care to the most appropriate location (e.g., the outpatient setting or to a participating specialist rather than a nonparticipating one). Third, the authorization system may be used to provide timely

38. Susan J. Stayn, Comment, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 Colum. L. Rev. 1674, 1680–81 (1994) (footnotes omitted).

39. *Id.* at 1681.

40. Kongstvedt, *supra* note 23, at 184. In an HMO, payment can be completely denied for failure to obtain required preauthorization. In most PPOs, however, if a subscriber does not obtain required preauthorization of a covered benefit, payment may not be denied, only significantly reduced. For example:

[A plan may pay] 90% of charges for authorized services but only 50% of charges for nonauthorized services or perhaps impose[] a flat dollar amount penalty for failure to obtain authorization. . . . In a PPO where a contractual relationship exists between the provider physician and the plan, the penalty may fall solely on the provider, who may not balance bill the member for the amount of the penalty. In the case of . . . a PPO in which the member received services from a nonparticipating provider[], the penalty falls on the member, who must then pay more out of pocket.

Id.

information to the concurrent utilization review system and to large case management.⁴¹

Plans differ in terms of exactly what services will require prior authorization. The more tightly controlled the system, the more services that require preauthorization and the greater the plan's ability to manage utilization. Plans also differ in terms of who may authorize use of services outside of the plan. In plans that are tightly controlled, the patient's PCP must authorize the service.⁴² In more loosely controlled plans, authorization may also come from plan personnel and not solely from the PCP or another physician.⁴³

For non-emergency care, the preauthorization role of the physician and that of UR often overlap.⁴⁴ In the context of emergency care, the two functions generally remain separate as there is often no time to consult UR for a decision before care is received. As a result, the plan or physician decision whether or not to preauthorize treatment precedes the UR determination. The UR determination typically is made retrospectively, and that determination is the basis for deciding whether the patient's care will be covered by the managed care plan.

4. *Emergency Care: Controlling Access and Denying Reimbursement*

As stated above, emergency care is one area that managed care plans often try to restrict. In part, this is because "ED visits generate higher charges [to plans] than comparable visits to physicians,"⁴⁵ and because,

41. *Id.* at 182.

42. However, authorization may be required from the plan's medical director for very "expensive procedures such as transplants and for controversial procedures that may be considered experimental or of limited value except in particular circumstances." *Id.* at 183.

43. *Id.* A study of federally-qualified HMOs found that in 41% of the plans surveyed, approval for ED use had to be obtained from a physician. Harry Davidson, *Access to Emergency Departments: A Survey of HMO Policies*, 18 *Annals Emergency Med.* 274, 276 (1989). In the other plans (59%), approval could be obtained from other plan employees such as nurses, emergency medical technicians, or administrative personnel. *Id.*

44. In fact, some see UR in that context as the usurpation of the medical judgment of the attending physician. See Helene L. Parise, Comment, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 *Temp. L. Rev.* 977, 983-84 (1991) (noting that one view of UR is that it acts "as the effective 'practice of medicine' under which the medical judgment of the attending health care professional is confirmed, modified or rejected by the persons implementing the [UR] plan") (quoting Gary Scott Davis, *Managed Health Care Primer, Introduction to National Health Lawyers Ass'n, The Insider's Guide to Managed Care: A Legal and Operational Framework* 31 (1990)).

45. Gary P. Young et al., *Ambulatory Visits to Hospital Emergency Departments: Patterns and Reasons for Use*, 276 *JAMA* 460, 460 (1996). High costs of care in an ED are attributed to:

in some cases, emergency care at a hospital is not necessary. Some patients, for example, inappropriately use EDs for their primary care needs. Plan administrators also are concerned about the "hidden costs" associated with ED use. In the ED, care is typically provided by the ED medical staff, and if the patient needs to be admitted he or she may be assigned to a physician who is not participating in the managed care plan. When that happens, the plan loses control of the care of the patient and the cost associated with that care.⁴⁶ Some managed care advocates argue further that "[p]atients admitted to the ED are a 'captive audience' subject to any costly diagnostic test or treatment that the emergency physician chooses to order. The emergency physician has no incentive to control costs and will in fact make more money if excessive testing is done."⁴⁷

Plan managers say "their costs could run out of control if they allowed patients unlimited access to hospital emergency rooms."⁴⁸ The mechanisms used by managed care plans to control ED utilization vary

[A]cquiring and maintaining (1) expensive specialized equipment used in the ED and (2) highly trained ED staff for 24 hours a day. A 1992 report on nine states . . . found that the average charges for treatment of a nonurgent condition in an ED were from one to five times the average charge for a Medicaid visit to a clinic or physician's office in the community.

U.S. Gen. Accounting Office, Pub. No. GAO/HRD-93-4, *Emergency Departments: Unevenly Affected by Growth and Change in Patient Use* 21 (1993) (footnote omitted) [hereinafter *GAO Report*]. A similar report by the Office of the Inspector General found that emergency room visits normally cost at least three times the charge for a community-based physician for the same care. Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Pub. No. OEI 06-90-00180, *Use of Emergency Rooms by Medicaid Recipients* app. B, at 1 (1992) [hereinafter *OIG, Recipients*]. But see Robert M. Williams, *The Costs of Visits to Emergency Departments*, 334 *New Eng. J. Med.* 642, 642 (1996) (finding in study of monthly data on costs of hospital and physician services from 1991 to 1993 in six Michigan hospitals that "[t]he true costs of nonurgent care in the emergency department are relatively low . . . [and that] [t]he potential savings from a diversion of nonurgent visits to private physicians' offices may therefore be much less than is widely believed"). In large part, the discrepancy may be explained by the difference between costs and charges for emergency care. Though costs may be low, charges to private third-party payors may be high as they are often cross-subsidizing costs of care to the uninsured and Medicaid population. *Id.* at 643-44.

46. See Kongstvedt, *supra* note 23, at 147.

47. Maryland Chapter of the Am. College of Emergency Physicians, *Physicians' Guide to State Legislation: Case Study—Definition of Emergency Services* 3 (1994) (describing managed care objections to legislation regulating plan coverage of emergency services); see also Johnson & Derlet, *supra* note 3, at 140 ("At present, most emergency departments treat everyone no matter how trivial the problem. This has resulted in strained relations between [managed care plans] . . . and emergency departments."); Martin S. Karpel, *Capitated Contracting for Emergency Services*, 50 *Healthcare Fin. Mgmt.* 33, 33 (1996) ("[Managed care organizations] believe emergency services are overutilized and too expensive, and that emergency department physicians are risk averse, order too many ancillary services, and over-admit.").

48. Robert Pear, *HMO's Refusing Emergency Claims, Hospitals Assert*, *N.Y. Times*, July 7, 1995, at A1.

from plan to plan. Many plans require preapproval for emergency care.⁴⁹ In cases where preauthorization is not possible, plans typically require notification within twenty-four to forty-eight hours of receipt of emergency services.⁵⁰ If preapproval is not received or notification is not given, coverage may be denied automatically.⁵¹ Some discourage use of 911 telephone calls to summon an ambulance and paramedics.⁵² Often plans retrospectively scrutinize claims for emergency care to determine if the patient's condition was truly an emergency. If the condition was not an emergency, claim reimbursement may be denied.

B. *The Consumer*

1. *The Choice of Managed Care*

Consumer enrollment in managed care plans in many cases has been a result of voluntary choice. But in others, consumers have had no alternative. The latter happens when employers offer only one health insurance option⁵³ or only managed care options, and when states mandate that Medicaid beneficiaries enroll in managed care plans.⁵⁴

49. Prior approval is most often required for "out of network" care, that is, care at a facility with which a managed care plan does not have a contractual relationship to provide services to the plan's members. However, it may also be required for facilities with which the plan has a contractual relationship. The prior approval requirement and the degree to which prior approval is granted may depend on the contractually-agreed-upon rate of payment for services rendered. See Kongsvedt, *supra* note 23, at 147 (stating that many plans contract for special discounted rates with both free-standing urgent care centers and hospital EDs and that if "discount is deep enough, the plan may be more willing to allow urgent care visits than if it is paying full charges at an ED").

50. Some plans recognize that in a true emergency, it may not be possible to obtain preauthorization. *Id.* at 183. In those circumstances, the plan may require notification within 24 to 48 hours of the emergency. Even in those cases, however, payment for the services may not be automatic. Notification simply may trigger review of the case to determine medical necessity. *Id.*

51. See Gregory Henry, *Emergency Care Under Managed Care: A Fatal Distraction*, Health Sys. Rev., Mar.-Apr. 1996, at 55, 55 (relating story of 46-year-old woman rushed by ambulance to Detroit ED in full cardiac arrest).

Her husband had called 911 after she collapsed while getting out of the car. Despite heroic attempts to revive her over a 30-minute period, the woman died. . . . Some months later, [the woman's husband] received a notice from the patient's HMO denying the claim because the patient hadn't called for authorization prior to going to the [ED].

Id.

52. According to the American College of Emergency Physicians, "[P]lans do not inform patients about the availability of the 9-1-1 emergency system and sometimes discourage or even prohibit patients from calling 9-1-1." American College of Emergency Physicians, *Talking Points: Managed Care 3* (1995) [hereinafter ACEP, *Talking Points*].

53. See Julie Kosterlitz, *Unmanaged Care?*, 26 Nat'l J. 2903, 2905 (1994) ("[M]any people don't have a choice of health plans. According to a survey by the accounting and employee

Consumers who have a choice often opt for a managed care plan because of the cost.⁵⁵ Managed care plans have considerably lower premiums than fee-for-service plans. What influences consumer choice among these different plans is not well documented but relevant factors are likely to include cost, location and convenience, whether their physician or a physician they know is affiliated with the plan, and reports from friends, relatives, and neighbors.⁵⁶

2. *The Uncertain Nature of the Benefit*

Although many consumers report satisfaction with their managed care plans,⁵⁷ others describe significant problems. These problems highlight what some call the “dark side” of managed care.⁵⁸ In signing up for a managed care plan, employees do not know what is in the fine

benefits consulting firm of KPMG Peat Marwick, 45 percent of Americans who get their health insurance through their employers are offered only one plan.”); *see also* Robin Toner, *Harry and Louise Were Right, Sort Of*, N.Y. Times, Nov. 24, 1996, at 4:1 (“[A]mong mid-size employers, 52 percent now offer their workers only one plan.”).

54. States may obtain what are referred to as Section 1915 “program” waivers to exempt them from certain statutory requirements set forth in the Social Security Act of 1935, § 1915, 42 U.S.C. § 1396n (1994). Section 1915(b) waivers “enable states to mandate participation [of Medicaid beneficiaries] in a managed care program and restrict the providers from whom recipients receive Medicaid-covered services Section 1915(b) waivers [have been] used extensively by the states.” Suzanne Rotwein et al., *Medicaid and State Health Care Reform: Process, Programs, and Policy Options*, 16 Health Care Fin. Rev. 105, 106 (1995).

55. *See How Good is Your Health Plan?*, Consumer Rep., Aug. 1996, at 28, 30.

56. *See* Martin Gottlieb, *Picking a Health Plan: A Shot in the Dark*, N.Y. Times, Jan. 14, 1996, at 3:1.

57. *See Member Satisfaction Exceeds 90 Percent for Blues-Related HMOs: Survey*, Nat’l Underwriter, June 8, 1992, at 14, 14 (“[S]tudy conducted by the Gallup Organization, which polled 11,179 members of 47 Blue Cross and Blue Shield Plan-related HMOs . . . found that HMO members are as satisfied with their health care coverages as those who have traditional insurance.”). Ninety-three percent of consumers surveyed were satisfied with the overall quality of their HMO. *Id.*; *see also* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1516 (1994). *But see* Charles S. Clark, *Emergency Medicine*, CQ Researcher, Jan. 5, 1996, at 3, 7, 9 (noting 1994 Harris poll of 3348 adults in three cities commissioned by Commonwealth Fund “found greater dissatisfaction levels among managed-care enrollees than those still in fee-for-service health plans”); *see also* Consumer Rep., *supra* note 55, at 29 (stating 10% of their readers said they did not get medical care they felt they needed because their HMO discouraged it, while only 2% of readers who had traditional indemnity insurance felt they did not get necessary care).

58. *See, e.g.*, Health Letter, *supra* note 12, at 3; *see also* Carolyn M. Clancy & Howard Brody, Editorial, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338 (1995); Suzannæ Gordon & Judith Shindul-Rothschild, *The Managed Care Scam: Playing the Denial Game*, 258 Nation 657 (1994); Freudenheim, *supra* note 14, at A1; Fred Schulte & Jenni Bergal, *Profits from Pain*, Sun Sentinel (Fort Lauderdale, Fla.), Dec. 11, 1994, at 1A.

print of their contract with the plan.⁵⁹ Typically, subscribers are given a certificate that provides a brief description of the policy, or they may be given a “Summary Plan Description.”⁶⁰ They do not receive a copy of the “Group Contract” between their employer and the plan. This contract provides the details of plan coverage.

3. *Obstacles to Care*

A primary complaint of managed care consumers is the incentives within the system for undertreatment and subsequent treatment denial or delay. Horror stories from patients harmed by delays in receiving appointments with PCPs or specialists make consumers particularly suspicious of the motives of managed care plans.⁶¹

Receipt of emergency care has proved especially problematic for some consumers.⁶² Plan members have complained that they have not been able to reach their plan for several hours when attempting to obtain preapproval for ED treatment.⁶³ In some cases, a secretary or bookkeeper

59. See Segal, *supra* note 22, at F1 (“Lured by low co-payments associated with HMOs, many consumers sign on the dotted line without understanding the limits of their coverage, and critics say the policies often disguise such limits in a morass of fine print.”).

60. The Federal Employee Retirement Income and Security Act (ERISA) imposes a requirement that beneficiaries of employee group benefit plans be issued a “Summary Plan Description.” Employee Retirement Income and Security Act § 102, 29 U.S.C. § 1022(b) (1994).

61. See, e.g., Edward Dolnick, *Death by HMO—One Woman’s Horror Story*, *Glamour*, Feb. 1996, at 158; Spencer Rich, *Managed Care, Once an Elixir, Goes Under Legislative Knife: Cost-Cutting Focus Feared Harmful to Patients*, *Wash. Post*, Sept. 25, 1996, at A1; Elizabeth Rosenthal, *Patients With Difficult Illnesses Fight New H.M.O.’s [sic] to Get Help*, *N.Y. Times*, July 15, 1996, at A1; Fred Schulte et al., *Audit Calls for Crackdown on Medicare HMOs*, *Sun Sentinel* (Fort Lauderdale, Fla.), Aug. 4, 1995, at 1A.

62. See, e.g., Clark, *supra* note 57, at 7, 9 (citing Harris poll finding that access to emergency care was rated as fair or poor by 12% of managed care patients compared with 5% in fee-for-service plans); see also Henry, *supra* note 51.

63. The American College of Emergency Physicians alleges that patients in some plans “must follow a very cumbersome preauthorization process. This means a patient who is suffering from very alarming and possibly painful symptoms must make several phone calls and experience prolonged waits before getting permission from their insurer to go to the emergency department.” ACEP, *Talking Points*, *supra* note 52, at 3; see also Lippman, *supra* note 10, at 23 (quoting Leslie Zun, Chairman of Emergency Medicine at Milwaukee’s Mount Sinai Hospital, as saying, “You call the HMO and you get an answering machine” and that hours can go by without return call). Although some plans are not available when called, other plans offer 24-hour urgent care. This type of arrangement usually obviates the need for patients to travel to an ED unless they happen to live considerably closer to the ED than to the urgent care center. Some plans also provide 24-hour on-call response to phone calls from patients or EDs requesting authorization for emergency care. This feature also reduces the difficulties for some patients in reaching their managed care provider.

rather than a trained health care provider denies preapproval.⁶⁴ According to one source, “[g]atekeeping responsibilities have been relegated to nonmedical personnel answering remote 800 telephone numbers during partial hours of service. Lacking a detailed knowledge of patients’ signs and symptoms and of local medical resources, these gatekeepers are nonetheless empowered to make critical authorization and referral decisions, further imperiling patients and providers.”⁶⁵

4. *Retroactive Denial of Coverage*

Consumers also have complained of plans that deny coverage retroactively even when plan approval was granted. In these cases, plans have determined that the treatment received was not for an emergency condition although it initially appeared to be an emergency to the consumer.⁶⁶ Although there is little empirical evidence of the number of patients who are experiencing denials of claims for emergency care, there is much anecdotal evidence and a few “small scale” studies suggesting that the practice is widespread. For example, a study of “emergency claims at Connecticut hospitals found that one out of every three was denied,” although half of those were reversed on appeal.⁶⁷ A recent study by the Pennsylvania Department of Health found that one managed care plan rejected forty-three percent of emergency claims.⁶⁸ Furthermore, in Oregon, a plan was fined for denying ED claims without a reasonable investigation. The state’s Department of Consumer and Business Services found that the plan had denied five thousand ED claims over a two-year period.⁶⁹

64. The American College of Emergency Physicians contends that the decision for preauthorization is typically “made over the phone, not based on an examination, and often by a clerk using some predetermined criteria.” ACEP, *Talking Points*, *supra* note 52, at 3.

65. Johnson & Derlet, *supra* note 3, at 139 (footnote omitted).

66. The study by Davidson found that 96% of federally-qualified HMOs reviewed ED visits retrospectively prior to payment. Davidson, *supra* note 43, at 274.

67. Lippman, *supra* note 10, at 23.

68. *Id.*; see also Lori Sham, *Cost-Control Efforts Lead to Claim Disputes*, USA Today, Apr. 22, 1995, at 1A. According to Sham, based on an analysis of claims handled by Emergency Physicians Billing Service in Oklahoma City, “[s]ome plans deny less than 1% of emergency room claims as non-authorized or non-urgent, while other plans deny 15% or more Some plans are denying two to three times as many claims as other plans at the same hospital.” *Id.* The article also reported that some plans deny payment even after they authorize the ED visit: The reporter found that one independent physicians’ association in California had been “retroactively denying 20%–25% of claims as non-urgent, even when the visits were authorized beforehand.” *Id.*

69. Lippman, *supra* note 10, at 23; see also Henry, *supra* note 51, at 53 (reporting that one hospital in South Bronx found that “in one month alone, July 1995, more than 48 percent of their

The American College of Emergency Physicians (ACEP) also has collected examples from its members of cases where patients have been denied coverage. Table 1 sets out some of the types of claims that have been denied and the reasons for denial.

*Table 1: Examples of Cases in Which Managed Care Patients Were Denied Coverage for Emergency Room Care*⁷⁰

<i>Chief Complaint</i>	<i>Patient Outcome</i>	<i>Status of Insurance Review</i>
17-month-old male with earache and vomiting presented at ED at 1:11 a.m. Sunday.	Patient could not sleep since 11:00 p.m. Saturday and had vomited up his medication (Tylenol). Child required an evaluation to assure no dehydration and no evidence of toxicity. He was diagnosed with acute bilateral otitis media.	PCP approval was obtained prior to the visit. However, HMO subsequently denied the visit [stating that] 'Emergency Services are covered under this member's contract only when the condition requires immediate medical attention.'
8-year-old male with infection in his fingers presented at ED at 7:24 p.m. Sunday.	Parents had tried soaking fingers at home, but there was no improvement after one day. They came to the [ED]. The infection required incision and drainage in the ED setting.	Claim was denied because there was no written referral from the PCP, even though there was an approval obtained from the PCP at the time of the ED visit.
31-year-old male with complaint of shortness of breath presented at ED at 8:52 p.m. Friday.	Patient had history of asthma that required nebulization treatment.	Visit was approved by the PCP and subsequently denied by the HMO for lack of a referral.

patients in managed care plans were denied emergency care by their HMOs, or authorization for treatment was denied pending review"). Moreover, "[m]any of the HMOs involved gave no telephone number to request permission, or callers simply got answering machines. Yet very few agreed to cover urgent treatment for their patients." *Id.*

70. Examples of retroactive denial of coverage for ED care. American College of Emergency Physicians, *Hospital "A" Examples/Hospital "B" Examples* (1994-1995) (on file with *Washington Law Review*).

17-year-old female presented at ED at 11:20 p.m. Tuesday with increasing headache, shaking spells, tonic-clonic activity.	Patient's mother stated that patient had shaking spells with her eyes rolling back. The patient was evaluated by the ED physician who ordered extensive blood work, a blood culture and a cat scan of the head. A lumbar puncture was attempted but not successful. The patient was given a large IV dose of rocephin and was admitted to the hospital. The ED physician ruled out meningitis and seizure disorder.	No gatekeeper was called since this patient's insurance did not require pre-approval. The plan retroactively denied authorization and stated this was not considered to be an emergency.
64-year-old male presented at ED at 7:10 a.m. with abdominal pain.	Patient was admitted to the intensive care unit and died less than 24 hours after admission.	Claim was denied because of no referral from the PCP. ED attending physician recalls patient referred to the ED by patient's physician.
7-month-old male with fever presented at ED at 9:00 a.m. Friday.	Patient had fever of 106 with history of fevers and increased crankiness. Child was diagnosed as having a urinary tract infection. Patient had fever for two days and had seen PCP one day prior to ED visit where they were told to wait and see. The night before coming to the ED, patient had vomiting and diarrhea.	Claim was denied because condition "did not require immediate medical attention."
50-year-old male with chin laceration presented at ED at 1:35 p.m. Sunday.	Patient had a 2 centimeter chin laceration requiring suturing.	Claim denied because no physician referral. PCP was called in the ED but never returned call.

5. *Definitions of Emergency Services*

In general, managed care plans provide that emergency services are covered only when they are for an emergency medical condition and are medically necessary.⁷¹ For example, a typical plan policy defines "Emergency Services" as:

71. Federally-qualified HMOs must provide basic and supplemental health services to their members. Section 1302 of the Public Health Service Act defines basic health services as including "medically necessary emergency health services." Public Health Services Act of 1986, § 1302, 42 U.S.C. § 300e-1 (1994). Federally-qualified HMOs were established in 1973 when Congress enacted legislation to promote HMOs. 42 U.S.C. §§ 280c, 300c (1994). HMOs that met certain requirements including the provision of a "prescribed range of basic health services" and consumer

Medically [n]ecessary [h]ospital or medical services for a [m]edical [e]mergency or accidental injury requiring immediate [m]edical [c]are. Immediate [m]edical [c]are is required if the lack of it would permanently endanger your health, cause other serious conditions, damage your bodily functions, or cause serious and permanent damage to any of your bodily organs or parts.⁷²

The policy further defines “Medical Emergency”:

[T]he sudden and unexpected onset of an acute medical condition requiring immediate [m]edical [c]are. Medical [e]mergencies include heart attacks, strokes, loss of consciousness or respiration, convulsions, and other acute conditions which *we determine* to be [m]edical [e]mergencies.⁷³

The plan often reserves the right to determine whether, in its judgment, a service is medically necessary and appropriate.⁷⁴ Furthermore, “[t]he fact that a physician has prescribed, performed, ordered, recommended or approved a service [may] not in itself make it medically necessary [or] appropriate.”⁷⁵

6. *Risks to Health and Pocketbook*

In large part, rules established by managed care plans regarding receipt of emergency care are problematic because emergencies are an indeterminate class and plans can define them overly narrowly. For example, many plans use the term “life-threatening” to define an

choice to purchase optional health services were deemed “federally qualified.” Health Ins. Ass’n of Am., *Source Book of Health Insurance Data* 25–26 (1994). In order to encourage the establishment of federally-qualified HMOs, the law initially “gave federally qualified HMOs substantial advantages over non-qualified HMOs.” Barry R. Farrow et al., *Health Law: Cases, Materials, and Problems* 716 (2d ed. 1991).

72. *Kelley v. HMO Health Ohio*, No. 68812, 1995 Ohio App. LEXIS 5200, at *11 (Nov. 22, 1995) (unpublished opinion) (describing HMO policy offered by Terms of Health Ohio).

73. *Id.* at *11–*12 (emphasis added).

74. Medically-necessary care is defined by one typical plan as care:

[C]onsistent with the symptoms or diagnosis of the [m]ember’s condition, disease, ailment or injury; appropriate with regard to standards of good medical practice; [sic] not primarily for the convenience of a member, physician, hospital, or other provider; and the most appropriate supply or level of services which can safely be provided to the [m]ember.

Fort Sanders Loudon Med. Ctr. v. Bump, No. 03A01-9207-CV-00262, 1993 Tenn. App. LEXIS 86, at *5–*6 (Jan. 28, 1993) (unpublished opinion) (describing policy offered by Tennessee Health Care Network).

75. *Id.* at *6.

emergency medical condition.⁷⁶ Without medical expertise, consumers are at the mercy of managed care plans that decide over the phone whether they or their children⁷⁷ appear to need emergency care,⁷⁸ or that retrospectively decide whether the patient's condition was an emergency.⁷⁹ The potential effect on consumers of "guessing" wrong may be devastating: "If they go to an [ED] without the permission of their managed care plan, they go at their financial peril. If they ignore their symptoms, they may be risking their lives"⁸⁰ In fact, plans that require preapproval or define emergency very narrowly "may deter requests for necessary care with potentially fatal results."⁸¹

Plan screening by telephone can also be problematic for patients:

Because of time constraints and absence of physical interaction, telephone medical conversations are necessarily less revealing than the usual physician-patient encounter. During a personal visit,

76. In a study of federally-qualified health plans, researchers found that:

[T]he vast majority (92%) [of plans] stated that their policy was to distinguish between life-threatening and non-life-threatening situations. Members could proceed by any means to EDs without obtaining permission if the problem was life threatening. . . . In non life-threatening situations . . . (80%) [of plans] required members to obtain permission from their physician, or from the HMO triage officer, prior to visiting an ED. [A] member's ability to define "life threatening" and "non life-threatening" determined whether he called 911 or the [plan's] triage number first. Understandably, these terms have not been easy to define, except in retrospect Much may depend on the ability to define "life threatening," and HMO members [are] expected to use their brochures or common sense for guidance.

Davidson, *supra* note 43, at 275-76. If a condition is not life-threatening, patients may have to wait several days to see a plan physician. For example, one article described a case in which the parents of a three-year-old child who had gotten a "pea-sized" pebble stuck in her nose on a Saturday morning were told by their managed care plan that the child could wait until Monday to see a plan physician. See Debra Lumpe, *Life Under Managed Care*, 15 *Emergency Med. News* 14, 14 (1993).

77. It is especially "difficult for parents to know when their child is suffering from a 'potentially life-threatening emergency.'" Kathy N. Shaw et al., *Indigent Children Who Are Denied Care in the Emergency Department*, 19 *Annals Emergency Med.* 59, 62 (1990); see also Young et al., *supra* note 45, at 464 ("Telephone triage may be particularly risky for pediatric patients.").

78. Although many plans use a telephone screening system to assess a patient's need for ED services, others do not believe such screening is appropriate. See Davidson, *supra* note 43, at 276 (citing study that found that medical directors of 10 plans "believed that telephone triage systems introduce undue delay in ED access and for that reason were not used by their HMOs").

79. In many cases, it is not possible to determine prior to a medical exam whether a patient's condition is an emergency. See Young et al., *supra* note 45, at 463 ("There is no consensus about what constitutes a nonurgent ED visit, and it is difficult to classify patients accurately [even for health professionals] without a complete examination or access to diagnostic tests.").

80. Henry, *supra* note 51, at 56.

81. According to the Maryland Chapter of the American College of Emergency Physicians, "patients are scared of coverage denial to the point of harm, including a death in Baltimore City in February [1995]." Letter from David S. Davis to Governor Parris Glendening, *supra* note 7, at 3.

much of the meaning behind what a patient says derives directly from the sound, pitch, and resonance of the voice and from physical posture, eye direction, and facial expression. Much of this is absent or distorted in telephone conversation.⁸²

Plans that require patients to justify their need for emergency services over the phone present unique difficulties for individuals whose “primary language is not English, who are illiterate or intoxicated, elderly, or who are frightened.”⁸³ Some individuals, Medicaid beneficiaries in particular, may not even have a phone.⁸⁴

C. *The Provider*

1. *Squeezed on Both Sides—The Dilemma of EMTALA*

Emergency providers also face dilemmas in treating managed care patients who appear at the ED because the providers must comply with the Emergency Medical Treatment and Labor Act (EMTALA).⁸⁵ EMTALA was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.⁸⁶ The law and subsequent amendments were aimed at addressing concerns that “because of increasing financial pressures, hospitals were denying emergency medical care to financially undesirable patients—a practice often referred to as ‘patient dumping.’”⁸⁷ Both patient health and the viability of public hospitals were being threatened by the private hospital practice of transferring uninsured emergency patients to public hospitals.

Under EMTALA, if a hospital provides emergency services, screening must be provided to any individual who comes to the hospital

82. Davidson, *supra* note 43, at 276.

83. *Id.*; see also Clark, *supra* note 57, at 3 (“The effectiveness of telephone triage ‘depends on the patient, their ability to respond, their education level and whether or not they are language impaired.’”) (quoting Diane Rowland, Executive Director, Kaiser Commission on Future of Medicaid).

84. One study—of indigent children denied approval by their managed care plan for emergency care—attempted to contact families for follow up after plan denial. The study concluded that “managed health care systems for indigent patients that rely on . . . good telephone communication with [primary care physicians may have a problem.]” Shaw et al., *supra* note 77, at 61. Many of the families the study attempted to contact “either had disconnected or no telephones.” *Id.*

85. Consolidated Omnibus Budget Reconciliation Act of 1985 § 9121, Pub. L. No. 99-272, 100 Stat. 82, 164 (1986) (codified as amended in scattered U.S.C. titles). Certain provisions of the Act were expanded in the Omnibus Reconciliation Act of 1989 §§ 6018, 6211, Pub. L. No. 101-239, 103 Stat. 2106, 2165, 2245 (1989) (codified as amended in scattered U.S.C. titles).

86. § 9121, 100 Stat. at 164.

87. MacDonald et al., *supra* note 20, § 20.01[2][b], at 20-8.

and requests examination or treatment for a medical condition.⁸⁸ Screening has become a significant dilemma for a number of emergency care providers who have questioned whether they must screen a patient when the managed care plan has denied approval or preauthorization for the ED treatment. Hospitals in a number of states have violated EMTALA regulations by failing to adequately screen patients upon admission to the ED when emergency treatment was not authorized by the patient's primary care physician.⁸⁹ EMTALA gives clear guidance as to the responsibility of a provider in these circumstances: "[A] hospital that has a hospital emergency department . . . must provide for an appropriate medical screening examination within the capability of [its] emergency department, including ancillary services routinely available . . . to determine whether or not an emergency medical condition . . . exists."⁹⁰ The only statutory reference to insurance states that "[a] participating hospital may not delay [providing] an appropriate medical screening examination . . . in order to inquire about the individual's method of payment or insurance status."⁹¹ Thus, a hospital that "triages a patient, then calls the patient's managed care plan for approval to further screen/treat, followed by discharge and referral to the managed care plan, risks a violation of the [EMTALA] regulation for failure to provide an appropriate medical screening examination and/or a delay in treatment."⁹²

If, upon screening, medical personnel determine that the individual has an emergency medical condition, the hospital must either treat and stabilize the individual or, in certain narrowly-defined situations, transfer the individual to another facility.⁹³ EMTALA defines the term "emergency medical condition" as:

88. 42 U.S.C. § 1395dd(a) (1994).

89. Health Care Fin. Admin., Department of Health & Human Servs., *Statements of Deficiencies and Plans of Correction, Form HCFA 2567* (Sept. 1992) (sample statements on file with *Washington Law Review*).

90. 42 U.S.C. § 1395dd(a).

91. 42 U.S.C. § 1395dd(h) (1994).

92. Letter from Rosemary Feild, Health Insurance Specialist, Health Care Financing Administration, to Linda DeFeo, M.D., J.D., Maryland Chapter of the American College of Emergency Physicians (Oct. 16, 1995) (citing 42 C.F.R. § 489.24(c)(3) (1994)) (on file with *Washington Law Review*). This puts some hospitals in a legal bind as many have contracts with managed care plans that require that emergency physicians call the plan before screening patients. Henry, *supra* note 51.

93. The law provides that a patient may be transferred prior to stabilization only if (1) the patient has requested the transfer in writing, after having been informed of (a) the hospital's obligation under EMTALA and (b) the risks of the transfer to the patient; or (2) the physician has certified in writing that, based upon the information available at the time of transfer, the medical benefits

(A) a medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant women [sic] who is having contractions—(i) that there is inadequate time to effect a safe transfer . . . or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.⁹⁴

There are significant penalties for failure to comply with EMTALA. Health care facilities or physicians “that negligently violate[] a requirement [are] subject to a civil money penalty of [up to] \$50,000” per violation.⁹⁵ In addition, any individual who is personally injured as a result of a hospital’s failure to comply with the statute, or any medical facility that suffers a financial loss as a result of a hospital’s violation, may bring a civil suit against the hospital and obtain civil damages to the extent such remedies are available under the law of the state where the hospital is located.⁹⁶

2. *Left Holding the Bag—A Fair Placement of Burden?*

Hospitals and physicians have taken EMTALA very seriously and thus are reluctant not to treat patients even if they do not receive preapproval from managed care plans for treatment. As a result, hospitals and physicians may be left with the financial burden of caring for those patients. This is often the case either because a patient’s managed care plan prohibits “balance billing”⁹⁷ or because a patient is judgment-proof and cannot pay the bill. Hospitals feel this burden acutely as they must absorb these costs on top of costs they already incur for care they provide to individuals who lack any health insurance.

ED doctors also claim that they are burdened inappropriately by the task of obtaining prior approval. They allege they are required to spend inordinate time on the phone “wrangling for approvals with insurers or

expected from the provision of treatment at the other facility outweigh the increased risk the transfer presents to the patient. 42 U.S.C. § 1395dd(c)(1) (1994).

94. 42 U.S.C. § 1395dd(e)(1) (1994) (footnote omitted).

95. 42 U.S.C. § 1395dd(d)(1) (1994).

96. See 42 U.S.C. § 1395dd(d)(2) (1994).

97. Physicians or hospitals “balance bill” when they charge the patient over and above what the patient’s managed care plan or other insurer pays for the visit or treatment. See Kongstvedt, *supra* note 23, at 184.

trying to find specialists 'in-network' for further treatment."⁹⁸ Some claim they spend hours doing the work of the plan to keep plan members in network. The placement of this type of burden on ED physicians raises questions of fairness and responsibility for the "managed care" function.

III. THE ROOT CAUSES OF THE CONFLICT

A. *A Clash of Cultures*

1. *The Philosophies of Managed Care and Emergency Care*

Some have argued that the philosophy of managed care is at odds with the nature of emergency care. They have, in fact, referred to it as a "clash of missions and cultures."⁹⁹ Managed care traditionally has emphasized regular preventive care and continuity of care wherein a physician coordinates all the medical services that a patient might need. In every sense of the word, the care is managed. In contrast, emergencies by their very nature are difficult if not impossible to manage. They are unexpected and episodic. Emergency physicians provide intermittent care to patients they have never seen before. The two modes of practice have different histories and different purposes.

Emergency medicine did not become a specialty until the late 1970s. Prior to that time, most hospital emergency facilities were staffed on a short-term basis by physicians with other specialties and other practice commitments.¹⁰⁰ Emergency rooms were considered a weak link in

98. Sham, *supra* note 68, at 1A; see also Deborah Glotzer et al., *Prior Approval in the Pediatric Emergency Room*, 88 *Pediatrics* 674, 678 (1991). In a study of HMO prior approval in a pediatric ED, Glotzer found that when ED staff were asked to name one major advantage of prior-approval policy, staff most commonly (33%) said:

[I]ncreased continuity of care . . . [and many (27%) said] reduced inappropriate [ED] use. [Others (20%)] saw no apparent advantage. The disadvantage[s] most frequently mentioned [were] the burden of telephone calls and paperwork involved in implementing the system (42%) . . . [and] decreased access to care and frequent failure to educate or inform patients about the system before reaching the emergency room. . . . [A large majority (70%)] did not think that the prior-approval system was worth the trouble.

Glotzer, *supra*, at 678.

99. Pear, *supra* note 48, at A22.

100. Jack Landry, *Federal Legislative Impact on Emergency Medicine Practice*, 5 *Prac. Mgmt. & Admin.* 31 (Emergency Clinics of N. Am. ed., Feb. 1987); see also *Birth of a Specialty*, CQ Researcher, Jan. 5, 1996, at 10, 10 (noting that during late 1950s and 1960s emergency room care was "often provided by nurses or moonlighting physicians from a hodgepodge of specialties in poorly equipped rooms").

hospital care.¹⁰¹ Emergency care was “low-tech” and messy. Emergency rooms were actually called “pits”:

They were named after the gory arenas in which bulldogs ravaged other dogs or mangled rats, or where gamecocks fought to the death on blood and offal-splattered floors. Even though hospitals euphematized them “accident rooms,” they *were* “pits.” In them, frightened interns waited while low, sleek, shiny red or jet black vehicles hauled in their cargoes of human misery.¹⁰²

There were a number of reasons for this ad hoc approach to emergency medical care. Most notably, there was not a widespread recognition of the need for specialization in this area. The variety of conditions seen and the range of care given in emergency rooms “obscured the complex and intensive nature inherent in emergency medical practice.”¹⁰³ Second, physicians did not believe that there was any money in caring for emergency patients. Most were uninsured and seeking charity care.¹⁰⁴

Emergency medicine began to change significantly during the 1960s. More people began to use the emergency rooms for sudden and episodic health care needs. According to one article describing this time, “[p]atients in large numbers turned to hospitals and their ERs as full service health care providers.”¹⁰⁵ American Hospital Association statistics showed that, in 1960, forty-two million patients received emergency medical treatment.¹⁰⁶ By 1970, that number had increased to nearly sixty million, and by 1984 it had grown to seventy-eight million.¹⁰⁷

It was also during this time that medicine in general was becoming more specialized. Emergency medicine was officially recognized as a

101. Landry, *supra* note 100, at 31; *see also* Paul Glastris, *Life and Death in the Emergency Room—Part 2*, Wash. Monthly, Feb. 1986, at 19, 21 (reporting that at time, “[f]ew [emergency rooms] had physicians staffing them around the clock, and many doctors who worked the ER beat had reputations, even among their peers, for incompetence”).

102. Landry, *supra* note 100, at 31 (citing J. Am. College Emergency Physicians, Dec. 1979).

103. *Id.*

104. *Id.*

105. *Id.* at 32.

106. *Id.*

107. *Id.* More recent statistics indicate that in 1993, there were 97.4 million visits to EDs. *See* Clark, *supra* note 57, at 3. Also fueling the growth in emergency care was the health care payment system. In 1965, the federal government passed legislation establishing the Medicare and Medicaid programs. These programs made it possible for many who had previously been unable to receive or pay for medical care to do so. *See* Landry, *supra* note 100, at 32–34.

specialty by the American Medical Association in 1979¹⁰⁸ and became one of the fastest growing specialties in the 1980s. During that decade “what were formerly called emergency rooms (ERs) were upgraded to emergency departments (EDs).”¹⁰⁹

2. *Different Approaches to Medical Practice*

The focus of the specialty of emergency medicine is “to evaluate, stabilize, and treat illnesses and injuries that require immediate care.”¹¹⁰ As a result, most EDs are set up to see patients with a wide spectrum of illnesses and injuries twenty-four hours a day. Individuals may present with life-threatening emergencies or with conditions requiring little treatment. Patients do not require an appointment and often are treated on an outpatient basis.

Once at the ED, patients are seen initially by a trained provider for the purpose of “triaging” them. This involves determining the severity of their illness or injury relative to that of other patients who are waiting for care. Typically, patients are designated as having a condition that is either emergent, urgent, or nonurgent:

Emergent conditions are illnesses or injuries that could be life- or limb-threatening and require immediate attention. Urgent conditions are not life- or limb-threatening, but are time-sensitive and need prompt medical attention, for example, a broken bone or injury that requires sutures. Nonurgent conditions are neither life- or limb-threatening nor time-sensitive.¹¹¹

The specialty of emergency medicine differs significantly from other specialties such as family medicine and internal medicine that predominate in the managed care setting. In emergency medicine,

[skill] involves not only the differentiation of patients who are sick from those who are worried but well, but also the recognition of patients who appear well but are candidates for sudden deterioration, as well as those who have a significant underlying illness that is not readily apparent. The initial assessment must be based on rapid evaluation of the patient’s appearance, chief complaint, and vital signs. This must lead to a rapid decision

108. Clark, *supra* note 57, at 5.

109. *Id.* at 5.

110. GAO Report, *supra* note 45, at 12.

111. *Id.* at 12–13.

concerning the stability of the patient and the necessity for early therapeutic intervention.¹¹²

In contrast to internal medicine, in emergency medicine, “diagnosis and assessment of problems are not in order of probability, with the most likely diagnosis listed first, but are rather in order of the ‘worst possible diagnosis.’”¹¹³ By its very nature then, emergency medicine may require “unnecessary” diagnostic tests in order to rule out life-threatening possibilities.

The “practice” of managed care, in contrast to that of emergency care, grew out of an effort to control our nation’s increasing health care costs. While many plans tout a focus on preventive care and health maintenance, the motivation for this emphasis has been the cost saving potential of identifying a condition or potential for illness before it becomes symptomatic and costly to treat.¹¹⁴ As data have emerged indicating that preventive efforts do not necessarily reduce costs,¹¹⁵ many plans are focusing less on preventive care and more on other ways to keep costs down.¹¹⁶ Thus, managed care plans, as discussed above, attempt to keep patients out of hospitals and away from specialists and direct them to less expensive sources of care such as outpatient primary care physicians.

3. *Duty Versus Economics*

Clearly, the practice philosophy of managed care is heavily influenced by economics. This economic “mindset” is further exacerbated by plans that pay physicians on a per capita basis. Although most managed care plans traditionally paid their physicians for each service provided (much like a fee-for-service system but at a significantly discounted rate), more and more plans are attempting to negotiate per-person (per capita) rates with physicians (whether they see

112. Barry E. Brenner & Robert R. Simon, *The Specialty of Emergency Medicine*, 1 J. Emergency Med. 349, 350 (1984).

113. *Id.*

114. See Mark Merlis, Congressional Research Serv., *CRS Report: Health Maintenance Organizations (HMO) and Employer Group Health Plans* 1 (Mar. 19, 1991).

115. See Elisabeth Rosenthal, *The H.M.O. Catch: When Healthier Isn't Cheaper*, N.Y. Times, Mar. 16, 1997, at 4:1 (While studies have shown that preventive care is generally good for your health, they have also shown that it often does not save money.”).

116. Consumer Rep., *supra* note 55, at 29 (citing survey finding that for some preventive measures, HMOs were no better than traditional health insurance arrangements, “which supposedly give short shrift to preventive care”).

the patients they are responsible for or not).¹¹⁷ Physicians who accept per capita payments take on the same sort of risks that insurance companies assume. Their hope is that the payments they receive from the managed care plan will be greater than the costs associated with caring for the plan's patients. If it costs physicians more to care for the patients than their per capita fees, the physicians will lose money. This can happen if their patients are sicker than they anticipated or use unnecessary services.¹¹⁸ Critics of per-person payment agreements argue that the arrangements may provide incentives for physicians to "pay attention to things other than the best medical treatment" for the patient.¹¹⁹

The era of managed care is not the first encounter emergency physicians have had with concerns about payment for care. EDs have had a long history of providing charity care and treating Medicaid patients.¹²⁰ This history, and the fact that under EMTALA, EDs have a duty to screen all who come to their doors, has made EDs sources of "bad debt" within hospitals.¹²¹ Hospitals in some parts of the country have closed their EDs because of their drain on institutional resources.¹²² The EDs that remain open are required to take all "comers" and, as a result, continue to incur bad debt. In some cases, this has put the financial viability of the hospital in jeopardy.¹²³ Prior to the growth of managed care, hospitals were able to shift much of the cost of treating

117. See Michael Quint, *Health Plans Are Forcing Change in the Method for Paying Doctors*, N.Y. Times, Feb. 9, 1995, at A1; see also Segal, *supra* note 22, at F3 ("About 60 percent of managed-care plans limit the number of referrals to specialists by paying physicians a 'capitated fee' In effect, the fewer referrals to specialists that such doctors make, the more money they earn.").

118. Quint, *supra* note 117, at A1.

119. *Id.* at D5 (quoting Sidney Wolfe, Public Citizen Health Research Group in Washington). As a result of such incentives, in 1996 voters in at least one state (Oregon) considered an initiative that would have outlawed capitation altogether. See Bodenheimer, *supra* note 33, at 1602. The Oregon ballot measure—Measure 35—failed, with 35% of voters in favor, but 65% opposed. See *Oregon Ballot Measures*, Oregonian (Portland), Nov. 6, 1996, at C5.

120. However, prior to EMTALA, there were many reports that EDs denied care to many who lacked insurance or could not pay for their care. See Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 Hous. L. Rev. 21, 60 n.292 (1989).

121. Frank Welsh, *Cost Containment in Emergency Departments*, 49 Healthcare Fin. Mgmt. 42, 42 (1995) ("Unlike most hospital departments, which are expected to break even or turn a profit, [EDs] traditionally have been run as a service to the community without much concern for the bottom line.").

122. See, e.g., Robert E. Tranquada, *Emergency Medical Care and the Public Purse*, 276 JAMA 945, 946 (1996) (stating that financial pressures have resulted in decrease in number of hospital-based EDs in Los Angeles County "from 103 in 1982 to 85 today").

123. See Jennifer Preston, *As Reserves Drop, Hospitals Talk of Forsaking Charity Care*, N.Y. Times, Apr. 14, 1996, at A1.

the uninsured in their EDs to paying patients. With managed care forcing hospitals to cut rates and reduce hospitalization, hospitals' ability to cover the costs of caring for the uninsured and underinsured has reached its limits.¹²⁴

B. Inappropriate Use of Emergency Departments

1. Empirical Evidence

Advocates for managed care plans argue that, without stringent controls on ED use, some plan members will inappropriately use EDs when other, less expensive care options are available. Historically, some groups have relied on hospital emergency facilities as a source of medical care even for non-emergent problems because they have lacked alternative sources of medical care and have known they cannot be turned away by EDs. But studies of the percentage of inappropriate visits to EDs have varied significantly in their findings, from as low as eleven percent¹²⁵ to as high as ninety-three percent, with most somewhere between thirty-eight and sixty-seven percent.¹²⁶

Rates of ED misuse also have been shown to vary considerably among different groups of patients. For example, there is little, if any, evidence that the privately-insured population inappropriately uses the

124. *Id.* In addition, the shift of Medicaid beneficiaries to managed care may be creating greater strains on hospital EDs. For those beneficiaries who continue to use the ED for nonurgent care, rather than receive some payment for these services through Medicaid, EDs may be denied any payment at all if the ED use was unauthorized or retrospectively deemed "unnecessary by a managed care plan." *Id.*; see also Tranquada, *supra* note 122, at 945.

125. Don P. Buesching et al., *Inappropriate Emergency Department Visits*, 14 *Annals Emergency Med.* 672, 673 (1985) (using guidelines established by American College of Emergency Physicians, authors found overall inappropriate visit rate to ED at three community hospitals to be 10.8%).

126. See GAO Report, *supra* note 45, at 20 (finding that, in 1990, approximately 43% of care provided at EDs was not for emergency or urgent condition, and that, in some rural areas, visits for nonurgent care were as high as 93%); Office of Inspector Gen., U.S. Dep't of Health & Human Servs. Pub. No. OEI 06-90-00181, *Controlling Emergency Room Use: State Medicaid Reports 1* (1992) ("[R]ecent studies show non-emergency visits for the general public range from 11 percent to 38 percent of all emergency room visits.") (footnotes omitted); J. Thomas Badgett, *Can Medicaid Format Alter Emergency Department Utilization Patterns?* 2 *Pediatric Emergency Care* 67, 67 (1986) ("Greater than two thirds of those receiving care in emergency departments do not qualify as clinical emergencies."); Robert Steinbrook, *The Role of the Emergency Department*, 334 *New Eng. J. Med.* 657, 657 (1996) ("The majority (55.4 percent) [of visits to emergency departments in this country in 1992] were classified as nonurgent."); William C. Stratmann & Ralph Ullman, *A Study of Consumer Attitudes About Health Care: The Role of the Emergency Room*, 13 *Med. Care* 1033, 1033 (1975) ("Estimates of nonurgent visits as a proportion of total ER visits range from one to two-thirds.").

ED.¹²⁷ In addition, “[t]he elderly have been shown to have low rates of inappropriate use in several studies, while high rates of inappropriate use have been noted in the pediatric age group, in patients who did not have private physicians, and in patients with lower socioeconomic status.”¹²⁸ More recent studies attribute the use of EDs for nonurgent care to whether the patient has a primary care physician. A recent General Accounting Office (GAO) report found, in 1990:

Of the 38 million nonurgent ED patient visits, about 42 percent (15 million) did not have a primary health care provider. About 6 million of these patients were unable to find primary care providers willing to treat them because the patients were either uninsured or their medical care costs were covered under a government-assisted program, such as Medicaid.¹²⁹

Much attention has been given to the Medicaid population and their “overuse” of the ED.¹³⁰ Several reports by the Office of the Inspector General have focused on the problem. The most recent report found that Medicaid recipients “consistently make a significantly higher proportion of non-emergency and marginally appropriate emergency room visits”¹³¹ than that among the general population. While non-emergency visits

127. In fact, a recent study found that, although the difference was not statistically significant, members of managed care plans were more likely than others to use the ED for emergent or urgent problems. See Young et al., *supra* note 45, at 462–63.

128. Marc Afilalo et al., *Emergency Department Use and Misuse*, 13 J. Emergency Med. 259, 262 (1995) (parenthetical information in quotation omitted). Afilalo relies on the following studies in drawing these conclusions: Buesching, *supra* note 125; A.G. Davison et al., *Use and Misuse of an Accident and Emergency Department in the East End of London*, 76 J. Royal Soc’y Med. 37 (1983); D.J.E. Eagle et al., *Misuse of the Emergency Department by the Elderly Population: Myth or Reality?* 19 J. Emergency Nursing 212 (1993); S.R. Lowenstein et al., *Care of the Elderly in the ED*, 15 Annals Emergency Med. 528 (1986); T.F. Oberlander et al., *Advice Seeking and Appropriate Use of a Pediatric Emergency Department*, 147 Am. J. Disabled Children 863 (1993); M. Prince et al., *A Study of “Inappropriate” Attendances to a Pediatric Accident and Emergency Department*, 14 J. Pub. Health Med. 177 (1992); E. Vayda et al., *Emergency Department Use at Two Hamilton Hospitals*, 112 Can. Med. Ass’n J. 961 (1975); M. Walsh, *Patient’s Choice: GP or A&E Department?* 5 Nursing Standard 28 (1990); B.W. Wolcot, *What is an Emergency? Depends on Whom You Ask*, 8 J. Am. C. Emergency Physicians 241 (1979).

129. GAO Report, *supra* note 45, at 21. Medicaid patients often lack primary care physicians because such physicians choose not to participate actively in the Medicaid program due to its low level of reimbursement. Furrow et al., *supra* note 71, at 745.

130. See, e.g., Richard I. Haddy et al., *Nonemergency Emergency Room Use in Patients With and Without Primary Care Physicians*, 24 J. Fam. Prac. 389 (1987); Robert E. Hurley et al., *Emergency Room Use and Primary Care Case Management: Evidence from Four Medicaid Demonstration Programs*, 79 Am. J. Pub. Health 843 (1989); The Medicaid Access Study Group, *Access of Medicaid Recipients to Outpatient Care*, 330 New Eng. J. Med. 1426 (1994).

131. OIG, *Recipients*, *supra* note 45, at 1.

among the general public, including Medicaid recipients, ranged between eleven percent and thirty-eight percent, those for Medicaid recipients alone were estimated from seventeen to sixty-one percent.¹³²

In an effort to control costs while insuring quality and access, many states have turned to managed care approaches for their Medicaid population.¹³³ Although there is some evidence that managed care is reducing ED visits by Medicaid beneficiaries¹³⁴ not all plans have been successful at steering patients from the ED,¹³⁵ finding that it is difficult to break old habits.¹³⁶ Some plans have also found it difficult to change physician practices regarding approval for emergency care. One study found that even an elaborate gatekeeping system was largely ineffective at preventing ED visits by pediatric Medicaid beneficiaries in managed care plans.¹³⁷ In addition, the majority of primary care physicians and ED staff surveyed found the gatekeeping policies, at least for after-hours visits, “burdensome and inappropriate.”¹³⁸

132. *Id.*

133. In 1994, “all states except Alaska, Connecticut, Maine, Nebraska, Oklahoma, Vermont and Wyoming reported having at least one Medicaid managed care program.” The Kaiser Comm’n on the Future of Medicaid, *Medicaid and Managed Care: Discussion Brief 2* (Feb. 1995). In 1995, over a quarter of Medicaid recipients were enrolled in some type of managed care program. See Office of Managed Care, *supra* note 18.

134. See, e.g., David Brown, *Deluged by Medicaid, States Open Wider Umbrellas*, Wash. Post, June 9, 1996, at A1 (reporting shift of Medicaid population in Tennessee to managed care).

In one year, the rate at which Medicaid patients under age 21 visited hospital emergency rooms was cut nearly in half. (It dropped from 900 visits per 1,000 Medicaid patients in 1993 to about 500 visits per 1,000 TennCare patients in 1994.) For people between age 21 and 64, ER visits dropped more than one-third.

Id.; see also Bettina French, *The Urgent Care Crunch: Medicaid Managed Care Tackles Emergency Use—With Mixed Results*, 69 Hosp. & Health Networks 34 (1995) (noting that in Arizona, first state to move all Medicaid patients into managed care, “ED use and the growth in per capita costs for care for the indigent are significantly lower than in states with traditional Medicaid programs”).

135. See Robert E. Hurley et al., *Gatekeeping the Emergency Department: Impact of a Medical Primary Care Case Management Program*, 14 Health Care Mgmt. Rev. 63, 70 (1989).

136. See French, *supra* note 134, at 38; see also Shaw et al., *supra* note 77, at 61 (finding, in their follow up study of indigent children in managed care plans who were denied authorization for ED care, that 58% of those contacted said they did not plan to change their use of ED, and only one-third said they would call their primary care physician before coming to ED in future).

137. Glotzer, *supra* note 98, at 674.

138. *Id.* Physicians surveyed indicated a reluctance to deny care to a child who had already been brought to the ED because of “clinical, ethical, and legal concerns.” *Id.*

2. *But Just How Big Is the Problem?*

Despite strong evidence that there is inappropriate use of EDs, the extent of that misuse is questionable. Some attribute the differences in study results to inconsistent methodologies. One study attributed its low findings of an eleven percent inappropriate-use rate to its definition of "appropriate."¹³⁹ The study was based on guidelines developed by the ACEP. These guidelines included thirteen clinical circumstances as well as the following introductory statement:

We feel that a patient has made an appropriate visit to an emergency department when: An unforeseen condition of pathophysiological or psychological nature develops which a prudent lay person, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention most likely available, after consideration of possible alternatives, in a hospital emergency department.¹⁴⁰

The authors point out that previous studies of ED utilization had relied on "urgency ratings based on physicians' retrospective assessment of disease process or 'threat to life and limb' criteria."¹⁴¹ Other studies have found that physician and patient perceptions of what constitutes an emergency differ dramatically.¹⁴²

139. Buesching, *supra* note 125, at 675–76; *see also* Afilalo et al., *supra* note 128. Afilalo and his co-authors similarly concluded that the variability in the rates of nonurgent ED use—which they found to be between 7% and 94% worldwide—was largely attributable to the differences in the operational definitions of appropriate ED users. *Id.* at 262. According to the authors, "[s]tudies that use only the physician's perception will generate data suggesting high levels of misuse (25–94%)." *Id.* (footnotes omitted). They cite a study by Hansagi and colleagues as an illustration of how perceptions of what is an emergency can vary. *Id.* (citing H. Hansagi et al., *Trial of a Method of Reducing Inappropriate Demands on a Hospital Emergency Department*, 101 *Pub. Health* 99 (1987)). Hansagi and colleagues "found that 45% of patients originally assigned to a nonurgent group by ED assistant nurses were later reclassified as emergency cases upon reassessment by a senior nurse advisor." *Id.* Also, "Davison and colleagues reported a 39% rate of inappropriate use based on a retrospective review of the medical records by a physician." *Id.* (citing Davison et al., *supra* note 128). However, "12% of the cases considered inappropriate were patients referred to the ED by a family physician." *Id.*

140. Buesching, *supra* note 125, at 672 (footnotes omitted).

141. *Id.*

142. *See* David W. Baker et al., *Determinants of Emergency Department Use by Ambulatory Patients at an Urban Public Hospital*, 25 *Annals Emergency Med.* 311, 313 (1995) (finding 89% of ER patients thought they needed to be seen immediately, but only 43% required care within 24 hours according to physician reviewers); *see also* Marilyn J. Gifford et al., *Emergency Physicians' and Patients' Assessments: Urgency of Need for Medical Care*, 9 *Annals Emergency Med.* 502 (1980); Wolcot, *supra* note 128.

IV. PROPOSED SOLUTIONS AND THEIR LIMITATIONS

A number of potential solutions have been implemented or suggested to mitigate the harms to consumers and the economic burden to EDs imposed by current managed care practices. These include relying on the market, suing plans for inappropriate denial of preapproval or coverage, and a variety of regulatory approaches, some taken by Medicare and others enacted as part of recent state statutes. This section summarizes each of these approaches and argues that all are significantly limited in their effectiveness.

A. Relying on the Market

Those who believe that government regulation should be kept to a minimum might argue that the best method to address this problem is through the market—competition among managed care plans for enrollees will lead to practices that take into account consumer concerns. Unfortunately, that is not likely to happen in the context of managed care. In large part, this is because consumers often do not have much choice when it comes to selecting a health insurance plan; it is their employers who make most of the choices. Additionally, there is little evidence that employers take into consideration consumer concerns when selecting health coverage and some evidence that they, in fact, ignore such concerns.

1. Limitations on Consumer Choice

An essential feature of a market-driven system is consumer choice. But consumers in our current health system often do not have any option but a managed care plan. Nor do they have the option to “take their business elsewhere” if they do not like a certain feature of their plan. According to recent studies, forty-five percent of individuals who get their health insurance through their employers are offered only one plan,¹⁴³ and fifty-two percent of midsize employers “now offer their workers only one plan.”¹⁴⁴ In other cases, where employees can choose among a number of plans, there is a dearth of good information about plan quality.

143. See Kosterlitz, *supra* note 53, at 2905.

144. See Toner, *supra* note 53, at 4:1.

Typically, employee information about the quality of various plans is by word of mouth. Consumers do not have access to comprehensive "report cards" about specific areas of plan services. Although there have been efforts to develop such consumer information, the quality of the information is not generally good or detailed enough to be of much assistance to most consumers.¹⁴⁵ For example, such information does not describe plan decisions regarding emergency care. Also, because emergencies are relatively "rare" events, consumers may not know of others who have experienced problems with emergency care; they may assume that how plans deal with emergencies is not of primary importance to them because they are unlikely to need emergency care. Such thinking, however, ignores the possible catastrophic harm that can occur in an emergency situation and is evidence that most individuals have difficulty accurately weighing the importance of rare events with potentially devastating outcomes.¹⁴⁶

Finally, even if there was good information about plans and an employee wanted to switch to another plan, employees are limited in their ability to shift from one plan to another. Typically, employers provide an open enrollment period during which employees can make a change among plans, but only at twelve-month intervals. Thus, consumer influence on plan behavior is likely to be negligible.

2. *Employers Show Little Interest in Quality*

Alternatively, the market might work to improve the behavior of managed care plans in a way that was more responsive to consumer concerns if employers, who do most of the selecting of plans, took into account the concerns of their employees. Unfortunately, the limited studies available indicate that that is not how employers make choices among plans. For most employers, it is a question of cost, not quality, of care that is important. For example, in selecting managed care plans, employers have been shown to give relatively little weight to a plan's accreditation for achieving certain quality standards by the National Committee for Quality Assurance, a private accreditation association for

145. See Consumer Rep., *supra* note 55, at 30 (stating that despite emergence of industry to give consumers relevant information about quality of plan services, "the tools for measurement are primitive at best, and the 'report card' movement is promising more than it can deliver").

146. Statisticians have pointed out that many individuals have difficulty evaluating probabilistic events. See, e.g., Richard Zeckhauser, *Procedures for Valuing Lives*, 23 Pub. Pol'y 419, 441 (1975) (arguing that we have great deal of difficulty thinking about very small probability levels); see also Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases* 3 (Daniel Kahneman et al. eds., 1982).

HMOs.¹⁴⁷ One study found that such certification was not one of the factors employers of large- and medium-sized companies considered most important when shopping for an HMO.¹⁴⁸

In addition to placing a premium on the cost of health insurance, there are other reasons why employers generally do not consider quality in selecting health insurance plans. Many employers, especially small- to medium-sized businesses, do not have the expertise or resources to evaluate the quality of managed care plans.¹⁴⁹ Moreover, quality is difficult to measure: data collection on quality of care indices is still in its infancy.¹⁵⁰ The larger employers that do have the resources and expertise, in many cases, are still reluctant to make decisions based on quality because they believe they are “crossing over the line” into making medical judgments and questioning the practice patterns of local physicians and hospitals.¹⁵¹

B. Taking Plans to Court

1. Recovery for Physical Harm

One potential or partial solution to the problems created by conflicts over emergency care between managed care plans and their members is for members who have been adversely affected by plan decisions to sue their plans for redress. Such actions could provide subscribers with some compensation for their harms and, ideally, would deter plans from

147. See David Segal, *HMOs: How Much, Not How Well: When Companies Go Shopping For Plans, Quality Ratings Are Given Short Shrift*, Wash. Post, Jan. 19, 1996, at F3.

148. *Id.* (reporting that study found “just 20 percent [of 197 midsize to large companies surveyed] consider the industry’s most respected seal of approval ‘extremely important’ when shopping for health care coverage”); see also John K. Iglehart, *The National Committee for Quality Assurance*, 335 *New Eng. J. Med.* 995, 997 (1996) (noting that according to Prudential Health Care System’s chief medical officer, company’s gain in business as result of gaining NCQA accreditation probably has not offset millions of dollars company spent obtaining accreditation).

149. See Peter Boland, *Market Overview and Delivery System Dynamics*, in *Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions* 3, 9 (Peter Boland ed., 1993); Laird Miller & Joanne Miller, *Why Employers Are Not Using Quality to Select Providers and Plan*, in *Making Managed Health Care Work: A Practical Guide to Strategies and Solutions*, *supra*, at 116–17; see also Iglehart, *supra* note 148, at 996 (explaining that NCQA estimates that although more than half of all large employers, that is, those with more than 5000 employees, “use data from accreditation surveys . . . in deciding which health insurance products to purchase,” small employers use accreditation surveys only 17% of time to purchase health insurance plans).

150. See, e.g., Iglehart, *supra* note 148, at 998; Consumer Rep., *supra* note 55, at 34–35; see also Boland, *supra* note 149, at 10 (noting that even if employers agree on quality of care indices, many employers are not willing to pay added cost of documenting quality care).

151. See Boland, *supra* note 149, at 8.

making future inappropriate decisions to deny coverage. Yet several obstacles to this traditional common law approach limit its effectiveness. In some cases, HMOs require that disputes over treatment are subject to binding arbitration, thus keeping such disputes out of court.¹⁵² Also, such suits may be preempted under the Federal Employee Retirement Income Security Act (ERISA).¹⁵³

a. The Roadblock Called ERISA

Under current law, many patients who are harmed because their managed care plan denies them preauthorization or access to benefits have little recourse against their plan. If an individual receives health insurance through an "employee benefit plan," a suit against the plan may be preempted under ERISA.¹⁵⁴ Most individuals in the United States receive their health insurance through such employee benefit plans.¹⁵⁵

152. See Richard C. Reuben, *In Pursuit of Health*, A.B.A. J., Oct. 1996, at 54, 56.

153. 29 U.S.C. § 1144 (1994). ERISA "was adopted to provide for national uniform administration of employee pension and health plans through federal legislation and to promote the growth of these private plans by freeing them from the scramble of state laws that unnecessarily complicated employee benefit administration." Robert L. Roth, *Recent Developments Concerning the Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents*, Health Law., Early Spring 1996, at 3, 7.

154. 29 U.S.C. § 1144(a). Employees are part of an employee benefit plan if their employer provides medical benefits to its employees "through an insured plan, an uninsured plan, an HMO or PPO, and memorializes [its] decision to do so through a memorandum distributed to employees, and provides copies of benefit booklets or outlines of available benefits." W. Eugene Basanta et al., *Recent Developments in Medicine and Law*, 31 Tort & Ins. L.J. 357, 362 (1996).

155. As of 1994, 60.5% of the U.S. population received their insurance through an employee benefit plan. Employee Benefit Research Inst., *Issue Brief 5* (Feb. 1996). A larger group may receive their health insurance through their employer, but not every purchase of group health insurance by an employer constitutes an "employee benefit plan" within the meaning of ERISA. See, e.g., *Blue Cross/Blue Shield v. Weiner*, 543 So. 2d 794 (Fla. Dist. Ct. App. 1989) (holding that ERISA plan did not exist where group health insurance policy was sold to individual through independent marketing company and plaintiff was merely sole proprietor who bought group policy for his family). According to one author:

Weiner underscores the proposition that an ERISA plan is not created by the mere marketing of group health-insurance policies by insurance brokers or other such entrepreneurs who often try to capture the market of small businesses with too few employees to enjoy favorable group rates on the open insurance market.

Theresa A. DiPaola, *Wrongful Denial of Health Insurance Benefits*, Trial, Mar. 1990, at 74, 75; see also 29 C.F.R. § 2510.3-1(j) (1995). These regulations, promulgated by the Department of Labor under ERISA, exclude from ERISA group insurance programs offered to employees

under which (1) [n]o contributions are made by an employer or employee organization; (2) [p]articipation . . . is completely voluntary for employees or members; (3) the sole functions of

Although ERISA does provide some remedies for wrongs committed by ERISA plans,¹⁵⁶ awards of damages “for bodily injury, emotional distress, property damage, lost wages, or punitive damages” by a plan member who claims to have been harmed by improper denial of benefits are not authorized under ERISA.¹⁵⁷

Numerous federal courts have considered whether patients who are enrolled in ERISA plans may bring state common law claims against the plan or whether such claims are preempted.¹⁵⁸ Most have held that where a plan member is injured because a managed care organization denied a necessary benefit or was negligent in administering benefits—for example, by negligently delaying a patient’s access to necessary treatment—the claim is preempted.¹⁵⁹ Four federal courts of appeals

the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and (4) [t]he employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services . . . [for] payroll deductions or dues checkoffs.

§ 2510.3-1(j).

156. The Act provides a “detailed system of filing suit, the grounds for such suits, and the relief to which the litigant is entitled.” Basanta, *supra* note 154, at 362.

157. *Id.* at 362–63 (“Nor can a plan participant who alleges that he has suffered physical injury because his medical condition deteriorated as a result of a denial of benefits recover compensatory damages. Recovery is limited to the value of the benefits that should have been provided.”).

158. *See, e.g.,* Anderson v. Humana, Inc., 24 F.3d 889 (7th Cir. 1994) (preempting employee’s claim under state law that HMO fraudulently induced participants to choose plan); Visconti v. U.S. Health Care, 857 F. Supp. 1097 (E.D. Pa. 1994) (holding that vicarious liability claim preempted by ERISA), *rev’d sub nom.* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S. Ct. 564 (1995); Rollo v. Maxicare, Inc., 695 F. Supp. 245 (E.D. La. 1988) (preempting claims for breach of contract, tortious interference with physician-patient relationship, intentional infliction of emotional distress, and consumer fraud because claims related to employee benefit plan). However, there are also cases in which managed care entities have been found liable for state law actions under either a theory of vicarious liability or corporate negligence. *See* Independence HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990) (holding that state law malpractice claim for negligent treatment by ostensible agent not preempted). Under the theory of corporate negligence, at least one court found that the claim that an HMO was negligent in selecting and retaining physician was not preempted. *See* Elsesser v. Hospital of the Phila. College of Osteopathic Med., Parkview Div., 795 F. Supp. 142, *modified*, 802 F. Supp. 1286 (E.D. Pa. 1992). A second court held that the issue of preemption was one that could not be resolved by the court (but could be raised again on remand). McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053 (Super. 1992), *aff’d*, 686 A.2d 801 (Pa. 1996). For a more detailed discussion of this issue see Robert Roth, *The Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, And Utilization Review Agents*, Health Law., Winter 1994–1995, at 7; and Roth, *supra* note 153.

159. *See* Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 Am. J. Pub. Health 863, 864 (1996); *see also* Roth, *supra* note 153, at 4 (“In general, state law claims against managed care entities arising out of their nonprovider roles are preempted by ERISA.”). These claims are brought

have agreed with this interpretation of the federal law.¹⁶⁰ In *Corcoran v. United HealthCare, Inc.*,¹⁶¹ the Fifth Circuit held that a “malpractice” claim against an HMO for denial of benefits was preempted by ERISA.¹⁶² The plaintiff had a high-risk pregnancy and her obstetrician had ordered her hospitalized shortly before her delivery date so that he could monitor her condition. Her health plan required preapproval for all hospitalizations. The plan denied the request for hospitalization on the ground that it was not medically necessary. Instead, it authorized ten hours per day of home nursing care. During a time when there was not a nurse on duty, the fetus went into distress and died.¹⁶³ The Sixth, Eighth, and Ninth circuits have all followed the approach taken in *Corcoran*.¹⁶⁴

b. One “Success” Story

In the context of emergency care, there are few reported cases where a plan member, injured as a result of a plan decision not to give preapproval or to delay receipt of care, has sued the plan. This may be due in large part to ERISA preemption of such suits. One of the only reported cases of this type where a plaintiff has been successful involved James Adams, a six-month-old boy from Fairburn County, Georgia. James and his family received their health care through the Kaiser

under a number of theories including bad faith, coverage denial, breach of contract, misrepresentation of available benefits, and many of the corporate issues involved in the provision of care by managed care plans. Basanta, *supra* note 154, at 363. A number of district courts have distinguished between these types of “malpractice” cases and those based on the quality of care provided in delivering a covered benefit, and have found that the latter are not preempted under ERISA. *See* Mariner, *supra* (discussing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S. Ct. 564 (1995)); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995)); *see also* Roth, *supra* note 153, at 4 (concluding that recent trend “appears to be for courts to find that state law tort claims against ERISA managed care entities in their capacity as arrangers for the provision of care and providers are not preempted by ERISA”).

160. *See* Mariner, *supra* note 159, at 865.

161. 965 F.2d 1321 (5th Cir. 1992).

162. *Id.* at 1331.

163. *Id.* at 1322–24.

164. *See* Mariner, *supra* note 159, at 865; *see* Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995) (holding that family’s claims of malpractice arising from Biodyne’s refusal to authorize psychiatric benefits pursuant to utilization review related to employee benefit plan and were preempted by ERISA); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (holding that family’s state law claim for wrongful death based on plan’s delay in approving autologous bone marrow transplant was preempted by ERISA because it was based on negligence in administering benefits); *Kuhl v. Lincoln Nat’l Health Plan, Inc.*, 999 F.2d 298 (8th Cir. 1993) (holding that health plan’s refusal to preapprove heart surgery was denial of benefits so that ERISA preempted malpractice claim).

Foundation Health Plan of Georgia. James's mother called Kaiser's emergency line one morning at 3:50 and reported that James was "moaning, panting, limp and running a 104-degree temperature."¹⁶⁵ The emergency line nurse told Mrs. Adams to place James in a tepid bath and then, after checking with a doctor, directed that the child be taken to a hospital forty-two miles from his home. The plan received a fifteen percent discount for patients treated at this hospital. On the way to the hospital, James' heart stopped beating. He was revived at another hospital with CPR "but circulation ceased to his extremities and he developed gangrene."¹⁶⁶ His physicians subsequently diagnosed a blood infection, and both his hands and legs had to be amputated as a result of the gangrene.¹⁶⁷

In a malpractice suit against the health plan, the plaintiffs' attorney argued that the child would not have been harmed if the plan had directed his parents to take him to the closest ED. A jury awarded the child forty-five million dollars—the largest verdict in a Georgia malpractice case.¹⁶⁸ The award was appealed by the health plan, which claimed that it would have made no difference if James had been sent to the nearest ED, but the parties settled prior to an appellate decision.¹⁶⁹ The claim was permitted to proceed because James's family did not receive their health insurance through an ERISA employee benefit plan and thus their claim was not preempted by the federal law.

2. *Recovery for Economic Losses*

Plan members who are not physically harmed as a result of plan denial of preapproval for ED care, because they sought the care in any case, may be left with significant medical bills. In these situations, plan members also may seek redress in court. Unlike cases involving claims for personal injury, however, ERISA does not bar claims for economic loss based on coverage denial. An ERISA plan participant or beneficiary may bring a civil action under ERISA "to recover benefits due to him

165. See Mark Silk, *\$45 Million Malpractice Verdict Fulton County Jury Award Against HMO Largest Ever in State*, Atlanta J. & Const., Feb. 4, 1995, at C10; see also Plaintiffs' Complaint for Damages at 3, *Adams v. Kaiser Found. Health Plan* (Ga. Ct. Fulton County 1995) (No. 93-VS-7985E) (on file with *Washington Law Review*).

166. See Silk, *supra* note 165, at C10.

167. *Id.*

168. *Id.*

169. Telephone conversation with Deborah Haas Thaler, Esq., Law Offices of Thomas William Malone, attorney for plaintiffs in *Adams v. Kaiser Foundation Health Plan* (July 10, 1996).

under the terms of his plan.”¹⁷⁰ Benefit claims litigation under ERISA is in the nature of an action to enforce beneficial rights under a trust.¹⁷¹ Damages are typically limited to the amount of the services in dispute (that is, contractual damages).¹⁷²

In cases brought under either ERISA or state common law, the court looks to the language in the health care agreement and “as with general contract terms [attempts] to ascertain and carry out the true intention of the parties.”¹⁷³ The intent of the parties is presumed to reside in the language they chose to employ in the agreement and common words appearing in the contract are “given their plain and ordinary meaning.”¹⁷⁴

There are relatively few court opinions involving disputes over managed care plan coverage for ED care. In three of the half-dozen cases reported, the plaintiffs lost because of clear noncompliance with the contract language—they failed to comply with the contract provisions requiring notification of the plan within a certain number of hours after receipt of the emergency services.¹⁷⁵ In cases where terms required judicial interpretation, however, plan members were more likely to win.

170. See 29 U.S.C. § 1132(a)(1)(B) (1994).

171. See Therese M. Connerton, *Suits by Beneficiaries Against Plans or Employers to Recover Benefits*, CA23 ALI-ABA 207, 213 (Feb. 1, 1996), available in WESTLAW, A.L.I.-A.B.A. CLE Materials File (explaining that principles of common law of trusts are incorporated into federal common law of employee benefits to guide courts in absence of express ERISA rules). The standard of review in cases involving benefits is a de novo standard unless the plan’s governing documents vest the plan fiduciary with discretionary authority to determine eligibility for benefits or to construe the terms of the plan documents, in which case the court applies an abuse of discretion standard. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

172. See Basanta, *supra* note 154, at 362–63.

173. See *White v. Keychoice Welfare Benefit Plan*, 827 F. Supp. 690, 696 (D. Wyo. 1993) (applying ERISA); see also *Kelley v. HMO Health Ohio*, No. 259003, 1995 Ohio App. LEXIS 5200, at *7 (Nov. 22, 1995) (unpublished opinion) (applying state common law).

174. See *Kelley*, 1995 Ohio App. LEXIS 5200, at *7.

175. See *Glass v. Complete Health Inc.*, No. 93-0938-RV-C, 1994 U.S. Dist. LEXIS 14510 (S.D. Ala. Oct. 12, 1994) (unreported opinion) (dismissing plaintiff’s claim, among other reasons, for failure to notify plan within 24 hours after receipt of emergency services as required by Group Master Contract), *aff’d*, 74 F.3d 1254 (11th Cir. 1996); *Humana Hospital-Bayside v. Lightle*, 407 S.E.2d 637 (S.C. 1991) (denying coverage for emergency services to HMO subscriber for failure to notify HMO within 48 hours of any hospitalization for emergency services in out of area hospital as required by plan); see also *Kelley*, 1995 Ohio App. LEXIS 5200, at *14 (affirming trial court’s summary judgment for defendant where plaintiff was seeking coverage for emergency treatment for head injuries on grounds that plaintiff’s extended inpatient stay for alcohol detoxification/rehabilitation did not constitute emergency services within terms of health plan and even if it did, coverage was not warranted because plaintiff failed to give plan required 24-hour notification).

a. *Judicial Interpretation of Contract Terms—Favorable to the Insured*

In cases involving interpretation of contract terms, courts have appeared to construe the language “as a reasonable person in the position of the HMO participant, not the actual participant, would have understood the words to mean.”¹⁷⁶ In *White v. Keychoice Welfare Benefit Plan*,¹⁷⁷ the case to articulate most clearly this standard of review in a dispute over emergency care, the plaintiff, Jerry Lee White, became seriously ill and was taken to the ED at Wyoming Medical Center. He was diagnosed as having a pelvic diverticular abscess that had penetrated into the supradural region of his spinal cord. His physician believed this was a severe, life-threatening infection and directed that White be airlifted to Denver to expedite therapy for a life-threatening problem and to minimize any neurological damage that might occur as a result of prolonged ground transport to Denver.¹⁷⁸

White’s HMO denied coverage for the cost of the air ambulance—\$4185.15.¹⁷⁹ The denial was based on the language in the plan’s Group Contract, which only covered ambulance services for surface transportation. The court noted that the Group Contract was not provided to employees. Instead, they received a Summary Plan Description (SPD), which did not indicate that air ambulance services were not covered. The SPD also stated that, “If any conflicts arise between the [SPD] and the plan documents (contracts), the plan documents will govern.”¹⁸⁰

Because the plan in question was an ERISA plan, the court looked to the provisions of ERISA requiring that an SPD must “be written in a manner calculated to be understood by the average plan participant, and be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”¹⁸¹ The court cited prior case law interpreting ERISA to hold that in reviewing the SPD and Group Contract, “the standard to be applied will be that of a reasonable person in the position of an employee welfare benefit plan participant.”¹⁸² Based on this standard, the court

176. See *White*, 827 F. Supp. at 696.

177. *Id.*

178. *Id.* at 692.

179. *Id.*

180. *Id.* at 693.

181. *Id.* at 694 (citing 29 U.S.C. § 1022(a)(1) (1994)).

182. *Id.* at 696.

found that the air ambulance cost was covered under the plan. The court quoted from precedent in explaining its decision:

The ambiguity in the summary plan description must be resolved in favor of the employee and made binding against the drafter. Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not the individual employee, who is powerless to affect the drafting of the summary of the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask. And it is especially not a lot to ask in return for the protection afforded by ERISA's preemption of state law causes of action—causes of action which threaten considerably greater liability than that allowed by ERISA.¹⁸³

Although *White* was based on ERISA, the few non-ERISA cases apply similar long-standing common law rules of contract and insurance policy interpretation.¹⁸⁴ Where policy language is clear, it is generally enforced as written, even where enforcement disadvantages the insured. Where there are questions of interpretation the terms are generally construed to protect the reasonable expectations of the insured.¹⁸⁵ However, such a standard is not always expressly articulated.¹⁸⁶ Nor does its application mean that the plan member will always succeed in his claim.

b. A Decision for the Plan

In *Fort Sanders Loudon Medical Center v. Bump*,¹⁸⁷ plan subscriber Richard Bump was denied coverage for several ED visits because the

183. *Id.* at 697–98 (quoting *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 982 (5th Cir. 1991)).

184. *See Kelley v. HMO Health Ohio*, No. 259003, 1995 Ohio App. LEXIS 5200 (Nov. 22, 1995); *Fort Sanders Loudon Med. Ctr. v. Bump*, No. 03A01-9207-CV-00262, 1993 Tenn. App. LEXIS 86 (Jan. 28, 1993).

185. Robert E. Keeton & Alan I. Widiss, *Insurance Law* § 6.3(a)(3), at 633 (1988). *But see* Robert H. Jerry, II, *Understanding Insurance Law* 143 (2d ed. 1996) (stating that “the existence of an ambiguity in the policy is not a predicate for the . . . application [of the doctrine of the reasonable expectations of the insured]” and that at least 16 states have applied doctrine in absence of ambiguous policy terms).

186. *See, e.g., Medical Ctr. Health Plan v. Brick*, 572 So. 2d 548 (Fla. Dist. Ct. App. 1990) (holding that plan arguably covered two out of three of plaintiff's ED visits, presumably because plan agreement was somewhat ambiguous regarding circumstances that would support emergency).

187. No. 03A01-9207-CV-00262, 1993 Tenn. App. LEXIS 86 (Jan. 28, 1993) (unpublished decision).

court found that the treatment afforded Bump did not “qualify under the policy as emergency services which may be rendered without authorization of the primary care physician.”¹⁸⁸ Bump had been experiencing migraine headaches and had been assigned by the plan to a primary care physician.¹⁸⁹ When Bump sustained headaches after his primary care physician’s normal office hours, he would go to the ED for treatment.¹⁹⁰ The medical charges in question were for fifteen ED visits from January 22, 1989 through November 20, 1989.¹⁹¹ The visits were not preauthorized.¹⁹² The plan stated that emergency services rendered under circumstances for treatment of an accidental injury or a medical emergency would be covered if not authorized.¹⁹³ Medical emergency was defined as “a serious health-threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.”¹⁹⁴ Although not express in its reasoning, the court apparently felt that Bump’s expectations that the visits were covered were not reasonable given the terms of the policy.

Thus, if the terms of an individual’s coverage regarding emergency services are unclear, he *may* recover in court for the cost of such services if his use of the services was “reasonable” in light of the language in the insurance policy. This, however, assumes individuals have the resources necessary to bring a legal action in the first place to prove their reasonableness—an obstacle that many individuals will not be able to overcome. Moreover, if the case involves an ERISA plan, individuals may have a difficult time securing a lawyer to represent them, due to “ERISA’s limited damage and attorneys’ fees.”¹⁹⁵

3. *Suing the Plan (Gatekeeper) Physician*

Although ERISA preempts most suits against managed care plans, it does not preempt suits against managed care physicians. Yet,

188. *Id.* at *8.

189. *Id.* at *6.

190. *Id.*

191. *Id.*

192. *Id.* at *8.

193. *Id.*

194. *Id.* at *4.

195. Patricia Butler & Karl Polzer, *Private-Sector Health Coverage: Variation in Consumer Protections Under ERISA and State Law* 26 (1996).

remarkably, few such suits have been brought or, perhaps more accurately, have resulted in published opinions.¹⁹⁶ One stumbling block to such suits has been an argument that physician gatekeepers have not established a physician-patient relationship with the managed care member.¹⁹⁷ Often, such physicians never meet the plan member and may never have spoken to them on the phone. Typically, the gatekeeper speaks directly to ED personnel.

This argument, however, was discredited in *Hand v. Tavera*.¹⁹⁸ In *Hand*, Lewis Hand, an enrollee in an HMO in San Antonio, Texas, and his wife, sued his primary care physician for failure to approve his treatment by an ED.¹⁹⁹ Hand, forty-nine years old with a history of high blood pressure, came to the ED of Humana Hospital complaining of a three-day headache.²⁰⁰ The ED physician, Dr. Daniel Boyle, was told that Hand's father had died of an aneurysm.²⁰¹ Boyle also observed that Hand's symptoms rose and fell with his blood pressure and that his blood pressure dropped periodically in response to medication.²⁰² Boyle, after observing Hand for a few hours, determined that Hand could be "on the brink of a stroke and should be admitted to the hospital."²⁰³ Dr. Boyle called Dr. Robert Tavera, who was Hand's primary care physician and who was responsible that evening for authorizing admissions for his practice's HMO patients.²⁰⁴ Boyle briefed Tavera by telephone and recommended hospitalization.²⁰⁵ Tavera, however, disagreed with Boyle's assessment and "concluded that Hand could be treated as an outpatient" with medication and follow-up.²⁰⁶ Hand "was sent home,

196. *Id.* at 50 ("One ERISA expert noted that, due to lack of potential remuneration, few lawyers have developed expertise representing employees in ERISA health plan litigation.").

197. Another explanation for the small number of suits of this type is that plaintiffs' attorneys perceive managed care plans rather than the plan physicians as ultimately responsible for decisions to deny care. *Id.*

198. 864 S.W.2d 678 (Tex. Ct. App. 1993).

199. *Id.* at 679.

200. *Id.* at 678-79.

201. *Id.* at 679.

202. *Id.*

203. *Texas Malpractice Case Clarifies Liability of Gatekeeper Physicians*, Med. & Health, May 1, 1995, at 3, 3.

204. *Hand*, 864 S.W.2d at 679.

205. *Id.*

206. *Id.*

where he suffered a stroke a few hours later.”²⁰⁷ He remains disabled from the stroke.²⁰⁸

Hand subsequently sued Tavera, Boyle, the health plan, and the hospital. He ultimately settled with the health plan²⁰⁹ and the hospital and dropped the case against Boyle after finding no negligence on his part.²¹⁰ At a hearing on the suit against Tavera before the District Court of Bexar County, Texas, Tavera moved for summary judgment “on the sole ground that he and Hand never established a physician-patient relationship and therefore he owed Hand no duty” of care.²¹¹ The lower court granted the summary judgment.²¹²

On appeal, the decision was reversed.²¹³ The court of appeals found that “when the health-care plan’s insured shows up at a participating hospital emergency room, and the plan’s doctor on call is consulted about treatment or admission, there is a physician-patient relationship between the doctor and the insured.”²¹⁴ The contract between the Humana plan and Tavera was determined to be the basis for the physician-patient relationship.²¹⁵ The court found that:

[T]he contracts . . . show[ed] that the Humana plan brought Hand and Tavera together just as surely as though they had met directly and entered the physician-patient relationship. . . . In effect, Hand had paid in advance for the services of the Humana plan doctor on

207. *Id.*

208. *Texas Malpractice Case Clarifies Liability of Gatekeeper Physicians*, *supra* note 203.

209. Humana Health Care Plans successfully argued “that as agents for Hand’s employer—who was self-insured—they were shielded under . . . ERISA.” Don Finley, *Malpractice Suit to Have Impact—Ruling in Case Having Ripple Effect in Medical, Legal Community*, San Antonio Express-News, May 14, 1995, available in 1995 WL 5561172.

210. Telephone conversation with Randall Jackson, Esq., Attorney for Lewis Hand (July 13, 1995). In addition, Hand could not have sued Boyle for a violation of EMTALA because the Act does not provide a private civil action for damages against individual doctors who violate the federal statute. It provides only a civil fine against offending physicians. In contrast, the Act provides for civil damage suits against offending hospitals. *See Hand*, 864 S.W.2d at 680 (referring to Hand’s additional claim against Tavera); *infra* note 208 and accompanying text.

211. *Hand*, 864 S.W.2d at 679.

212. *Id.* at 678.

213. *Id.* at 678, 681.

214. *Id.* at 679.

215. The contract provided that “PHYSICIAN agrees to provide or arrange for covered health care services for ENROLLEES in accordance with ATTACHMENT B [Attachment B specifies various physician responsibilities, including ‘emergency care of a covered ENROLLEE who has been assigned to PHYSICIAN’].” *Id.*

duty that night, who happened to be Tavera, and the physician-patient relationship existed.²¹⁶

The court also found that, under the contract between the HMO and the medical group that employed Tavera, the physicians in the group were “obligated . . . to treat Humana [plan] enrollees as they would treat their other patients.”²¹⁷

4. *The Limited Reach of EMTALA*

Although ED physicians and hospitals that provide emergency services may be penalized under EMTALA for failure to screen and stabilize managed care patients who appear at the hospital seeking emergency care, and hospitals may be sued for harms suffered by patients for refusal of care, EMTALA does not allow for administrative or private actions against managed care plans.²¹⁸ Thus, patients have not been able to use EMTALA against managed care plans that deny authorization for ED services.

C. *The Medicare Approach: A Possible Model?*

Although private managed care plan members have few protections or remedies regarding receipt of emergency care, those in public insurance programs do enjoy some protections. Those safeguards have been developed most extensively for Medicare beneficiaries.²¹⁹ These

216. *Id.*

217. *Id.* The case was remanded to the trial court to determine negligence on the part of Tavera but the case was settled prior to trial.

218. See *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103, 1108 (S.D. Fla. 1993) (holding that EMTALA does not apply to HMOs or similar health plan providers). However, in limited circumstances, administrative actions might be brought against managed care physicians. See *Hand*, 864 S.W.2d at 680. In *Hand*, the plaintiff's brief also argued that Tavera, as an “on-call” physician, violated EMTALA. Plaintiff's Brief at 16, *Hand* (No. 04-92-00618-CV). EMTALA requires hospitals to maintain a list of on-call doctors to treat emergency patients. 42 U.S.C. § 1395cc(a)(1)(I)(iii) (1994). Furthermore, “doctors accepting ‘on-call’ coverage are required to provide timely treatment in accordance with anti-dumping requirements.” Plaintiff's Brief at 16, *Hand* (No. 04-92-00618-CV) (citing 42 U.S.C. § 1395cc(a)(1) (1994)). Although the court rejected this claim because the statute does not include a private right of action for damages against physicians who violate it, an administrative enforcement action, arguably, could be brought against physicians in these limited circumstances (that is, where the gatekeeper is also the “on-call” physician). See *Hand*, 864 S.W.2d at 680.

219. There are several arrangements that allow Medicare beneficiaries to enroll in managed care plans. HMOs offer coverage through two types of Medicare contracting options. The first are “risk-based contracts” under which an HMO accepts a per capita payment for each Medicare beneficiary who chooses to enroll. The second type of HMO option is a cost-based contract. Under this option,

protections include regulations stating that plans cannot require prior authorization for emergency services²²⁰ and an interpretation of coverage for emergency services that is favorable to the enrollee.²²¹

Medicare law provides that disputes between beneficiaries and managed care plans over emergency care or other benefits are subject to an appeal process.²²² An initial appeal is provided by the plan itself. But if this appeal is not totally favorable to the enrollee, the case is automatically referred to the Health Care Financing Administration (HCFA).²²³ In 1989, HCFA hired a contractor, Network Design Group, Inc. (NDG),²²⁴ to conduct a prospective review of requests by Medicare beneficiaries for reconsideration after disputes with their managed care

an HMO is paid a predetermined monthly amount based on an estimate of the total cost of Medicare covered services for enrolled beneficiaries. At the end of the year, adjustments are made, based on the amount of services actually provided. Medicare beneficiaries may also join a third type of managed care organization called a competitive medical plan (CMP). A CMP is a prepayment organization that does not meet the strict requirements of the HMO provisions of the Public Health Service Act for federally certified HMOs but that still is capable of providing services to Medicare beneficiaries on a prepaid basis. 42 C.F.R. § 417.407(c) (1996).

220. See 42 C.F.R. § 417.414(c)(1) (1996) (“An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services . . . that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP even in the absence of the HMO’s or CMP’s prior approval.”).

221. See discussion *infra* notes 269–271 and accompanying text.

222. The Medicare managed care appeals process was modeled after, “and is comparable to, the multi-level due process procedures in the Medicare [fee-for-service] program. These appeal systems derived from a long history of Congressional efforts to protect Social Security Act beneficiaries from inappropriate adverse benefit decisions.” David A. Richardson et al., Network Design Group, Inc., *HCFA Cooperative Agreement No. 17-C-90070/2-01, A Study of Coverage Denial Disputes Between Medicare Beneficiaries and HMOs* 9 (Sept. 1993) (on file with *Washington Law Review*).

223. In this respect, the appeal process under Medicare for managed care enrollees is unique. “By comparison, employer group HMO programs rely almost exclusively on the HMO’s internal grievance system to address disputes.” *Id.* at 11. There are at least two significant implications of this type of independent third-party review. First, “[p]lans are aware that every (appealed) benefit denial will come under the direct scrutiny of its payor (HCFA). Consequently, the Medicare appeal program may act to deter inappropriate or marginal claim denials. Secondly, the system generates a census of benefit denials contested by enrollees.” *Id.* These data are not readily available in employer group programs. *Id.* Once HCFA has made its determination, the beneficiary may appeal the decision to a Social Security Administration administrative law judge (ALJ) if the amount in controversy is more than \$100. *Id.* at 10, fig. 2.1. The beneficiary may request subsequent Appeals Council review of the ALJ’s decision as well as judicial review if the amount in dispute exceeds \$1000. *Id.*

224. In August 1996, NDG changed its name to the Center for Health Dispute Resolution, but it will be referred to as NDG in this Article.

plan.²²⁵ From 1989 to 1992, the contractor processed more than ten thousand reconsideration cases to determine if the plan had “correctly” or “incorrectly” denied the initial request for payment.²²⁶ In approximately sixty percent of the cases, the contractor determined that the plans correctly denied benefits, but in forty percent of the cases benefits were incorrectly withheld.²²⁷ Disputes over emergency care were a significant number of the reconsideration cases.²²⁸

The contractor also completed a more detailed analysis of a sample of over seven hundred reconsideration cases.²²⁹ Approximately sixty percent of the sample cases involved disputes over either in-area emergency services or “urgent” out-of-area services.²³⁰ In these cases, plan denials were upheld seventy-five and sixty percent of the time, respectively.²³¹

The authors of the study concluded that these case types were “dispute prone” and most often decided against the beneficiary in part because of HCFA’s regulatory definitions of “emergency” and “urgent.”²³² The regulations define “emergency services” as:

[C]overed inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions:

- (1) Are needed immediately because of an injury or sudden illness.
- (2) Are such that the time required to reach the HMO’s or CMP’s providers or suppliers (or alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee’s health.²³³

According to the authors of the study:

These definitions place [enrollees] in the unreasonable position of making quasi-clinical evaluations of their symptoms and conditions and do not, expressly, make allowance for subjective experience (e.g., pain or suffering). As a consequence, enrollees

225. Subsequently, HCFA contracted with NDG to serve as the outside reviewer for all Medicare HMO requests for reconsideration. Telephone conversation with David Richardson, President, Network Design Group (Apr. 1996).

226. See Richardson, *supra* note 222, at 53.

227. *Id.*

228. *Id.* at 51.

229. *Id.* at 65–66.

230. *Id.* at 3.

231. *Id.*

232. *Id.*

233. 42 C.F.R. § 417.401 (1996).

who appear to act prudently from a lay perspective may face substantial or even catastrophic out-of-pocket liabilities.²³⁴

They further determined that “some denials place enrollees who make ‘honest and reasonable’ mistakes” at great financial risk, which may ultimately benefit providers.²³⁵ These penalties, they concluded, “seem . . . out of proportion to the offense while creating perverse provider incentives.”²³⁶

In January 1992, HCFA revised its manual regarding emergency care for Medicare managed care beneficiaries.²³⁷ Although the definition of “emergency services” was not changed, the new guidelines provide that:

An emergency is determined at the time a service is delivered. . . . If it is clearly a case of routine illness where the patient’s medical condition never was, or never appeared to be, an emergency as defined above, then [the plan is] not responsible for payment of claims for the services. [Plans may] not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.²³⁸

Moreover, the guidelines provide that “[a]ll procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered.”²³⁹ In the period between January 1992 and June 1994, HCFA also began to rethink its definition of emergency services and make some refinements to the definition in terms of guidelines for their contractor, NDG, in reviewing claims. These guidelines provided that an emergency should be determined from the perspective of the beneficiary.²⁴⁰

Based on these refinements, in June 1994, NDG distributed a newsletter, *Reconsideration Notes*, to Medicare managed care providers, describing how they would be reviewing disputes regarding emergency care services and hoping to educate plans as to how to assess these cases

234. Richardson, *supra* note 222, at 3.

235. *Id.* at 4.

236. *Id.*

237. *HMO/CMP Manual* § 2104 (9th rev. ed. Jan. 1992).

238. *CCH Medicare and Medicaid Guide* ¶ 13,960.22, at 5842 (1996).

239. *Id.* For example, the guidelines state that where a member who is treated in an ED for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation, the plan may not decide, upon retrospective review, that the angiography was unnecessary and refuse to cover this service. *Id.*

240. *See infra* notes 241–244 and accompanying text.

on their initial review.²⁴¹ The *Notes* state that, when applying the definition of emergency care, a key issue is the *risk* to the health of the enrollee that would result if access to medical treatment was significantly delayed.²⁴² In determining that risk, NDG stated that it recognizes that plans will likely apply “expert medical judgment” but it warned plans that they cannot expect enrollees to have clinical expertise; rather enrollees “will generally make the assessment of risk as lay patients.”²⁴³ Specifically, the *Notes* explain that:

[T]he HCFA HMO/CMP Manual § 2104.1 makes clear that [a managed care plan] must base its determination on the member’s presenting symptoms and conditions, not the diagnosis established after medical evaluation. . . .

Accordingly, NDG will *begin* its evaluation of emergency/urgent cases by giving consideration to the expert medical assessment of the Plan. However, NDG will not ignore credible member testimony—particularly contemporaneous to the emergency/urgent care seeking—in judging whether “risk” exists. “Contemporaneous” testimony includes, for example: member statements recorded in ambulance vendor notes; statements made to family or friends; and ER Department notes. Testimony NDG would weigh strongly includes statements like: “I thought I was having a heart attack”; “it felt like a stroke”; “there was so much blood, I didn’t think I should wait.” In each of these statements, the member has stated or clearly implied their lay assessment that risk of permanent damage existed.²⁴⁴

On March 27, 1995, HCFA sent out a letter to all current Medicare-Contracting HMOs reminding them of policies relating to the provision of emergency services for Medicare beneficiaries.²⁴⁵

241. Reconsideration Notes (Network Design Group, Inc., Health Care Fin. Admin., Pittsford, N.Y.), June 1994, at 2.

242. *Id.*

243. *Id.*

244. *Id.*

245. See Letter from Rodney C. Armstead, M.D., Director, Office of Managed Care, Health Care Financing Administration, to current Medicare-Contracting Health Maintenance Organizations and Competitive Medical Plans (Mar. 27, 1995) (on file with *Washington Law Review*). On October 13, 1995, HCFA sent a similar letter to state Medicaid directors regarding Medicaid Managed Care Plans and Emergency Services. See Letter from Gale A. Drapala, Deputy Director, Office of Managed Care, HCFA, to Managed Care Plans and Emergency Services (Oct. 13, 1995) (on file with *Washington Law Review*). Although the Medicaid state and federal regulations do not address this issue directly, HCFA has interpreted the requirement for Medicaid coverage of emergency

During the period January 1992 to December 1995, the number of reconsideration requests regarding Medicare managed care and emergency care declined significantly from approximately one in two thousand enrollees in 1992, to one in five thousand enrollees in 1995.²⁴⁶ During the same time frame there was also a decrease in the percent of plan decisions upheld from seventy-eight percent in 1992 to seventy-two percent in 1995 and a corresponding increase in percent of plan decisions overturned—from nineteen to twenty-five percent.²⁴⁷

The downward trend in the number of plan decisions upheld may be attributable to the more recent application of the “patient-centered” definition of emergency services applied by NDG. However, there has been no systematic effort to study this question, and it is difficult to interpret the data in light of the decline in total number of requests for reconsideration of plan decisions to deny coverage of emergency care. The latter decline may mean that plans are doing a better job at the initial plan level of appeal in interpreting the definition of emergency condition and/or of educating enrollees about the appropriate use of emergency services. This would mean that the bulk of cases being submitted for reconsideration are those where plans believe the use of EDs is unreasonable from the perspective of the plan member. Thus, these cases would be more difficult to decide at the reconsideration level and one might expect a fairly even number of cases overturned and upheld. On the other hand, the reduction in number of requests for

services to parallel the Medicare requirements, that is, that a Medicaid HMO must “assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services . . . that are obtained by its Medica[id] enrollees from providers and suppliers outside the HMO . . . even in the absence of the HMO’s . . . prior approval.” 42 C.F.R. § 417.414(c)(1) (1996). The letter from Drapala, however, did not inform Medicaid Directors of how HCFA interprets emergency services for Medicaid beneficiaries based on the reasonable perception of the beneficiary. Letter from Gale A. Drapala, *supra*. More recently, HFCA has drafted another letter on this issue to All Medicare-Contracting Health Maintenance Organizations and Competitive Medical Plans. The letter clarifies the definition of Emergency Services, by stating that the “determination of whether an emergency exists should be made from the perspective of the patient and within the context of the circumstances existing at the time the patient sought emergency care. Beneficiaries, therefore, have a right to emergency service if they have symptoms of sufficient severity and sudden onset and they are acting reasonably given their knowledge, experience and state of mind.” Memorandum from Bruce M. Fried, Director, HCFA Office of Managed Care, to All Medicare-Contracting Health Maintenance Organizations and Competitive Medical Plans, Draft (Apr. 3, 1997) (on file with *Washington Law Review*).

246. Network Design Group, Inc., Medicare HMO/CMP Reconsideration Project, *Computer Printouts of Reconsideration Statistics* (Sept. 23, 1996) (on file with *Washington Law Review*).

247. *Id.* According to statistics provided by the Reconsideration Project on September 23, 1996, the percentages of ED cases upheld and overturned in 1996 were approximately two-thirds and one-third, respectively, indicating a continuing trend. *Id.*

reconsideration could mean that plans are not making enrollees aware of the appeals process.²⁴⁸

Although there is some evidence that the Medicare approach has been responsible for helping to reduce the number of beneficiaries who are retroactively denied coverage for emergency care, the guidelines for a patient-centered standard for review are limited to Medicare enrollees, and they are simply guidelines—they have not been included in the Medicare statute or adopted as formal regulations.²⁴⁹

D. Recent State Legislation

1. Limited and Comprehensive Approaches

During the last three to four years, a number of states also have recognized the problem of emergency care for managed care subscribers and have passed legislation to deal with it. Much of the earliest legislation focused narrowly on the problem, simply changing the definition of emergency condition in the state's HMO Act or health insurance laws. Many of the more recent state statutes, however, have taken a more comprehensive approach, attempting to address various

248. Medicare law requires that Medicare HMOs have a comprehensible and publicized grievance and appeals process. See Eleanor D. Kinney, *Medicare Managed Care from the Beneficiary's Perspective*, 26 Seton Hall L. Rev. 1163, 1178 (1996). Their internal grievance procedures must be clearly described in written membership rules. *Id.* at 1179. Despite these requirements, some Medicare beneficiaries do not know about the appeals process. One study found that 25% of beneficiaries who were plan members did not know that they had the right to appeal their HMO's refusal to provide or pay for services. See Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Pub. No. OEI-06-91-00730, *Beneficiary Perspectives of Medicare Risk HMOs* 8 (Mar. 1995).

Even if members know about the appeal process, however, they may be stymied by its slowness and defeated by its "arbitrariness." In some cases, enrollees may not be able to get past the plan for a third-party review of their claim. According to the opinion in a recent class action suit brought by Medicare beneficiaries denied medically-necessary services, in many cases "the HMOs hide the ball [and fail to inform Medicare patients that they have] a right to present additional evidence to the HMO for reconsideration. This omission violates [federal regulations]." *Grijalva v. Shalala*, 946 F. Supp. 747, 758 (D. Ariz. 1996); see also Robert Pear, *Medicare Patients in H.M.O.'s [sic] Win a Case*, N.Y. Times, Oct. 31, 1996, at B15.

249. In the 104th Congress, Sen. Bob Graham (Democrat representing Florida) offered an amendment to the Medicare budget appropriation that would have required plan coverage for ED visits if a "prudent layperson" would have thought he or she was experiencing an emergency medical condition. Although the amendment passed on the Senate floor, negotiations on the budget appropriation package collapsed and the bill was vetoed by President Clinton. See 141 Cong. Rec. H14136-H14137 (daily ed. Dec. 6, 1995) (veto message of President Clinton). In his most recent Medicare budget proposal, however, President Clinton has incorporated the "prudent layperson" standard. *President's Fiscal Year 1998 Budget Proposal* (last modified Apr. 7, 1997) <<http://www.hcfa.gov/regs/fy98.html>> (on file with *Washington Law Review*).

aspects of the problem, from preauthorization requirements to who should be required to pay for services received.

a. The First Round

Maryland was the first state to pass legislation addressing this problem. In 1991 and 1992, emergency care physicians in the state began to notice what they considered to be a pattern of abuse on the part of HMOs in the use of EDs. They felt that HMOs and other managed care plans were sending their patients to out-of-network EDs in order to satisfy their legal mandate to provide emergency services to their subscribers.²⁵⁰ They also believed that HMOs had an incentive to do this under the payment provisions of the state's HMO Act.²⁵¹ Under the Act, non-HMO providers in emergency facilities who treated HMO patients were required to accept a fee for their services that was determined by the HMO and state insurance commission, without input from or review by non-HMO providers.²⁵² These rates were significantly below the customary fee charged by EDs for their services. In some cases, emergency physicians also observed that plans would retroactively deny coverage for the services provided by the ED.

In response to these practices, emergency physicians in the state proposed legislation that would: (1) require that HMO emergency rates be established in an open process—subject to public review and comment, and not based on Medicare and Medicaid rates;²⁵³ and (2) change the definition of emergency services in the HMO Act so that it would be more beneficial to patients. They proposed that “emergency services” be defined as:

[T]hose health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected *by a prudent lay person, who possesses an average knowledge of health and medicine*, to result in:
 Placing the patient's health in serious jeopardy;
 Serious impairment to bodily functions; or

250. See Interview with David S. Davis, M.D., J.D., Chair, Public Policy Committee, Maryland Chapter of ACEP, in Baltimore, Md. (July 14, 1995).

251. See Maryland Health Maintenance Organization Act, Md. Code Ann., Health-Gen. II §§ 19-701 to -735 (Supp. 1996).

252. See Interview with David S. Davis, *supra* note 250.

253. S. 701, Reg. Sess. (Md. 1993) (codified at Md. Code Ann., Health Gen. II § 19-716).

Serious dysfunction of any bodily organ or part.²⁵⁴

The definition was taken, in part, from HCFA's revised interpretation of emergency services.²⁵⁵ Maryland's HMO Act provides that HMOs practicing in the state must provide emergency services.²⁵⁶ Thus, the change in definition would require HMOs to cover emergency services as defined in the statute. They would no longer be able to decide unilaterally how emergency would be defined. The state emergency physicians, with the help of the state hospital association, were successful in getting both bills passed. The changes became effective on October 1, 1993. Within the first eighteen months after the law took effect, a representative from the State Insurance Commission stated at a hearing at the State Legislature that the Commission had seen a significant decline in the number of complaints against HMOs involving emergency care.²⁵⁷

In 1995, two additional states—Virginia and Arkansas—passed legislation in this area. Both followed the Maryland model of including a statutory definition of emergency services that would apply to HMO services and of basing that definition on a “prudent layperson” standard. The Arkansas Legislature passed a free-standing bill entitled “Definition of Emergency Medical Care Act.”²⁵⁸ The Virginia Legislature, like the

254. S. 701 (codified at Md. Code Ann., Health Gen. II § 19-701(d) (emphasis added)).

255. See Interview with David S. Davis, *supra* note 250.

256. Md. Code Ann., Health-Gen. II § 19-701(f)(2) (1996).

257. See telephone interview with Randy Reichel, Associate Commissioner, Maryland Insurance Administration (July 18, 1995). The statement was made on February 16, 1994 in Ms. Reichel's testimony before the Senate Finance Committee on S. 450, Reg. Sess. (Md. 1994). Although Ms. Reichel made this statement, the Insurance Commission has no empirical evidence to confirm her impressions.

258. The law defines “emergency medical care” as:

[H]ealth care services provided in a hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a *prudent layperson, possessing an average knowledge of medicine and health*, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (A) placing the patient's health in serious jeopardy; (B) serious impairment to bodily functions; (C) or serious dysfunction of any bodily organ or part.

Ark. Code Ann. § 20-9-309(c)(1) (Michie Supp. 1995) (emphasis added). The Legislature stated in the policy and purpose section of the new law,

Because of the need for rapid assessment and care, in order to protect the life and health of the people of Arkansas, during a medical emergency, it is hereby found and declared necessary:

- 1) To establish a definition for emergency medical care
- 2) To ensure that emergency medical care is provided in a timely manner by licensed and qualified personnel at a hospital's emergency department; and
- 3) To ensure that emergency medical care is not delayed or denied based on:

Maryland Legislature, dealt with this issue through an amendment to its existing HMO law.²⁵⁹

b. The Second Round

California, the “birthplace of HMOs,” and the state with one of the highest HMO enrollments,²⁶⁰ was one of the first to take a more comprehensive legislative approach to the problem of managed care and emergency care. The California Medical Association sponsored a bill, which passed and then took effect on January 1, 1995.²⁶¹ Since California passed its broad law, a handful of other states also have adopted more comprehensive legislation to address this problem.²⁶² Common features of these statutes include (1) a new definition of emergency services; (2) restrictions on the use of prior authorization; (3) twenty-four hour telephone access for authorization for treatment of non-emergency conditions by an out-of-network provider; and (4) required coverage for federally mandated ED screening and treatment.

-
- a) A person’s ability to pay for expenses incurred during a medical emergency; or
 - b) Prospective authorization of treatment by an insurance company, health maintenance organization, hospital medical service corporation, health benefit plan, or any other insurer.

Ark. Code Ann. § 20-9-309(b) (Michie Supp. 1995).

259. Va. Code Ann. § 38.2-4300 (Michie Supp. 1996).

260. See *Western Market Characterized by Extremes, but Choice Seen as Common Thread*, *Managed Care Outlook*, Nov. 29, 1996, at 1, 5.

261. Cal. Health & Safety Code § 1371.4 (Deering Supp. 1996). Although comprehensive in nature, the legislation includes an exemption. The law provides that most of the requirements do not apply

with respect to either a provider with which the health care service plan has a contract that includes the provision of emergency services and care and necessary medical care or a health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes telephone availability (within 30 minutes) of an emergency physician who is on duty at an emergency department of a general acute care hospital.

Id. Based on this provision, California’s largest HMO, Kaiser Permanente, as well as hospitals contracted by HMOs to provide emergency care for their members are exempt from the law’s emergency requirements. See *Health Letter*, *supra* note 12, at 3.

262. See, e.g., Ariz. Rev. Stat. Ann. §§ 20-821, -923, -1068, -1137, -2801 to -2804 (West Supp. 1996); Fla. Stat. Ann. § 641.513 (West Supp. 1997); Ga. Code Ann. §§ 31-11-80 to -82, (1996); Ga. Code Ann. §§ 33-20A-1 to -10, 33-21-1, -13, -18.1 (Supp. 1996); New York Regulation of the Delivery of Managed Care Act, S. 7553, 219th Leg., 2d Sess. (N.Y. Oct. 9, 1996). Maryland also passed a second statute making its coverage of the issue more comprehensive. Md. Code Ann., Health-Gen. II §§ 19-705.1(b), -712.5, -716 (Supp. 1996).

While some statutes include more unique features,²⁶³ these four are the predominant elements of most legislation and are discussed in more detail below.

1) *Definition of Emergency Services*

Some states taking a more comprehensive approach have adopted the prudent layperson standard originally passed in Maryland.²⁶⁴ However, other states have not modified their definition of emergency services or have adopted a slightly different formulation of the prudent layperson standard. The California statute, for example, requires that plans pay for emergency services provided by a non-participating hospital without prior authorization unless the patient did not need emergency care and reasonably should have known that an emergency did not exist.²⁶⁵

Minnesota and Pennsylvania also take a slightly different approach to determining what constitutes emergency for the purposes of plan coverage. Pennsylvania law provides that in making a decision whether

263. *See, e.g.*, Ariz. Rev. Stat. Ann. § 20-2803 (requiring health plans to have physician specialists available 24 hours per day to provide emergency specialty care and if plan fails to provide appropriate specialist within reasonable time of request for specialty consultation, provision of necessary medical care by any available provider is deemed authorized by plan, and payment for such care may not be denied). Specialty consultation for treatment of an immediate life-threatening medical condition is deemed authorized by plan and payment for such care may not be denied. Ariz. Rev. Stat. Ann. § 20-2803. Florida requires:

[In] providing for emergency services and care as a covered service, a health maintenance organization may not . . . (b) Indicate that emergencies are covered only if care is secured within a certain period of time; (c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; (d) Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given.

Fla. Stat. Ann. § 641.513 (West 1996); *see* Cal. Health & Safety Code § 1371.4(d) (providing for dispute resolution mechanisms between plans and providers). California law provides that in disputes between plans and examining physician over need for further care after patient has been stabilized, plan must have its own medical staff take over case or transfer patient to hospital under contract with plan. § 1371.4(d). If the plan fails to do so, further treatment at first hospital will be deemed authorized and payment for it shall not be denied. § 1371.4(d). Arizona law provides that in any disputes between plans and emergency department providers over medical necessity of specific emergency services, plan must assume care of enrollee within reasonable period of time after disagreement and if it does not, plan may not deny coverage for medically-necessary emergency services provided due to lack of prior authorization. *See* Ariz. Rev. Stat. Ann. § 20-2803(G); *see also* Ariz. Rev. Stat. Ann. § 20-2804 (including provisions regarding patient payment for care; generally, providing that if it is determined that care was not emergency, patient may be responsible for payment to hospital and provider); Fla. Stat. Ann. § 614.513(3)(a) (same); H.R. 859, 1996 Md. Laws ch. 503 (same).

264. *See, e.g.*, Ga. Code Ann. § 33-20A-3(2); S. 7553 (N.Y. Oct. 9, 1996).

265. Cal. Health & Safety Code § 1371.4(c).

to reimburse a member of a managed care plan for emergency services, a plan must consider the patient's presenting symptoms and the services provided.²⁶⁶ Also, in Minnesota, instead of adopting the "prudent layperson" terminology, regulations provide that emergency services are those that "a reasonable person" would have believed could not wait until the next work day or until an appointment could be made.²⁶⁷

2) *Restrictions on Plans' Ability To Require Preauthorization for Emergency Services*

Most of the states that have passed legislation in this area have provisions in their laws addressing prior authorization for emergency care.²⁶⁸ Most prohibit any preauthorization requirement as a condition for reimbursement of any services necessary to comply with federal law. For example, the California law states that as long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care services plan shall not require a provider to obtain authorization prior to the provision of emergency services and care.²⁶⁹ A few states limit the prohibition on prior authorization to services that a reasonable person or prudent layperson would think are necessary to treat an emergency condition.²⁷⁰

Finally, a few state statutes set limits on plan requirements for prior authorization for post-stabilization treatment or nonemergency treatment for someone who seeks care at the ED. For example, the Arizona law provides:

A health care services plan may require as a condition of coverage prior authorization for health care services arising after the initial medical screening examination and immediately necessary stabilizing treatment. Prior authorization is granted unless denied or direction of the enrollee's care is initiated by the plan within a

266. Pennsylvania Hospital Emergency Insurer Reimbursement Act, No. 112, 1996 Pa. Legis. Serv. 464 (West).

267. Minn. R. 4685.1010 (7)(E) (1996).

268. *See, e.g.*, Ariz. Rev. Stat. Ann. § 20-2803; Cal. Health & Safety Code § 1371.4; Fla. Stat. Ann. § 614.513(1)(a) (West Supp. 1997); Ga. Code Ann. §§ 33-20A-5, -20A-9 (Supp. 1996); Md. Code Ann., Health-Gen. II § 19-712.5(d) (Supp. 1996); W.Va. Code § 33-25A-8d (Supp. 1996); S. 7553 (N.Y. Oct. 9, 1996).

269. Cal. Health & Safety Code § 1371.4(c); *see also* Fla. Stat. Ann. § 641.513(1)(a); Md. Code Ann., Health-Gen. II § 19-712.5(c) (Supp. 1996).

270. *See, e.g.*, Cal. Health & Safety Code § 1371.4(c); Ga. Code Ann. §§ 33-20A-3, -20A-9 (Supp. 1996).

reasonable period of time after the plan receives the prior authorization request.²⁷¹

3) *Twenty-Four Hour Access Requirements to Emergency Care and/or Telephone Access to Plan for Prior Authorization*

A few statutes state explicitly that a plan must provide twenty-four hour access to emergency care. Legislation in Maryland, for example, provides that an HMO must have a system "for providing a member with 24-hour access to a physician in cases where there is an immediate need for medical services, including providing 24-hour access by telephone to a person who is able to appropriately respond to calls from members and providers concerning after-hours care."²⁷² To meet this requirement, Maryland law states that the plan may "provide for access to a physician who does not have a contract with the HMO or a facility, such as a hospital emergency room."²⁷³

A few states have required that plans have in place a twenty-four hour telephone access number if any type of preauthorization for ED use is required.²⁷⁴ Because most of the legislation prohibits preauthorization for initial screening and stabilization, the twenty-four hour access is required for authorization for post stabilization treatment. For example, Arizona law states that a plan that requires prior authorization after screening and stabilization must provide twenty-four hour access by phone or fax to respond to requests, and plan personnel must have access to a physician if necessary to assist in making the determination.²⁷⁵

4) *Requiring Plans To Reimburse Emergency Care Providers for Services That Are Required Under Federal Law*

Many of the new laws not only prohibit a preauthorization requirement for emergency services mandated by EMTALA,²⁷⁶ but also require that plans cover these screening and stabilization services. The

271. Ariz. Rev. Stat. Ann. § 20-2803(C). The statute also states that a provider must attempt to comply with instructions received after a reasonable period of time, but the plan must cover all costs incurred up until that time. § 20-2803(C).

272. Md. Code Ann., Health-Gen. II § 19-705.1(b)(2) (Supp. 1996).

273. § 19-705.1(b)(2).

274. See, e.g., Ariz. Rev. Stat. Ann. § 20-2803(D) (West Supp. 1996); Cal. Health & Safety Code § 1371.4(a) (Deering Supp. 1996); Md. Code Ann., Health-Gen. II § 19-705.1(b)(2) (requiring 24-hour telephone access whether or not preauthorization is required).

275. Ariz. Rev. Stat. Ann. § 20-2803(D).

276. See *supra* Part II.C.1.

Arizona law, for example, provides that “[a] health care services plan shall provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required by the Emergency Medical Treatment and Labor Act.”²⁷⁷ In some cases, coverage is limited to situations where the care is determined to be an emergency under a prudent layperson standard²⁷⁸ or a reasonable person standard.²⁷⁹

2. *Unsuccessful Efforts*

In states where this type of legislation has been proposed, it has generally been supported by emergency care providers and opposed by managed care plans. In two states, bills that passed the legislature were subsequently vetoed by the governor.²⁸⁰ For example, in 1995, the Maryland Legislature passed and the Governor vetoed House Bill 615.²⁸¹ The bill would have required all managed care plans to pay for any services provided to its enrollees in a hospital emergency facility whether or not a reasonable person would have believed they required emergency services.²⁸² In 1995, proposed legislation on this issue also

277. Ariz. Rev. Stat. Ann. § 20-2803(A) (West Supp. 1996); *see also* Cal. Health & Safety Code § 371.4(b) (Deering Supp. 1996); Fla. Stat. Ann. § 641.513 (West Supp. 1997); Ga. Code Ann. § 33-20A-9 (Supp. 1996); Md. Code Ann., Health-Gen. II § 19-712.5(c) (Supp. 1996); Va. Code Ann. § 38.2-4300 (Michie Supp. 1996); Minn. R. 4685.1010 (1996); 25 Tex. Admin. Code § 119.52 (1996).

278. *See, e.g.*, Ga. Code Ann. § 33-20A-3, -20A-9 (Supp. 1996); Va. Code Ann. § 38.2-4300.

279. *See* Cal. Health & Safety Code § 1371.4; Minn. R. 4685.1010.

280. *See infra* notes 281–284 and accompanying text.

281. H.R. 615, Reg. Sess. (Md. 1995).

282. In his letter to the Speaker of the House of Delegates, the Governor explained his position on the bill:

The decision to veto this bill was a most difficult one because the bill is an attempt to balance the interests, sometimes competing, of the major elements in our health care delivery system—hospitals, emergency room health care providers, health maintenance organizations, and most importantly, patients. However, the bill is sufficiently burdened with legal and substantive flaws that fairness requires that it be vetoed.

Letter from Governor Parris N. Glendening to The Honorable Casper R. Taylor, Jr., Speaker of the House of Delegates, Maryland General Assembly (May 24, 1995) (on file with *Washington Law Review*). The Governor was particularly concerned about changes made by members of the Conference Committee after the bill had passed both houses. As introduced and passed by the House, the bill compelled HMOs to reimburse health care providers for “emergency” services provided in a hospital emergency room. *Id.* However, the Conference Committee of the House and Senate significantly expanded the scope of the bill to cover *any* service rendered in an emergency room setting. *Id.* This change and others, the Governor wrote,

have the potential for a significant, unanticipated financial impact not only on the HMO industry, and ultimately their subscribers, but on the State as well. Care provided in an

passed the Texas legislature, but it ultimately was vetoed by Governor Bush.²⁸³ The bill was strongly opposed by the state's managed care industry.²⁸⁴

3. *Limitations on Effectiveness of State Statutes—Foiled by ERISA Again*

Although many of these reforms conceptually have merit, the enacted state laws—even the most comprehensive ones—will be greatly limited in their effectiveness. A significant obstacle to implementation of state legislative reforms to address this problem is ERISA. In addition to preempting state common law claims for malpractice and denial of benefits, the law also may preempt state statutes attempting to regulate employee benefit plans.

emergency room is the most expensive way to deliver health care. The bill removes any financial disincentive for subscribers to seek care in costly settings such as emergency rooms. For example, under the bill as finally passed, an HMO subscriber including a State employee in a managed care plan, or a client of the State Medicaid program, could seek treatment at a hospital emergency room in contravention of the rules of the HMO, . . . and yet the HMO or the State would be liable for payment to the provider. . . . Given that Maryland is currently shifting toward having a greater percentage of Medicaid patients in managed care plans, the ultimate fiscal impact on the State could be substantial . . .

Id.

283. On June 16, 1995, Governor Bush vetoed The Patient Protection Act, H.B. 2766, 74th Leg., Regular Sess. (Tex. 1995), which, among other significant regulations of managed care plans, would have set standards for emergency care coverage. In vetoing the bill, the Governor stated:

This Bill attempted the difficult task of balancing the often conflicting interests of the parties in the health care delivery system while attempting to preserve consumer affordability. Had that focus remained sharp, good law would have resulted. Unfortunately, the final Bill imposes numerous new regulations on managed care organizations, adds potentially significant costs to state and local governments and private employers, and contains exemptions which may give a competitive advantage to some managed care organizations. The result was too little protection for patients and much too much protection for special interests.

George W. Bush, Governor of Texas, Proclamation by the Governor of the State of Texas (June 16, 1995) (transcript on file with *Washington Law Review*).

284. According to the President of the Texas Medical Association,

No piece of legislation in recent session [of the legislature] was lobbied as intensely as the Patient Protection Act. The opponents to this legislation—principally the managed care industry, the Texas Business Group on Health, and the Texas Association of Business and Chambers of Commerce—conducted a high-profile advertising campaign that relentlessly propagandized the legislation. . . . These tactics were disingenuous at best. Some local mayors, chambers of commerce, and even some physicians, panicked by this calculated technique, took those alerts at face value and appealed to the governor to veto the bill.

Governor Bush Vetoes Patient Protection Act: Message from TMA President Mark J. Kubala, MD, Action (Texas Med. Ass'n), July 5, 1995, at 2.

Whether a state law would be preempted requires an analysis of the state law under ERISA's several preemption provisions. These include "the 'preemption' clause, the 'savings' clause, and the 'deemer' clause."²⁸⁵ Under the preemption clause, ERISA preempts state laws insofar as they "relate to any employee benefit plan."²⁸⁶ The savings clause creates an exception to this preemption provision for state laws that regulate insurance "out of deference to the traditional state regulatory roles in these areas."²⁸⁷ The deemer clause, however, prohibits states from enlarging the scope of their accepted regulatory authority in the area of insurance by "providing that states may not treat self-insured ERISA plans as insurers in order to subject them to state insurance regulation."²⁸⁸

Thus, the first step in determining whether state laws regulating managed care provision and coverage of emergency care would be preempted by ERISA is to determine whether they "relate to" an employee benefit plan. This preemption provision²⁸⁹ historically has been interpreted expansively by federal courts, including the U.S. Supreme Court.²⁹⁰ However, a more recent decision by the U.S. Supreme Court suggests that the Court may be contracting its interpretation of the preemptive reach of the provision. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,²⁹¹ several commercial insurers, managed care plans, and their trade organizations challenged New York's rate setting system for payment of hospital bills by third party payors on the ground that they were preempted by ERISA.²⁹² Both the district court and Second Circuit Court of Appeals

285. Roth, *supra* note 153, at 3 (referring to 29 U.S.C. § 1144(a) (1994)).

286. 29 U.S.C. § 1144(a).

287. Roth, *supra* note 153, at 3 (commenting on rationale behind 29 U.S.C. § 1144(b)(2)(A) (1994), which states that "[e]xcept as provided in subparagraph (B) [(the deemer clause)], nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").

288. Christine C. Rinn, *ERISA and Managed Care: The Impact of Travelers*, Health Law., Early Spring 1996, at 19, 19 (discussing 29 U.S.C. § 1144(b)(2)(B) (1994), which states that certain employee benefit plans and trusts shall not be "deemed to be an insurance company [or similar] for purposes of any law of any State purporting to regular insurance companies, insurance contracts, banks, trust companies, or investment companies"); see *infra* notes 282-92 and accompanying text.

289. 29 U.S.C. § 1144(a).

290. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

291. 115 S. Ct. 1671 (1995).

292. *Id.* at 1675. Under the New York law, "patients with Blue Cross/Blue Shield coverage, Medicaid patients, and HMO participants are billed at a hospital's DRG rate. Patients covered by commercial insurers and self-insured plans are billed at the DRG plus a 13% surcharge, which is retained by the hospital, and an additional 11% surcharge, which is given to the state. HMOs are

found that the rate setting system “related to ERISA plans because they could indirectly increase plan costs and influence an ERISA plan’s choice for obtaining medical insurance.”²⁹³ The U.S. Supreme Court reversed. The Court stated that “such state laws [which have only an indirect economic impact on ERISA plans] do not bear the requisite ‘connection with’ ERISA plans to trigger pre-emption.”²⁹⁴ Thus, *Travelers* somewhat narrowed the scope of ERISA preemption and paved the way for some adjustments to previous broad interpretations of the “relates to” language.

In *CIGNA Healthplan v. Louisiana*,²⁹⁵ decided by the Fifth Circuit Court of Appeals after *Travelers*, the court found that a state’s “any willing provider” law—which requires that all licensed health providers who agree to terms of a preferred provider contract must be accepted as providers in a preferred provider organization (PPO)—was preempted by ERISA.²⁹⁶ This decision was based, in part, on an initial determination that the state law “relates to” employee benefit plans within the meaning of ERISA’s preemption clause.²⁹⁷ In making its decision, the court in *CIGNA* cited the consistent position of the U.S. Supreme Court that ERISA preempts “state laws that mandat[e] employee benefit structures or their administration.”²⁹⁸

Based on this criterion alone, it would appear that state laws regulating emergency care for purposes of managed care coverage would “relate to” ERISA benefit plans. Such statutes arguably mandate broader coverage than plans might otherwise provide for emergency care. This appears to be the case even after *Travelers*’ narrowing of ERISA’s preemptive scope.

subject to surcharges as high as 9% depending on the number of Medicaid recipients they enrolled.” *Id.* at 1674; Rinn, *supra* note 288, at 19.

293. *Travelers*, 115 S. Ct. at 1675–76; Rinn, *supra* note 288, at 19.

294. *Travelers*, 115 S. Ct. at 1680. In part, the Court explained its determination by concluding that ERISA preemption was not designed to assure cost uniformity and as long as the law did not “bind plan administrators to any particular choice [for medical insurance or] . . . preclude uniform administrative practice or the provision of a uniform interstate benefit package,” it would not be preempted. *Id.* at 1679–80.

295. 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996).

296. *Id.* at 650.

297. *Id.* at 648.

298. *Id.* at 647 (quoting *Travelers*, 115 S. Ct. 1678 (1995)). *But see* *Napoletano v. CIGNA Healthcare*, 680 A.2d 127 (Conn. 1996) (holding that “Connecticut’s somewhat different version of an ‘any willing provider’ law did not relate to employee benefit plans and so was not pre-empted”), *cert. denied*, 117 S. Ct. 1106 (1997); *see also* Linda Greenhouse, *Justices Refuse Case on Whether Health Care Networks Must Be Open to All Doctors*, N.Y. Times, Nov. 5, 1996, at A16.

The second step in the ERISA preemption analysis is whether the state law is “saved” because it regulates insurance.²⁹⁹ In *Metropolitan Life Insurance Co. v. Massachusetts*,³⁰⁰ the U.S. Supreme Court set forth the requirements that a statute must meet to come within the savings clause. First, the statute must fit the “common sense” definition of insurance regulation.³⁰¹ Second, the statute must satisfy each of the following tests: (1) it must have the effect of spreading the policyholders’ risk; (2) the practice that it attempts to regulate must be an integral part of the policy relationship between the insurer and the insured; and (3) the statute must be limited to entities within the insurance industry.³⁰² In *CIGNA*, the Fifth Circuit held that Louisiana’s “any willing provider” statute did not fit within the savings clause because it did not satisfy the third element of the second prong of the test—the statute was not limited to “entities within the insurance industry.”³⁰³ The statute stated specifically that it also applied to “self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self-funded trusts or programs,’ [as well as] ‘health care financiers, third party administrators, providers, or other intermediaries.’”³⁰⁴ Thus, under the rationale applied in *CIGNA*, whether a state statute regulating emergency care is preempted under ERISA for all ERISA plans will depend on the types of entities to which the statute applies. Existing state statutes regulating emergency care typically apply to health insurance carriers through amendments to the state insurance laws and to HMOs through the state’s HMO Act. Most states now have such statutes regulating HMOs.³⁰⁵ Although these statutes would appear to be safe from ERISA attack,³⁰⁶ that conclusion is not certain.³⁰⁷

299. 29 U.S.C. § 1144(b)(2)(A) (1994).

300. 471 U.S. 724 (1985).

301. *Id.* at 740.

302. *Id.* at 743.

303. *CIGNA*, 82 F.3d at 650. *But see* *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993) (holding that Virginia statute that prohibits insurance companies from unreasonably discriminating in establishing preferred provider organizations was not preempted by ERISA because it fell within ERISA’s savings clause).

304. *CIGNA*, 82 F.3d at 650 (footnote omitted).

305. *See* *Butler & Polzer*, *supra* note 195, at 56.

306. *See, e.g.*, Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 *New Eng. J. Med.* 1986, 1987 (1996).

Because ERISA contains an exception allowing states to regulate insurance, state laws can force insurance companies and managed-care organizations to include specific ‘mandated’ benefits and certain other provisions in the insurance contracts they sell. . . . The effect of [this] exception[], according to a 1985 decision of the U.S. Supreme Court, is to permit states to regulate the benefits covered by policies sold by insurance companies

If the state statute was determined to come under the savings clause, however, the “deemer” clause would still apply.³⁰⁸ The “deemer clause,” as mentioned above, limits the reach of the savings clause by prohibiting states from including self-insured plans³⁰⁹ as insurance companies. For this reason, if the state statute meets the “relates to” criteria and if the plan in question is a self-insured plan, the plan is not subject to the state law. This provision greatly limits the effectiveness of many state laws regulating health insurance plans.³¹⁰ As of 1990, more than half of all U.S. workers were covered by self-insured plans.³¹¹

As a result, state laws attempting to regulate managed care plan coverage of emergency care are likely to have little impact on managed care plans. Clearly, all self-insured plans will not be required to comply with them. Also, depending on how such statutes are written and how the savings clause is interpreted, it is possible that all ERISA plans may be exempt from such state laws. The ambiguity of the law, moreover, and the uncertainty of most employees regarding whether they are part of an ERISA plan, make many state statutes practically ineffective.³¹²

Id. (citations omitted).

307. Federal courts have held that HMOs are not insurers as a matter of law. *See Travelers Ins. Co. v. New York State Conference of Blue Cross & Blue Shield Plans*, 14 F.3d 708 (2d Cir. 1993), *rev'd*, 514 U.S. 645 (1995); *O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. 1990); *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993). However, one author points out that these decisions “do not appear to apply the Supreme Court’s test for what is the business of insurance.” *Butler & Polzer*, *supra* note 195, at 56. In addition, at least one district court has held that HMOs are in the business of insurance. *See Physicians Health Plan, Inc. v. Citizens Ins. Co. of Am.*, 673 F. Supp. 903 (W.D. Mich. 1987).

308. 29 U.S.C. § 1144(b)(2)(B) (1994); *see supra* notes 285–287 and accompanying text.

309. Self-insured plans are those where the employer assumes the risk of medical claims.

310. However, some types of managed care plans, such as HMOs, may not be considered self-insured if an employer pays the HMO on a capitation basis and shifts all the insurance risk to the plan.

311. Sharon Silow-Carroll et al., Economic & Social Research Inst., Wash., D.C., *In Sickness and in Health? The Marriage Between Employees and Health Care* 15 (1995). *But see* Gregory Acs et al., *Self-Insured Employer Health Plans: Prevalence, Profit, Provisions, and Premiums*, 15 *Health Aff.* 267 (1996) (estimating that about 40% of employees with health coverage are in self-insured plans, defined as plans not buying coverage from health insurers or HMOs).

312. For example, in states that prohibit prior authorization for emergency services, if the patient does not know whether or not he or she is in an ERISA plan the state’s protective statute will not be of any assistance to the patient, and hospital ED personnel, also unsure of whether the state statute applies, will likely believe they need to obtain the plan’s prior authorization in order to ensure coverage of the patients’ services.

V. THE NEED FOR A FEDERAL SOLUTION

A. *The Goals of Federal Legislation*

Given the significant limitations of the market and existing law to deal with the problems created by the conflicts between managed care and emergency care, a federal legislative solution is needed. This solution must recognize the health and safety needs of plan members and the validity of reasonable efforts by managed care plans to contain health care costs. Moreover, the solution must include a fair mechanism to apportion burdens among the various stakeholders.

1. *Protecting the Consumer*

When individuals must wait for hours for plan approval before receiving emergency care, or are denied preapproval by health care plan personnel who have not examined them, they may face significant risks to their life and health. This is truly the case for those experiencing “real” emergencies. In order to prevent death, disability, or other serious harms to the consumer, federal legislation that will protect consumers from such risks is warranted. Congress, through its enactment of EMTALA, already has recognized a role for the federal government in ensuring that individuals who need emergency care receive it and are not thwarted by inability to pay or other obstacles.³¹³ Efforts by managed care plans to discourage plan members from seeking emergency care may not technically violate the terms of EMTALA, but arguably they violate the spirit of that legislation. The irony of the current state of affairs is that due to EMTALA and managed care policy, individuals without health insurance may have more access to emergency care than those with health insurance—a result that undermines the broad goals of EMTALA.³¹⁴

313. 42 U.S.C. § 1395dd (1994).

314. See 42 U.S.C. § 1395dd(a); see also Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 St. Mary's L.J. 463, 465 (1996) (“Although concerns regarding the availability of emergency medical care for the poor or uninsured prompted the drafting of EMTALA, the statute applies to the treatment of all patients, regardless of a patient's ability to pay or insurance coverage.”) (citing *Correa v. Hospital of S.F.*, 69 F.3d 1184, 1193 (1st Cir. 1995) (noting that presence of insurance coverage is irrelevant for purposes of EMTALA because hospital's motive is not necessary element for establishing liability under statute), *cert. denied*, 116 S. Ct. 1423 (1996); *Brooks v. Maryland Gen. Hosp.*, 996 F.2d 708, 710–11 (4th Cir. 1993) (explaining that EMTALA applies to all patients with emergency medical conditions, regardless of whether they have insurance to pay for treatment)).

Government also has historically played a role in the regulation of the insurance industry, protecting consumers from “unscrupulous” insurers and insurance practices. While most of this regulation has taken place at the state level (pursuant to the McCarran-Ferguson Act³¹⁵), Congress has also recognized the need, in certain situations, to protect individuals from abuses of the insurance industry. For example, in 1982, Congress passed amendments to the Medicare law aimed at protecting the elderly from unfair practices in the sale and administration of Medigap insurance policies.³¹⁶ More recently, Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA),³¹⁷ which prevents insurers from denying coverage to individuals based on pre-existing medical conditions or limiting periods of ineligibility for coverage due to a pre-existing condition and requires employers to make insurance coverage available to certain individuals who have previously lost other coverage.³¹⁸ Finally, and most recently, Congress passed the Newborns’ and Mothers’ Health Protection Act of 1996³¹⁹ and the Mental Health Parity Act of 1996.³²⁰ The former amends ERISA to prohibit a health plan or insurer from restricting “benefits for any hospital length of stay in connection with child birth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or for women giving birth by Cesarean section, to less than 96 hours.”³²¹ The latter requires that plans provide some types of parity in coverage between medical and surgical benefits and mental health

315. 15 U.S.C. §§ 1011–1015 (1994) (“Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest.”).

316. Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 507(b), 94 Stat. 441 (1980) (codified as amended at 42 U.S.C. § 1395ss (1994 & Supp. I 1995)). Medigap policies “are designed to cover the gaps in Medicare coverage—primarily by paying the required hospital and physician bill deductibles . . . and required coinsurance.” Julie Rovner, *Climbing Medigap Premiums Draw Attention on Hill*, Cong. Q., Feb. 17, 1990, at 527. Further amendments regulating Medigap insurance were passed by Congress in 1990. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4352, 104 Stat. 1388, 1388-129 (1990) (codified as amended at 42 U.S.C. § 1395ss).

317. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

318. 110 Stat. 1936.

319. Pub. L. No. 104-204, 110 Stat. 2874, 2934–44, tit. VI (1996) (codified in scattered sections of 29 U.S.C. and 42 U.S.C.).

320. Pub. L. No. 104-204, 110 Stat. 2874, 2944–50, tit. VII (1996) (codified in scattered sections of 29 U.S.C. and 42 U.S.C.).

321. Newborns’ and Mothers’ Health Protection Act of 1996 § 711, 29 U.S.C. § 1185 (1996).

benefits.³²² Thus, congressional action in this area is not without precedent.³²³

2. *Controlling Health Care Costs*

Managed care has been encouraged by federal policy as a mechanism to control our seemingly uncontrollable health care costs. This policy goal is still important as health care costs continue to climb³²⁴ and take up a significant proportion of our gross domestic product.³²⁵ Therefore, federal legislation aimed at curbing managed care denials of ED care and coverage must not overreach in a way that excessively limits or stifles the ability of plans to exercise control over utilization of expensive sources of medical care.

3. *Fair Apportionment of Burden Among the Stakeholders*

Apart from the health risks to consumers posed by plan policies that excessively discourage ED use, the conflict between managed care plans and EDs is essentially one of who should bear the cost of emergency care for plan members. Managed care plan administrators want to control unnecessary health care costs and presumably believe that it is fair to make providers or patients responsible for payment of these services in situations that are not truly emergencies. Patients do not want to be responsible for paying for these services when they sincerely believed they were experiencing emergencies because of extreme pain, shortness of breath, loss of blood, or other symptoms that would prompt most people to conclude that they need to seek medical care immediately. Finally, hospitals and emergency physicians argue that it is not patients who actually get saddled with payment for the unreimbursed

322. Mental Health Parity Act of 1996 §§ 712, 2705, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5 (1996).

323. Moreover, there is now developing a broad consensus of the need for consumer protections against managed care plans. See Toner, *supra* note 53, § 4 (“President Clinton . . . has announced that he will appoint a panel of experts to recommend ways of protecting consumers in this fierce new health care marketplace. . . . [B]ipartisan consensus [on this issue] reflects the broad popularity of these regulatory moves.”).

324. Note that although growth of health care costs have slowed for some large employers, overall growth in health care costs continues to climb. See Milt Freudenheim, *Survey Finds Health Costs Rose in '95*, N.Y. Times, Jan. 30, 1996, at D1.

325. In 1991, the United States spent 13.2% of its gross domestic product for health care while Germany spent 8.5%, Japan spent 6.8%, and the United Kingdom spent only 6.6%. See Furrow et al., *supra* note 36, at 853.

care; it is typically the health care providers who must seek payment from patients or absorb the costs of their care.³²⁶

What is fair in this context requires consideration of (1) the provisions of the insurance policy, which in virtually all cases will cover emergency care and (2) determination of what constitutes an emergency and who makes that determination. A fair solution in general terms would appear to be one that made the insurer/plan responsible for coverage of services necessary to treat potential emergencies,³²⁷ providers responsible for costs above and beyond what is necessary to treat such emergencies; and patients responsible for the costs associated with ED visits that are obvious non-emergencies. The challenge for legislators will be to create a process that fairly distinguishes potential or highly probable emergencies from the rest.

B. *Proposed Federal Legislation*

Significant headway has already been made toward a federal solution to this problem. On February 25, 1997, U.S. Representative Benjamin Cardin (Democrat, Maryland), introduced House Bill 815,³²⁸ and Senator Bob Graham (Democrat, Florida) introduced Senate Bill 356.³²⁹ The identical bills, both titled "Access to Emergency Medical Services Act," adopt features of many of the existing state statutes. For example, they prohibit managed care plans from requiring prior authorization for emergency medical care³³⁰ and establish a uniform definition of emergency medical condition that protects patients through the adoption of a prudent layperson standard.³³¹ Plans that cover emergency services

326. See Clark, *supra* note 57, at 7 (reporting physicians' argument that, "for HMOs to take the final diagnosis and then say they won't pay is immoral"). "We're made to look like bad guys because we must then send a bill back to the patient. Payment should be decided not on the final diagnosis but on the presenting complaint." *Id.*

327. Potential emergencies would be those that appear to be emergencies based on presenting symptoms prior to treatment and ultimate diagnosis by a medical professional.

328. Access to Emergency Medical Services Act of 1997, H.R. 815, 105th Cong. (1997).

329. Access to Emergency Medical Services Act of 1997, S. 356, 105th Cong. (1997). Cardin previously had introduced a similar bill, H.R. 2011, 104th Cong. (1995), on July 11, 1995 and a parallel bill had been introduced in the Senate by Senator Barbara A. Mikulski. See S. 1233, 104th Cong. (1995). Although neither bill passed in the 104th Congress, H.R. 2011 had 154 cosponsors and S. 1233 had 11.

330. H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4.

331. H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4. Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(i)

would be required to cover services provided to a patient in an ED if the patient presented with symptoms that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect to result in serious impairment to the patient's health. In addition, the bills establish coverage standards for out-of-plan emergency care to protect patients who, under reasonable circumstances, seek care in an out-of-plan emergency department. These standards provide that health plans must cover services received in an out-of-plan emergency department if (1) the patient was unable to reach an in-plan emergency department due to circumstances beyond his or her control, (2) the patient reasonably believed he or she could not safely reach an in-plan emergency department without suffering from adverse consequences to his or her health, or (3) the health plan directed the patient to an emergency department other than a participating emergency department.³³² The bills further provide that if a patient does not meet any of these conditions, a plan may deny or otherwise limit coverage of such services.³³³ Moreover, the plans may also impose different cost sharing arrangements for use of out-of-plan EDs, as long as such differences are "reasonable."³³⁴ In addition, the bills allow plans greater control over care received once a patient has been stabilized. In these circumstances, an ED is:

required to contact the patient's health plan to obtain authorization of any medically necessary services (other than emergency services) identified by the treating physician within 30 minutes of the point that a physician determines that the patient is stabilized. The health plan would be required to either deny or approve the request within 30 minutes of the time when it is notified. If the health plan denies the request, the treating physician may request a consultation with one of the health plan's participating physicians within 30 minutes of the time the health plan is notified of the request for consultation. If the [ED] does not call the health plan, the health plan is not responsible for payment of any services provided after stabilization of the patient. If the health plan does not respond to the [ED] in a timely fashion, the health plan can not

placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."

H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4.

332. H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4.

333. H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4.

334. H.R. 815, §§ 2, 3, 4; S. 356, §§ 2, 3, 4.

retrospectively deny payment for post-stabilization services unless those services were subsequently determined to be medically unnecessary.³³⁵

Finally the bills require that health plans educate members about “coverage of emergency services, the process for obtaining emergency services, the location of participating medical facilities and cost-sharing provisions for emergency and other medical services, as well as the appropriate use of emergency medical services” such as the 911 telephone number.³³⁶ The bills have been enthusiastically supported by ACEP as well as by a number of provider and consumer groups.³³⁷

1. *Essential Elements and a Justification*

The proposed legislation meets the goals of a federal solution to this problem by including (1) provisions that eliminate managed care obstacles to ED use for reasonably perceived emergencies, and (2) a mechanism that allows plans, providers, and consumers to distinguish fairly reasonably-perceived emergencies from other ED visits. These provisions are the prohibition of a requirement for prior authorization for emergency services and the adoption of a “prudent lay person” standard in defining what constitutes an emergency for purposes of plan coverage. The proposed legislation implements these provisions by

335. Office of Representative Benjamin Cardin, *Detailed Summary, Access to Emergency Medical Services Act of 1997 2* (Feb. 1997) (on file with *Washington Law Review*). Moreover, the bill provides:

[If] an emergency physician in a non-participating hospital and a health plan cannot agree on a course of treatment after a patient is stabilized, the health plan must either cover the recommended services, subject to a review of whether those services were medically necessary, or send a physician with privileges at the hospital to assume responsibility for the patient. The health plan must cover medically necessary services required to maintain the patient in a stable condition.

Id.

336. *Id.*

337. Similar bills introduced in the 104th Congress were supported by Public Citizen, Citizen Action, the American Heart Association, the American Academy of Pediatrics, the International Association of Fire Fighters, the National Association of EMS Physicians, and the Emergency Nurses Association. Clark, *supra* note 57, at 16. Kaiser Permanente, the nation’s largest HMO, also has expressed its support for most provisions of the bill. Doug Levy, *Taking guesswork out of ER coverage*, USA Today, Aug. 19, 1996, at D1. Most recently, the American Association of Health Plans (AAHP), which represents the majority of the nation’s managed care health plans, although not announcing support of federal legislation on the issue, said that their member plans “should cover emergency-room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient’s presenting symptoms.” AAHP, Press Release, *Health Plans Announce Policies on Appeal Rights and Emergency Care Coverage*, Jan. 30, 1997.

mandating that insurers incorporate them in the policies they offer. A justification for each of these elements and for mandating that all policies include them is provided below.

a. Prohibition on Prior Approval

Without prior screening, some individuals who do not need emergency care will go to the ED. But with a prior approval requirement, some individuals who truly need emergency care may not get to the ED. The issue is: On which side should we err? Managed care plan administrators argue that the prior approval system is necessary to avoid loss of control by and significant costs to the plan. As one plan executive stated:

The purpose of the emergency room authorization process is to keep medical treatment of a patient under the medical supervision of their primary care physician. This physician knows the patient's medical history and is the best judge of care needed. In the case of a true emergency, the PCP can notify the emergency room of the patient's pending arrival and give direction for the specific needs of the patient. This saves the patient time waiting in the emergency room, saves them the discomfort and risk associated with unnecessary diagnostic tests, and provides continuity of care.³³⁸

But at least some research has shown that preauthorization in the ED context does not necessarily alter patient behavior, may not cut costs in the long run, and may cause harm to patients.³³⁹ In addition, in the

338. Letter from Elizabeth J. Misek, President, Prudential Health Care Plan, to The Honorable Benjamin L. Cardin, U.S. House of Representatives (Aug. 21, 1995) (discussing "Access to Emergency Medical Services Act of 1995") (on file with *Washington Law Review*).

339. See, e.g., Anne M. Gadomski et al., *Diverting Managed Care Medicaid Patients From Pediatric Emergency Department Use*, 95 *Pediatrics* 170, 177 (1995). This study, which evaluated the health outcomes of managed care Medicaid children with nonemergent conditions who were not authorized to be seen in the ED by their primary care provider, was motivated by reports from the Children's Hospital of Philadelphia, where two adverse outcomes in children denied ED visits (respiratory arrest in a two-month old infant with a "cold," and febrile convulsion requiring intubation in another child) led to termination of gatekeeping and assumption of costs of unauthorized visits by the hospital. *Id.* at 170-71. The study, based on Maryland Medicaid patients, did not find any adverse health outcomes because of delay in health care delivery but concluded that although the practice of preapproval for emergency care can be safe in the short term, denial of an ED visit has no impact on subsequent ED utilization by Medicaid participants and may be associated with higher hospitalization rates. *Id.* at 170. Thus, "[g]atekeeping in this setting does not necessarily change the health care seeking behavior of these patients." *Id.*; see also Shaw et al., *supra* note 77, at 61 (concluding in study that "parents of indigent children who are denied ED care may not contact their primary care physician or take their child to physician" even if ED classified child's case as "urgent").

current health care system, few patients actually have a physician who knows them at all, let alone one who is intimately familiar with their medical history.

Although preapproval has much merit for cost savings in the context of non-emergency care—for specialty care or expensive treatment of questionable value—it is not appropriate in the emergency context, where there is not time for extensive analysis and scrutiny of the patient's condition. Because emergencies cannot easily be determined without a professional medical examination,³⁴⁰ it is wholly inappropriate that the obstacle of prior authorization to an ED visit be allowed to stand. In these situations, it is appropriate to err on the side of the patient.³⁴¹ Moreover, justice requires some modification to the preauthorization requirement because most plan members have no redress when plans deny authorization for emergency care and, as a result, members do not receive emergency treatment and suffer harm.

Under ERISA, as discussed above, most plans are insulated from liability for a negligent determination and are not held responsible for the consequences of their actions. It is the patient who suffers. This outcome alone argues for elimination of a prior authorization requirement or, alternatively, that a plan be subject to liability if it chooses to maintain a prior authorization requirement and negligently denies preapproval.

While this provision in federal legislation will help protect consumers who need emergency care, arguably it will limit a plan's ability to control unnecessary ED use. However, plans have other mechanisms to achieve this goal. In order to avoid unnecessary use of the emergency room by enrollees, plans will need to develop alternative strategies or may need to build these costs into the premium structure of the plan. Patients should be provided with educational materials or even courses to understand when ED use is appropriate.³⁴² Managed care plans that want to cut unnecessary ED use must make alternative options available to individuals at times and places that are accessible to them. This may

340. In some cases, it is difficult to determine if a patient is experiencing an emergency, even with a professional medical exam.

341. As Steinbrook argues, "some emergency department care for patients who do not present true emergencies is unavoidable and must be provided unless we are to miss patients with real emergencies." Steinbrook, *supra* note 126, at 658.

342. Some studies have shown that inappropriate ED visits can be reduced in a population by means of a patient education program. See, e.g., J.R. Benz & J.C. Shank, *Alteration of Emergency Room Usage in a Family Practice Residency Program*, 15 J. Fam. Prac. 1135 (1982).

mean opening twenty-four hour urgent care centers or contracting with EDs for care at a discounted rate.³⁴³

Economic incentives, such as guaranteeing coverage if prior authorization is obtained or requiring copayments, may also alter front-end use. A recent study of the effect of imposing a copayment on Kaiser Permanente enrollees for ED use found that the copayments significantly reduced utilization³⁴⁴ without affecting health outcomes for the population studied.³⁴⁵

While cost-sharing for emergency services may be an option for privately-insured individuals, cost-sharing for Medicaid beneficiaries enrolled in HMOs is explicitly prohibited.³⁴⁶ This population thus presents special challenges. A number of studies have shown that it is the lack of a PCP that pushes many Medicaid patients to the ED for nonurgent care. Therefore, placing Medicaid beneficiaries in managed

343. As regards use of EDs for pediatric visits, Gadomski et al., *supra* note 339, at 177, argue that practices other than gatekeeping may be necessary to divert nonemergent ED utilization toward use of a primary health care provider (PHCP). *Id.* at 177.

Factors such as convenience, accessibility of PHCP, parental employment, age of the child, perception of severity of illness, and waiting times to be seen may all influence a parent's choice for an ER as a source of care. Unless these factors are addressed by expanding hours of PHCP accessibility and improving waiting times and by addressing parental perception of disease severity, it is unlikely that onsite PED visit denial will decrease PED utilization for nonemergent conditions in the long term.

Id.

344. See Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in Health Maintenance Organizations*, 334 *New Eng. J. Med.* 635, 638 (1996). This study looked at over 30,000 subjects who were members of Kaiser Permanente in northern California. *Id.* at 635. The population was divided into an experimental and a control group. *Id.* The experimental group was assessed a copayment of \$25 to \$35 for their use of the ED. The researchers found that there was a significant decline in the number of ED visits in the copayment group. *Id.* at 638.

345. *Id.* The authors tentatively concluded that “[a]lthough our ability to detect any adverse effects of the copayment was limited, there was no suggestion of excess adverse events in the copayment group, such as increases in mortality or in the number of potentially avoidable hospitalizations.” *Id.* at 635. However, the authors also warned that their results “should not be generalized to apply to low-income groups or the elderly, particularly as regards the possibility that imposing a copayment could lead to adverse effects.” *Id.* at 640; see also Steinbrook, *supra* note 126. In reviewing the study by Selby and his co-authors., Steinbrook argued that although the authors did not detect any adverse outcomes from the copayment policy, the results of their study are troubling because there was a significant decline in emergency department visits among patients with diagnoses classified as “often an emergency” in the copayment group as compared with the control group. *Id.* at 657. Individuals in this group had diagnoses such as “head trauma, sickle cell crisis, complications of pregnancy, pelvic inflammatory disease, pancreatitis, asthma, transient ischemic attack, and chest pain.” *Id.* According to Steinbrook, “By any standard, a substantial proportion of patients with these diagnoses should be evaluated in the emergency department.” *Id.*

346. See Social Security Act of 1935 § 1916(a)(2)(D), (b)(2)(D), 42 U.S.C. § 1396o (1994).

care plans where they are assigned to a provider who will see them should make a difference. Beyond that, plans will have to devote additional resources to educating this group about appropriate ED use and to changing old patterns of use.

b. A Prudent Layperson Standard

What is fair in allocating the cost of ED care is in part based on expectations of the parties and their understanding of what would be covered under the plan's policy. When a policy states that it covers emergency care and the patient (prior to a medical exam) believed that he or she was experiencing a medical emergency, but the plan upon retrospective review of medical records determines there was no emergency, the question becomes: Whose determination should govern?

The prudent layperson standard offers a compromise between the subjective views of the parties. Though not without critics in the context of emergency care,³⁴⁷ the standard appears to be a "close relative" of the reasonable person standard and is consistent with long-standing principles of contract, insurance, and tort law. In the insurance law context, which has its roots in fundamental contract law,

Courts are uniquely willing to construe the meaning of an insurance contract against an insurer, in spite of the evident meaning of the policy. Theories for denying insurers range from perceptions that the policy is unclear, ambiguous, or incomplete, to sympathetic reaction to the view that it is a contract of adhesion to be construed against its drafter. The doctrine of reasonable expectations of consumers, and the recognition of rights at variance with policy provisions figure prominently in so construing insurance contracts.³⁴⁸

Courts and juries tend to view disputes over policy provisions as issues of fairness.³⁴⁹ Most courts give effect to the "objectively

347. Although managed care plans are concerned that a prudent layperson standard will require them to pay for inappropriate ED use, some argue that it is not protective enough of managed care enrollees. *See, e.g.,* Clark, *supra* note 57, at 18. At least one health care provider who is critical of the prudent layperson standard has remarked that the ability of any layperson to act rationally and make prudent decisions when they are in great pain and emotionally distraught or fearful may be unrealistic. *Id.* According to this critic, "to expect a patient who hurts [to make rational decisions about emergency care is] unrealistic and punitive." *Id.* (quoting Casey Jason, Acucare President).

348. 1 Bertram Harnett & Irving I. Lesnick, *The Law of Life and Health Insurance* § 1.08, at 1-90 (1991); *see also* Jerry, *supra* note 185, at 141-47.

349. They tend to see cases in terms of "well capitalized insurers . . . seeking to escape the liabilities to ordinary people and small business that the insurers had presumably undertaken by

reasonable expectations” of the insured in order “to render fair interpretations of insurance coverage.”³⁵⁰ As stated by the New Jersey Supreme Court:

When members of the public purchase policies of insurance they are entitled to the broad measure of protection necessary to fulfill their reasonable expectations. They should not be subjected to technical encumbrances or hidden pitfalls and their policies should be construed liberally in their favor to the end that coverage is afforded “to the full extent that any fair interpretation will allow.”³⁵¹

Under this doctrine, courts will construe policies “as any laymen would” seeking “an objective standard of a reasonable layman [whereby] insurers should not be able to escape coverage with qualifications and exceptions that are not consistent with reasonable expectations of a policyholder possessing ordinary familiarity with the coverage involved.”³⁵²

The application of a prudent layperson standard in the context of insurance coverage for emergency care is consistent with this reasoning. In disputes over coverage for emergency services where an insured’s policy states that it will cover “emergency medical care,” and a reasonable person would think what is occurring is an emergency, the insured will have reasonably expected that the emergency services would be covered.

Both insurance and tort law not only generally favor an objective patient standard over a medically based standard³⁵³ but also favor it over a subjective patient standard. In tort law, what is considered negligence is based on whether the actions of the defendant are consistent with what a “reasonable and prudent” person would have done in the same or

accepting premium money.” 1 Hamett & Lesnick, *supra* note 348, § 1.08, at 1-91. Consequently, “[i]n modern light, technicality and small print generally do not go down easily in court, and insurance, with its heavy freight of dependency by the insureds, is particularly vulnerable. This point is essentially an ethical one.” *Id.*

350. *But see* Jerry, *supra* note 185, at 145. (“[A]lthough the doctrine . . . speaks to the ‘objectively reasonable’ expectations of the insured, the extent to which an insured actually, *subjectively* expects coverage is relevant.”) (emphasis added).

351. *Meier v. New Jersey Life Ins. Co.*, 503 A.2d 862, 869–70 (N.J. 1986) (quoting *Kievit v. Loyal Protective Life Ins. Co.*, 170 A.2d 22 (N.J. 1961)).

352. 1 Hamett & Lesnick, *supra* note 348, § 1.08[3], at 1-100.

353. In tort law, one exception to this general rule is the law on informed consent. In determining what is a “material” risk for purposes of disclosure, a slight majority of jurisdictions apply a physician-centered determination, while a slight minority favor a reasonable person standard. *See* Furrow et al., *supra* note 36, at 268–69.

similar circumstances.³⁵⁴ The basis for the rule is multifaceted. In part, it is one of administrative ease—it is difficult to truly ascertain how a particular individual would act in a given situation. But the standard has also been defended as necessary to ensure at least some “fairness” in interactions between members of a community. Without some requirement that all members of a managed care plan meet some minimum standard of conduct, some members of the plan consistently will benefit at the expense of others.³⁵⁵ To adopt a subjective standard wherein ED visits would be covered as long as a particular patient, no matter his individual peculiarities, felt he had a medical condition that could not wait to be treated, would undermine any effort on the part of managed care plans to control ED use.

Conceptually, the prudent layperson standard is useful to apply to the conflict over who pays for emergency care that is not truly an emergency. The actual wording of the proposed federal law and the state statutes that have adopted the standard, however, may create problems in its application. The language that has been incorporated in the majority of these statutes is that of “a prudent lay person, *who possesses an average knowledge of health and medicine.*”³⁵⁶ HCFA has argued that this standard is more stringent than the standard HCFA applies in its manual instructions for Medicare managed care contractors.³⁵⁷ In comments on the proposed federal legislation, the agency stated: “We are concerned that the ‘prudent layperson’ standard as defined in the bill could actually *narrow* the liability of managed care plans in dealing with people of *less than* ‘average knowledge’—i.e. It appears to offer less protection for *vulnerable* patients than does current Medicare policy.”³⁵⁸

354. See W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 32, at 174 (5th ed. 1984).

355. See Oliver W. Holmes, *The Common Law* 108 (1881).

When men live in society, a certain average of conduct, a sacrifice of individual peculiarities going beyond a certain point, is necessary to the general welfare. If, for instance, a man is born hasty and awkward, is always having accidents and hurting himself or his neighbors, no doubt his congenital defects will be allowed for in the courts of Heaven, but his slips are no less troublesome to his neighbors than if they sprang from guilty neglect.

Id.

356. See, e.g., Md. Code Ann., Health-Gen. II § 19-701(d) (1996) (emphasis added); see also Ark. Code Ann. § 20-9-309(c)(1) (Michie Supp. 1995); Ga. Code Ann. §§ 33-20A-3, -20A-9 (Supp. 1996); Va. Code Ann. § 38.2-4300 (Michie Supp. 1996); New York Regulation of the Delivery of Managed Care Act, S. 7553, 219th Leg., 2d Sess. (N.Y. Oct. 9, 1996).

357. See *supra* Part IV.C.

358. Letter from Joan Steiber, Health Care Financing Administration, Office of Legislative & Inter-Governmental Affairs to Bruce Lesley, Office of Senator Bob Graham (Oct. 19, 1995) (on file with *Washington Law Review*).

Moreover, in interpreting the “reasonable person” or the “reasonable expectations of the insured,” courts, in the context of tort and insurance law, more often use the term “ordinary” person than “average” person,³⁵⁹ and the use of the term “average knowledge” may be more confusing than helpful. The potential problem lies in the fact that the term “average” has two definitions—one of a more empirical nature and one of a more general nature.³⁶⁰ Though the intent of the drafters may be to apply the ordinary person standard, the potential for the application of a more technical definition actually may raise the standard. If interpreted as a higher standard by the courts, the language may be particularly harmful to individuals from different cultural backgrounds who have very different ideas about the concepts of health and disease.³⁶¹ In addition, the standard would seem to harm those who are not well educated and may be particularly harsh for Medicaid beneficiaries.

c. *A New Mandated Benefit*

As a public policy matter, the most likely criticism of the proposed federal legislation is that it mandates that insurers provide certain health benefits that they might not otherwise provide, such as visits to an ED that are not preauthorized or that, on retrospective review, turn out not to have been an emergency. While emergency care is a mandated benefit

359. In the insurance law context, although judicial concepts of what constitutes a reasonable expectation of coverage in the insurance contract are not “monolithic,” there is a common factor running through the majority of the cases. See Jerry, *supra* note 185, at 143 (citing Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 Va. L. Rev. 1151, 1153 (1981)). According to Abraham: “[t]he insured is an ordinary, unsophisticated consumer, possessing an understanding of only the most rudimentary aspects of the coverage. Thus, the reasonable expectations doctrine is used by courts to protect consumers, not to adjust a commercial relationship between parties with roughly equal bargaining power.” *Id.* In the context of tort law, the level of knowledge to attribute to the “reasonable person” has been “[o]ne of the most difficult questions in connection with negligence.” Keeton et al., *supra* note 354, § 32, at 182. According to Prosser and Keeton, a reasonable person must be held to a “minimum standard of knowledge, based upon what is common to the community.” *Id.* at 184. But above this minimum, “the individual will not be held to knowledge of risks which are not known or apparent to him.” *Id.*

360. See, e.g., *Black’s Law Dictionary* 123–24 (6th ed. 1990) (“In ordinary usage the term signifies the mean between two or more quantities, measures, or numbers. If applied to something which is incapable of expression in terms of measure or amount, it signifies that the thing or person referred to is of the ordinary or usual type.”).

361. Davidson argues that “medical and insurance professionals define ‘emergency’ differently from the way laymen of different cultures and social groups define it [and that differences in] age, ethnic group, social class, and sex influence significantly what individuals perceive as an emergency.” Davidson, *supra* note 43, at 276–77 (citing Clifford V. Colman & Howard Robboy, *The Social Construction of a Medical Emergency*, 1 *Topics Emergency Med.* 61, 66 (1980)).

under the Federal HMO Act³⁶² and many state HMO Acts, insurers would argue that the emergency benefit is limited to “medically necessary” emergency care. Thus, plans are at liberty to incorporate mechanisms in their policies to screen out care that is apparently not medically necessary either before the fact, through prior approval, or after the fact, through denial of coverage.

If these restrictive practices were challenged in the courts, however, courts would likely require plans to cover such visits on the grounds that the plan’s policy provisions were “vague” or “ambiguous” and did not meet the “reasonable expectations” of the insured.³⁶³ However, current law does nothing to prevent insurers from modifying their insurance provisions to be very clear that they will only cover ED visits for which the patient receives prior approval or that are determined retrospectively, after review of clinical test results, to have constituted an emergency.³⁶⁴ If such policies were significantly less expensive than others that did not require prior approval and that covered ED services based on a “prudent layperson” standard, economists would argue that it would be more efficient, from a market perspective, to let consumers choose which of these policies to purchase, based on willingness to pay. Thus, they would argue that rather than mandating the less restrictive policy, Congress should simply mandate that insurers offer both the less restrictive and the more restrictive policy—a “mandated offering” approach.

For a number of reasons, this argument is flawed. For example, the solution would not apply to Medicaid beneficiaries, who do not pay premiums, yet are the most likely group to use the ED for non-emergencies. Moreover, as regards the privately insured, the assumptions underlying the argument for a mandated offering—a significant cost differential between the plans, informed choice on the part of consumers, willingness to pay, and insignificant or negligible externalities—are unfounded.

362. 42 U.S.C. § 300e to 300e-1 (1994).

363. See Part V.B.1.b.

364. Under such provisions, courts would be less likely to find for the insured. See Jerry, *supra* note 185, at 147.

1) *Costs*

State mandated health insurance benefits³⁶⁵ have been criticized by insurers, HMOs, and health plan administrators as “adding unnecessary costs” to our health care system, increasing health insurance premiums, and potentially reducing the number of employers who offer and individuals who purchase health care insurance.³⁶⁶ However, there is limited data on the effect of mandated benefits on insurance premiums, and most research has not taken into account the possibility that some mandates may actually reduce health care costs.³⁶⁷

As regards emergency care, this cost-saving potential may be relevant. If individuals are inappropriately denied prior approval for ED access because of an inaccurate assessment of their condition and, as a result, their condition is worsened, they may ultimately require more expensive and extensive medical treatment than they would have required if seen in the ED on initial manifestation of their symptoms.³⁶⁸

Second, the differential in price between the relevant policies is not that between emergency care and no emergency care or between unlimited emergency care and restricted emergency care. Rather, it is between (1) coverage of emergency care based on prior approval and a

365. Such benefits vary from state to state but common examples include “covering newborns from the date of birth (49 states), mammography screening (46 states), alcoholism treatment (39 states), . . . services of optometrists (46 states), . . . chiropractors (43 states) and psychologists (42 states).” Butler & Polzer, *supra* note 195, at 25–26. Other less common mandated benefits include in vitro fertilization, scalp hair prosthesis for alopecia areata, and acupuncture. *See id.* at 34–36, tbl. 4.1; *see also* Jerry, *supra* note 185, at 437. Most recently, the federal government has mandated that all health insurers cover up to at least 48 hours of inpatient hospital care after a mother has had an uncomplicated vaginal delivery or 96 hours following a Cesarean-section for both the mother and newborn and that plans that offer mental health benefits provide some elements of parity in the provision of those benefits and medical and surgical benefits. *See supra* notes 321–322.

366. *But see* Butler & Polzer, *supra* note 195, at 30 (citing John R. Gabel & Gail A. Jensen, *The Price of State-Mandated Benefits*, 26 *Inquiry* 419, 431 (1989)).

The authors [of the study] . . . examined the effect of [mandated health benefits] on a small employer’s likelihood of offering health insurance in each state. The authors found that several individual mandates, such as mental health, alcoholism, and drug abuse treatment were not statistically significantly associated with the probability that small employers would not insure.

Id.

367. Although mandated treatment for substance abuse and outpatient mental health care has been shown to increase premiums by 8.8% and 12.8 % respectively, home health care and nursing home care have been shown to lower them by between 3.2% and 3.6%. *Id.*

368. At least one study of pediatric Medicaid patients concluded that denial of an ED visit may be associated with subsequent higher hospitalization rates. *See* Gadowski et al., *supra* note 339, at 170.

retrospective assessment of whether the condition was truly an emergency and (2) coverage of care based on a "prudent layperson" standard. This cost differential will primarily be based on the costs of care for those who go to the ED with symptoms that a prudent layperson would regard as indicative of an emergency but that turn out not to be related to an emergency after appropriate screening and diagnostic tests. Examples of such cases would include patients who experience chest pains, excessive bleeding, a severe and sudden headache, or a painful arm after a serious fall. Based on this more limited distinction, the cost differential is unlikely to be significant, and the difference in premiums between these two types of policies may be negligible.³⁶⁹

2) *Consumer Choice and Willingness To Pay*

If, however, for purposes of discussion, premiums for the two types of policies were significantly different, economists would argue that a mandated benefit would force employers to offer only this more expensive plan to their employees and force employees and others who do not wish to pay the additional premium cost to do so. This argument assumes that consumers, in fact, are able to assess accurately the risks of needing the more expensive policy and that they will have sufficient information to make an informed choice as to how the need for ED care will be assessed by the plan.

If the debate focused simply on plans that covered and did not cover any emergency care, arguably there would be no consumer demand for the latter.³⁷⁰ However, given the choice between a plan that covered emergency care only with prior authorization and retrospective assessment of emergency ("Type 1") and a plan that covered emergency care under a prudent layperson standard ("Type 2"), some market segmentation might occur based on the price of the policies.³⁷¹ Whether

369. In any case, empirical data regarding this differential cost could advance the debate by clarifying the extent of the cost implications. For instance, a recent article found that the marginal cost of a nonurgent ER visit was only \$24.40. See Williams, *supra* note 45, at 24.

370. See Peter Passell, Editorial, *Economic Scene: When Politicians Seek to Please on Medical Benefits*, N.Y. Times, Oct. 10, 1996, at D2 (arguing that certain mandated health benefits, such as recent requirement that plans cover at least 48 hours of inpatient hospital care after woman has had uncomplicated vaginal delivery, might be avoided if consumers make choices among health plans that do and don't offer such coverage but that other types of benefits, such as trauma care, do not merit even offering consumers choice because "[h]ardly anyone, presumably, would choose to opt out of the right to trauma care in the emergency room in order to save on insurance premiums").

371. It is questionable under a mandated offering approach, however, whether employers would offer the more restricted policy in light of experience with "bare bones" insurance policies authorized by about half the states in 1990 and 1991 for small firms. These policies, which limited

the decision to choose one policy over another, however, would be truly informed and “voluntary,” that is, based on willingness to pay as opposed to ability to pay, is open to debate. As discussed above, individuals generally have a difficult time assessing the significance to be given small probabilities of potentially catastrophic outcomes³⁷² (for example, being denied prior authorization for ED treatment when experiencing chest pains that turn out to be symptoms of a heart attack). Second, even with a requirement that policies disclose the fact that an individual’s ED treatment will not be covered unless the individual receives prior authorization or the treatment is determined retrospectively to be for a true medical emergency, consumers will be unlikely to have sufficient information about how those mechanisms will be implemented to make an informed choice. The type of information that would be important would include: (1) the average waiting or response time from initial calls requesting approval for an ED visit to a decision on the part of the plan; (2) who is making the decision for the plan—a physician or someone without medical expertise; (3) the financial incentives, in terms of limiting ED visits, of the person making the decision; and (4) the number of individuals denied prior approval for emergency care and details about their experience—pain and suffering due to delay in receipt of care, how soon they were able to see a plan physician, their ultimate health outcome (length of time ill, lost time at work, inability to function, or residual pain). This information would likely be significant to an individual’s determination yet possibly would be more costly to provide than the unrestricted benefit.

Finally, there is an argument that an individual’s decision between the two policies may be made more on ability to pay than on willingness to pay. This argument will have more merit as the premium differential between the two plan types increases. If the broader coverage is mandated, however, the additional costs of the broader benefit will be spread among a larger population and the per-person cost will decline, making the coverage available to some who might otherwise not be able to afford it.³⁷³

services below what most considered standard coverage, were generally not attractive to employers or their workers. Butler & Polzer, *supra* note 195, at 30.

372. See *supra* note 146 and accompanying text.

373. This across-the-board increase, however, also must be evaluated in terms of the number of individuals who might decide, as a result of the incremental increase in cost, not to buy insurance at all.

3) *Externalities*

Finally, a modified market-based approach mandating that plans offer the two types of policies overlooks some significant costs to society that may result from those who purchase the Type 1 plan. The most significant cost is the loss of life or productive capacity for an individual who is inappropriately denied timely prior approval, who does not get to the ED as a result, and who suffers a catastrophic outcome—either death or significant injury. The cases of Lewis Hand and James Adams are illustrations of such outcomes.³⁷⁴ These outcomes not only will affect the families of these individuals but also will affect society. In many cases, the state will contribute to the support of these individuals throughout the remainder of their lives or to the support of their families, in cases where death results.

This argument clearly has more strength when applied to the prohibition on prior approval, but also has some relevance to the requirement of a prudent layperson standard. The argument about externalities based on risks to life and health will apply to the prudent layperson standard to the extent that the more restrictive policy provision, that is, retrospective assessment of whether the condition was truly an emergency, “over-deters” individuals from obtaining necessary emergency care. There are no data on whether retrospective review has such an effect, although there is some anecdotal evidence from ED physicians that individuals who do not receive affirmative indication from their plan that a test or procedure will be covered (prior to receipt of the test or procedure) are reluctant to obtain the test or undergo the procedure.

The requirement of a prudent layperson standard, however, also can be justified on the basis of other externalities resulting from a plan that denies coverage when a prudent layperson would have thought an emergency existed. In those cases, the ED likely will have to cover the costs associated with the patient’s screening and treatment. This has a number of implications for health care costs and access to ED care. First, to the extent a hospital is able to cross-subsidize losses in the ED with higher prices to other “insured” patients, costs and ultimately premiums for this group will increase. Second, if these costs cannot be recovered through cross-subsidization, eventually the ED may have to close because of financial inability to sustain itself. These externalities potentially could be avoided by mandating that managed care plans

374. *See supra* Parts IV.B.3, .1.b.

cover these services. Although infrequent, there are cases where governments mandate insurance coverage to reduce such externalities. Most recognized is the requirement that automobile owners purchase liability insurance to cover costs to person or property of others who may be harmed as a result of the owner's driving.³⁷⁵

The public policy debate over mandated benefits generally boils down to a question of "[t]o what extent . . . health benefits policy [should] protect a vulnerable minority or advance the larger community's interest in containing health care costs."³⁷⁶ That question, in turn, is influenced by "citizens' often imperfectly estimated perceptions of their personal risks of contracting certain conditions and by their belief in the community's responsibility to share in the misfortunes of its individual members."³⁷⁷ This trade-off was acknowledged by the U.S. Supreme Court in *Metropolitan Life Insurance Co. v. Massachusetts*,³⁷⁸ when it found that "sharing the risk of the need for mental health care to assure its affordability for those who might need it was the essence of the 'business of insurance,' which ERISA permits states to regulate."³⁷⁹ Given the life and death stakes that may be associated with policies requiring prior approval, the uncertainty associated with experiencing a true emergency, the difficulty for consumers to be informed about this issue, and the potential inability of some segments of the population to afford a policy with less restrictive benefits, there is a strong argument for mandating the less restrictive coverage and for spreading the costs associated with that coverage among the community of insureds.

375. See Jerry, *supra* note 185, at 847.

Currently, forty-two states and the District of Columbia require every person registering a motor vehicle in the state to present a certificate stating that he or she has liability insurance in at least a specified minimum amount. These statutes provide victims of automobile accidents with access to funds to cover their loss by requiring each vehicle owner in the state to have "security for any judgments that may be registered against the owner of the vehicle arising out of the vehicle's operation.

Id.

376. Butler & Polzer, *supra* note 195, at 30.

377. *Id.*

378. 471 U.S. 724 (1985).

379. See Butler & Polzer, *supra* note 195, at 32 n.60.

2. *Strengths and Potential Weaknesses of the Federal Proposal*
 - a. *Strengths—A Compromise Between Controlling Costs and Safeguarding Patients*

The primary strength of the proposed Federal Access to Emergency Medical Services Act (FAEMSA) is the balance it achieves between controlling costs and safeguarding patients. In addition to the prudent layperson standard that ensures that only ED visits that are “reasonable” will be reimbursed, the law does not prevent plans from requiring prior approval for further care once a patient has been stabilized. This type of requirement on the part of plans is well-founded and will deter EDs from providing care that can be as effectively provided by a plan physician. Moreover, the proposed legislation permits plans to impose a copayment on ED visits as a way to control inappropriate ED use³⁸⁰ and, unlike some state laws, does not require plans to cover all costs associated with mandated screening under EMTALA.³⁸¹ In addition, nothing in the legislation deters an ED physician from eliminating all possible risks of catastrophic outcome for patients that come to the ED. The legislation does not alter ED physician incentives to rule out even small probabilities of serious outcomes before transferring or discharging a patient. As such, it is a reasonable compromise in its effort to protect consumers yet allow plans to discourage inappropriate ED use.

- b. *Potential Weaknesses—Enforcement Provisions*

The proposed federal law follows the complex structural contours of the recently enacted Health Insurance Portability and Accountability Act (HIPAA) and would be implemented through amendments to the Internal Revenue Code (IRC), ERISA, and the Public Health Service (PHS) Act. As a result, the enforcement mechanisms vary according to the enforcement provisions in each of these Acts for violations of HIPAA. The FAEMSA would require compliance by private health

380. Although the bill places limits on a plan’s ability to impose cost-sharing for services provided at an ED (that is, such cost-sharing may not be greater than that imposed for comparable services in other settings, often 20%), a health plan “may impose a reasonable copayment (as determined in accordance with standards established by the Secretary) . . . to deter inappropriate use of services of hospital [EDs].” Access to Emergency Medical Services Act of 1995, H.R. 2011, 104th Cong. § 3(b)(1)–(2) (1995).

381. These state provisions, by requiring plans to pay for all federally mandated screening and treatment, arguably undermine the goals of the “prudent layperson” standard.

plans in both the group and individual market, by insurance issuers, and by plans serving the Medicare or Medicaid population.

The provisions regarding group health plans are enforced under both the IRC and ERISA. Under the IRC, a group health plan is defined as:

[A] plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.³⁸²

Failure of a group health plan to comply with the provisions of FAEMSA would be governed by the relevant enforcement provisions of the IRC. These provide that a tax of up to one hundred dollars for each day of noncompliance with respect to each individual may be imposed on the employer sponsoring the plan³⁸³ or on the plan in the case of a multiemployer plan.³⁸⁴ There are exceptions to the application of the tax. In general, no tax or a limited tax will be imposed if the violation was unintentional³⁸⁵ or corrected within thirty days.³⁸⁶ Moreover, no tax may be imposed “on a small employer (defined as an employer who employed an average of 50 or fewer employees on business days during the preceding calendar year) that provides health care benefits through a contract with an insurer or HMO and the violation is solely because of the coverage offered by the insurer or HMO.”³⁸⁷

In amending ERISA, the Act would adopt that law’s existing enforcement mechanisms, as modified by HIPAA. Under ERISA, the

382. 26 U.S.C.A. § 5000(b)(1) (West Supp. 1997).

383. 26 U.S.C.A. § 4980D(e)(1) (West Supp. 1997); *see also* H.R. Conf. Rep. No. 104-736, at 316 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, 2129.

384. 26 U.S.C.A. § 4980D(b) (West Supp. 1997).

385. 26 U.S.C.A. § 4980D(c)(1) (West Supp. 1997).

386. 26 U.S.C.A. § 4980D(c)(2) (West Supp. 1997).

The maximum tax for unintentional violations that can be imposed generally is the lesser of (1) 10 percent of the employer’s payments during the taxable year in which the failure occurred under group health plans (or 10 percent of the amount paid by the multiemployer plan or multiple employer welfare arrangement during the plan year in which the failure occurred for medical care, if applicable), or (2) \$500,000. The Secretary may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

H.R. Conf. Rep. No. 104-736, at 316-17 (referring to 26 U.S.C.A. § 4980D(c)(3), (4) (West Supp. 1997)), *reprinted in* 1996 U.S.C.C.A.N. at 2129-30.

387. H.R. Conf. Rep. No. 104-736, at 316 (referring to 26 U.S.C.A. § 4980D(d) (West Supp. 1997)), *reprinted in* 1996 U.S.C.C.A.N. at 2129.

enforcement mechanisms are somewhat different depending on whether the party is a "group health plan"³⁸⁸ or is a health insurance issuer.³⁸⁹ Relevant provisions with respect to group health plans allow for civil actions by beneficiaries "to recover benefits due . . . under the terms of [the] plan,"³⁹⁰ and to enforce their rights under the terms of the plan, or to clarify rights to future benefits.³⁹¹ In addition, a beneficiary or the Secretary of Labor may sue a plan (1) to enjoin any act or practice that violates any provision of the law regarding protection of employee benefits or violates the terms of the plan, or (2) to obtain other appropriate equitable relief to redress such violations or to enforce any provisions of the law regarding protection of employee benefits or violations of the terms of the plan.³⁹² Regarding the provisions of the law applicable to health insurance issuers, enforcement provisions are limited to ERISA's private rights of action for beneficiaries.³⁹³ Civil monetary penalties also may be levied against either state or local health plans or insurance issuers, but not under ERISA. They are based on such remedies established under HIPAA amendments to the PHS Act.³⁹⁴

Under the PHS Act, each state may require that health insurance issuers (but not health plans) meet the Act's requirements.³⁹⁵ States have significant discretion in how they enforce the law.³⁹⁶ In the case of a determination by the Secretary of HHS that a state has failed to enforce substantially a provision of the Act, the Secretary would enforce the provision or provisions.³⁹⁷

388. Group health plan is defined in ERISA as "an employee welfare benefit plan to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement, or otherwise." 29 U.S.C.A. § 1191b(a)(1) (West Supp. 1997).

389. A health insurance issuer is defined as "an insurance company, insurance service, or insurance organization (including a health maintenance organization . . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance Such term does not include a group health plan." 29 U.S.C.A. § 1191b(b)(2) (West Supp. 1997).

390. 29 U.S.C. § 1132(a)(1)(B) (1994).

391. § 1132(a)(1)(B).

392. 29 U.S.C. § 1132(a)(3), (5) (1994). Civil monetary penalties are limited to violations of the information and reporting requirements of the law, 29 U.S.C. § 1132(c) (1994), and violations by fiduciaries, 29 U.S.C. § 1132(i), (l), (m) (1994).

393. 29 U.S.C.A. § 1132(b)(3) (West Supp. 1997).

394. 42 U.S.C.A. § 300gg-22 (West Supp. 1997); *see also* H.R. Conf. Rep. No. 104-736, at 192, *reprinted in* 1996 U.S.C.C.A.N. 1990, 2005.

395. 42 U.S.C.A. § 300gg-22(a)(1).

396. The Act provides no guidelines for states in enforcing the provisions of the law.

397. 42 U.S.C.A. § 300gg-22(a)(2) (West Supp. 1997); *see also* H.R. Conf. Rep. No. 104-736, at 193 ("Secretarial enforcement would apply only in the absence of state enforcement and with

The PHS Act amendments provide that in the case where a health insurance issuer fails to comply with the Act's provisions, a civil monetary penalty is to be levied directly on the issuer.³⁹⁸ Where a nonfederal governmental health plan fails to comply with the Act's requirements, the plan is liable if it is sponsored by two or more employers (that is, governmental entities); otherwise, the employer is liable.³⁹⁹ The maximum penalty which could be levied is "\$100 for each day for each individual with respect to which such a failure occurs."⁴⁰⁰

In determining the penalty amount, the Secretary of HHS would have to take into account the previous record of compliance and the gravity of the violation. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment. Collected penalties would be paid to the Secretary of HHS and would be available for the purpose of enforcing the provisions with respect to which the penalty was imposed.⁴⁰¹

The enforcement provisions also require that the Secretaries of Treasury, Labor, and HHS "ensure, through execution of an interagency memorandum of understanding, that regulations, rulings, and interpretations are administered so as to have the same effect at all times."⁴⁰² In addition, "[i]t requires the Secretaries to coordinate enforcement policies for the same requirements to avoid duplication of enforcement efforts and assign priorities in enforcement."⁴⁰³

FAEMSA also would require compliance by insurers offering policies in the individual market. These provisions would be enforced in a manner similar to the enforcement provisions for the large group market.⁴⁰⁴ Each state could require such issuers to meet the FAEMSA's

respect to group health plans that are nonfederal governmental plans."), *reprinted in* 1996 U.S.C.C.A.N. at 2006.

398. 42 U.S.C.A. § 300gg-22(b)(2)(B)(i) (West Supp. 1997).

399. 42 U.S.C.A. § 300gg-22(b)(2)(B)(ii) (West Supp. 1997); *see also* H.R. Conf. Rep. No. 104-736, at 194, *reprinted in* 1996 U.S.C.C.A.N. at 2007.

400. 42 U.S.C.A. § 300gg-22(b)(2)(C)(i) (West Supp. 1997).

401. H.R. Conf. Rep. No. 104-736, at 194, *reprinted in* 1996 U.S.C.C.A.N. at 2007; *see also* 42 U.S.C.A. § 300gg-22(b)(2)(C), (D), (E), (G) (West Supp. 1997).

402. H.R. Conf. Rep. No. 104-736, at 194, *reprinted in* 1996 U.S.C.C.A.N. at 2007.

403. *Id.*

404. *See* 42 U.S.C.A. § 300gg-61 (West Supp. 1997).

requirements. If a state failed to enforce the provisions of the law, the Secretary of HHS would be responsible for their enforcement.⁴⁰⁵

Finally, the Access to Emergency Medical Services Act amends the Medicare and Medicaid laws to require that all plans enrolling Medicare beneficiaries or Medicaid recipients comply with the Act.⁴⁰⁶ For Medicare plans that fail to comply with the provisions of the Act, the Secretary of HHS may terminate the plan's Medicare contract⁴⁰⁷ or may impose one of a number of intermediate sanctions such as civil monetary penalties, suspension of enrollment of individuals, or suspension of payment to the organization.⁴⁰⁸ These actions only may be taken, however, where the Secretary determines that a plan has "substantially" failed to carry out the contract or "substantially" fails to carry out certain "applicable conditions."⁴⁰⁹

Regarding enforcement of the provisions of FAEMSA applicable to Medicaid plans, a state Medicaid plan will not be approved by the Secretary of HHS unless the "plan requires each health insurance issuer or other entity with a contract with such plan to provide coverage or benefits to individuals eligible for medical assistance under the plan to comply with [the provisions of the Act.]"⁴¹⁰

Whether or not the law is followed will depend primarily on two factors: (1) the effectiveness of the substantive enforcement provisions; and (2) the ability of each of the responsible agencies to enforce their respective portions of the law. As regards the first factor, the substantive provisions themselves leave some doubt as to the likely effectiveness of the law. Although states have significant discretion in how they will enforce the law and are free to set higher civil monetary penalties than are available to the Secretary of HHS, there is no indication, as yet, as to how well states will implement the relevant provisions of the law or what type of substantive enforcement mechanisms they will impose. In addition, where states fail to enforce the law against health insurance issuers and when enforcement action is necessary against health plans, the penalties that may be imposed by DHHS are relatively minor, that is, either a one hundred dollar tax or civil monetary penalty for each day of violation per individual. For plans or issuers that violate the prior

405. 42 U.S.C.A. § 300gg-61.

406. H.R. 815, 105th Cong. § 6 (1997).

407. 42 U.S.C.A. § 1395mm(i)(1) (West Supp. 1997).

408. 42 U.S.C.A. § 1395mm(i)(6)(B), (C) (West Supp. 1997).

409. 42 U.S.C.A. § 1395mm(i)(1).

410. H.R. 815, 105th Cong. § 6.

approval provisions or prudent layperson standard, it is unclear how the violations would be counted. A plan that had a written policy requiring prior approval for emergency care conceivably could be fined for each day the policy is in place after the effective date of the law multiplied by the number of individuals enrolled in the plan. A cap of \$500,000 would apply for group plans, but no such cap would apply to health insurers. However, if a plan did not have a written policy of prior authorization but instead plan personnel occasionally told enrollees over the phone that they should not go to the ED because the plan would not cover it, the infraction probably would be considered only a one-time violation (each time the plan personnel told this to an individual) and thus only subject to a fine of up to one hundred dollars. This hardly seems likely to be effective at changing plan behavior, given that the cost of emergency care avoided is likely to be less than the penalty involved.

As regards violation of the prudent layperson standard, which would arise upon plan review of a claim for payment, this probably also would be considered a one-time (day) violation for each time a plan made a decision that clearly was based on a retrospective review of clinical records rather than a prospective review of patient symptoms. As a result, the plan would only be subject to a one hundred dollar penalty. Again, this seems insufficient to motivate plans to change their behavior.

The private right of action provisions may also lack the teeth necessary to ensure compliance with the law. They are limited to the private right of action provisions currently in ERISA and, as discussed *supra*,⁴¹¹ are quite limited and inadequate for individuals who have suffered injury. This is most likely to occur where a plan requires prior approval for emergency care and as a result an individual either does not receive necessary emergency treatment or receives it "too late." Moreover, even in those cases where the harm is solely economic, that is, payment of a large ED bill, individuals may have difficulty asserting a private right of action. Although the bill may be large to an individual, it often is insufficient in terms of attorney time and payment to warrant an attorney's interest or willingness to take the case.

The provisions for Medicare and Medicaid plans may be more effective in terms of achieving compliance although this is not wholly clear. Although Medicare administrators have some effective intermediate sanctions that can be imposed for failure to comply with the provisions of the proposed law, the violations must meet a "substantiality" test. Whether an occasional requirement of prior

411. *See supra* Part IV.B.1.a.

approval for emergency services or denial of coverage based on a clinical retrospective review would meet the test is unclear. For Medicaid to take action, a similar substantiality test is not imposed and HCFA's ability to dictate the terms of plan participation should ensure that plans, at a minimum, do not have written policies at odds with the Act's requirements.

The second part of the enforcement equation is whether the agencies responsible for implementing the provisions of the law will be effective at doing so. This will depend in large part on staffing and resources devoted to the effort as well as adequate coordination among the agencies.

Those individuals who are responsible for implementing HIPAA will likely also be responsible for implementing the provisions of FAEMSA. HIPAA itself has yet to be enforced and enforcement action is not likely to begin until January 1, 1998. Thus, it is too early to tell how effective these agencies will be at implementing the provisions of that law. However, some judgments can be made about the likely effectiveness of the agencies in implementing the law. One noteworthy factor is that Congress did not appropriate funds or personnel (FTEs) to implement HIPAA. As a result, unless future appropriations are made for implementation of HIPAA or as a result of the passage of FAEMSA, the agencies will be limited in their ability to enforce the provisions of the laws. In addition, the responsible agencies have limited experience in implementing similar laws from which to extrapolate their likely effectiveness in enforcing the provisions of a new law.⁴¹²

As a result, there is considerable uncertainty as to how effective the enforcement provisions of the proposed Access to Emergency Medical Services Act law will be and without significant attention to their implementation, they could prove a potential obstacle to its overall success.

VI. CONCLUSION

Although it is appropriate and understandable that managed care plans seek to control unnecessary health care costs, a check is needed on some of their overly broad efforts to limit health care spending,

412. Analogous efforts might be those by the IRS to ensure insurer compliance with the health care insurance continuation rules (the COBRA requirements) and by the Department of Labor to enforce the provisions of ERISA as they apply to employee health plans. Yet there is little, if any, published data on how well these agencies have enforced these provisions.

especially when a potential emergency is involved. The current practice of managed care plans to deny or discourage access to emergency care for plan members is placing in jeopardy members who truly need emergency care. Moreover, plan practices that retroactively deny coverage for emergency care are unfair when the plan members had good reason to believe that they were experiencing emergencies. In these situations it is often the ED providers who are left covering the cost of the care they provide. This puts the burden of “gatekeeper” on the emergency medical personnel—an unfair and impossible task when they are required under federal law to screen all individuals who come to the hospital seeking emergency care. Furthermore, it shifts the insurance “risk” to the provider when it is the managed care plan that has agreed to accept the financial risk associated with providing health care for their subscribers.

Current law and policies to address these “unfair” practices on the part of managed care plans are limited in their effectiveness in large part by ERISA, which in many cases prevents suits against plans for negligent denial of prior authorization for emergency care and preempts state statutory efforts to address the problem. As a result, a federal solution to the problem is necessary. Essential elements of a federal solution must include a prohibition on prior authorization requirements for emergency care and a requirement that plans cover ED care obtained in circumstances that a “prudent lay person” would consider to be an emergency. These provisions will insure some balance among the concerns of (1) managed care plans in reducing utilization of unnecessary or inefficient use of health care resources, (2) plan members in receiving emergency treatment and not being left with a large bill when emergency care appears warranted, and (3) emergency care providers in being adequately compensated for patients that they treat. Without such efforts to regulate plan decisions and protect subscribers, individuals who join managed care plans unknowingly face risks to their health, their lives, and their pocketbooks.

