

United States Senate

WASHINGTON, DC 20510

March 2, 2018

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable R. Alexander Acosta
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20201

Dear Secretary Azar and Secretary Acosta:

We write to request that your departments look into recent, potential Prudent Layperson Standard violations by certain health insurance issuers in multiple states. As you know, patients must be able to seek emergency care without fearing their health insurance company will require prior authorization or deny their claims. Patients should never be in a position of correctly diagnosing their specific emergency medical condition before seeking professional medical help.

From the 1980s-2000s, private insurers would routinely require prior authorization for emergency department (ED) visits or deny payments for visits that they deem inappropriate for that care setting, often based on retrospective review or discharge diagnoses. If an individual wanted insurance to cover an emergency treatment, the patient was expected to contact his or her insurer prior to the ED visit.

In response to these dangerous and unfair requirements, 47 states¹ and later in 1997, Congress enacted the Prudent Layperson Standard to apply to Medicare and Medicaid managed care plans.² The Prudent Layperson Standard defines an "emergency medical condition" as one that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious bodily functions, or serious dysfunction of any bodily organ or part.³ The policy was extended to apply to group and individual market health insurance plans in 2010.⁴

¹ All except MS, NH, WY.

² P.L. 105-33; 42 C.F.R. § 438.114.

³ P.L. 111-148; 29 C.F.R. §2590.715-2719A(b)(4)(i).

⁴ P.L. 111-148; 29 C.F.R. §2590.715-2719A.

Despite federal law, private insurers are once again using tactics to prevent people from seeking care in the emergency room. On January 24, 2018, the *Los Angeles Times* reported that Anthem, one of the nation's largest health insurers, has over the last few months informed patients in six states that "if they show up at the emergency room with a problem that later is deemed to have not been an emergency, their ER claim won't be paid."⁵ Furthermore, reports indicated that when Anthem reviews emergency department claims, the insurer made its judgements based on the diagnostic codes entered on the claim documents rather than reviewing the patient's hospital treatment record.⁶ By denying patient claims based on the patient's final diagnosis and ignoring the patient's symptoms present at the time of the emergency, we believe that Anthem likely violated federal law.

Anthem's ED policy contains the following list of exceptions when the insurer will "always pay" the patient's claim:

- A consumer was directed to the emergency room by a provider (including an ambulance provider)
- Services were provided to a consumer under the age 15
- The consumer's home address is >15 miles from an urgent care center
- The visit occurs between 8:00 PM Saturday and 8:00 AM Monday or on a major holiday*
- The consumer is traveling out of state
- The consumer received any kind of surgery
- The consumer received IV fluids or IV medications
- The consumer received an MRI or CT scan
- The visit was billed as urgent care
- The ER visit is associated with an outpatient or inpatient admission⁷

While we appreciate Anthem on their effort to encourage patients to seek medical care in lower-cost settings, we remain concerned that Anthem's ED policy still forces patients to determine, before they even leave their home, if their symptoms are serious enough to go to the emergency room. The Prudent Layperson Standard was specifically drafted to allow patients to get the services they need, when they need them. Patients should not be forced to act as their own doctors and second guess themselves when they truly believe that they are having a medical emergency. Anthem's coverage denials are creating obstacles to emergency room care and are leaving patients responsible for thousands of dollars in medical bills.

⁵ Hiltzik, Michael, *Anthem expands its policy of punishing patients for 'inappropriate' ER visits*, THE L.A. TIMES (Jan. 24, 2018 3:45 PM), <http://www.latimes.com/business/hiltzik/la-fi-hiltzik-anthem-er-20180124-story.html>.

⁶ *Id.*

⁷ Liss Samantha, *Anthem's controversial emergency room policy is target of Missouri lawmakers*. ST. LOUIS POST-DISPATCH (Feb. 16, 2018), http://www.stltoday.com/news/local/govt-and-politics/missouri-lawmakers-aim-to-limit-anthem-s-controversial-er-policy/article_c6f0302a-2fa2-5eb2-9867-01b06e0fbdf.html; Gillespie, Lisa, *Anthem Tweaks Policy on Non-Emergency ER Visits*. 89.3 WFPL (Feb. 16, 2018), <http://wfpl.org/anthem-to-quasi-reverse-non-emergency-er-visit-denial-policy/>; *We Want you to Know About a Change in Our Emergency Room Program in Missouri*. (Feb. 14, 2018). Anthem BlueCross BlueShield, https://www.anthem.com/blog/member-news/emergency_room_program_in_missouri/.

In light of these developments we request the following documents and a response to the following questions by March 30, 2018:

1. Please identify all of the guidance that HHS and DOL have issued on the Prudent Layperson Standard for Medicare, Medicaid Managed Care Plans, group health plans, and plans sold on the individual and group health insurance exchanges.
2. Regarding the Prudent Layperson Standard, CMS prohibits the use of codes (either symptoms or final diagnosis) for denying Medicare and Medicaid managed care plan claims because the agency believes there is no way a list can capture every scenario that could indicate an emergency medical condition under the Balanced Budget Act of 1997 provisions. However, commercial plans have been able to use CPT codes to flag claims that are later determined to be an “avoidable emergency” and not covered by the insurance company. Is there a reason for this discrepancy? Please explain.
3. Anthem’s guidelines appear to violate Federal law that requires insurance sold on the individual and group markets and group health plans to abide by the Prudent Layperson Standard.
 - a. If HHS and/or DOL believes that Anthem’s policy is in full compliance with Federal law, please provide any documents that demonstrate the legal justification HHS and/or CMS is relying on to draw that conclusion.
 - b. If HHS and/or DOL conclude that any or all provisions of Anthem’s policy are in violation of Federal law, please provide a copy of any documentation of this conclusion.
 - c. If HHS and/or DOL have concluded that any or all provisions of Anthem’s policy are in violation of Federal law, please provide a written explanation of the Department and/or Agency’s plan to enforce the law, including potential engagement with state regulators and insurers.
4. In addition to Anthem, is HHS and/or DOL aware of other group health plans or health insurance issuers offering individual or group health insurance coverage implementing similar policies that discourage patients from seeking emergency medical care in emergency departments? If so, please disclose those group health plans and/or health insurance issuers.
5. Is CMS aware of other health insurance issuers with Medicare and Medicaid managed care contracts implementing similar policies that discourage patients from seeking emergency medical care in emergency departments? If so, please disclose those group health plans and/or health insurance issuers.
6. Has HHS and/or DOL received complaints from state regulators about health insurer issuers offering group health coverage potentially violating the Prudent Layperson

Standard? If so, please provide a copy of all communications, including e-mail related to this topic.

7. Has HHS and/or DOL received complaints about group health plans potentially violating the Prudent Layperson Standard? If so, please provide a copy of all communications, including e-mail related to this topic.
8. Has CMS received complaints about insurance issuers with Medicare and Medicaid managed care contracts potentially violating the Prudent Layperson Standard? If so, please provide a copy of all communications, including e-mail related to this topic.

Sincerely,



Benjamin L. Cardin
United States Senator



Claire McCaskill
United States Senator

cc: Seema Verma, Administrator for the Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244