Federal and state law define emergency care as health care services provided to evaluate and stabilize a medical condition that would lead “a prudent layperson” possessing an average knowledge of medicine to believe that a failure to get immediate medical care could result in a serious threat to their health. A patient’s presenting symptoms are central to determining the need for emergency care.

The Problem

Despite clear guidance from the Texas Department of Insurance, some health plans condition reimbursement for emergency services that hospitals already provided on a patient’s ultimate diagnosis, rather than the symptoms with which the patient presented to the emergency department.

Under federal law, hospitals are required to provide emergency health care services to anyone who seeks them, regardless of their ability to pay. The Emergency Medical Treatment & Labor Act prohibits hospitals from seeking, or directing an individual to seek, insurer authorization for screening or stabilization services until after the hospital has provided a medical screening examination and begun stabilizing treatment.

When a health plan retroactively defines emergency care based on the patient’s final diagnosis instead of the symptoms that brought them to the ED, it disregards the resources, time and clinical decision-making required to care for patients and deters patients from seeking medically necessary care.

SB 1139/HB 1236 would:

- Align the statutory definition of the prudent layperson standard with its legal interpretation.
- Clarify the definition of “emergency care” in the Insurance Code to include “regardless of the final diagnosis of the condition.”
- Support patients’ ability to get emergency health care services when they need them.
- Ensure reimbursement for emergency services provided.