OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

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S.B. 165
136th General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Sen. Manchester

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SUMMARY

- Prohibits health insuring corporations and sickness and accident insurers (collectively "health insurers") from reducing or denying claims for emergency services solely based on a diagnosis code or impression, the duration of an appointment as deemed clinically necessary by the health care provider, current Internal Classification of Diseases (ICD) code, or select procedure code.
- Prohibits health insurers from reducing or denying claims for emergency services due to the absence of an emergency medical condition if a prudent layperson would have reasonably expected the presence of an emergency medical condition.
- Requires health insurers to inform enrollees that they are not required to self-diagnose.
- Revises the scope of existing requirements that health insurers cover emergency services by expanding the definition of "emergency medical condition" to include physical and mental health conditions.

DETAILED ANALYSIS

Claim reimbursement

The bill prohibits health insuring corporations and sickness and accident insurers (collectively "health insurers") from doing either of the following with respect to a claim for emergency services:

- Reducing or denying a claim for reimbursement for emergency services based solely on a diagnosis code or impression, current Internal Classification of Diseases ("ICD") code, the duration of an appointment as deemed clinically necessary by the health care

provider, or select procedure code relating to the enrollee's condition included on a form submitted to the health insurer by a provider for reimbursement of a claim;[1]

- Reducing or denying reimbursement for an emergency service based on a determination of the absence of an emergency medical condition if a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of an emergency medical condition.[2]

The bill states that it must not be construed as exempting a health insurer from the Ohio Prompt Pay Law.[3]

Notice and disclosure requirements

Continuing law requires health insurers to inform enrollees of the scope and coverage of emergency services, the appropriate use of emergency services, cost sharing requirements or copayments for emergency services, and the procedures for obtaining emergency and other medical services. The bill also requires a health insurer to inform its enrollees that they are not required to self-diagnose.[4]

Coverage for mental health emergencies

Continuing law requires health insurers to cover emergency services for enrollees with emergency medical conditions without regard to the day or time the emergency services are rendered or to whether the enrollee, the hospital's emergency department where the services are rendered, or an emergency physician treating the enrollee obtained prior authorization for the emergency services.[5] The bill specifies that these requirements apply respecting both physical and mental health emergencies. Current law applies the requirements to "medical emergencies," which might include mental health emergencies, but is open to interpretation.[6]

HISTORY

Action	Date
Introduced	04-01-25

ANSB0165IN-136/ts

[1] R.C. 1753.29(A) and 3923.66(A).

[2] R.C. 1753.29(B) and 3923.66(B).

[3] R.C. 1753.29(C) and 3923.66(C); R.C. 3901.381 to 3901.3814, not in the bill.

[4] R.C. 1753.28(D)(5) and 3923.65(C)(4).

[5] R.C. 1753.28(B) and 3923.65(B).

[6] R.C. 1753.28(A)(1).