

**As Introduced**

**135th General Assembly  
Regular Session  
2023-2024**

**H. B. No. 99**

**Representative Manchester**

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**A BILL**

To amend sections 1753.28 and 3923.65 of the Revised Code to regulate the practice of reducing benefits related to emergency services if a condition is determined, after the fact, to not be an emergency.

**BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:**

**Section 1.** That sections 1753.28 and 3923.65 of the Revised Code be amended to read as follows:

**Sec. 1753.28.** (A) As used in this section:

(1) "Emergency medical condition" means a ~~medical-physical~~ or mental health condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.	19
(2) "Emergency services" means the following:	20
(a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;	21 22 23 24 25
(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.	26 27 28 29 30
(3) (a) "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:	31 32 33 34 35 36
(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;	37 38 39
(ii) Serious impairment to bodily functions;	40
(iii) Serious dysfunction of any bodily organ or part.	41
(b) In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.	42 43 44
(4) "Transfer" has the same meaning as in section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.	45 46

1395dd, as amended. 47

(5) "Emergency services utilization review" means a review 48  
of a claim related to emergency services for the purpose of 49  
determining whether the claim relates to an emergency medical 50  
condition. "Emergency services utilization review" includes a 51  
determination as to whether or not a prudent layperson with an 52  
average knowledge of health and medicine would have reasonably 53  
expected the presence of an emergency medical condition. 54

(B) A health insuring corporation policy, contract, or 55  
agreement providing coverage of basic health care services shall 56  
cover emergency services for enrollees with emergency medical 57  
conditions without regard to the day or time the emergency 58  
services are rendered or to whether the enrollee, the hospital's 59  
emergency department where the services are rendered, or an 60  
emergency physician treating the enrollee, obtained prior 61  
authorization for the emergency services. 62

(C) A health insuring corporation policy, contract, or 63  
agreement providing coverage of basic health care services shall 64  
cover both of the following: 65

(1) Emergency services provided to an enrollee at a 66  
participating hospital's emergency department if the enrollee 67  
presents self with an emergency medical condition; 68

(2) Emergency services provided to an enrollee at a 69  
nonparticipating hospital's emergency department if the enrollee 70  
presents self with an emergency medical condition and one of the 71  
following circumstances applies: 72

(a) Due to circumstances beyond the enrollee's control, 73  
the enrollee was unable to utilize a participating hospital's 74  
emergency department without serious threat to life or health. 75

(b) A prudent layperson with an average knowledge of 76  
health and medicine would have reasonably believed that, under 77  
the circumstances, the time required to travel to a 78  
participating hospital's emergency department could result in 79  
one or more of the adverse health consequences described in 80  
division (A)(1) of this section. 81

(c) A person authorized by the health insuring corporation 82  
refers the enrollee to an emergency department and does not 83  
specify a participating hospital's emergency department. 84

(d) An ambulance takes the enrollee to a nonparticipating 85  
hospital other than at the direction of the enrollee. 86

(e) The enrollee is unconscious. 87

(f) A natural disaster precluded the use of a 88  
participating emergency department. 89

(g) The status of a hospital changed from participating to 90  
nonparticipating with respect to emergency services during a 91  
contract year and no good faith effort was made by the health 92  
insuring corporation to inform enrollees of this change. 93

(D) A health insuring corporation that provides coverage 94  
for emergency services shall inform enrollees of all of the 95  
following: 96

(1) The scope of coverage for emergency services; 97

(2) The appropriate use of emergency services, including 98  
the use of the 9-1-1 system and any other telephone access 99  
systems utilized to access prehospital emergency services; 100

(3) Any cost sharing provisions for emergency services; 101

(4) The procedures for obtaining emergency services and 102

other medical services, so that enrollees are familiar with the 103  
location of the emergency departments of participating hospitals 104  
and with the location and availability of other participating 105  
facilities or settings at which they could receive medical 106  
services; 107

(5) That enrollees are not required to self-diagnose. 108

(E) (1) A health insuring corporation shall not reduce or 109  
deny a claim for reimbursement for emergency services based 110  
solely on a diagnosis code or impression, current ICD code, or 111  
select procedure code relating to the enrollee's condition 112  
included on a form submitted to the health insuring corporation 113  
by a provider for reimbursement of a claim. 114

(2) Reimbursement for an emergency services claim shall 115  
not be reduced or denied based on the absence of an emergency 116  
medical condition if a prudent layperson with an average 117  
knowledge of health and medicine would have reasonably expected 118  
the presence of an emergency medical condition. 119

(3) Before reducing or denying a claim for emergency 120  
services, a health insuring corporation shall perform an 121  
emergency services utilization review of the claim. 122

(F) (1) An emergency services utilization review shall be 123  
conducted by a physician in good standing with the state medical 124  
board who is board-certified by the American board of emergency 125  
medicine or American osteopathic board of emergency medicine and 126  
is not otherwise directly or indirectly hired by the health 127  
insuring corporation except for the purpose of utilization 128  
review. 129

(2) A physician shall not be eligible to provide emergency 130  
services utilization reviews unless that physician has 131

substantial professional experience providing emergency medical 132  
services, within the two years previous, in an acute care 133  
hospital emergency department. 134

(G) An emergency services utilization review shall include 135  
a review of the entire medical record of the patient, including 136  
all of the following: 137

(1) The complaint in question including presenting 138  
symptoms; 139

(2) The patient's medical history. Repeated utilization of 140  
the emergency department may be considered. 141

(3) The patient's diagnostic testing; 142

(4) Whether a prudent layperson would reasonably presume 143  
the presence of an emergency medical condition. 144

(H) Division (E) of this section does not apply when a 145  
reduction in reimbursement is made by a health insuring 146  
corporation based on a contractually agreed upon reimbursement 147  
rate. 148

(I) If a health insuring corporation requests records 149  
related to a potential denial of or reimbursement reduction for 150  
an enrollee's benefits when emergency services were furnished to 151  
an enrollee, a provider of emergency services has a duty to 152  
respond to the health insuring corporation in a timely manner. 153

(J) If an emergency services utilization reviewer 154  
determines that the reimbursement or any part of the claim 155  
should be denied, reduced, or paid at a lower level of emergency 156  
service, or as a nonemergency service, or otherwise, the 157  
reviewer shall explain in writing the reason for the reduction 158  
or denial of reimbursement. The written explanation for the 159

reduction or denial and the reviewer's name, date, signature, 160  
and supporting evidence shall be provided in writing to the 161  
enrollee and provider. 162

(K) Nothing in this section shall be construed as 163  
exempting a health insuring corporation from the prompt payment 164  
requirements prescribed in sections 3901.381 to 3901.3814 of the 165  
Revised Code. 166

**Sec. 3923.65.** (A) As used in this section: 167

~~(1) "Emergency, emergency medical condition," means a~~ 168  
~~medical condition that manifests itself by such acute symptoms~~ 169  
~~of sufficient severity, including severe pain, that a prudent~~ 170  
~~layperson with average knowledge of health and medicine could~~ 171  
~~reasonably expect the absence of immediate medical attention to~~ 172  
~~result in any of the following:~~ 173

~~(a) Placing the health of the individual or, with respect~~ 174  
~~to a pregnant woman, the health of the woman or her unborn~~ 175  
~~child, in serious jeopardy;~~ 176

~~(b) Serious impairment to bodily functions;~~ 177

~~(c) Serious dysfunction of any bodily organ or part.~~ 178

~~(2) "Emergency services" means the following:~~ 179

~~(a) A medical screening examination, as required by~~ 180  
~~federal law, that is within the capability of the emergency~~ 181  
~~department of a hospital, including ancillary services routinely~~ 182  
~~available to the emergency department, to evaluate an emergency~~ 183  
~~medical condition;~~ 184

~~(b) Such further medical examination and treatment that~~ 185  
~~are required by federal law to stabilize an emergency medical~~ 186  
~~condition and are within the capabilities of the staff and~~ 187

~~facilities available at the hospital, including any trauma and~~ 188  
~~burn center of the hospital. "emergency services," and "emergency~~ 189  
~~services utilization review" have the same meanings as in~~ 190  
section 1753.28 of the Revised Code. 191

(B) Every individual or group policy of sickness and 192  
accident insurance that provides hospital, surgical, or medical 193  
expense coverage shall cover emergency services without regard 194  
to the day or time the emergency services are rendered or to 195  
whether the policyholder, the hospital's emergency department 196  
where the services are rendered, or an emergency physician 197  
treating the policyholder, obtained prior authorization for the 198  
emergency services. 199

(C) Every individual policy or certificate furnished by an 200  
insurer in connection with any sickness and accident insurance 201  
policy shall provide information regarding the following: 202

(1) The scope of coverage for emergency services; 203

(2) The appropriate use of emergency services, including 204  
the use of the 9-1-1 system and any other telephone access 205  
systems utilized to access prehospital emergency services; 206

(3) Any copayments for emergency services; 207

(4) That the covered person is not required to self- 208  
diagnose. 209

(D) This section does not apply to any individual or group 210  
policy of sickness and accident insurance covering only 211  
accident, credit, dental, disability income, long-term care, 212  
hospital indemnity, medicare supplement, medicare, tricare, 213  
specified disease, or vision care; coverage under a one-time- 214  
limited-duration policy that is less than twelve months; 215  
coverage issued as a supplement to liability insurance; 216



insurance arising out of workers' compensation or similar law; 217  
automobile medical payment insurance; or insurance under which 218  
benefits are payable with or without regard to fault and which 219  
is statutorily required to be contained in any liability 220  
insurance policy or equivalent self-insurance. 221

(E) (1) A sickness and accident insurer shall not reduce or 222  
deny a claim for reimbursement for emergency services based 223  
solely on a diagnosis code or impression, current ICD code, or 224  
select procedure code relating to the covered person's condition 225  
included on a form submitted to the sickness and accident 226  
insurer by a provider for reimbursement of a claim. 227

(2) Reimbursement for an emergency services claim shall 228  
not be reduced or denied based on the absence of an emergency 229  
medical condition if a prudent layperson with an average 230  
knowledge of health and medicine would have reasonably expected 231  
the presence of an emergency medical condition. 232

(3) Before reducing or denying a claim for emergency 233  
services, a sickness and accident insurer shall perform an 234  
emergency services utilization review of the claim. 235

(F) (1) An emergency services utilization review shall be 236  
conducted by a physician in good standing with the state medical 237  
board who is board-certified by the American board of emergency 238  
medicine or American osteopathic board of emergency medicine and 239  
is not otherwise directly or indirectly hired by the sickness 240  
and accident insurer except for the purpose of utilization 241  
review. 242

(2) A physician shall not be eligible to provide emergency 243  
services utilization reviews unless that physician has 244  
substantial professional experience providing emergency medical 245

<u>services, within the two years previous, in an acute care</u>	246
<u>hospital emergency department.</u>	247
<u>(G) An emergency services utilization review shall include</u>	248
<u>a review of the entire medical record of the patient, including</u>	249
<u>all of the following:</u>	250
<u>(1) The complaint in question including presenting</u>	251
<u>symptoms;</u>	252
<u>(2) The patient's medical history. Repeated utilization of</u>	253
<u>the emergency department may be considered.</u>	254
<u>(3) The patient's diagnostic testing;</u>	255
<u>(4) Whether a prudent layperson would reasonably presume</u>	256
<u>the presence of an emergency medical condition.</u>	257
<u>(H) Division (E) of this section does not apply when a</u>	258
<u>reduction in reimbursement is made by a sickness and accident</u>	259
<u>insurer based on a contractually agreed upon reimbursement rate.</u>	260
<u>(I) If a sickness and accident insurer requests records</u>	261
<u>related to a potential denial of or reimbursement reduction for</u>	262
<u>a covered person's benefits when emergency services were</u>	263
<u>furnished to a covered person, a provider of emergency services</u>	264
<u>has a duty to respond to the sickness and accident insurer in a</u>	265
<u>timely manner.</u>	266
<u>(J) If an emergency services utilization reviewer</u>	267
<u>determines that the reimbursement or any part of the claim</u>	268
<u>should be denied, reduced, or paid at a lower level of emergency</u>	269
<u>service, or as a nonemergency service, or otherwise, the</u>	270
<u>reviewer shall explain in writing the reason for the reduction</u>	271
<u>or denial of reimbursement. The written explanation for the</u>	272
<u>reduction or denial and the reviewer's name, date, signature,</u>	273

and supporting evidence shall be provided in writing to the 274  
covered person and provider. 275

(K) Nothing in this section shall be construed as 276  
exempting a sickness and accident insurer from the prompt 277  
payment requirements prescribed in sections 3901.381 to 278  
3901.3814 of the Revised Code. 279

**Section 2.** That existing sections 1753.28 and 3923.65 of 280  
the Revised Code are hereby repealed. 281