



Senator Susan Manchester - 12th District

Senate Committee on Financial Institutions, Insurance and Technology

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Senate Bill 165 – Sponsor Testimony

Chairman Wilson, Vice Chairman Lang, Ranking Member Craig, and members of the committee. Thank you for the opportunity to provide sponsor testimony on Senate Bill 165. Senate Bill 165 does two things. The first of which is protecting and strengthening the integrity of Ohio’s prudent layperson standard. Secondly, the bill prohibits insurers from denying coverage of a claim based solely on a diagnosis code or impression, current ICD code, duration of an appointment as deemed clinically necessary by the enrollee's provider or select procedure code relating to the enrollee's condition. This practice is called downcoding and occurs when a payer changes a claim to a lower-cost service than what was delivered to the patient by the provider, leading the practice to get paid for a lower level of care than what was provided.

Ohio currently has a prudent layperson standard law. This means that if a person with average medical knowledge believes they have an emergency medical condition, that visit to the emergency department should then be considered a medical emergency and therefore is covered by insurance. In these instances, an exam is usually administered by a physician and often accompanied by testing to determine the cause of these potentially serious symptoms. Unfortunately, some insurers are denying legitimate insurance claims of patients who sought care in the emergency department, if after the medical screening the patient’s condition was determined to be non-emergent. This retroactive denial by the insurance company results in a “surprise lack of coverage” for the patient, often resulting a higher out-of-pocket cost to patients and, if they can’t afford to pay, a loss to hospitals and clinicians. These patients seeking what is believed to be emergent medical care were not uninsured. They were denied their appropriate coverage. Senate Bill 165 strengthens and clarifies the existing prudent layperson standard and stresses that it applies regardless of the final diagnosis.

This clarification is essential, as many symptoms can be indicative of both a harmless condition and a serious, life-threatening issue. For example, if you- “google”-headache, you will see advice to:

Seek medical attention immediately if you experience:

- A sudden, severe headache
- A headache that is accompanied by fever, stiff neck, or confusion
- A headache that worsens over time
- A headache that is triggered by a recent head injury
- A headache that is accompanied by vision changes or weakness

If your headache falls into these categories, the public is educated to err on the side of caution. To call 911 and go to the ER for symptoms that present as a life-threatening emergency. Should the expectation be that if a patient has a sudden onset headache, or crushing chest pain, or sudden weakness in their arms or legs, that they wait until the morning when they may or may not be able to see their primary care doctor? That they google and self-diagnose their disease? Many conditions such as stroke, heart attack and brain aneurysm, are time sensitive diagnosis. The prudent layperson standard exists to protect patients from the unfair position of risking their health out of fear of financial consequences when seeking potentially lifesaving care during an acute health crisis.

Most times, a headache is just a headache, but it could be a brain aneurysm, an infection, a tumor, or some other very serious diagnosis. Only a trained physician can make that determination. Patients should NOT be expected to try and determine what the cause of their symptoms are before deciding whether to seek emergency care. Insurance companies should not retroactively deny a claim as being non-emergent if they are arbitrarily determined to not be having a “true emergency.”

This legislation also prohibits health plans from downcoding payments for all providers and includes a prohibition on limitations on reimbursement for time spent with patients. Providers submit reimbursement to health plans based off the care they provided to the patient. Yet, I have heard from the providers in my district, and around Ohio that their claims are being downcoded. The providers are then being reimbursed at a significantly lower rate, without explanation, leading to a higher out of pocket cost for the patient and reduced revenue for the practice. As a result, the practice has a lesser ability to invest in resources and necessary equipment. Some practices even struggle to keep their doors open.

NBC News published a national article on the issue of downcoding titled “Guilty until proven innocent: Inside the fight between doctors and insurance companies over downcoding.” The article exposes how a health plans efforts to “advance quality and affordability” is, in practice, placing significant strain on family practices in Ohio – forcing physicians to reduce time spent with patients, discontinue care for current patients, or close their practice all together.

A white paper published by the American Hospital Association reports that 89% of hospitals and health systems surveyed had experienced an increase in claim denials over the past three years, with 51% calling the increase significant. A practice recently shared that they received 152 downcoded claims from one insurer within the past year without any notification. The plan downcoded the claim submitted by this practice from a level four to a level three at the reduction of about \$45 a claim. A decision made without a chart review or additional information resulted in a \$6,480 loss in revenue for the practice and resulted in a higher out-of-pocket cost to the patient.

These reductions are not only occurring in the doctor's office but are also happening in the mental health space. Denials and down codes are being made on the time a provider spends with a patient. A 60-minute mental health appointment is being downcoded to a 45-minute appointment by a health plan who has no idea how long a provider needs to spend with a patient in crisis during a clinically necessary appointment.

This legislation protects Ohioans from unfair insurance denials driven by algorithms when they seek emergency care in a moment of crisis. Senate Bill 165 ensures that every claim is thoroughly reviewed before a coverage determination is made – putting the patients' health first. Thank you for the opportunity to provide sponsor testimony. I am happy to answer any questions.