OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 270
134th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 270's Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Manchester and Upchurch

Local Impact Statement Procedure Required: No

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Highlights

- The bill may minimally increase administrative costs for the Department of Insurance to monitor health insurers' compliance with the bill's requirements. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill specifies that a health plan issuer that repeatedly violates the bill's provisions is considered to have engaged in an unfair and deceptive act or practice in the business of insurance, which carries civil penalties. Any revenue from the penalties would depend on health issuers' compliance with the requirement. Any revenue from the penalties would be deposited into Fund 5540.
- No direct fiscal effect on political subdivisions.

Detailed Analysis

Health insurers

The bill prohibits any reductions or denials of a claim for reimbursement for emergency services based solely on a final diagnosis or impression, the International Classification of Diseases (ICD) code, or select procedure codes. The bill also requires health insurers to obtain an independent emergency physician review[1] before an insurer does any of the following: (1) deny

[1] "Independent emergency physician review" means a utilization review conducted by a physician in good standing with a state medical board who is (1) board certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine and (2) is not otherwise directly or indirectly hired by the insurer except for the purpose of utilization review.

benefits, (2) select a Current Procedural Terminology (CPT) evaluation and management or procedure code of lesser acuity than what was billed by the emergency service provider, (3) reduce reimbursement for an emergency service based on a determination of the absence of an emergency medical condition, or (4) make a determination that medical necessity was not present and therefore reimbursement will be for a lower level of care or as a nonemergency service.[2] The requirement related to the independent emergency physician review does not apply when a reduction in reimbursement is made by a health insurer based on a contractually agreed upon adjustment for health care services.

The bill specifies items that must be included in a utilization review of emergency services, including steps that must be taken by an independent emergency physician reviewer when he or she determines that the reimbursement or any part of the claim should be denied, reduced, or paid at a lower level of emergency service or as a nonemergency service, or otherwise. The bill also specifies eligibility requirements for a physician to be allowed to provide such review, and specifies that, for utilization reviewers operating in Ohio, the process of providing utilization review is considered the practice of medicine and is subject to the oversight and review of the State Medical Board of Ohio.

The bill requires insurers (1) to inform their enrollees at the time of enrollment, and not less than annually thereafter, that emergency care is a covered benefit and provide the enrollee with the legal definition of an "emergency medical condition" as provided in the bill,[3] (2) to clearly educate their enrollees on the fact that, if an enrollee believes they may have an emergency medical condition as defined in the bill, the insurers will cover the emergency services, even if after emergency evaluation, no emergency is found, and (3) to disclose to enrollees that they are not required to self-diagnose. The bill prohibits insurers from providing false or misleading information to enrollees and from discouraging appropriate use of the emergency department. The bill also requires insurers to educate enrollees as to the appropriate site of service based upon symptoms and availability of alternative sites of care.

The bill specifies that repeated violations of the bill's provisions is considered as an unfair and deceptive act or practice in the business of insurance and is subject to sections 3901.19 to 3901.26 of the Revised Code.

The bill's requirements apply to health insuring corporations (HICs) and sickness and accident insurers. The bill also specifies that it does not exempt insurers from the prompt payment requirements under existing law.

Fiscal effect

The bill may minimally increase the Department of Insurance's administrative costs for regulating health insurers. Any increase in the Department's administrative costs would be paid from the Department of Insurance Operating Fund (Fund 5540). Any civil penalties that may arise

[2] The required independent emergency physician review must include, at minimum, a review of the following related to the emergency service: (1) the enrollee's medical record, including the nature of the presenting problems or symptoms, (2) the enrollee's patient history, and (3) the examination and medical decision making.

[3] The bill modifies the definition of "emergency medical condition." Please see the bill for the changes.

from repeated violations of the bill's provisions related to emergency services coverage, the amount of revenue from which would depend on health issuers' compliance with the provisions, would be deposited into Fund 5540. The Superintendent of Insurance is authorized under continuing law to assess an insurer for half of Department costs, up to $100,000, reasonably incurred to conduct investigations of that insurer's committing unfair or deceptive acts in the business of insurance; violations of a cease and desist order issued by the Superintendent may lead to a court order of civil penalties up to $3,500 for each violation or a total of $35,000 in any six-month period. In addition, the bill's provision related to utilization review of emergency services may increase administrative costs of the State Medical Board of Ohio. Any increase in the Board's administrative costs will be paid from the Board's appropriation item 883609, Operating Expenses (Fund 5C60). Fund 5C60 is funded by licenses, fees, and penalties.

The bill has no direct fiscal effect on political subdivisions.

The bill's prohibition against any reductions or denials of a claim for reimbursement for emergency services based solely on a final diagnosis or impression, the ICD code, or select procedure codes would have no fiscal effect to public hospitals' reimbursements related to emergency claims.

The bill's requirements, prohibitions, and modifications of emergency services requirements would likely increase HICs' and sickness and accident insurers' costs. Some portion of such cost increases may be passed through to enrollees and plan sponsors that contract with such insurers (e.g., local government health plans). Generally, LBO staff consider that such cost increases are indirect fiscal effects if they do not affect self-insured government plans or if they create administrative costs but not new claims costs for health insurers, e.g., through mandated coverage of a medical condition. LBO staff could not determine the magnitude of the effects of the bill on plan sponsors due to lack of information related to such insurers' emergency services coverage. But survey responses to the 2015 National Hospital Ambulatory Medical Care Survey indicate that roughly 5.5% of emergency room visits that year were classified as being for nonurgent medical situations. The bill would make it more difficult for health insurers to avoid paying for care provided in an emergency room setting that could have been provided in a lower cost setting, suggesting insurers may experience significant costs that are claims related. It is likely that at least a portion of those costs would be passed on to governments that provide health benefits by using HICs or sickness and accident insurance policies.

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