

From: [Tom Hurley](#)
To: [E-OHPSCA1251.EBSA](#)
Subject: Comment on Proposed Regulation pertaining to out of network emergency care
Date: Thursday, July 15, 2010 11:36:01 AM

As an attorney with a large preferred provider organization, I read with interest Section 54.9815-2719AT(b) of the proposed regs. This section requires non-grandfathered plans to pay for out of network emergency care furnished to their covered persons in an amount equal to the highest of 3 alternative amounts calculated in the manner described in the regulation. One of these alternative amounts is the median amount that a plan would pay for the same care if such care was furnished by any in-network provider. **In many instances plans will not be able to calculate these median amounts.**

Many provider networks do not negotiate with providers to obtain firm prices for particular care (e.g., \$450 to set a particular broken bone) but rather a discount expressed as a percentage of the rate set forth in the provider's chargemaster (e.g., 70% of chargemaster rate, or chargemaster rate less 30% discount). When the network reprices an in-network provider's claim, it takes the dollar amounts set forth in the provider's bill as representing the chargemaster rates for the procedures identified in the claim, and applies its negotiated discounts in order to determine the dollar amount of the re-priced claim. Note that the network does not have the chargemaster of each network provider in a database.

When emergency care is furnished by an out of network provider, networks that (1) have provider participation agreements of the kind described above, and (2) do not maintain a database containing each provider's chargemaster will have no way to determine how much any one network provider would charge (much less the median of the amounts all network providers would charge) for the emergency care given by the out of network provider because the in-network provider has not sent a bill containing the relevant "rack rates" from the provider's chargemaster for the care furnished.

When I discovered this problem, I spoke with our senior hospital relations manager. He believes that many network providers will be extremely resistant to turning over a complete chargemaster, or even the portion of it dealing with emergency services. And we have about 400 hospitals in our provider network. If even one of these refuses to turnover chargemaster information, we will be unable to furnish our plan clients with truly accurate median amounts for any particular claim. Unless providers are legally compelled to do so, far more than 1 of our 400 hospitals can be expected to refuse our request to turnover chargemaster data.

By the way, even if hospitals can be compelled to provide chargemaster data, calculating the median for a particular claim will be very costly. With our 400 hospital network, we (or a plan client remotely accessing our repricing system) would have to do a hypothetical repricing of the claim 400 times. When a particular claim needs to be manually repriced, this could become inordinately time consuming and expensive. This will add significantly to the administrative component of total healthcare costs.

Regrettably, I am unable to propose to you any particular solution, only to present to you the very real, very significant problem.

Thomas F. Hurley