Emergency Department EDPMA Practice Management Association

Pursuant to 2017 Senate and House Appropriations Report Language

Recommendation for Implementing Congressional Directive to HHS and CCIIO

Clarifying the Definition of the "Usual, Customary and Reasonable Amount" (UCR) Determining a Minimum Benefit Standard (MBS) for the Reimbursement of Out-of-Network Emergency Medical Services in Accordance with the 'Greater of Three' Test

Proposed FAQs

1) **Question:** What is the meaning of the term "usual, customary and reasonable amount" when calculating the minimum benefit standard for out-of-network emergency care?

   Answer: The term "usual, customary, and reasonable amount" (UCR) is defined as the eightieth percentile of all billed physician charges for the particular healthcare service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in either the FAIRHealth® database or another database approved by the Department of Health and Human Services (HHS). For purposes of qualifying as an appropriate benchmarking database to calculate UCR or the minimum benefit standard, the database must 1) contain sufficient data for the geographic area to serve as a benchmarking database, 2) be publicly available, and 3) be maintained by an independent, non-profit organization that is not financially sponsored or organizationally affiliated with an insurance carrier, group health benefits plan or administrator or payer of health insurance claims.

2) **Question:** Can a payer of health insurance claims comply with the minimum benefit standard for out-of-network emergency care without calculating the three payment floors?

   Answer: Yes. A payer of health insurance claims is considered in compliance with the minimum benefit standard for determining the reimbursement of out-of-network emergency care if that payer reimburses the provider at an amount that is not less than the "usual customary and reasonable amount", defined as the eightieth percentile of all billed physician charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in the FAIRHealth® or other HHS-approved benchmarking database, reduced by any in-network patient cost-sharing amounts.

3) **Question:** Does a payer need to disclose how it calculates the minimum benefit standard for out-of-network emergency care?

   Answer: To ensure transparency and to better protect patients from the effects of balance billing attributable to unreasonably low out-of-network payments, patients and providers must have objective and readily available access to information used to calculate out-of-network reimbursement. For those out-of-network payments issued that do not reflect the defined 'usual and customary amount', the payer is required to disclose any non-public information such as (1) the payer's or insurer's average in-network rate and the data used to make that calculation and (2) the method the payer uses for determining the reimbursement of out-of-network services and the data used to determine the basis for that payment.