

MEMBER MESSAGE GUIDE

Surprise Medical Bills



No one should ever face a surprise medical bill that can lead to financial ruin. Yet before the No Surprises Act, millions of patients faced surprise medical bills they did not expect at prices they could not afford. Thanks to congressional champions and the Biden Administration, patients are now protected from surprise bills.

Key Messages

Most physicians and hospitals play by the rules – it was a small but significant number of hospital-based providers that were responsible for the majority of surprise medical bills. **It was price gouging, plain and simple.** And we all paid for it.

Health insurance providers know that high-value provider networks give patients meaningful choices about where to seek the care they need when they need it, with the assurance the provider they're seeing is held to the highest standards of quality and accountability.

That's why we supported a federal solution that would protect patients and grow provider networks while reducing health care spending. **The No Surprises Act ended the practice of surprise medical billing in most circumstances** while encouraging more providers to join health plan networks.

When clinical specialists choose not to participate in health insurance providers' networks—or if they do not meet the high-quality standards for inclusion—they often created a business model centered on using patients and their insurance providers as a blank check. **The consequences were significant: financial stress; fighting a complicated, confusing bureaucracy; harassed by collection agencies; and often legal action for non-payment.**

With the January 1, 2022, implementation of the No Surprises Act, more Americans are protected from surprise medical bills. But more work needs to be done to ensure a broken bone doesn't break the bank. With a market failure now addressed, it is time for the market to encourage more network participation.

We applaud the Administration for writing federal regulations that encourage greater network participation, certainty around out-of-network payment rates, and discourage overuse of arbitration. As further regulations and guidance are developed defining the details of how the No Surprises Act process will work, AHIP will advocate for a balanced system that protects consumers and does not lead to increased health care costs.

As states consider enacting state-specific protections we continue to advocate for an approach that relies on fair, market-based prices based on locally negotiated rates – without loopholes. **That's how to ensure their health care costs remain more affordable.**

Outrageous Surprise Medical Bills

Hospital-based, out-of-network physicians send a disproportionate number of surprise bills, charging prices well beyond their peers:

Anesthesiologists:

Nearly 6X the Medicare reimbursement rate

Radiologists:

4.5X the Medicare reimbursement rate

Emergency medicine physicians:

4X the Medicare reimbursement rate



Stats and Facts

Before the No Surprises Act, 1 in 5 patients admitted to a hospital on an in-patient basis received a bill from an out-of-network physician.

In 2018, Americans made about **130 million visits to emergency rooms**. At least 1 in 6 patients who had health insurance received a surprise medical bill from a provider or specialist who treated them.

One study on surprise medical bills found that:

- Anesthesiologists charge, on average, **nearly 6 times** the Medicare reimbursement rate. They account for 16.5% of all surprise medical bills.
- Radiologists charge, on average, **4.5 times** the Medicare rate.
- Emergency medicine physicians and pathologists charge, on average, **4 times** the Medicare rate.

FAQ

What does the No Surprises Act do? When did it take effect?

In December 2020, Congress enacted the No Surprises Act, which applies to out-of-network emergency care, out-of-network care delivered at an in-network hospital, and emergency air medical transport. In these scenarios consumer cost sharing is limited to what they would have paid in-network and providers are prohibited from balance billing patients. The law applies to plans in the individual and group markets and also applies to self-funded plans regulated by the Department of Labor under ERISA. These protections take effect for plan years that begin on or after January 1, 2022. Regulations are now in effect governing how out-of-network bills will be resolved with the patient taken out of the middle. Independent Dispute Resolution entities are to first consider which reimbursement offer is closest to the median of prevailing market rates in that geographic region, as well as considering unique circumstances of the case at issue.

Every year, before the No Surprises Act, the outrageous out-of-network bills from a subset of specialty physicians result in **\$40 billion in additional spending in employer-provided coverage alone**.

The number of in-network physicians has increased by 16% since California passed surprise medical billing legislation (AB 72) in 2016. The legislation set a benchmark reimbursement rate for out-of-network providers.

Arbitration has been disastrous for New York patients.

Under arbitration models, both insurance providers and care providers submit a proposed dollar amount to government-appointed arbiters, who then choose the final monetary award. The result has been a 300% increase in the price of emergency services claims that have gone to arbitration since the program began.

Do all physicians send surprise medical bills?

A small but significant group of physicians historically had been responsible for the vast majority of surprise medical bills. The real issue is when clinical specialists or providers choose not to participate in health insurance providers' networks—or if they do not meet the standards for inclusion in a network—and can then demand a blank check from patients for their services.

These specialty providers charge substantially more than their peers. They do not accept private insurance, and patients often don't even know they're part of their treatment. Studies have found that surprise medical bills are most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.

Fixing the problem means that for the vast majority of physicians and hospitals who don't rely on surprise billing patients, the solution won't impact them.

How does private equity play a role in surprise medical bills?

Private equity—and their drive for massive profits—is often the bad actor behind outrageous surprise medical bills that bankrupt families across the country. These private-equity firms buy medical practices . . . deliberately keep them out-of-network . . . and then price gouge patients with out-of-control prices.

That's why health insurance providers supported the No Surprises Act, which went into effect January 1, 2022. Before the No Surprises Act, providers lacked the same incentives to join networks, resulting in lower network participation rates for certain providers, like those that provide emergency care, or are assigned by the hospital without patient direction, such as anesthesiologists and pathologists.

The No Surprise Act fixes the market dysfunction that saddled patients with exorbitant medical bills for they had no opportunity to turn down.

Why wouldn't arbitration work to solve surprise medical billing?

Experience proves that arbitration does not work. It protects the profits of a small but politically influential group of providers – not patients. It leaves patients paying higher premiums.

Arbitration increases the financial burden on everyone with coverage, increasing patient premiums and driving up the cost of health care. Arbitration also allows private-equity firms and certain providers to price gouge patients and then shifts the final decision to a government-imposed "third party." This process introduces new bureaucracy and red tape into the system, costing hard-working taxpayers more than \$1 billion.

Using arbitration to determine out-of-network payments would impose administrative burdens on the entire health-care system. Employers offering self-funded plans would be forced to hire outside consultants to manage the process. When Texas established an arbitration process in 2013 to resolve surprise medical bills, it initially received 43 requests for arbitration. In a few short years, there was a backlog of 4,000 arbitration requests.

Independent experts, employers, health insurance providers, consumer groups, labor unions, and patient groups agree: Arbitration is not the solution. Only one group wants arbitration: specialty physicians and the private equity firms with a stake in their financial success. They created the problem and now they want arbitration to protect their bottom line.

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Why are some physicians and hospitals suing to stop surprise billing protections?

Health insurance providers strongly supported Congressional efforts to ban surprise billing and the Biden Administration's rules implementing its important patient protections. Specialty physicians, private-equity providers, and air ambulance companies have filed lawsuits in federal court to strike down some or all of the rules that make protections against surprise billing work. They profited from sending surprise bills and have a business model that relies on getting paid as much for out-of-network care as possible. AHIP believes consumers should be protected in a way that brings down health care costs for everyone – which the recent federal rules accomplish.

Does the state of New York have a good model for solving surprise medical bills?

No. Many providers have urged Congress to use the [New York arbitration model](#) for the entire country. But recent analyses show that this approach [drives up costs](#). Under New York's guidance, arbiters should consider the 80th percentile of billed charges—or what 80% of physicians charge for a given billing code—when determining final payment. A New York State Department of Financial Services report found that arbitration decisions have averaged 8% higher than the 80th percentile of charges—higher than negotiated in-network rates. The Brookings Institution believes that it is likely that very high out-of-network reimbursement that physicians can get through arbitration will lead to providers dropping out of networks or demanding higher payment rates – or both. This would raise premiums for all New Yorkers.

A New York model increases health costs – taking our country in the wrong direction at a time when consumers are already paying too much for care.

Do health insurance networks help avoid surprise medical billing?

Yes. Health insurance providers work with hospitals and physicians to negotiate fair payment rates. These fair, locally negotiated payments cover the cost of care and much of the cost for patients who receive in-network services. Networks help to protect patients from surprise medical bills.

What is the best way to stop surprise medical bills?

Any real solution to surprise medical bills must protect patients and set a fair payment for physicians. A fair, market-based price based on local negotiated rates will stop abuse of the system by some providers.

[California's experience shows](#) how such an approach works for patients. Physicians in California are paid either the physician's average contracted reimbursement rate or 125% of the Medicare reimbursement rate, and patients don't receive any extra bills beyond that amount. Patients are protected and more physicians are participating in health plan networks, helping avoid out-of-network bills in the first place and increasing access to quality in-network care.

AHIP continues to analyze recently passed surprise billing legislation that moves to an arbitration model. However, the only workable remains developing fair, market-based prices based on locally negotiated rates – without loopholes. That's how to ensure their health care costs remain more affordable. As real-world experiences in both [Texas](#) and [New York](#) have clearly demonstrated, private-equity firms will continue to find ways to exploit the arbitration process to price gouge patients and raise health care costs for everyone.

Quotes from AHIP and Coalitions

“At the end of last year, Congress passed legislation to protect patients from surprise bills from physicians, hospitals and air ambulance companies. And that's a positive step that protects patients. But it will still mean extensive use of arbitration, which we have already seen will raise health care costs for everyone. New York has experienced it. New Jersey has experienced it. Texas has experienced it. Arbitration undermines health insurance providers' ability to negotiate for lower prices for patients and consumers.”

– [Matt Eyles, AHIP, State of the Industry, January 2021](#)

Resources

[AHIP Amicus Brief in American Medical Assn. v. HHS: Protect Patients from Surprise Medical Bills](#)

[AHIP Amicus Brief in Assn of Air Medical Services v. HHS: Surprise Billing Rules Remedy Air Ambulance Market Dysfunction](#)

[AHIP Files Amicus Brief in Texas Medical Assn. v. HHS: Surprise Medical Billing Rules Should Stand](#)

[AHIP Response to the Interim Final Rule Concerning Requirements Related to Surprise Billing; Part I](#)

[AHIP President and CEO Matt Eyles' Opening Remarks at AHIP's 2021 Consumer Experience & Digital Health Forum Online](#)

[AHIP Comments on Interim Final Rule Regarding Requirements Related to Surprise Billing](#)

[AHIP Issues Statement on Congress' Surprise Medical Billing Agreement](#)

[New Study: California's Surprise Medical Bill Legislation Protects Patients Without Threatening Provider Networks](#)

[STOP Surprise Billing Ad](#)