BlueCross BlueShield Association

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SURPRISE BILLING

MYTHS VS. FACTS

Congress is considering two different ways to resolve payment disputes involving surprise bills. We've fact-checked the arguments:

MYTH	FACT
Setting a benchmark to pay surprise bills is like government rate-setting.	Benchmarks would use the negotiated, market rates between private insurers and clinicians, and do not rely on a government standard.
A benchmark would reduce payments below what doctors and hospitals need to stay in business.	Private health insurers already pay well above Medicare rates. For example, the national median reimbursement for anesthesiologists is currently 344 percent of Medicare. *Source: Journal of the American Medical Association
A payment benchmark would deter health plans from contracting with doctors and hospitals.	Creating a benchmark payment will not erode networks. Health plans develop different types of networks based on employer and consumer needs, and state laws also require adequate numbers of doctors and hospitals in networks.
Arbitration would not raise healthcare costs.	Arbitration requires an expensive new infrastructure and would continue to give physicians an incentive to remain out-of-network to chase higher reimbursements.
Arbitration will only be used to resolve a small number of cases.	In states that have implemented arbitration like New York and Texas, the number of arbitration cases has been increasing over time, sometimes with a growing backlog and wait times for resolution.