Ban Surprise Billing Act

Background
Surprise medical bills—which are large, unanticipated out-of-pocket expenses that insured patients incur through no fault of their own—have a devastating financial impact on patients and their access to health care.

According to a recent survey, 57 percent of consumers report they have received an unexpected medical bill that they thought would be covered by their insurance. A separate survey found that seven in 10 patients who have received unaffordable out-of-network medical bills were unaware that their provider was out-of-network at the time they received the services.

Congress must act to protect patients from devastating out-of-pocket costs—including the nearly 160 million Americans who have employer-sponsored health insurance. A federal solution is necessary, because even where states have enacted reforms to protect patients, these reforms cannot cover all individuals with employer-sponsored coverage.

About the Ban Surprise Billing Act
The bipartisan Ban Surprise Billing Act provides important consumer protections for Americans who receive health care coverage through their employer and for those enrolled in the individual market.

The bill:
• Holds patients harmless by limiting cost-sharing under the plan to the in-network rate and prohibiting out-of-network providers from sending balance bills that exceed the in-network rate.

• Requires that any costs for out-of-network care that would have otherwise resulted in a surprise bill be counted toward the in-network deductible or out-of-pocket maximum.

• Protects air ambulance patients and takes steps to address ground ambulance surprise bills.

• Establishes two mechanisms to resolve payment disputes between providers and payers:
  o For amounts less than or equal to $750 (or $25,000 for air ambulance services), relies on a market-based benchmark of the median in-network rate of providing similar items or services in the same geographic area.
  o For amounts above $750 ($25,000 for air ambulance services), providers and payers may elect to use independent dispute resolution (IDR) to determine a fair payment amount.

• Includes a number of bipartisan reforms to improve transparency in health coverage, including:
  o Requiring health plans to maintain up-to-date and accurate provider directories.
  o Improving consumer access to information regarding expected cost-sharing.
  o Improving transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.