Section-by-Section
COMMITTEE ON EDUCATION & LABOR
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The Hon. Robert C. "Bobby" Scott • Chairman

The Ban Surprise Billing Act (H.R. 5800)

Section 1. Short Title
This Act may be cited as the *Ban Surprise Billing Act*.

Section 2. Preventing Surprise Medical Bills
Protects participants, beneficiaries, and enrollees in group health plans or coverage in the group or individual market from surprise medical bills.

Limits cost-sharing to the in-network rate when a participant, beneficiary, or enrollee:

- Receives out-of-network emergency care, including air ambulance services, in which the individual had no opportunity to choose the facility or provider.
- Receives out-of-network care from certain ancillary providers chosen without the individual's knowledge, including pathologists, radiologists, anesthesiologists, and neonatologists.

Allows for the receipt of elective out-of-network care in non-emergency situations if notice that the care is out-of-network is provided at least 72 hours in advance and the individual signs a consent form prior to receiving the care.

Requires that out-of-network care received in a situation where a surprise bill would have arisen be counted towards the in-network deductible or out-of-pocket limit under the plan or coverage.

To resolve payment disputes between providers and health plans, establishes a market-based benchmark based on the median in-network rate for similar services in a geographic area.

Allows state laws to remain in effect for plans and coverage within the jurisdiction of states.

Section 3. Preventing Certain Cases of Balance Billing
Prohibits balance billing by out-of-network facilities and providers of emergency care, including air ambulances, as well as by out-of-network ancillary providers.

Requires out-of-network providers and facilities to provide notice to a participant, beneficiary, or enrollee of a group health plan of their network status and a good faith estimate of charges that may be applied for the out-of-network care.

Provides for enforcement of balance billing and other provider requirements by the states and the Secretary of Health and Human Services. Authorizes the Secretary of Labor to investigate and refer complaints of violations impacting individuals in group health plans or coverage.

Section 4. Independent Dispute Resolution
Requires the Secretaries of Health and Human Services, the Treasury, and Labor to jointly establish an Independent Dispute Resolution (IDR) process to determine payment amounts. The Secretaries shall jointly certify such IDR entities.

Permits providers and payers to elect to utilize the IDR process for any amounts for which the median in-network rate is over $750 ($25,000 for air ambulance services).

Authorizes certified IDR entities to consider several factors in determining payment amounts, including the level of training and experience of the provider and extenuating circumstances such as the complexity of the specific case.

Puts in place several commonsense guardrails to prevent the IDR process from leading to higher health care costs and premiums for consumers and from excessive utilization of the process.

Section 5. Advisory Committee on Ground Ambulance and Patient Billing
Requires the Secretaries of Health and Human Services, Labor, and the Treasury to establish an advisory committee to develop recommendations to protect consumers from ground ambulance balance bills.

Section 6. Improving Provider Directories
Requires group health plans and issuers offering coverage in the group or individual market to establishes business processes to verify and update provider directories and to respond to inquiries with respect to the network status of a provider within 1 business day of a request.

Limits cost-sharing to the in-network rate when consumers rely in good faith on out-of-date directories and information from the plan or coverage.

Section 7. Improving Transparency in Health Coverage
Requires brokers and consultants to disclose to plan sponsors and consumers enrolled in coverage in the individual market whether they have received any direct or indirect compensation received for referrals.

Requires the Secretary of Labor to develop a standardized form to allow group health plans and coverage to report information to state All-Payer Claims Databases.

Section 8. Access to Cost-Sharing Information
Requires providers, group health plans, and issuers offering coverage in the group or individual market to provide to a participant, beneficiary or enrollee a good faith estimate of cost-sharing owed for a health care service within 2 business days of a request.

Section 9. Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations
Requires group health plans and issuers offering coverage in the group or individual market to include on insurance identification cards the amount of the in-network and out-of-network deductibles and out-of-pocket limitations under the plan or coverage.