State Surprise Billing Laws and the No Surprises Act

This document is for consumer advocates and others to use when helping individuals with surprise medical bills. It helps to explain how state laws that protect consumers from surprise medical bills interact with the federal No Surprises Act.

The No Surprises Act created new consumer protections against surprise bills from out-of-network providers (also called non-participating providers) in certain circumstances. These protections generally apply to consumers covered under group health plans and group and individual health insurance coverage. This includes consumers with a plan or coverage through an employer, Federal Employees Health Benefits Program, the Health Insurance Marketplace®,[1] or an individual plan purchased directly from an insurance company.

The No Surprises Act applies to certain types of covered items or services, including:

- Most emergency services (including post-stabilization services);
- Non-emergency items and services furnished by out-of-network providers with respect to a patient visit to certain types of participating health care facilities; and
- Air ambulance services furnished by out-of-network providers of air ambulance services.

Some states have their own surprise billing laws that protect consumers against surprise medical bills. Consumer advocates should review the following resources to explore if a state's surprise billing law applies, either in part or in whole, to a consumer's complaint:

- State Insurance Agency websites
- The Commonwealth Fund's Map of State Balance Billing Protections
- Consumer Assistance Programs (in some states)

Keep in mind that some states are updating their state laws to align more closely with the No Surprises Act.

What's Important to Know:

- Some states have their own surprise billing laws.
- State surprise billing laws may cover different health care items and services than the No Surprises Act.
- Some state laws may have stronger consumer protections than the No Surprises Act.
- Some state laws have their own provider payment formulas or methods for determining patient cost-sharing amounts for the same out-of-network items and services that are also subject to the No Surprises Act. In these states, a patient's cost sharing for out-of-network services may be based on an amount calculated under state law.
- It is important to determine whether a state law may apply to a consumer complaint before disputing a bill under the No Surprises Act or reporting a No Surprises Act violation. The **No Surprises Help Desk** can help determine whether state law applies.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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When Do State Laws Apply?

The No Surprises Act supplements state surprise billing law protections; it does not replace them. For example, a consumer may receive a surprise bill in a state that has a surprise billing law. If that state law applies to the consumer's bill and provides at least the same level of consumer protection as the No Surprises Act, the state law will generally apply. However, if the state law does not apply to the consumer's bill or only applies in part, and the federal protections do, the consumer can pursue their rights under the federal protections where those protections apply.

In order for a consumer's complaint to be subject to state law, any such law must at least apply to:

- **The plan or issuer**: The state law must apply to the type of health coverage the patient has;*
- **The out-of-network provider or out-of-network emergency facility involved:** The provider or facility that treated the patient must be subject to the state law; and
- **The item or service involved:** The state law must cover the items and services the patient received.

**This analysis should include whether the consumer is enrolled in a self-insured group health plan that opted into state law. State surprise billing laws generally do not apply to self-insured group health plans sponsored by a private employer. However, the Employee Retirement Income Security Act (ERISA) does not prevent state laws from allowing self-insured, ERISA-covered plans to choose to voluntarily comply with them.*

When reviewing a complaint about a medical bill, consumer advocates will need to determine:

1. If a consumer received services in a state with its own surprise billing state law;
2. If the consumer's complaint (including the type of plan, type of provider or facility, and item or service involved) is covered under that state law; and,
3. If the state law is a "specified state law," meaning the state law has its own method to determine patient cost sharing and the out-of-network rate to be paid to a provider or facility.[2]

Determining the Consumer Cost-Sharing Amount

A state may have a "specified state law" or an All-Payer Model Agreement that applies with respect to the consumer cost-sharing amount for the types of emergency services and certain non-emergency services covered by the No Surprises Act.

As mentioned above, a "specified state law" is a state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage offered by a health insurance issuer to a non-participating provider or non-participating emergency facility. In cases where a specified state law applies, the out-of-network payment rate for items and services and the amount upon which patient cost sharing is based are calculated according to the method provided under the specified state law. Where an All-Payer Model Agreement applies, the out-of-network rate and patient cost sharing for the items and services provided are determined under the state approved agreement.

In circumstances where a specified state law or All-Payer Model Agreement does not apply to determine

[2] Regarding air ambulance services, given the applicability of the Airline Deregulation Act of 1978, the Departments are not aware of any state laws that would meet the criteria to set the out-of-network rate for nonparticipating providers of air ambulance services when providing services subject to the protections in the No Surprises Act. See https://www.federalregister.gov/d/2021-14379/p-132.

the cost-sharing amount, and in all circumstances related to the cost sharing for air ambulance services, cost sharing must be based on the lesser of:

- The amount billed by the provider or facility; or
- The Qualified Payment Amount (QPA) for the item or service, which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

Keep in mind that under the No Surprises Act, the consumer's cost-sharing requirement for out-of-network items or services cannot be greater than the requirement that would apply if the item or service was provided in-network. For example, a consumer's costs for the out-of-network service would be determined using in-network copay amounts or coinsurance percentages. This is true regardless of whether an All-Payer Model Agreement or state law applies to determine cost sharing. For more information on how to calculate cost sharing under these circumstances, see No Surprises Act: Overview of Key Consumer Protections.

Both Federal and State Law Could Apply to a Single Episode of Care

State surprise billing laws do not always cover the same health care items or services, health insurance issuers and health plans, and providers and facilities as the No Surprises Act. In some cases, both the federal No Surprises Act and a state law may apply, but to different items or services within a single episode of care. For example, a state surprise billing law may apply to labor and delivery services, but not to neonatologists. In this case, assuming the No Surprises Act otherwise applies, the No Surprises Act would determine the cost-sharing amount for the neonatology services, while state law would apply to the labor and delivery services.

State laws might differ from the federal No Surprises Act in terms of their definitions of emergency services. The No Surprises Act includes post-stabilization services within its definition of emergency services. Many state laws do not. In a state in which the law does not include post-stabilization services, the No Surprises Act emergency services protections apply to post-stabilization services.

You may also call the Help Desk at 1-800-985-3059 for assistance in determining whether state law applies and how to calculate a consumer's cost-sharing amount.

Examples

The following examples illustrate how state laws may or may not apply.

Example 1

A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by a non-participating provider in a participating health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided.

In Example 1, State A's law would prohibit balance billing and would apply to determine the cost-sharing amount and the out-of-network rate.

Example 2

Same facts as Example 1, except that the non-participating provider and participating health care facility are located and licensed in State B. State A's law does not apply to the provider, because the provider is licensed and located in State B.

In Example 2, State A's law would not apply to prohibit balance billing or to determine the cost-sharing amount or out-of-network rate. Instead, balance billing would be prohibited under the federal No Surprises Act, and the lesser of the billed amount or QPA would apply to determine the cost-sharing amount.

Example 3

A self-insured plan, subject to ERISA, covers a specific non-emergency service that is provided to a participant by a non-participating provider in a participating health care facility, both of which are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. State A's law applies to health insurance issuers and providers licensed in State A and provides that plans that are not otherwise subject to State A's law may opt in. State A's law also applies to the type of service provided. The self-insured plan has opted into State A's law.

In Example 3, State A's law would apply to prohibit balance billing and determine the cost-sharing amount and the out-of-network rate.

Example 4

An individual receives emergency services at a non-participating hospital located in State A. The emergency services furnished include post-stabilization services. The individual's coverage is through a health insurance issuer licensed in State A, and the coverage includes benefits with respect to services in an emergency department of a hospital. State A has a law that prohibits balance billing for emergency services provided to an individual at a nonparticipating hospital located in State A and provides a method for determining the cost-sharing amount and total amount payable in such cases. The State A law applies to issuers licensed in State A. However, State A's law has a definition of emergency services that does not include post-stabilization services.

In Example 4, State A's law would apply to prohibit balance billing and determine the cost-sharing amount and out-of-network rate for the emergency services, as defined under State A's law. State A's law would not apply for purposes of prohibiting balance billing and determining the cost-sharing amount and out-of-network rate for the post-stabilization services. Instead, balance billing would be prohibited under the federal No Surprises Act and the lesser of the QPA or billed amount would apply to determine the cost-sharing amount for the post-stabilization services.

Example 5

A community-rated Federal Employee Health Benefits plan covers a specific non-emergency service that is provided to a covered individual in State A by a nonparticipating provider in a participating health care facility. Both the provider and the facility are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by non-participating providers in a participating health care facility and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A and applies to the type of service provided. The Office of Personnel Management and the Federal Employee Health Benefits plan carrier, through the annual contract negotiation cycle, have elected to utilize State A's law, and the Federal Employee Health Benefits plan contains a term expressly incorporating the State A law prohibiting balance billing.

In Example 5, the Federal Employee Health Benefits plan contract terms apply the state law to prohibit balance billing and determine the cost-sharing amount and the out-of-network rate.

Example 6

Same facts as Example 5, except that the Federal Employee Health Benefits plan contract terms do not incorporate or expressly refer to the balance billing law of State A.

In Example 6, State A's law prohibiting balance billing would be preempted by the terms of the Federal Employee Health Benefits plan contract. Balance billing would be prohibited under the federal No Surprises Act and the lesser of the billed amount or QPA would apply to determine the cost-sharing amount. The out-of-network rate would be determined through open negotiation between the non-participating provider and the Federal Employee Health Benefits plans carrier, or in the case of failed negotiations, an amount determined under the federal Independent Dispute Resolution (IDR) process.