

# Protecting Consumers from Surprise Medical Billing

## POLICY SNAPSHOT

Protecting consumers from surprise medical billing—when patients are unknowingly charged the difference between what the provider bills and the insurer pays—has long been a priority for state lawmakers. Many states have enacted legislation protecting consumers from surprise health care bills over the last few years. Then, in late 2020, Congress enacted the [No Surprises Act](#). The act requires health plans to hold patients harmless from surprise medical bills from out-of-network providers. While federal law typically supersedes state law, Congress deferred to state surprise billing laws in certain circumstances. Consequentially, state policymakers may want to understand the latest federal guidance for implementing the law, how their state's laws differ from the new federal protections and potential policy opportunities to address gaps.

## Federal Action

### No Surprises Act Summary

The No Surprises Act prohibits providers and facilities from billing patients an amount above what they would typically pay for their [in-network cost-sharing](#)—an amount outlined in patients' insurance plans. These protections apply to health care delivered in emergency settings (including air ambulances but excluding ground ambulances) and in non-emergency settings when a patient receives care from an out-of-network provider (without advance notice).

The No Surprises Act also outlines processes for resolving payment disputes between an out-of-network provider or facility and the health plan.

Providers and plans will have a 30-day negotiation period to settle disputes. If they cannot reach an agreement, the parties can use a [binding arbitration process](#), also known as an independent dispute resolution (IDR), where one offer prevails. Processes will be administered by third party, unbiased entities with no affiliation to the providers or payers. The administrators must consider the market-based, median in-network rate, along with other relevant information provided by the parties. Following the IDR, the party who initiated the process may not request another arbitration process with the same party for the same item or service within 90 days of a decision.

### Latest Federal Guidance for Implementation

While the No Surprises Act includes broad protections relating to surprise billing, it leaves certain implementation details to relevant federal agencies. Agencies released the first of this implementation guidance in July 2021, with more to come ahead of 2022.

The U.S. Departments of Labor, Treasury and Health and Human Services jointly released an [interim final rule](#), effective January 2022, which outlines regulations for implementation and echoes key elements of the act. Specifically, the rule underscores various **consumer protections**, bans out-of-network **cost-sharing**, provides **notice and consent** requirements for waiving protections and issues rules for calculating **qualified payment amounts**—which is an [insurer's median in-network rate](#) for similar services in that geographic region.



## Key Aspects of the Rule

- **Consumer protections.** The interim rule restates key consumer protections from the act—prohibits plans (including group health plans, ACA marketplace plans, and federal employee health plans, as well as out-of-network health care providers, facilities and air ambulance services) from billing patients an amount beyond what they would typically pay for their in-network cost-sharing.
- **Cost-sharing.** The rule reiterates that an individual is limited to paying their in-network cost-sharing amount and clarifies that the patient’s cost-sharing amount will be based on either state law (if one applies) or the qualified payment amount.
- **Notice and consent.** The rule explains the circumstances in which providers may ask patients to consent to pay higher out-of-network charges.
- **Qualified payment amounts.** The rule builds on the No Surprises Act’s definition of qualified payment amount and clarifies how it will be calculated.

## How States Resolve Payment Disputes

State policymakers and industry experts alike agree consumers should not be held responsible for surprise bills from situations where patients are not given a choice, but opinions often diverge in the amount providers should be reimbursed. To resolve payment disputes between providers and health insurers, state surprise billing laws often use a payment standard, an IDR process or some hybrid of the two.



**Payment Standard:** States calculate what health insurers are required to reimburse out-of-network providers, which often account for a provider’s geographic area and case complexity. States frequently use a predetermined fee schedule (e.g., Medicare fee schedule), all-payer claims data or an insurer’s internal claims data to calculate the payment standard.



**Independent Dispute Resolution/Arbitration:** An independent third party, such as an arbitrator, reviews bid amounts submitted by a provider and insurer and determines the amount a health insurer is required to pay a health care provider. States often require providers and insurers to go through good-faith negotiation prior to invoking IDR.



**Hybrid Approach:** States use a payment standard to determine what insurers are required to pay an out-of-network provider. The provider or insurer has the opportunity to challenge a payment amount through IDR.

## State Policy Options

Although federal surprise billing protections now exist, states still have opportunities to step in and establish surprise billing protections and procedures. State legislators may consider the following policy options related to surprise billing and the implementation of the No Surprises Act:

- Consider the benefits and limitations of establishing a state-led payment standard or independent dispute resolution process.
- Identify gaps in protection or opportunities to exceed federal standards for surprise billing.

| POLICY OPTIONS  | STATE EXAMPLES  |
|---|---|
| <p><b>Identify State Opportunities and Challenges Related to the ‘No Surprises Act’ Implementation:</b> Prior to the new federal law, <b>33 states</b> had state laws providing some level of protection for consumers from surprise bills. Of these, the Georgetown Center for Health Insurance Reforms identified <b>18 states</b> with comprehensive consumer protections. These state laws extend protections to both emergency settings and in-network hospital settings; apply to all types of health insurance; hold consumers harmless from costs above their cost-sharing obligation and prohibit providers from balance billing; and establish a process for resolving payment disputes between providers and insurers.</p> <p>As previously mentioned, the No Surprises Act <b>defers to state surprise billing laws</b> in a few key areas. These include how a state determines payment (including patient cost-sharing and amounts paid by the health insurer) to out-of-network health care providers and requirements for insurers to update their <b>in-network provider directories</b>. However, issues surrounding self-funded health plans—which states are largely unable to regulate—may arise when determining how the new federal law interacts with state laws. Various policy experts also noted <b>certain gaps in federal protections</b>—including for ground ambulance services—where consumers still may be susceptible to surprise and balance billing, which may leave room for state action.</p> |   |
| <p><b>Consider the benefits and limitations of establishing a state-led payment standard or IDR process.</b> States may prefer to establish or maintain their own process for resolving payments disputes between providers and insurers for various reasons, such as <b>avoiding inflation</b> in reimbursements to providers and insurance premiums.</p> <p>However, these state-led protections only apply to certain health plans, including individual and small group plans and fully insured large group plans. Self-funded health plans are subject to requirements and protections laid out in the No Surprises Act. <b>Some researchers</b> note this may cause confusion and administrative complexities for states, since regulations and requirements will differ depending on the type of health plan involved in the surprise billing dispute.</p>   | <p>For the <b>18 states providing comprehensive protections</b> against surprise bills, <b>four</b> states rely solely on a payment standard, <b>five</b> use arbitration only and <b>nine</b> established a hybrid approach.</p> <p><b>Georgia</b> requires insurers to reimburse a provider either the most recent negotiated rate between the provider and insurer or the average median reimbursement rate paid to all in-network providers for that given service. Providers have 30 days after receiving payment to initiate “baseball-style” arbitration, where the provider and insurer each submit a reimbursement proposal and an arbitrator chooses one of the two proposed payments.</p> <p><b>New Mexico</b> uses claims data to calculate the reimbursement amount, requiring insurers to reimburse providers the 60th percentile of the allowed commercial reimbursement rate for the same service in the same geographic area.</p> <p><b>Texas</b> established a non-binding mediation process for settling payment disputes between insurers and out-of-network facilities and an arbitration process for disputes between insurers and out-of-network providers (not facilities).</p> |
| <p><b>Identify gaps in protection or opportunities to exceed federal standards for surprise billing.</b> Although the No Surprises Act required an advisory committee to further study surprise billing for ground ambulance services, the federal law currently does not establish protections for consumers who may receive a surprise or balance bill after receiving these services. Regulating ambulances often presents unique challenges to state policymakers, since many are owned and operated by local governments and municipalities.</p>   | <p><b>Colorado</b> requires health insurers to reimburse non-contracted private ground ambulances 325% of the Medicare rate for the same service in the same geographic area.</p> <p><b>Connecticut</b> requires ambulance providers to make good-faith efforts to bill a patient’s insurer before seeking payment from the patient. Ground ambulance providers are authorized to seek payment from the patient if the insurer declines to cover the ground ambulance services.</p> <p><b>Ohio</b> prohibits out-of-network ground ambulances from balance billing patients and established a payment standard where insurers must pay ground ambulance providers based on an insurer’s in-network reimbursement rates, out-of-network reimbursement rates or Medicare rates.</p>   |

## Additional Resources

- [Health Innovations State Law Database](#) (NCSL)
- [Surprise and Balance Billing State Policy Options](#) (NCSL, May 2021)
- [Protecting Patients from Surprise Medical Bills](#) (Georgetown Center for Health Insurance Reforms)
- [Guidance on Federal Surprise Billing Legislation Released](#) (NCSL, July 2021)

*Please note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.*

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