



## **The No Surprises Act and Preemption of State Balance Billing Protections**

The No Surprises Act adopts comprehensive consumer protections against surprise medical bills. These federal protections address potential surprise bills in most settings, including emergency and post-stabilization care as well as non-emergency care provided at in-network facilities and air (but not ground) ambulances. The legislation also applies to all types of comprehensive health insurance products, including fully insured individual and group plans as well as self-funded group health plans.

In general, federal law preempts state law. But, in enacting the No Surprises Act, Congress recognized that [many states](#) already passed (or will pass) state-level protections against surprise medical bills for fully insured plans. Congress thus deferred to some state laws and limited the degree to which the No Surprises Act preempts state laws. This fact sheet summarizes our current understanding of this preemption framework and highlights considerations for policymakers.

**Can states regulate self-funded group health plans or extend state surprise medical bill protections to these plans?** No. States generally cannot regulate self-funded group health plans or require these plans to comply with state surprise medical bill protections. The No Surprises Act does not disturb the long-standing preemption of state laws as they apply to group health plans under the Employee Retirement Income Security Act. Self-funded group health plans will be subject to the No Surprises Act, but not state surprise medical bill laws.

Preemption may extend to the handful of states that have established “opt-in” programs for self-funded group health plans. Under these laws, employers and other group health plan sponsors could opt-in to state surprise medical bill protections for their enrollees. States adopted these programs to extend some protections for consumers in self-funded plans given the gaps in federal law. But, with the No Surprises Act now in place, self-funded group health plans will likely be required to comply with federal law and cannot choose to instead be governed by state protections.

**Does the No Surprises Act preempt state laws for fully insured plans?** It depends. The No Surprises Act adopts the long-standing preemption framework that was first [adopted](#) under the Health Insurance Portability and Accountability Act and [continued](#) under the Affordable Care Act. This framework, in [Section 2724 of the Public Health Service Act](#), addresses the potential preemption of state laws that regulate insurers that offer fully insured individual and group plans.

State laws are preempted only when those laws impose a requirement that “prevents the application” of the No Surprises Act. As such, state laws can generally *exceed* standards in the No Surprises Act by adopting heightened standards that are more protective of consumers. But state laws cannot impose requirements that undermine or prevent the operation of the No Surprises Act. “State law” is defined broadly to include any state legislation, decisions, rules, regulations, or other state action that has the effect of a law.

Given this framework, state laws that differ from the No Surprises Act are *not necessarily* preempted by the new law and could continue to apply. Some states, for instance, do not allow patients to consent to waiving surprise medical bill protections; others include a broader scope of providers in state law compared to the No Surprises Act. These could be examples of state laws deemed more protective than the No Surprises Act and thus not preempted. Federal officials may provide additional guidance on their view of the scope of preemption in forthcoming federal rules.

**Does the No Surprises Act explicitly defer to state law on any issues?** Yes. The No Surprises Act defers to state laws in two key areas: 1) state methods for determining payment; and 2) provider

directories. This deference exists only for fully insured plans in the individual and group markets; it does not apply to self-funded group health plans that will be regulated under the No Surprises Act.

First, the No Surprises Act explicitly defers to a “specified state law” that establishes “a method for determining the total amount” that should be paid to an out-of-network provider by an insurer. This means that state laws that set a payment standard, require a dispute resolution process (such as arbitration), or use a hybrid of both are not displaced by the No Surprises Act. A state with such a law can continue applying its method of determining payment to resolve disputes between insurers and out-of-network providers. The state law also dictates the amount of cost-sharing that a patient owes for out-of-network services. The No Surprises Act states that patients will pay the same cost-sharing that they would have owed for in-network services based on the “recognized amount” of the cost of such services as determined by the specified state law.

Deference to state law only extends as far as state law applies, meaning that a state’s standard only extends to providers and facilities that are covered under existing state law. If providers or facilities are not covered under state law, disputes with those providers would be resolved under the No Surprises Act. Similarly, if certain services (e.g., non-emergency services) are not covered under state law, those disputes would be resolved under the federal process.

As an example, consider a state that meets the requirements for having a “specified state law.” That state law does not, however, include neonatologists in its definition of surgical and ancillary services. Because neonatologists are included under the No Surprises Act (but not state law), the federal rules for arbitration (rather than the state’s payment methodology or process) would apply to any disputes between fully insured plans and out-of-network neonatologists. The same is true if state law is silent on an issue and does not, for instance, explicitly include procedures for addressing post-stabilization services provided at an out-of-network facility. The No Surprises Act includes provisions that govern this issue, so the federal law and process would apply. To ensure that the state’s payment standard or process would apply in these circumstances, state law would have to be amended or clarified to extend to neonatologists and post-stabilization services.

Note that some states without comprehensive protections against surprise medical bills have adopted methods for resolving payment disputes for the services covered under those laws. Given the degree of variation in state law, federal officials may provide more guidance on the types of state statutes that qualify as a “specified state law.” It is not yet clear how robust a state’s method for determining payment needs to be to qualify for deferral under the No Surprises Act.

Second, the No Surprises Act requires health care providers and facilities to adopt processes so insurers and group health plans can maintain updated provider directories. Providers must submit a minimum level of data to help ensure that information is accurate. The No Surprises Act makes clear that nothing in this provision should be construed to preempt state laws related to health care provider directories that apply to insurers that offer fully insured individual and group plans.

**How will federal and state policymakers determine which state laws are preempted by the No Surprises Act?** Federal regulators are expected to provide guidance on their approach to the preemption of state surprise medical bill laws under the No Surprises Act. It is not yet clear what approach federal policymakers will take to assessing whether state requirements are preempted. But, in general, policymakers may undertake a provision-by-provision analysis of state law to see if state requirements exceed, or could undermine, application of the No Surprises Act. If state requirements exceed those included in the No Surprises Act (through, say, additional notice requirements), state law is likely not preempted. But if state requirements undermine application of the No Surprises Act (through, say, exemptions for certain providers), state law could be preempted.

Federal regulators adopted a similar approach when addressing state restrictions on navigators under the Affordable Care Act. In [regulations](#), federal officials reiterated that state law could not prevent the application of the Affordable Care Act and included a non-exhaustive list of the types of state laws that, in the Department of Health and Human Services’ view, met this standard.

It is not yet clear what preemption standard will be adopted by federal officials. Although federal guidance can help clarify the scope of preemption under the No Surprises Act, some preemption questions may result in legal challenges. In those instances, a federal court—not federal or state officials—will be the ultimate arbiter of whether a state law is preempted under the No Surprises Act.

**Can states regulate air ambulances under the No Surprises Act?** No. Although states can regulate medical care (such as the qualifications for medical personnel on board air ambulances), states are generally preempted under the Airline Deregulation Act from regulating air ambulance prices, routes, and services. This is true even though states have the authority to *enforce* the requirements of the No Surprises Act against air ambulances in their state. While states have authority to enforce federal law, this does not mean that states can enact their own laws to *broadly regulate* air ambulance prices, routes, or services. This perceived gap has already led to [calls for amendments](#) to the Airline Deregulation Act to ensure that states can protect consumers in this area.

**What factors should states consider in deciding whether to amend or adopt state surprise medical bill protections?** States can, but are not required to, act in response to the No Surprises Act, which makes clear that states can play a continued role in setting standards for fully insured plans. As noted above, Congress explicitly deferred to some state standards, including state payment standards and methodologies, suggesting that those state laws will not be preempted. On the one hand, conforming state law to the federal minimum standards included in the No Surprises Act avoids the potential for the preemption of state surprise medical bill protections and makes clear how all the protections will apply. On the other hand, in states that choose not to conform state law to the No Surprises Act, states could maintain many of their own protections (some of which are long-standing) so long as those protections do not prevent the application of the No Surprises Act.

Given the comprehensive nature of the No Surprises Act, some states are considering whether to maintain existing state protections or to adopt new protections. There are many state-specific issues to address in answering this question, but here are some questions for policymakers to consider:

- Does the state law meet the definition of a “specified state law” by clearly establishing a method for determining the total amount paid to a provider for out-of-network services?
- Given the size of the state’s fully insured market, does it make sense to have two separate reimbursement methodologies in the same state (one for fully insured plans under state law and one for self-funded group health plans under the No Surprises Act)?
- Has the state already developed a payment determination methodology or process that it believes is working well and has created certainty for fully insured plans? Would moving away from a state-specific payment standard in favor of the No Surprises Act standard introduce complexity and uncertainty in a way that increases costs?
- Is the state using a payment determination methodology that is not working well or tends to be inflationary? Would eliminating the state method in favor of the No Surprises Act standard create more consistency across payers and reduce costs?
- Are there gaps in the scope of state law that need to be filled to be as comprehensive as the No Surprises Act? Conversely, are there gaps in the scope of the No Surprises Act (e.g., ground ambulances, non-covered facilities) that state policymakers would like to fill? If the scope of state law differs from the No Surprises Act, a single claim from an out-of-network provider could include some services subject to *state* rules (e.g., pre-stabilization services) *and* some services subject to *federal* rules (e.g., post-stabilization services).
- Do states have sufficient legal authority to enforce the No Surprises Act (even if state policymakers defer to the federal standards in the No Surprises Act)? Is this authority clear for insurers, providers, and air ambulances?