Appendix 1. Comparison of Select State Surprise Billing Laws

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STATE	CALIFORNIA	NEW YORK	OHIO	VIRGINIA
Statutory authority	California Code, California Health and Safety Code § 1371.30[26]	N.Y. Comp. Codes R. & Regs. Tit. 23 § 400.5[27]	Ohio Revised Code §§ 3902.50–3902.54[28]	Code of Virginia, Title 38.2 Insurance, §§ 38.2-3445.01 through 38.2-3445.07[29]
Applicable insurers	State-regulated health plans, excluding Medicaid managed care plans.[30]	State-regulated health plans, including Medicaid managed care plans.	State-regulated health plans.	State-regulated health plans, state employee health plans, and self-funded plans that have voluntarily opted into this Virginia law.[31]
Patient protections	**Yes.** Restricts out-of-network providers from balance billing patients for services delivered at an in-network facility. Health plans are required to align cost-sharing requirements for the services listed above with the in-network rate, unless the patient provides written consent to billing.[32] Note: Due to a California Supreme Court case, providers may not balance bill for out-of-network emergency services.	**Yes.** Restricts providers from surprise billing patients for 1) out-of-network emergency services, 2) covered services delivered by an out-of-network provider at an in-network hospital or ambulatory surgery center, where an in-network provider is unavailable and without the patient's knowledge, 3) covered services delivered by an out-of-network provider based on a referral from an in-network provider without written consent from the patient, and 4) noncovered services delivered by a physician, hospital or ambulatory surgery center, where the patient was not provided timely notice or warning.[33] Health insurers are required to align cost-sharing requirements for the services listed above to the in-network rate.[34]	**Yes.** Restricts out-of-network providers from balance billing patients for 1) emergency services provided at an out-of-network facility, 2) emergency services provided by an out-of-network ambulance, and 3) unanticipated out-of-network care provided at an in-network facility. Health plans are required to align cost-sharing requirements for the services listed above to at least the in-network rate.[35]	**Yes.** Restricts out-of-network providers from balance billing patients for 1) emergency services and 2) nonemergency services provided to a patient at an in-network facility if such nonemergency services involve surgical or ancillary services provided by an out-of-network provider.[36] Health plans are required to align cost-sharing requirements for the services listed above to the in-network rate, based on the "median in-network contracted rate" for the same or similar services in the same or similar geographic area.[37]

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Out-of-network payment standard	**Yes.** Health insurers must pay out-of-network providers the greater of 1) the average contracted rate paid by the insurer for the same or similar services in the same geographic area or 2) 125% of the Medicare fee-for-service rate.[38]	**No.** *In certain cases, health insurers by default must pay out-of-network providers an undefined "reasonable" fee for emergency services, or for nonemergency services, the insurer shall pay the billed amount or "attempt to negotiate reimbursement."*[39] For hospital payments for emergency services, health insurers are required to pay at least 25% more than the payment rate based on the most recent contract between the plan and hospital.[40]	**Yes.** Health insurers by default must pay out-of-network providers the greater of 1) the median in-network rate for the services for that applicable geographic region, 2) the health insurer's out-of-network rate for the service, also known as the usual, customary and reasonable rate for such services, and 3) the Medicare rate.[41]	**Yes.** Health insurers must offer to pay out-of-network providers a "commercially reasonable amount" based on payments for the same or similar services provided in a similar geographic area, within 30 days of receiving a claim/bill from such provider.[42]
Payment arbitration process (for example, IDR)	**Yes.** IDR entities are required to consider any information submitted by the relevant parties as well as the factors below when making a payment decision:[43] • The provider's training and qualifications. • The nature of the services provided. • *The fees usually charged by the provider for the type of service.* • *The fees usually charged by similar providers for the service in the geographic area in which the services were rendered.* • In limited circumstances: negotiated rates for the same services as listed in a 3rd party all payer claims database.	**Yes.** The IDR entity shall select either the health plan's payment or provider's fee, and is required to make a decision within 30 business days and consider the following factors in determining what is a "reasonable fee":[44] • Whether there is a "gross disparity" between the provider's charges and the payments from out-of-network insurers and other insurer payments made to other "similarly qualified" out-of-network providers for the same services in the same region. • The provider's training. • Complexity of the particular case. • Median in-network rates for similarly qualified providers for the same or similar services. • *With regard to physician services, the usual and customary cost of the service (that is, the 80th percentile of all provider charges for the particular health care service performed by a provider in the same specialty and geographic area).*	**Yes.** IDR entities are required to render a decision within 30 days, determining which payment offer reflects a "fair reimbursement rate," after considering the evidence submitted by both parties, including the following factors:[45] • In-network rates paid by the health plan and other health plans. • Whether the health plan and the provider had a prior contractual relationship within the past six years. • Documentation submitted from previous arbitration cases (if applicable). Note: No party may submit "billed charges" or public payer rates as evidence for IDR consideration.	**Yes.** IDR entities are required to consider the following factors: • Evidence and methodology submitted by parties. • Patient characteristics and circumstances of the case. • Datasets provided by a benchmarking database selected by the Virginia commissioner (that is, Virginia's all-payer claims database).[46]

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Other guardrails and miscellaneous	Out-of-network providers who dispute the initial payment provided are first required to pursue the plan's internal appeals process prior to submission to IDR.[47]	If the IDR entity determines that a private settlement between the plan and provider is likely or that the plan's payment and provider's fee represent "unreasonable extremes," then the entity may direct both parties to attempt good faith negotiation for settlement. Note: Starting August 26, 2026, IDR entities adjudicating cases involving state employee health benefit plan shall choose between the provider's or plan's payment depending on which is closer to the 50th percentile of all in-network rates for the particular service among providers with the same or similar specialty and in the same geographical area, with certain exceptions.[48]	Prior to IDR arbitration, the parties must spend 30 days negotiating a reimbursement rate.	Virginia applies a good faith negotiation period of 30 days, after which either party may escalate the case as an IDR dispute. Virginia law forbids insurers or providers from initiating arbitration with "such frequency as to indicate a general business practice."[49] The law also established a total limit for eligible arbitration requests: no more than one arbitration request per provider group (or sole health care professional not part of provider group) during a seven-day period — defining such limit as an aggregate limit, regardless of geographic area, service/CPT code or insurer involved.[50]

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