No Surprises Act - Your Rights and Protections Against Surprise Medical Bills and Tri-State Memorial Hospital's Obligations to Eligible Patients

What are surprise medical bills?
Surprise medical bills are unexpected balance bills that can happen when an eligible patient is not able to control who is involved in their care and they receive care from a provider or facility that is not in-network/not contracted with their health plan - for instance when the eligible patient has an emergency or when they schedule a service at an in-network hospital/facility, but they are unexpectedly treated by an out-of-network provider. In these situations, the patient may have received a bill for the difference between what their health plan allowed as payment and the full amount of the out-of-network provider's/facility's billed charges, which is known as "balance billing."

What should be known about the new federal law?
Starting January 1, 2022, the federal No Surprises Act protects ***patients who have coverage under group and individual health plans (eligible patients)*** from getting surprise medical bills when:

1. receiving emergency services from non-network hospitals, providers, and/or air ambulance services.
2. receiving non-emergency services from out-of-network providers at in-network hospitals or ambulatory surgical centers.

The federal No Surprises Act also provides for an independent dispute resolution process for applicable payment disputes between plans and providers from which the eligible patient/member must be protected. The plans and providers must achieve all resolutions between each other without involving the eligible patient/member.

For uninsured and self-pay patients, there are new protections under which they can often get a good faith estimate for the cost of care before their visit. If they disagree with the bill, they may be able to dispute the final charges if they are more than $400 higher than the patient, pre-service requested good faith estimate and if the claim dispute is filed within 120 days of the date on the bill. If an uninsured or self-pay patient is interested in obtaining a good faith estimate for Tri-State Memorial Hospital Services, please contact _____ at _____.

Patients with Medicare, Medicaid, TRICARE, Indian Health Services, or the Veterans Health Administration already had the benefits of these protections and have not been at risk for surprise billing. Due to Washington State Laws under the Washington State Office of the Insurance Commissioner, regulated health plans have also already had these protections. The No Surprises Act supplements state surprise billing laws, it does not replace them. In general, if a state's surprise billing law provides at least as much protection as the federal law, the state law will generally apply. This is the case for the Washington State surprise billing law and it is why Tri-State Memorial Hospital supplies our patients with the Washington Office of Insurance Commissioner's, "Your Rights and Protections Against Surprise Medical Bills and Balance Billing." A copy of this publication is also available here at this website.

What are the group and individual health plans responsible to do?

1. At either their websites or upon request, these health plans are responsible to tell their members which providers, hospitals, and facilities are in their networks.
2. Cover emergency services without requiring prior authorization/advance approval.
3. Cover emergency services by out-of-network providers.
4. Base the member responsibility (cost-sharing) on what it pays to an in-network provider or hospital/facility and show that amount on the explanation of benefits. This also applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, surgeons, and assistant surgeons, hospitalists, or intensivist services.
5. Count the amount the member pays for emergency services or out-of-network services toward any deductible or out-of-pocket limit.

What is Tri-State Memorial Hospital responsible to do for eligible patients?

1. Bill the group or individual plans in-network cost-sharing amount (such as copayment or coinsurance) with no balance billing for emergency services, including services eligible patients may receive after they are in a stable condition unless the patient has given written consent and given up their protections to not be balance billed for post stabilization services.
2. Make best faith efforts to identify the group and individual health plans with which it holds in-network contracts. Please see below.
3. Provide a list of out-of-network providers from whom eligible patients may receive care during the course of their treatment, emergency or non-emergency, despite Tri-State Memorial Hospital's in-network status with the eligible patient's health plan. Please see below.

Please note that patients are never required to give up their protections from balance billing. Patients aren't required to get care out-of-network. Patients can choose a provider or facility in their network's plan.