NCHA
North Carolina Healthcare Association

2023 NCHA Legislative Brief

Surprise Billing & Assignment of Benefit

Legislative Priorities

North Carolina's hospitals and health systems support measures ensuring that providers are reimbursed for care provided to patients who have insurance coverage and patients are held harmless when they are seen by an out-of-network provider at an innetwork facility.

- **Protect patients from getting caught in the billing cycle by enforcing assignments of benefits, joining 32 other states.**
- **Protect patients from the unnecessary fear of medical bills when they visit an innetwork hospital but see an out-of-network provider by holding them harmless while also enabling a fair negotiation between the providers and insurance companies.**

Context & Insights

Surprise Billing

North Carolina is one of the few states fortunate enough to have laws protecting patients with health insurance from out-of-network or "surprise" billing. Introducing new legislation at the state level would do nothing to protect patients currently insured under ERISA plans from receiving a surprise bill after visiting an out-of-network provider. Congress passed the No Surprises Act in late 2020, accomplishing the overarching goal of protecting patients from receiving surprise medical bills, while leaving reimbursement negotiations open to all parties. Coupled with state law, patients are fully protected from surprise bills while physicians are not handicapped in negotiations. There is no need for further state legislation.

Assignment of Benefits

An Assignment of Benefits (AOB) is a simple document allowing someone other than the insured to receive money payable by an insurance policy. Many healthcare providers have patients sign an AOB document on their first visit, allowing them to bill health insurance companies directly for the cost of care. It makes the process of paying for medical needs faster and less painful for patients, except in North Carolina, where AOB agreements between patients and out-of-network providers are not honored. Instead, insurance companies can send reimbursement directly to the patient with little or no information about their responsibility to pay the provider. There is a strong case that, when assignments of benefits are honored, healthcare costs are lowered and physicians spend less time with administrative actions such as collecting payment.[1]

During times of crisis, such as the ongoing coronavirus pandemic (COVID-19), health systems must have a reliable source of income and patients should feel confident that their insurance carrier will cover their care. When a patient makes the informed choice to

assign their benefits to a provider, their decision should be honored. When an infectious disease is prevalent in a community, patients should not have to expose themselves to danger when the insurer could simply honor the assignment. Further, patients should not have to worry if they will receive surprise medical bills, but the providers should not be disadvantaged by a statutory setting of these out-of-network rates.

The solutions are simple: Require insurance companies to honor the patient's choice in assignment of benefits, ban sending surprise bills to patients, and ensure that providers and insurance companies have a fair negotiating space by not setting out-of-network rates for surprise bills.

Key Advocacy Messages

Not honoring AOB agreements between healthcare providers and patients is a brutal negotiating tactic used by insurance companies to force providers into networks with low reimbursement rates. It is an unfair practice that favors insurers over the people actually delivering care. Because of its continued use, patients are forced into increasingly narrow networks and healthcare costs continue to increase for everyone.

- Allowing health insurance companies to reject AOB agreements presents healthcare providers with the undesirable choice of either entering a network and accepting lower reimbursement rates or staying outside the network and chasing payments that the insurer sends to their patients.

AOB legislation would provide fairness to healthcare professionals and ensure they receive compensation for the services they provide.

- Medical group administrators and doctors note that collection problems involving patients who have received reimbursements are becoming an increasingly common occurrence.
- Narrow networks, a new scheme offered by insurers, bars multiple providers from being in a network. Those out-of-network do not have the option of joining. Health plans should honor assignments of benefits in situations where the insurer will not entertain negotiations to join.
- Regardless of the reasons why patients fail to pay providers after receiving a reimbursement check, the result is that some providers accumulate a significant amount of charges that must be written off as a loss and re-classified as an expense because it is unable to be collected (i.e., bad debt).

Mandatory AOB legislation would eliminate many administrative problems associated with billing and collections, allow healthcare providers to challenge lower reimbursements, and reduce the number of providers who require full payment up front.

- When a patient is paid directly by the insurer, there is no onus on the patient to challenge the reimbursement amount. A healthcare provider is in the best position to investigate and appeal reimbursements when a dispute exists about the amount a health plan should cover, but those providers are currently not given the opportunity to do so.

North Carolina's hospitals and health systems are working with Congress to address this issue at the federal level since North Carolina laws already protect patients. Any new state law would only benefit insurers' profits.

- The current patient protection law (N.C.Gen.Stat. § 58-3-200) has protected patients in North Carolina for two decades. When there are complaints by our state's patients, they usually stem from ERISA and self-funded health plans that are not subject to North Carolina's patient protection law and would also not be subject to any new regulations created by state law.

Insurance companies are asking for statutory language to set the out-of-network price, instead of negotiating directly with providers.

- Setting any rate in statute, either directly or

by reference, would be an unprecedented government takeover of the already limited private healthcare market. It would eliminate physician freedom to contract by forcing independent providers and labs to accept rates that are non-negotiable.

Sources

1. The Case for State Mandatory Assignment of Benefits, chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fmckinneylaw.iu.edu%2Fihlr%2Fpdf%2Fvol8p171.pdf&clen=4233750&chunk=true

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