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SEEKING A SECOND OPINION: A CALL FOR CONGRESSIONAL EVALUATION OF ANTI-ASSIGNMENT PROVISIONS IN EMPLOYEE HEALTH PLANS

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In the health insurance context, anti-assignment provisions are contractual clauses that restrict an insured individual's ability to assign rights due under a health plan to another party, such as a medical provider. As these provisions have become increasingly prevalent in employer-sponsored health plan agreements, they have effectively stripped medical providers of enforcement and litigation rights previously utilized under the Employee Retirement Income Security Act of 1974 (ERISA)—the relevant federal regulation governing employee benefit plans, including health insurance plans.

This Note examines these effects in light of ERISA's intended protections of employees participating in employer-sponsored benefit plans and considers whether congressional intervention is warranted to address the respective impacts as a result. This Note contends that while persuasive arguments exist both in support of a need for reform and for sufficiency of the status quo, arguments around these dueling views tend to draw on merely anecdotal evidence and theoretical economic contestations. Accordingly, this Note argues that Congress should develop empirical evidence to determine whether intervention is needed and proposes plausible long-term amendments to ERISA, should they be warranted, along with interim solutions to help address problematic impacts while such study is conducted.

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INTRODUCTION

> The importance of gaining health insurance coverage for a household's financial security and stability is undisputed. But the lesson here is that gaining coverage is not the end of the battle . . . .
>
> —Erin C. Fuse Brown[1]

A modern part of this battle is the increasingly common trend of health insurance companies adding provisions into consumer contracts that restrict patients' ability to effectively assign rights and duties due under their health insurance plans to other parties.[2]

These clauses, known as anti-assignment provisions, often specifically intend to inhibit the transfer of such rights to health care providers, such as doctors and hospitals, leading to the providers facing steep obstacles when seeking adequate reimbursement from the insurance companies for services rendered.[3] This practice has hampered both the providers' ability to enforce the terms of a patient's employer-sponsored health insurance plan against insurers and their ability to bring suit against insurers for nonpayment or insufficient payment.[4]

Dr. Ross Cooperman's experience with patient LPH[5] illustrates the implications outlined above. In 2018, LPH required a two-stage, postmastectomy breast reconstruction following her treatment for breast cancer.[6] Because LPH's health insurance plan had no doctor to perform the procedure in-network, LPH sought care from Dr. Cooperman, an out-of-network[7] provider.[8] Despite Dr. Cooperman's reaching a compensation agreement with the insurance company before performing the surgeries, the insurance company paid Dr. Cooperman only $5485.66 of the $431,592 billed.[9]

With it being unlikely that Dr. Cooperman would recover the sizable outstanding balance directly from LPH, his most realistic option for recovering the remainder of the expected fee was suing the insurance

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1. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 200 (2017).

2. *See infra* Part I.C. *See generally* David M. Hyman et al., *Hey, What About Me?: Non-participating Healthcare Providers' Ability to Sue Health Insurance Companies Regarding Payment of Claims*, N.J. LAW., Feb. 2007, at 37.

3. *See* Hyman et al., *supra* note 2, at 38.

4. Tania E. Yusaf, *The Out-of-Network Reimbursement System Is out of Control: An Analysis of Payment by Managed Care Organizations to Out-of-Network Providers*, 14 QUINNIPIAC HEALTH L.J. 85, 91–92 (2010); *see infra* Parts I.C, II.A.2.

5. Patients' names in health-related lawsuits are often anonymized for privacy purposes.

6. Cooperman, M.D., LLC *ex rel.* Patient LPH v. Horizon Blue Cross Blue Shield of N.J., No. 19-CV-19225, 2020 WL 5422801, at *1 (D.N.J. Sept. 10, 2020), *motion for reconsideration denied*, No. 19-CV-19225, 2020 WL 7264144 (D.N.J. Dec. 10, 2020), *appeal dismissed sub nom.*, Ross Cooperman MD LLC v. Horizon Blue Cross Blue Shield, No. 20-2899, 2020 WL 8921018 (3d Cir. 2020).

7. See *infra* Part I.B for a discussion of in-network versus out-of-network providers.

8. *Cooperman*, 2020 WL 5422801, at *1.

9. *Id.* at *2.

company.[10] Dr. Cooperman, like many providers in his position, however, ran into a major roadblock in that effort: the anti-assignment provision in LPH's insurance agreement.[11] The provision barred LPH from assigning the right of recovery to Dr. Cooperman, essentially stripping Dr. Cooperman of the ability to bring a claim on LPH's behalf[12] under the relevant federal cause of action.[13] Accordingly, the court dismissed Dr. Cooperman's claim, leaving him with no way of collecting the outstanding balance from the insurance company.[14]

This Note examines whether the impact of anti-assignment provisions warrants remedial action by Congress and/or the executive branch.[15] More specifically, it seeks to determine whether the effect of anti-assignment provisions undermines the intended federal law protections of employee welfare benefit plans, which include employer-sponsored employee health insurance plans like LPH's.

Part I examines key background concepts, including the relevant federal legislation, the modern healthcare[16] and health insurance landscape, and the importance of contractual assignment of healthcare benefits generally. Part II identifies the impact of valid and enforceable anti-assignment provisions in healthcare contracts and outlines arguments as to whether or not federal intervention is warranted. Finally, Part III argues that Congress should undertake a comprehensive, empirical examination of anti-assignment provision before potentially moving forward on an amendment to existing federal law. Part III also discusses interim solutions that could be utilized during the assessment period to mitigate the existing effects of anti-assignment provisions.

I. THE U.S. HEALTH INSURANCE LANDSCAPE

While a visit to your local physician may seem like a fairly simple endeavor, the relevant laws and insurance processes at work behind the scenes are anything but straightforward. Part I of this Note presents background on federal law governing employer-sponsored health insurance plans and the role that contractual relationships play in the delivery of medical services. Part I.A outlines the contours of the Employment

10. *See id.*

11. *See id.* at *3–4.

12. *See infra* Part I.C (explaining the relevance of assignment in the health insurance context).

13. *See Cooperman*, 2020 WL 5422801, at *3–4; *infra* Part II.A.2.

14. *See Cooperman*, 2020 WL 5422801, at *4.

15. This Note examines these branches specifically, as federal courts have already taken a position on the anti-assignment provisions issue, as detailed in Parts II.A.1 and III.A below.

16. This Note proceeds by using "healthcare" to refer to the general system or industry that encompasses the delivery of medical-related services to patients or customers and "health care" to refer specifically to medical providers' delivery of medical-related services to a patient or customer. *See Healthcare vs. Health Care*, ARCADIA: THE FINAL WORD (June 30, 2014), https://arcadia.io/final-word-healthcare-vs-health-care [https://perma.cc/3KT2-ZWBT].

Retirement Income Security Act of 1974[17] (ERISA), a federal statute governing employee benefit plans, and its relevance to health insurance. Part I.B discusses how health insurance operates, with a focus on the importance of networks of providers. Part I.C examines the contractual nature of health insurance plans, specifically the right to assign benefits due under a plan and the increasingly popular effort by insurers to inhibit such assignments.

A. A Primer on ERISA

Congress enacted ERISA in response to the growth of employee benefit plans in both scope and number.[18] The term "employee benefit plans" refers to two distinct types of programs typically offered by employers: pension benefit plans and welfare benefit plans.[19]

A pension benefit plan is an employer-sponsored plan that provides retirement income to employees.[20] A welfare benefit plan—the type that includes health plans and is therefore critical to this Note—is defined as: "any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits."[21] ERISA serves as the primary federal legislation regulating the administration of health insurance plans offered by companies to their employees and disputes related to those plans.[22] It does so by establishing uniform standards governing the creation, administration, and management of such plans.[23]

Though ERISA covers both pension and welfare plans,[24] a review of ERISA's legislative history suggests that Congress was far more concerned about pension plans during enactment.[25] ERISA's legislative history shows that comprehensive findings from an investigation of consumer abuses in the

17. 29 U.S.C. §§ 1001–1461.

18. *See* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, §§ 1–2, 88 Stat. 829, 829–33 (codified as amended at 29 U.S.C. § 1001, § 1001 note) (discussing relevant background and purpose).

19. *See* 29 U.S.C. §§ 1002(1), 1002(2)(A).

20. *See id.* § 1002(2)(A).

21. *Id.* § 1002(1); *see* Radha A. Pathak, *Statutory Standing and the Tyranny of Labels*, 62 OKLA. L. REV. 89, 107 (2009) ("An 'employee welfare benefit plan' is basically any organized provision of health or disability insurance by an employer." (footnote omitted) (quoting 29 U.S.C. § 1002(1))).

22. *See* Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 449 (3d Cir. 2018); Fuse Brown, *supra* note 1, at 183; Hyman et al., *supra* note 2, at 38–39. ERISA does not cover *all* types of group health plans. For instance, it does not cover plans established or maintained by governmental entities or those that are church based. PETER R. KONGSTVEDT, HEALTH INSURANCE AND MANAGED CARE: WHAT THEY ARE AND HOW THEY WORK 241 (5th ed. 2020).

23. Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 225 (3d Cir. 2020) ("To achieve this goal, ERISA . . . [established] 'various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans.'" (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983))).

24. *See supra* text accompanying note 19.

25. *See infra* notes 26–27 and accompanying text.

private pension industry were the foundation of the legislation.[26] "Given ERISA's broad preemption of state laws related to *all* employee benefit plans, ERISA's legislative history is remarkable . . . for what it does not contain. [It] provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans."[27]

To address the notable impact that participation in benefit plans had on interstate commerce and employees and their families,[28] Congress sought to create "a [federal] uniform regulatory regime"[29] that would "protect interstate commerce" and "promote the interests of employees and their beneficiaries" with respect to their participation in employee benefit plans.[30]

ERISA contains a "'carefully integrated' civil enforcement scheme"[31] to promote compliance with the respective rules and regulations and to provide an avenue of relief in federal court for plan participants and beneficiaries.[32] A remedial provision, section 502(a),[33] in relevant part, creates a federal private cause of action for plan participants[34] and beneficiaries[35] (collectively, "insureds") to enforce the terms of employee welfare plans and/or to recover benefits due under such plans.[36] As noted by Justice Thomas, section 502(a) "is a distinctive feature of ERISA, and [is] essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans."[37]

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26. *See* Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 972 (2000); *see also* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 415 (2020) ("Congress enacted ERISA in 1974 to regulate pensions (hence the 'Retirement Income Security' in its title), but the statute's broad preemption language has wrought unintended consequences, blocking numerous state health reform laws over the past forty years as impermissibly 'relat[ing] to' employer-sponsored health insurance." (alteration in original) (footnote omitted)).

27. Bogan, *supra* note 26, at 972 (emphasis added).

28. *See* 29 U.S.C. § 1001(a). Congress was concerned with protecting against the increasing prevalence of instances where employers and unions sought to use private pension plan assets for purposes other than benefitting retired workers and their surviving dependents. PATRICK PURCELL & JENNIFER STAMAN, CONG. RSCH. SERV., RL34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 2 (2009). One such instance, where an automobile company left thousands of workers and retirees without previously promised pensions, prompted Congress to begin considering legislation around pension plans. *Id.*

29. Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004).

30. 29 U.S.C. § 1001; Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983).

31. Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987)).

32. *See* PURCELL & STAMAN, *supra* note 28, at 32; *see also Aetna Health Inc.*, 542 U.S. at 210 ("If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits.").

33. ERISA section 502(a) is codified at 29 U.S.C. § 1132(a).

34. A participant is an employee (or former employee) who is eligible (or may become eligible) to receive benefits from an employee benefit plan. *Id.* § 1002(2)(7).

35. A beneficiary is a person designated by a participant or by an employee benefit plan's terms, who is entitled (or may become entitled) to benefits under such a plan. *Id.* § 1002(2)(8).

36. *See id.* § 1132(a)(1)(B); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

37. *Aetna Health Inc.*, 542 U.S. at 208.

To ensure that the desired uniformity in employee benefit plan regulation came to fruition,[38] Congress opted to include broad, express preemption provisions in the statutory text of ERISA.[39] Under the doctrine of preemption, federal laws supersede conflicting state laws.[40] This concept is premised on the Supremacy Clause, which invalidates state laws that "interfere with, or are contrary to the laws of Congress."[41] Representative John Dent, a sponsor of the initial ERISA legislation, emphasized the importance of the intended preemption, asserting his wish "to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans."[42]

Two distinct sections of the statute establish express preemption: sections 502(a) and 514(a).[43] Section 502(a) preempts state law claims that fall within the scope of ERISA's remedial provision.[44] In other words, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy"[45] is preempted because it would "conflict[] with the clear congressional intent to make the ERISA remedy exclusive."[46] As a result, private litigants pursuing a lawsuit against an insurer, an employer, or another sponsor of an employee welfare benefit plan often are left with a single available course of action: a federal lawsuit under section 502 of ERISA.[47]

Section 514(a) displaces an even broader category of state law by establishing that ERISA "supersede[s] any and all State laws . . . [that] relate to any employee benefit plan."[48] A state law relates to an employee benefit plan when it either: (1) has a "connection with" or (2) contains a "reference to" such a plan.[49] Section 514 "has been construed extremely broadly to displace a swath of state laws, including many state laws that regulate provision of or payment for health care, because of their impermissible

38. *See supra* text accompanying notes 29–30.

39. *See Aetna Health Inc.*, 542 U.S. at 208.

40. *See* U.S. CONST. art. IV, cl. 2; *infra* text accompanying note 41. *See generally* JAY B. SYKES & NICOLE VANATKO, CONG. RSCH. SERV., R45825, FEDERAL PREEMPTION: A LEGAL PRIMER (2019). Preemption can generally occur in two distinct ways: expressly and impliedly. *Id.* at 2. Express preemption occurs when a federal statute or regulation contains language explicitly stating the intent of preemption. *Id.* Contrarily, implied preemption occurs when a statute's or regulation's purpose and/or structure implicitly reflects a preemptive intent. *Id.*

41. Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 211 (1824).

42. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 99 (1983) (quoting 120 CONG. REC. 29,197 (1974)).

43. *See* PURCELL & STAMAN, *supra* note 28, at 39. ERISA § 514(a) is codified at 29 U.S.C. § 1144(a).

44. *See* Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987) (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54–55 (1987)); *see also* PURCELL & STAMAN, *supra* note 28, at 42.

45. Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004).

46. *Id.*

47. *See supra* text accompanying notes 44–46.

48. 29 U.S.C. § 1144(a); *see* Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016); PURCELL & STAMAN, *supra* note 28, at 39–42.

49. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983).

connection to employee health plans."[50] Though states generally play the "role as primary regulators of insurance,"[51] ERISA's preemption provisions tend to supersede state efforts to legislate on employee benefit plans, including health plans.[52]

B. The Modern Healthcare System and the Importance of Networks

To fully grasp the implications presented by anti-assignment provisions, it is critical to first understand the inner workings of our modern system of health insurance. At its most basic level, the concept of health insurance is a simple one: individuals purchase it as a mechanism to avoid the "financial risks of health care consumption, which tend[] to be both unpredictable and extremely expensive."[53]

A look beyond this elementary view, however, leads to a bevy of confusion, littered with ambiguous acronyms, complex jargon, and an inevitable litany of questions about how the health insurance system truly functions.[54] This section seeks to provide a baseline of knowledge to clarify those uncertainties. Part I.B.1 outlines the evolution of healthcare and health insurance to its current form, generally referred to as "managed care." Part I.B.2 explains the importance of out-of-network providers and the implications of receiving care from them.

1. An Explanation of Managed Care

Before the inception of today's healthcare approach, medical care and health insurance operated on a "fee-for-service" basis.[55] A fee-for-service model is relatively straightforward: physicians render care to patients based on their best judgment and bill either the patient or the patient's insurance company, if applicable, under the provider's standard rates for those services.[56] An individual generally could seek and receive care from any licensed medical physician, even a specialist, without a referral.[57]

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50. Fuse Brown, *supra* note 1, at 184; *see infra* text accompanying notes 243–45.

51. *See* Fuse Brown, *supra* note 1, at 144. Under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015, states retain powers pertaining to regulation and taxation of insurance companies. Yusaf, *supra* note 4, at 100. However, ERISA supersedes such legislation when the respective state law seeks to regulate employee benefit plans as they pertain to participants, as opposed to providers. Fuse Brown, *supra* note 1, at 184–85; *see also supra* text accompanying notes 48–49.

52. *See* Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829–30 (1988).

53. Fuse Brown, *supra* note 1, at 136; *see also* Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75, 81 (1993) ("Health insurance plans exist mainly because of the consumer's desire to share the financial risk arising from expenses associated with treating (or preventing) an illness or injury.").

54. *See* KONGSTVEDT, *supra* note 22, at 30. *See generally* Weiner & de Lissovoy, *supra* note 53.

55. *See* JASON S. LEE, CONG. RSCH. SERV., 97-913EPW, MANAGED HEALTH CARE: A PRIMER 2–3 (1997).

56. *See* Yusaf, *supra* note 4, at 98.

57. *See* Weiner & de Lissovoy, *supra* note 53, at 76.

Under this approach, insurers and providers did not have any sort of contractual agreements stipulating, for example, specific fees—instead "[f]or the most part, insurers let providers determine the rates and terms of reimbursement."[58] Under the fee-for-service model, the delivery of health-related services and the payment for such services operated in an entirely separate manner.[59] However, towards the latter part of the twentieth century, the healthcare industry, driven by evolution of its insurance counterpart, started to see significant change—delivery of care and payment for it began to merge.[60]

Over the course of the 1960s and 1970s, costs and spending associated with the provision of health care became an increasingly prevalent topic of discussion in both American society and U.S. politics.[61] From the perspective of those supporting change, the fee-for-service model had incentivized "healthcare providers to provide patients with 'more care, not less,' [which] gave rise to concerns about mounting healthcare costs that outstripped the value of care provided."[62] In other words, those calling for change felt that providers were incentivized to provide extra, costly services with little oversight to counterbalance those incentives.[63] The increased prevalence of this position changed U.S. health insurance, leading to the promulgation of what we know today as managed care.[64]

The term "managed care" is essentially a catchall for various models of health insurance, epitomized by Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) that have a common goal of "aim[ing] to reduce healthcare costs without sacrificing quality of care by creating networks of doctors."[65]

Over the course of the 1970s and 1980s, managed care, especially in the form of HMOs, became increasingly popular, largely replacing the traditional fee-for-service model.[66] These managed care plans attracted

58. *See id.* at 77.

59. *See* LEE, *supra* note 55, at 2.

60. *See id.*

61. *See* KONGSTVEDT, *supra* note 22, at 6–7; *cf.* LEE, *supra* note 55, at 4 ("The Health Maintenance Organization Act of 1973 . . . encouraged the development of HMOs by providing federal funds . . . to help qualified HMOs through their start-up period.").

62. Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 227 (3d Cir. 2020) (quoting Pegram v. Herdrich, 530 U.S. 211, 218 (2000)); *see also* LEE, *supra* note 55, at 4 ("Traditional fee-for-service payment arrangements—which dominated public and private health care delivery systems—were seen by many as an important root cause of runaway health care costs.").

63. *See* LEE, *supra* note 55, at 2 ("Traditionally, [a provider] was exposed to few, if any, incentives for efficiency or cost control.").

64. KONGSTVEDT, *supra* note 22, at 7.

65. *Plastic Surgery Ctr.*, 967 F.3d at 227; *see also* Carol K. Lucas & Michelle A. Williams, *The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments*, 3 J. HEALTH & LIFE SCI. L. 132, 135 (2009) ("[M]anaged care refers to a prepaid system in which patients (enrollees) trade free provider choice and the ability to self-refer to self-selected medical providers in exchange for reduced out-of-pocket costs and certainty regarding financial liability.").

66. *See* KONGSTVEDT, *supra* note 22, at 8.

consumers with low premiums[67] and reduced cost sharing[68] in addition to more extensive benefits—for example, prescription drug coverage—than traditional insurance plans offered.[69]

The growth of HMOs skyrocketed over the last two decades of the twentieth century and by 1999, sixty-three million individuals were enrolled in a commercial HMO, as compared to just fifteen million in 1984.[70] However, the HMO model was not the only form of managed care to arrive on the scene during that period. In the late 1970s, PPOs came to the forefront of the healthcare landscape[71] and in 2016, nearly half of the employed population had a PPO insurance plan, making it the most popular type of managed care at that time.[72] As a result, whereas traditional models of health insurance accounted for 75 percent of the market in the mid-1980s, by the mid-1990s, they held less than 33 percent of the market share and by 2000, that share was in the single digits.[73]

Provider networks—groupings of medical professionals and facilities that enter into contractual arrangements with insurance companies[74]—are the "backbone" of these various types of managed care plans.[75] One critical element of these agreements between providers and insurers is the inclusion of specified fee arrangements where, before service is rendered, the provider and insurer have agreed on the amount the insurer will pay for each service a provider renders to a patient.[76] This approach facilitates insurer-imposed cost restrictions on medical care and protects insurance companies from surprise billing.[77] This puts insurance companies in the driver's seat, whereas the historical fee-for-service model was consumer-centric, allowing the patient and provider to agree on services.[78]

An individual enrolled in a managed care plan must generally use a medical provider or facility that participates in the individual's network to take advantage of lower cost sharing offered by the plan[79]—in other words, to obtain discounted rates for services received.[80] Accordingly, the insured

67. A premium is the amount of money that an insured individual pays to the insurance company to participate in one of the insurer's health insurance plans. *See id.* at 293.

68. Cost sharing refers to the amount a member must pay out of pocket for each type of covered benefit. *Id.* at 33. Types of cost sharing include: (1) copayments, meaning a fixed dollar amount for a type of service paid to a provider; (2) coinsurance, meaning a percentage of the total cost of a medical service that is covered by the insurance plan; and (3) deductibles, meaning an amount of money that an insured individual must pay before the insurance plan begins to contribute. *Id.* at 33–34.

69. *Id.* at 8.

70. *Id.* at 10.

71. *Id.* at 9.

72. *See id.* at 24.

73. *Id.* at 10.

74. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 227 (3d Cir. 2020).

75. KONGSTVEDT, *supra* note 22, at 53.

76. *See id.* at 45, 54.

77. Yusaf, *supra* note 4, at 88.

78. *See supra* text accompanying notes 56–58.

79. *See supra* note 68 and accompanying text.

80. Weiner & de Lissovoy, *supra* note 53, at 84.

must use the facilities, physicians, and/or other medical providers—i.e., the network—that have contracted with the insurance company to receive the savings anticipated by enrolling in the plan in the first place.[81] Contrarily, such savings are generally unavailable, only partly available, or only available in select situations, should the insured individual seek services from a provider who has not contracted with the insurance company, commonly referred to as an out-of-network provider.[82]

From the providers' perspective, there are a number of advantages associated with becoming an in-network option for patients.[83] First, in-network providers have a greater likelihood of receiving repeat patients because insureds enrolled in a given plan will seek out care, at least most of the time, from in-network providers.[84] Another advantage is that by entering into a contract with the insurer, the provider is able to efficiently collect payment for services because payment will come directly from the insurer, rather than the patient.[85] Additionally, rights related to payment and disputed claims are typically defined within the insurer-provider agreement, which provides a layer of protection and transparency before services are rendered.[86]

2. The Impact of Receiving Out-of-Network Care

While insureds enrolled in managed care plans have a network of providers to choose from when seeking health care services,[87] certain circumstances necessitate out-of-network care.[88] This can have significant financial ramifications depending on the specific terms of the insured's plan and the type of care received.[89]

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81. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 228 (3d Cir. 2020) ("[Managed care organizations], in essence, restrict an individual's choice of healthcare providers in exchange for access to and cost effectiveness of the healthcare they provide."). Further, an insured individual may be responsible for any charges by an out-of-network provider above and beyond the insurer's allowed charges, whereas this is not the case for in-network care. *See* KONGSTVEDT, *supra* note 22, at 45–46.

82. *See* KONGSTVEDT, *supra* note 22, at 9; *infra* Part I.B.2.

83. *See infra* text accompanying notes 84–86.

84. *See* Yusaf, *supra* note 4, at 88, 118; *supra* text accompanying notes 79–81.

85. *See* KONGSTVEDT, *supra* note 22, at 55 tbl.3.1; *see also infra* text accompanying notes 149–50.

86. *See* KONGSTVEDT, *supra* note 22, at 55 tbl.3.1; Yusaf, *supra* note 4, at 90 ("There are few payment conflicts between [managed care organizations] and network providers because both parties are subject to contracts that specify the methods used for reimbursement."); *see also* Lucas & Williams, *supra* note 65, at 137 ("Within the contracted in-network universe, although disputes arise, the contracts themselves will usually determine the rights and obligations of the parties."). However, in an out-of-network provision of services context, no contract exists and "this orderly system collapses." *Id.* at 137.

87. See *infra* Part I.B.1 for an explanation of provider networks.

88. *See infra* text accompanying notes 90, 94, 96.

89. *See supra* notes 81–82 and accompanying text; *infra* text accompanying notes 105–07; Part I.B.2.

One such circumstance is the need for specialized care, such as a procedure that no in-network provider is qualified or available to perform.[90] For example, in *Plastic Surgery Center, P.A. v. Aetna Life Insurance Co.*,[91] a plaintiff required facial reanimation surgery, "a niche procedure performed by only a handful of surgeons in the United States"[92]—none of whom were in-network providers.[93]

On the other hand, an individual may receive out-of-network care unintentionally, incurring unanticipated costs in the process.[94] For instance, while a planned surgery may be performed by an in-network orthopedist at an in-network hospital or surgical center, an anesthesiologist who does not participate in the same managed care plan, and would bill for services as an out-of-network provider, may be called on to assist in the operation.[95]

Lastly, patients may receive out-of-network care in emergency situations.[96] In such scenarios, the out-of-network service provider could be the hospital that a patient is rushed to, a physician at that hospital, or even the ambulance called to handle the emergency transport.[97]

The possibility of accidental or involuntary out-of-network care discussed above becomes increasingly problematic as insurers have continually narrowed networks of providers to keep premiums down.[98] Networks with fewer providers inherently create a greater likelihood that an insured will receive care at an out-of-network facility in an emergency or from an out-of-network provider inadvertently.[99]

While health plans cannot technically restrict an individual from receiving medical care from an out-of-network provider,[100] insurers can, and do, decide what services will and will not be covered and, for those that are covered, how much the insurer will pay.[101] Because an out-of-network provider does not have contractually stipulated fees with the insurance company,[102] the provider, on behalf of an insured patient, typically bills insurers whatever

90. *See, e.g.*, Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 223 (3d Cir. 2020).
91. 967 F.3d 218 (3d Cir. 2020).
92. *Id.* at 223.
93. *Id.*
94. *See* Fuse Brown, *supra* note 1, at 136.
95. *See id*. at 136–37.
96. *Id*. at 136.
97. *Id.*
98. *See generally* Daniel Polsky et al., *Marketplace Plans with Narrow Physician Networks Feature Lower Monthly Premiums Than Plans with Larger Networks*, 35 HEALTH AFFS. 1842 (2016). For a discussion of the related topic of "network adequacy," see *infra* notes 236–38.
99. Fuse Brown, *supra* note 1, at 138.
100. Of course, however, the potential financial impact of an unapproved or uncovered treatment may disincentivize the patient from seeking treatment. *See* KONGSTVEDT, *supra* note 22, at 31.
101. *Id.*
102. *See supra* text accompanying notes 74, 77.

their "normal" amount is—meaning the full and undiscounted rate[103]—for each and every service rendered.[104]

Generally, an insurer receiving a bill from an out-of-network provider will compensate that provider with a certain percentage of what the insurer deems to be the "usual, customary, and reasonable charge" (UCR).[105] Because the UCR amount tends to be significantly less than the ultimate bill, the provider often opts to bill the patient the difference between the two amounts—a practice known as "balance billing,"[106] which may be unexpected and expensive.[107] Not only can the bill be surprisingly large but it is often unclear how the amount has been calculated in the first place, creating uncertainty for patients.[108]

In addition to the impact on patients, who may be called on to make up the difference, low out-of-network reimbursement has significant impacts on providers.[109] "Because health insurers have tremendous monopoly and monopsony power, any reimbursement rate they determine is likely to grossly underestimate the costs of services performed by . . . providers."[110] Further, because no contract exists between the out-of-network provider and the patient's insurer, the provider is simply forced to accept the payment rate determined by the insurer—that is, unless the provider is interested in litigating to collect the outstanding fee.[111]

McCulloch Orthopaedic Surgical Services, PLLC v. Aetna Inc.[112] lends a helpful illustration of the payment dilemma incurred by out-of-network providers. There, an out-of-network provider sought to perform two knee surgeries on a patient insured by Aetna, a large insurance company.[113] Given that the doctor, as an out-of-network provider, did not have a contractual set fee arrangement with Aetna,[114] a member of the doctor's staff called Aetna to confirm that Aetna would cover the costs of the operation.[115] In reliance on Aetna's confirmation that it would reimburse 70 percent of the UCR rate based on industry standards, the doctor conducted the surgeries and accordingly billed $66,048.[116] However, Aetna proceeded to pay the doctor

103. *See* Fuse Brown, *supra* note 1, at 138.
104. Yusaf, *supra* note 4, at 90.
105. *Id.* For PPOs, the UCR reimbursement may be based on the insurer's in-network fee schedule, which is still likely to be less than the out-of-network provider's billed charges, thus warranting a bill to the insured for the balance. *Id.*
106. *Id.*
107. *See* David A. Hyman et al., *Surprise Medical Bills: How to Protect Patients and Make Care More Affordable*, 108 GEO. L.J. 1655, 1656 (2020).
108. *See* Yusaf, *supra* note 4, at 105–06 (providing examples of the opaque language used by insurers to explain how out-of-network reimbursement rates are determined).
109. *See infra* text accompanying notes 110–11.
110. Yusaf, *supra* note 4, at 103. However, litigation costs often dissuade taking action. *See id.* at 104.
111. *See id.* at 102.
112. 857 F.3d 141 (2d Cir. 2017).
113. *Id.* at 144.
114. *See supra* text accompanying notes 74, 77.
115. *McCulloch*, 857 F.3d at 144.
116. *Id.*

a mere $15,267.51—far less than the anticipated amount based on Aetna's representation.[117]

Therefore, the doctor was left in the difficult position that out-of-network providers often face: whether to simply accept the seemingly inadequate payment, to bill the patient the massive difference, or to sue the insurer for underpaying.[118] However, even if the doctor chooses to pursue litigation against the insurer, as Part II.A.2 explains, doing so is not always a feasible option.[119]

C. The Importance of Contractual Assignment

Building on the basics of health insurance outlined above, Part I.C narrows in on the contractual relationship between an insurer and an insured and the involvement of providers in that relationship. Doing so is critical, as the foundation of all managed care plans is the contractual agreement that outlines "the various players' rights and responsibilities."[120]

Generally, a party to a contract may choose to assign a benefit (e.g., the right to receive money) or an obligation (e.g., the requirement to make a future payment) to another party.[121] Under general principles of contract law, a party is typically free to assign benefits "unless an assignment would . . . materially alter the obligor's duty of risk, or there is a provision in the contract restricting its assignability, or the assignment would violate a statute."[122] Critically, because parties are permitted to limit assignability if desired, the right to assign persists only if not otherwise specified.[123]

In the managed care era, out-of-network providers have "almost universally" sought patient agreement to an assignment of health insurance benefits before rendering care.[124] Simply put, the assignment transfers to the health care provider the right to send claims directly to the insurer on a patient's behalf and receive compensation directly from the insurer for services rendered, as occurs when in-network providers render services.[125] As previously noted, an out-of-network health care provider is not a party to a contract between an insurer and an insured.[126] Accordingly, an assignment, where valid, is necessary to convey to the provider the right to enforce the

117. *Id.*

118. *See infra* Part II.A.2.

119. *See infra* Part II.A.2 (discussing the challenges that providers face in pursuing litigation against insurers when out-of-network patients' health plans include anti-assignment provisions).

120. Lucas & Williams, *supra* note 65, at 136.

121. *See* RESTATEMENT (SECOND) OF CONTRACTS § 317 (AM. L. INST. 1981) (outlining contractual assignment rights generally).

122. 6 AM. JUR. 2D *Assignments* § 15 (2020).

123. *See* Allhusen v. Caristo Constr. Corp., 103 N.E.2d 891, 893 (N.Y. 1952) ("When 'clear language' is used, and the 'plainest words . . . have been chosen', parties may 'limit the freedom of alienation of rights and prohibit assignment.'" (alteration in original) (quoting State Bank v. Cent. Mercantile Bank, 162 N.E. 475, 477 (N.Y. 1928))).

124. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 228 (3d Cir. 2020).

125. Hyman et al., *supra* note 2, at 37–38.

126. *Id.* at 37; *see supra* text accompanying notes 74, 77, 82.

terms of the patient's plan against the insurer, including the right to seek respective payment due under the patient's plan.[127]

Importantly, under ERISA, with the right to recoup payment comes the assignment of the right to sue the insurer of an insured receiving coverage from an employee health plan.[128] Because section 502(a) limits standing to participants and beneficiaries only, as discussed above,[129] the insured's assignment agreement is necessary to enable providers to bring suit directly against an insurer under ERISA for any payment issues associated with the provision of care.[130]

Recently, however, insurers, by incorporating anti-assignment provisions into participant agreements, have increasingly limited or entirely prohibited the ability of insureds to assign their rights to providers, disrupting the previous norm.[131] These clauses typically restrict assignment of the right to enforce benefits or receive payment due under a plan and/or the right to sue.[132] A representative example of such a clause reads: "Aetna will not accept an assignment to an out-of-network provider . . . of: The benefits due under this contract; The right to receive payments due under this contract; or Any claim you make for damages resulting from a breach or alleged breach, of the terms of this contract."[133]

From the insurers' perspective, effective anti-assignment provisions help to accomplish a number of goals simultaneously[134]: First, they entice providers to come in network,[135] increasing the insurer's bargaining

127. Hyman et al., *supra* note 2, at 38; *see* City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc., 156 F.3d 223, 228 (1st Cir. 1998) ("It is generally understood that 'the assignee acquires rights similar to those of the assignor, and is put in the same position with reference to those rights as that in which the assignor stood at the time of assignment.'" (quoting 3 SAMUEL WILLISTON & WALTER H. E. JAEGER, A TREATISE ON THE LAW OF CONTRACTS § 404, at 5 (3d ed. 1960))).

128. *See, e.g.*, N. Jersey Brain & Spine Ctr. v. Aetna, Inc., 801 F.3d 369, 373 (3d Cir. 2015); Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 329 (2d Cir. 2011) ("[W]e have 'carv[ed] out a narrow exception to the ERISA standing requirements' to grant standing 'to healthcare providers to whom a beneficiary has assigned his claim in exchange for health care.'" (second alteration in original) (quoting Simon v. Gen. Elec. Co., 263 F.3d 176, 178 (2d Cir. 2001))).

129. *See supra* text accompanying notes 33–36.

130. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 228 (3d Cir. 2020); *supra* text accompanying notes 32–36. Here, the term "standing" goes beyond the "Cases and Controversies" requirement of Article III of the Constitution. Rather, it pertains to statutory standing, which applies to legislatively created causes of action and "asks whether a statute creating a private right of action authorizes a particular plaintiff to avail herself of that right of action." Pathak, *supra* note 21, at 91.

131. *See, e.g.*, Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 447 (3d Cir. 2018).

132. Hyman et al., *supra* note 2, at 38.

133. McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc., 857 F.3d 141, 144 (2d Cir. 2017). Part II.A.2 further explains how these rationales operate in the broader healthcare context.

134. *See Plastic Surgery Ctr.*, 967 F.3d at 228; *infra* text accompanying notes 136–38.

135. Yusaf, *supra* note 4, at 91–92 ("Essentially, insurers argue that network providers would have little incentive to contract with an insurer if they could receive reimbursement the same way as an out-of-network provider could, without agreeing to a lower rate of reimbursement."); *see supra* text accompanying notes 83–86.

power.[136] Second, they help minimize unanticipated charges from out-of-network providers "whose billing practices may vary significantly from those of in-network providers."[137] Third, anti-assignment provisions minimize the possibility of insurers being sued in a section 502(a) lawsuit by a provider who has been assigned an insured patient's health plan benefits.[138] As explained in Part II below, these purported goals have been achieved, benefitting insurers and significantly impacting providers and insureds along the way.

II. DO ANTI-ASSIGNMENT PROVISIONS COMPORT WITH ERISA'S INTENDED PROTECTIONS OF EMPLOYEES?

While insurers' efforts toward obstructing assignment of benefits may seem unremarkable at first, anti-assignment provisions within a participant agreement can—and certainly do—have a major impact on the delivery of medical services to out-of-network patients and related payment disputes.[139] The question of whether federal government action is warranted in response to this impact on insureds in employer-sponsored health plans, especially given ERISA's *intended* protections, arises as a result.[140] Part II.A examines this impact. Part II.B outlines the opposing arguments as to whether and why federal intervention is warranted in the matter.

A. The Impact of Anti-assignment Provisions

Federal courts of appeals are undoubtedly familiar with challenges to the validity and enforceability of anti-assignment provisions, as such arguments have been litigated regularly.[141] Part II.A.1 reviews how courts have responded to these contentions. Part II.A.2 details the significant ramifications of valid and enforceable anti-assignment provisions.

1. Federal Courts' Assessment of Anti-assignment Provisions

To the dismay of providers and insureds alike, challenges to the validity and enforceability of anti-assignment provisions have been universally rejected.[142] Courts typically cite two specific rationales to support this

136. *Plastic Surgery Ctr.*, 967 F.3d at 228.

137. *Id.*

138. *See id.*; *supra* Part I.C.

139. *See infra* Part II.A.2 (examining the impact that anti-assignment provisions have had on providers' ability to enforce the terms of out-of-network patients' health plans against insurers).

140. See *infra* text accompanying notes 255–62 for an explanation of why Congress is the most likely body of the federal government to act on this issue.

141. *See* Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 453 (3d Cir. 2018) (surveying cases).

142. *See, e.g.*, *id.* ("[E]very Circuit to have considered the arguments presented [against anti-assignment] has rejected them . . . ."); *see also* LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc., 298 F.3d 348, 352 (5th Cir. 2002) ("Applying universally recognized canons of contract interpretation to the plain wording of the instant anti-assignment clause leads inexorably to the conclusion that any purported assignment of

finding: First, fundamental principles of black letter contract law require "that the terms of an unambiguous private contract must be enforced."[143] Second, the right to assign benefits due under a health plan can be freely negotiated as part of the formation of health insurance contracts.[144]

With respect to upholding such provisions in light of ERISA's intended protections, the Third Circuit has noted that neither the statutory text nor congressional policy "justify a departure from the general rule that courts will enforce the terms of an agreement that was freely negotiated between contracting parties."[145] Therefore, a clear and unambiguous provision barring assignment will generally be enforced when included in a participant agreement.

2. The Ramifications of Valid and Enforceable Anti-assignment Provisions

Courts' handling of anti-assignment provisions has had significant consequences for insurers, insureds, and providers.[146] This section details these consequences and highlights why they are critical to the way health care is delivered to individuals insured through employer-sponsored health plans.

While insurers capitalize on the advantages of anti-assignment provisions,[147] insureds and providers may suffer negative effects. Perhaps the most direct impact is that insureds are thrust into a financial intermediary role between an out-of-network provider and a respective insurer.[148] As previously discussed, an anti-assignment provision renders providers unable to seek compensation directly from the insurance company on the patient's behalf.[149] Instead, because the provider is left with no choice but to bill patients directly, and in full, the responsibility falls on patients to sort out payment with their insurance companies and to pay providers directly.[150] A patient in this position may have to outlay a potentially hefty sum of money

benefits . . . would be void."); *cf.* King v. Cmty. Ins. Co., 829 F. App'x 156, 159–60 (9th Cir. 2020) (allowing assignment despite the inclusion of an anti-assignment clause on the basis that the anti-assignment language was ambiguous with respect to assignment from the insured to a provider).

143. Travelers Indem. Co. v. Bailey, 557 U.S. 137, 150 (2009); *see* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 228 (3d Cir. 2020) ("[A]s a matter of federal common law, we recently joined our sister circuits in holding that anti-assignment provisions, like other unambiguous terms in a contract, are enforceable.").

144. *See LeTourneau Lifelike Orthotics & Prosthetics*, 298 F.3d at 352 ("Our case law affirms . . . 'Congress's intent that employers remain free to create, modify and terminate the terms and conditions of employee benefits plans without governmental interference.'" (quoting McGann v. H&H Music Co., 946 F.2d 401, 407 (5th Cir. 1991))); *see also* City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc., 156 F.3d 223, 229 (1st Cir. 1998).

145. *Am. Orthopedic*, 890 F.3d at 449. See *infra* notes 323–27 for a discussion of bargaining power with respect to contractual terms of employee health plans.

146. *See infra* Part II.A.2.

147. *See supra* text accompanying notes 134–38.

148. *See supra* text accompanying note 85.

149. Yusaf, *supra* note 4, at 91–92; *see supra* text accompanying note 125.

150. Yusaf, *supra* note 4, at 91–92.

before receiving reimbursement from the insurer, if reimbursement comes at all.[151]

And while this may be an unpleasant experience for patients themselves, providers are the ones who could end up feeling the brunt of the problem.[152] First, as noted above, the lack of assignment results in the patient receiving payment from the insurer instead of the provider receiving that payment.[153] There exists the possibility that even if the patient does receive adequate payment from the insurer, that payment may not be conveyed to the provider, forcing the provider to decide between suing the patient and simply accepting the situation.[154]

Further, should the process of receiving payment from the patient go awry due to an issue with the insurer, an anti-assignment clause deprives the provider of standing to sue the insurer under ERISA.[155] As explained above, a cause of action under section 502(a) exists *only for a participant or beneficiary* of an employee welfare plan.[156] Accordingly, whereas a medical provider has typically been able to seek enforcement of an out-of-network patient's insurance plan's terms against the insurer by way of assignment from the patient,[157] a valid and enforceable anti-assignment provision prohibits a provider from doing so.[158] Instead, anti-assignment provisions have effectively stripped out-of-network medical providers of standing via assignment, creating "a considerable hurdle in establishing the right to demand or contest payment from health insurance companies."[159]

Moreover, ERISA's "extremely strong . . . preemption doctrine" exacerbates the significance of anti-assignment provisions, as ERISA largely eliminates the availability of alternative remedies in state court for parties aggrieved in relation to an employee welfare benefit plan.[160] Where an anti-assignment provision is in effect, a provider with a grievance over payment from an insurer, or lack thereof, is left with "only one option: Sue the patient, hoping that the patient either is willing or able to pay significant, unexpected costs or has the interest and wherewithal to file suit against the insurer under section 502(a)."[161] Potentially detrimental results for a provider facing such

151. *Id.*
152. *See infra* text accompanying notes 155–62.
153. *See supra* notes 85, 127 and accompanying text.
154. *See, e.g.*, King v. Cmty. Ins. Co., 829 F. App'x 156, 157–58 (9th Cir. 2020).
155. Hyman et al., *supra* note 2, at 38.
156. *See supra* text accompanying notes 31–36.
157. *See supra* note 127 and accompanying text.
158. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 236 (3d Cir. 2020) (citing N. Jersey Brain & Spine Ctr. v. Aetna, Inc. 801 F.3d 369, 372 (3d Cir. 2015)) ("Absent the assignment of benefits, a healthcare provider may not pursue its own section 502(a) cause of action . . . .").
159. Hyman et al., *supra* note 2, at 38; *see Plastic Surgery Ctr.*, 967 F.3d at 228–29.
160. *See* Pathak, *supra* note 21, at 108–09 ("[Section 502] represent[s] the only way . . . [to] obtain judicial remedies for violations of ERISA. And because ERISA has such a wide scope . . . [§ 502(a)] provide[s] the only means . . . to seek redress for most of the wrongs . . . suffered in the context of employer sponsored health care.").
161. *Plastic Surgery Ctr.*, 967 F.3d at 238. Unfortunately, "the prospect of suing patients to eventually recover from their insurers is unpalatable, to say the least, from a reputational

a scenario include lost revenues, increased debt, and collection expenses, exacerbating the current trend of medical practices' decline in revenue.[162]

To illustrate the concepts outlined above, we return to *Plastic Surgery Center*—where a plaintiff received facial reanimation surgery from an out-of-network provider because no in-network provider could perform the procedure.[163] Despite Aetna's agreement with the provider, before the surgery, to pay a "reasonable amount" and to do so at the highest amount that an in-network provider would receive, Aetna paid only $40,230.32 of the $420,750 billed by the provider.[164] Though the provider was able to move forward on claims of breach of contract and promissory estoppel,[165] ERISA's preemption provisions prohibited the provider's claim for unjust enrichment due to "an impermissible 'reference to' the ERISA plan[]."[166] Further, regardless of the preemption pertaining to the state law contract claims, the provider would have been unable to bring suit under ERISA's remedial provision due to a lack of standing because the patient's agreement with Aetna contained an anti-assignment provision.[167]

As outlined above, the effects of anti-assignment provisions are significant: providers cannot assert a patient's insurance plan's terms directly against the insurer and pursuing litigation is problematic due to ERISA's broad preemption and standing requirement, which out-of-network providers cannot meet due to anti-assignment provisions. While providers are the direct recipients of these litigation-related detriments, they may also indirectly burden insureds in employer-sponsored health plans.[168] Part II.B explores arguments around whether these effects are incompatible with ERISA's intended protections of those enrolled in such employee benefit plans.

B. Is Congressional Intervention Warranted?

Though courts have been unwavering in their stance regarding anti-assignment provisions, the implication of these provisions warrant further assessment to determine whether federal legislation or other action is called for. More precisely, the question is whether ERISA fails to promote the interests of employees and beneficiaries, as intended, where anti-assignment provisions are concerned, and, if so, whether ERISA should be amended or other legislation enacted.

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and business development standpoint, not to mention the damage it would cause to the doctor-patient relationship." *Id.* at 239.

162. *See* Yusaf, *supra* note 4, at 92.

163. *Plastic Surgery Ctr.*, 967 F.3d at 240.

164. *Id.* at 224 (noting that "Aetna declined to pay the [out-of-network provider] anything for some services and paid less than it allegedly agreed to for others").

165. *Id.* at 230. For a discussion of state contract law claims as an alternative remedy, see Parts II.B.3, III.B.2.

166. *Plastic Surgery Ctr.*, 967 F.3d at 240; *see supra* notes 48–49 and accompanying text.

167. *See Plastic Surgery Ctr.*, 967 F.3d at 228–29; *see supra* text accompanying notes 31–36, 132, 138.

168. *See infra* text accompanying notes 200–03.

Two opposing perspectives can be deduced from relevant case law and legal scholarship. The following section outlines the plausible arguments from each side. Part II.B.1 describes these conflicting views through the lens of ERISA's text. Part II.B.2 reviews perspectives on whether the impacts of anti-assignment provisions comport with, or run contrary to, ERISA's stated purpose. Part II.B.3 examines arguments as to whether adequate judicial remedies and state legislative efforts currently exist rendering federal intervention unnecessary.

1. Arguments Based on ERISA's Text

"It is a 'fundamental canon of statutory construction' that, 'unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning.'"[169] This cardinal principle of statutory interpretation, however, proves problematic in the context of ERISA and its provisions governing the right to assignment.[170] While ERISA's text is unequivocally clear on the list of parties that can bring a claim under its remedial provision,[171] in the welfare benefit plan context, the assignment question is far less clear.[172] While section 206(d)[173] expressly bars the assignment of benefits for *pension* benefit plans specifically,[174] the welfare benefit plan provisions contain no such mandate—instead, they are silent on the matter.[175] This silence directs an interpreter of the statute toward the principle of meaningful exclusion,[176] which lends support to two competing views: the idea that ERISA has no view on assignment and the view that the text supports free assignment.

Much of the interpretive debate on this omission draws on *Mackey v. Lanier Collection Agency & Service, Inc.*[177] There, the U.S. Supreme Court noted:

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169. Sandifer v. U.S. Steel Corp., 571 U.S. 220, 227 (2014) (quoting Perrin v. United States, 444 U.S. 37, 42 (1979)).

170. *See infra* text accompanying notes 171–76. *See generally* Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988) (discussing the absence of language regarding assignment for welfare benefit plans).

171. *See* City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc., 156 F.3d 223, 226 (1st Cir. 1998) ("Thus, when we previously considered ERISA's standing provision, we stated that 'since Congress has carefully catalogued a selected list of persons eligible to sue under ERISA, there is no plausible rationale for us gratuitously to enlarge the roster.'" (quoting Kwatcher v. Mass. Serv. Emps. Pension Fund, 879 F.2d 957, 965 (1st Cir. 1989))); *see also supra* text accompanying notes 33–36.

172. *See infra* text accompanying notes 173–76.

173. ERISA section 206(d) is codified at 29 U.S.C. § 1056(d)(1).

174. *Mackey*, 486 U.S. at 836. Pension benefit plans, distinct from employee welfare benefit plans, are also governed by separate provisions of ERISA. *See supra* text accompanying notes 18–20.

175. *Mackey*, 486 U.S. at 836.

176. "Meaningful exclusion" refers to the general presumption that Congress acts "intentionally and purposely in the disparate inclusion" of "particular language in one section of a statute" that is omitted in another section of that statute. Russello v. United States, 464 U.S. 16, 23 (1983) (citing United States v. Wong Kim Bo, 472 F.2d 720, 722 (5th Cir. 1972)).

177. 486 U.S. 825 (1988).

> [T]here is no ignoring the fact that . . . [Congress] had before it a provision to bar the [assignment] of ERISA plan benefits, and chose to impose that limitation only with respect to ERISA pension benefit plans . . . . In a comprehensive regulatory scheme like ERISA, such omissions are significant ones.[178]

The generally accepted takeaway from Congress's lack of express instructions with respect to welfare benefit plan assignment is implicit approval of then existing practices.[179] Yet, just what those practices were is far from settled.[180] In other words, Congress passively endorsed the status quo by not expressly speaking on the matter but was not necessarily clear as to what that status quo exactly was.

Read one way, this omission could suggest that general principles of contract law should control; because assignment is not explicitly mandated, anti-assignment clauses must be enforceable.[181] The Ninth Circuit has said as much, interpreting Congress's silence to mean an intention "*not* to mandate assignability, but intended instead to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve."[182]

Another reason to allow the continued practice is that despite "repeated amendments and a largescale overhaul of the healthcare system,"[183] Congress has taken no legislative action to indicate any concern about or antipathy toward barring assignment, despite the increasingly pervasive inclusion of anti-assignment provisions in participant agreements.[184]

However, the absence of an express bar on assignability is not necessarily dispositive that Congress had *no* intent on the matter. For one thing, ERISA's text is to be construed in a manner consistent with the intent of the legislation, and mandated assignment could have significant positive benefits for

178. *Id.* at 837.

179. *See, e.g.*, *id.* at 837–38 ("Once Congress was sufficiently aware of the prospect that ERISA plan benefits could be attached and/or garnished—as evidenced by its adoption of § 206(d)(1)—Congress' decision to remain silent concerning the attachment or garnishment of ERISA welfare plan benefits 'acknowledged and accepted the practice, rather than prohibiting it.'" (quoting Alessi v. Raybestos–Manhattan, Inc., 451 U.S. 504, 516 (1981))).

180. *Compare* Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 451 (3d Cir. 2018) (identifying the "fairly ubiquitous" assignment of benefits as the status quo), *with* Davidowitz v. Delta Dental Plan of Cal., Inc., 946 F.2d 1476, 1480–81 (9th Cir. 1991) (identifying the traditional norm as permitting use of business competitive mechanisms like anti-assignment provisions).

181. *Am. Orthopedic*, 890 F.3d at 450; *cf.* St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc., 49 F.3d 1460, 1464 (10th Cir. 1995) (finding, based on the Court's reasoning in *Mackey*, that "Congress did not intend to enact a policy precluding [welfare plan benefits] assignability").

182. *Davidowitz*, 946 F.2d at 1480–81.

183. *Am. Orthopedic*, 890 F.3d at 450.

184. *See id.*; *see also* Bob Jones Univ. v. United States, 461 U.S. 574, 600–01 (1983) ("Nonaction by Congress is not often a useful guide, but . . . . [i]n view of [Congress's] prolonged and acute awareness of so important an issue, [its] failure to act . . . provides added support for concluding that Congress acquiesced.").

participants and beneficiaries.[185] Thus, it is conceivable that ERISA should actually be read to mandate the permissibility of assignment.

Additionally, it is plausible that silence suggests implicit approval of the status quo—one in which the market, which has been characterized by "fairly ubiquitous" assignment of plan benefits for some time, is allowed to play out as players see fit.[186] Accordingly, Congress's "silence does not necessarily mean [it] intended to permit plan trustees to extinguish" the right to assign benefits "through a blanket contractual waiver."[187] It could, in fact, mean the opposite—leaving out a prohibition on assignment for welfare plans, unlike pension plans, meant that Congress actually wanted such rights to be freely assignable.[188]

2. Arguments Based on Congress's Intent in Enacting ERISA

Moving beyond the statutory text, legislative intent may also help shed light on whether the promulgation of anti-assignment provisions in health plans violates ERISA's intended protections of employees and their beneficiaries participating in benefit plans. To use legislative intent "is to construe the language [of a statute] so as to give effect to the intent of Congress."[189] Assessing the impact of anti-assignment provisions in the context of congressional intent requires no difficult deduction or mind reading; desire to "promote the interests of employees and their beneficiaries" is clearly stated in the text.[190] One prudent way to evaluate whether this intent is effectuated in the health plan context is to determine whether anti-assignment provisions promote or restrict access to health care.[191]

Proponents of anti-assignment clauses purport that the clauses further ERISA's intentions, especially from a financial perspective.[192] As anti-assignment provisions induce providers to come in network and help control

185. *Am. Orthopedic*, 890 F.3d at 451–52; *see infra* text accompanying notes 282–83.

186. *Am. Orthopedic*, 890 F.3d at 451.

187. *Id.*

188. *See supra* text accompanying notes 186–87.

189. John F. Manning, *Without the Pretense of Legislative Intent*, 130 HARV. L. REV. 2397, 2404 (2017) (citing United States v. Am. Trucking Ass'ns, 310 U.S. 534, 542 (1940)). Beyond the text, legislative history around the statute's enactment, such as floor debates, may be used to determine intent. *See* Cass R. Sunstein, *Interpreting Statutes in the Regulatory State*, 103 HARV. L. REV. 405, 429 (1989).

190. *See supra* note 30. This Note proceeds under the normative determination that the legislative intent behind ERISA is clear and obvious, based on the text, such that the legislative history and other interpretative sources need not be consulted to deduce it. This follows the view that "judicial efforts to impeach a clear text through . . . 'nontextual sources' will yield only 'conjectural' *benefits* (in terms of further accuracy) along with [significant] *costs* (in terms of searching and processing extrinsic sources). Hence, judges should forgo reliance on such sources and stick to the surface meaning of the text." Manning, *supra* note 189, at 2429 (footnote omitted) (quoting ADRIAN VERMEULE, JUDGING UNDER UNCERTAINTY 115, 186, 189–90 (2006)).

191. *Am. Orthopedic*, 890 F.3d at 451 (citing CardioNet, Inc. v. Cigna Health Corp., 751 F.3d 165, 179 (3d Cir. 2014)).

192. *Id.* at 452.

costs,[193] they allow insurers to charge lower premiums than would otherwise be possible.[194] Under this view, anti-assignment provisions promote an individual's access to care because less costly health insurance coverage is more readily obtainable which, in turn, makes the same true for obtaining health care services as needed.[195] Although *providers*' interests may not be promoted as a result of barring assignment,[196] such impacts are not relevant to the debate, as ERISA was enacted to protect the interests of individuals insured by employer-sponsored plans, not the providers.[197]

On the other hand, those who challenge the pervasive use of anti-assignment clauses emphasize that they are, in some ways, directly counterproductive to Congress's intent in enacting ERISA because they limit consumer choice.[198] Under this view, though harm incurred by a provider is not necessarily *directly* relevant to the interests of employees and their beneficiaries, it is plausible to say that the effects on providers actually lead to a hesitance to serve out-of-network patients and, in some cases, a decision not to do so.[199]

The concerns of treating out-of-network patients begin with the cost and administrative headaches associated with out-of-network care.[200] These issues are exacerbated by anti-assignment clauses because the provider's only remedy, if and when payment becomes problematic, is a suit against the patient directly—"a proposition that is both expensive and bad for business."[201]

As a result, access to health care for those participating in employer-sponsored health plans is limited because insureds needing out-of-network care face limited options.[202] Where this burden disincentivizes providers from rendering care to out-of-network patients in some or all instances, the impacts are clearly against congressional intent, as this directly contradicts the argument that anti-assignment provisions serve "participants' interests . . . by 'increasing their access to care.'"[203]

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193. *See supra* text accompanying notes 84–86.

194. Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341, 1348–49 (8th Cir. 1991).

195. *Am. Orthopedic*, 890 F.3d at 452.

196. *See infra* text accompanying notes 199–201.

197. *See supra* text accompanying note 30; *cf.* McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc., 857 F.3d 141, 149 (2d Cir. 2017) ("[B]ecause [the out-of-network provider] is not a valid assignee and has no plan-related relationship with [the insurer], the benefits under the health care plan belong to the patient, not to [the out-of-network provider].").

198. *See, e.g.*, *Am. Orthopedic*, 890 F.3d at 449; *cf.* Misic v. Bldg. Serv. Emps. Health & Welfare Tr., 789 F.2d 1374, 1377 (9th Cir. 1986) (asserting that assignability protects insureds "by making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment, and by eliminating the necessity for [insureds] to pay potentially large medical bills and await compensation from the plan").

199. *See McCulloch*, 857 F.3d at 148.

200. *See* Hyman et al., *supra* note 2, at 37.

201. *Am. Orthopedic*, 890 F.3d at 451.

202. *McCulloch*, 857 F.3d at 148.

203. *Am. Orthopedic*, 890 F.3d at 451 (quoting CardioNet v. Cigna Health Corp., 751 F.3d 165, 179 (3d Cir. 2014)); *see also* Mem'l Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d

Additionally, providers' failure to capture revenues due to anti-assignment provisions can infringe on the opportunities to update their practices with the latest technology and innovative methods.[204] Again, this would not promote the interests of employees in such plans who would not be getting the best possible medical care and suggests that anti-assignment provisions may run against congressional intent.

3. Arguments Based on Existing Judicial Remedies and State Legislative Protections

Looking beyond ERISA's text and purpose, the question of whether federal intervention—a legislative amendment by Congress[205]—is necessary depends, in part, on whether alternative judicial remedies and existing state legislative efforts are sufficient to address the effect of anti-assignment provisions.

In response to the increasing prevalence of anti-assignment provisions in their out-of-network patients' health plans, and with ERISA's preemption precluding plan-related suits, many providers "have attempted to secure a new foothold" by proactively seeking promise of payment from the insurers before rendering services.[206] Put differently, when an out-of-network patient seeks nonemergency care from a provider, a member of that provider's staff will seek to reach an ad hoc agreement with the patient's insurance company outlining specific compensation for the respective treatment.[207] The remedial implication is clear: should the insurer not comply with the agreement—for example, underpay or not pay at all—contract common-law causes of action, like breach of contract and promissory estoppel, may suffice as an adequate alternative to a section 502(a) suit, which would be unavailable to the provider due to the anti-assignment provision.[208]

Importantly, these state law causes of action predicated on the separate ad hoc arrangement between the provider and insurer could not be brought under section 502(a) because the insurer's alleged liability would flow from that independent agreement, as opposed to the patient's insurance plan.[209] Further, where an ad hoc agreement of this nature is the basis of the provider's claim, no preemption issue arises because the claims do not "relate

236, 247 (5th Cir. 1990) ("[D]iscouraging health care providers from becoming assignees would 'undermine Congress' goal of enhancing employees' health and welfare benefit coverage.'" (quoting Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286, 1289 n.13 (5th Cir. 1988))).

204. Yusaf, *supra* note 4, at 92–93.

205. *See infra* Part III.A.

206. Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 229 (3d Cir. 2020).

207. *Id.* at 228.

208. *Id.* at 229.

209. *Id.*; *see also* McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc., 857 F.3d 141, 149 (2d Cir. 2017) ("[The out-of-network provider's] promissory-estoppel claim does not depend on the specific terms of the relevant health care plan or on [the insurer's] determination of coverage or benefits pursuant to those terms."). This rationale was invoked by the courts in *Plastic Surgery Center* and *McCulloch*—the example cases detailed in Parts II.A.2 and I.B.2, respectively.

to" an ERISA plan[210] but rather an independent contractual agreement with obligations unrelated to an ERISA-governed plan.[211]

The U.S. Department of Labor[212] (DOL) has advocated this position, emphasizing the "overwhelming and persuasive consensus" among courts that disputes pertaining to these ad hoc contracts are not preempted by ERISA.[213] Accordingly, in theory, out-of-network providers can sufficiently protect themselves from the negative impacts of anti-assignment clauses by proactively establishing such agreements. Additionally, where necessary, providers can enforce the terms of the agreements through contract law, rather than ERISA's remedial provision.[214]

However, while contract common-law causes of action provide a feasible avenue of relief in some scenarios, a number of issues can still arise that make this approach an inadequate solution.[215] For instance, some state law claims may invite preemption issues;[216] contractual agreements are not feasible in all scenarios;[217] and even if such agreements can be formed, use of contract law in the context of employer-sponsored health insurance arguably defies ERISA's intentions regarding uniform federal regulation.[218]

First, as to preemption, though courts often allow such state law claims to proceed,[219] sometimes the payment terms of these ad hoc arrangements may default to rates of payment outlined in the respective patient's ERISA-governed plan, bringing the claim back under ERISA's preemption umbrella.[220] This primarily results because, "[a]s out-of-network providers migrate from accepting assignment of plan benefits from the insured to forming their own agreements with the insurers, many have not yet developed a standard form of contract."[221] This can bring about the very preemption issues that the contracts seek to avoid because defaulting to an ERISA-governed plan creates an impermissible "reference to" that plan.[222] Additionally, as previously discussed, though claims for breach of contract

210. *See supra* text accompanying notes 48–49.

211. *Plastic Surgery Ctr.*, 967 F.3d at 229, 236 (highlighting courts of appeals' "overwhelming" view that common-law contract claims, like breach of contract and promissory estoppel, pleaded by out-of-network providers against insurers, "are not expressly preempted because . . . they arise out of a relationship ERISA did not intend to govern at all").

212. The DOL is responsible for setting rules governing certain health insurance plans provided by employers and unions, which are enforced under ERISA. *See* KONGSTVEDT, *supra* note 22, at 240, 247.

213. Brief for the Secretary of Labor as Amicus Curiae in Support of Plaintiff-Appellant at 18, 23, McCulloch Orthopaedic Surgical Servs., PLLC v. United Healthcare Ins. Co., No. 15-2144 (2d Cir. Oct. 22, 2015) [hereinafter Brief for the Secretary of Labor]. This is because "the relationship between the healthcare providers with the insurer is a separate relationship with independent duties from the one between the insurer and the plan participants." *Id.* at 25.

214. *See supra* text accompanying notes 206–13.

215. *See infra* text accompanying notes 216–18.

216. *See infra* text accompanying notes 220–24.

217. *See infra* text accompanying notes 225–26.

218. *See infra* text accompanying note 228.

219. *See supra* notes 211–13 and accompanying text.

220. Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 229 (3d Cir. 2020).

221. *Id.*

222. *See supra* text accompanying notes 48–50, 165–66.

and promissory estoppel may proceed,[223] claims for unjust enrichment are preempted because the respective "benefit conferred" is premised on the existence of an ERISA plan, stripping the provider of one typical contract-related remedy.[224]

While use of contract claims has proven to be an effective remedy in some scenarios, it falls short in others. For instance, the myriad ways in which out-of-network care may be necessitated renders it difficult to always reach such agreements ahead of time.[225] As discussed above, oftentimes out-of-network care is rendered on an emergency basis and, in such scenarios, providers cannot be expected to confirm with a critically sick or injured patient's insurance company whether services will be covered, and if so, how much will be paid.[226]

Further, state contract law is inherently disjointed, as the applicable rules vary across jurisdictions.[227] To use state law as a relief mechanism related to welfare benefit plans seemingly runs directly contrary to Congress's intent that ERISA disputes be governed under uniform legislation and solely be a matter of federal concern.[228]

Beyond these potentially available judicial remedies, state legislatures, acting in their insurance regulator capacity,[229] have regularly attempted to protect health care consumers,[230] including from some of the effects associated with anti-assignment provisions. Whether these efforts are sufficient alternatives to federal legislative action is a debate with support on both sides.[231]

Specifically targeting anti-assignment provisions, a number of states have enacted mandatory assignment of benefits laws.[232] Under a mandatory assignment of benefits regime, an insurer has no choice but to honor an assignment made by an insured to a provider and to pay the provider directly.[233] These laws may either cover all services, as enacted in a few jurisdictions,[234] or more commonly, only emergency medical services.[235]

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223. *See supra* text accompanying notes 208–11.

224. *Plastic Surgery Ctr.*, 967 F.3d at 240.

225. *See supra* text accompanying notes 88, 94–97.

226. *See supra* text accompanying notes 96–97.

227. *See* RESTATEMENT (SECOND) OF CONFLICT OF L. § 188 (AM. L. INST. 1981) ("The rights and duties of the parties with respect to an issue in contract are determined by the local law of the state which, with respect to that issue, has the most significant relationship to the transaction . . . .").

228. *See supra* text accompanying notes 38–42. *But see infra* Part III.B.2 (discussing the plausible perspective that the duties established in such ad hoc arrangements are distinct from the ERISA-governed plan terms).

229. *See supra* note 51 and accompanying text.

230. *See* Fuse Brown, *supra* note 1, at 183; Yusaf, *supra* note 4, at 114.

231. *See infra* Part II.B.3.

232. *See* Yusaf, *supra* note 4, at 114–19 (describing mandated assignment of benefits laws in Colorado and Florida).

233. *See id.* at 115.

234. *See, e.g.*, TENN. CODE ANN. § 56-7-120(a) (2021).

235. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1371.4(a)–(d) (West 2021).

Network adequacy laws employed by a number of states are another reason why intervention may be unnecessary.[236] As provider networks have continually narrowed in recent years,[237] many states have responded by establishing insurance regulations that require networks to be stronger and broader.[238] This feasibly reduces the need for out-of-network care, thus minimizing the relevance of anti-assignment clauses.

"Any willing provider laws" adopted by state legislatures also have an indirect effect on anti-assignment provisions.[239] These laws require that insurers accept into their provider networks any and all providers that meet a stated set of criteria as long as the provider agrees to the insurer's contractual terms governing provider participation.[240] In theory, similar to network adequacy laws, any willing provider laws create sufficiently robust networks where an insured will not need out-of-network care.[241]

However, moving to the contrary view, while "states' powers to regulate their health care systems are historic and expansive,"[242] these powers, as they relate to employee health plans, are tapered by ERISA's preemption, as discussed in Part I.A above.[243] ERISA has "erected a notorious obstacle to state regulation of health insurance,"[244] as express preemption makes substantive patient financial protections legislated by states "inapplicable for a large proportion of consumers who get their health insurance from employer-based plans."[245]

Further, section 502 completely preempts state legislative remedies pertaining to *all* ERISA health plans.[246] As a result, any detrimental impacts arising due to anti-assignment provisions generally cannot be remedied

236. Fuse Brown, *supra* note 1, at 144–45 ("Network adequacy refers to a health plan's ability to provide enrollees with timely and reasonable access to a sufficient number of in-network primary care and specialty physicians and other health care services included under the terms of the contract.").

237. *See* Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES (May 12, 2014), https://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html [https://perma.cc/ERC3-YPE5].

238. *See* KONGSTVEDT, *supra* note 22, at 237 ("Most states have network adequacy laws requiring [managed care organizations] to have sufficient healthcare providers available for enrollees.").

239. *See, e.g.*, KY. REV. STAT. ANN. § 304.17A-270 (West 2021) ("A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer . . . .").

240. *See* KONGSTVEDT, *supra* note 22, at 45.

241. *See supra* Part I.B.2.

242. Fuse Brown & McCuskey, *supra* note 26, at 415.

243. *See infra* Part I.A.

244. Fuse Brown & McCuskey, *supra* note 26, at 415; *see supra* Part I.A (explaining the impact of ERISA's preemptive powers on the ability of states to regulate employee health plans).

245. Fuse Brown, *supra* note 1, at 183; *see id.* at 156 ("[T]o the extent they regulate health plans, state laws on network adequacy or surprise billing are subject to preemption by ERISA. . . . [I]n practical terms, many of these emerging state consumer protections are simply inapplicable and unavailable if the consumer is one of the millions insured by an employer-based health plan, particularly a self-funded plan.").

246. *Id.* at 189.

through a state consumer protection law or state law cause of action.[247] For example, multiple federal courts of appeals have found that mandatory assignment of benefits laws enacted by state legislatures are preempted by ERISA, meaning they are inapplicable for employer-sponsored health plan participants and beneficiaries.[248]

Setting aside the view that state laws are ineffective because of preemption, it is also plausible to see these state legislative efforts as insufficient because some individuals will still inevitably receive out-of-network care on an involuntary or accidental basis.[249] Additionally, even the most conscientious individuals may find themselves in a challenging situation while attempting to determine which provider to visit because "the lack of disclosure or network transparency makes it difficult or impossible for a patient to avoid out-of-network providers."[250]

III. CALLING ON CONGRESS FOR A DELIBERATE REVIEW OF ANTI-ASSIGNMENT PROVISIONS

Undoubtedly, anti-assignment provisions are a tiny piece of a broken healthcare puzzle that has plagued contemporary American society. While there are surely countless ways to improve the existing healthcare system, this Note focuses on determining what steps the federal government should take, if any, to address anti-assignment provisions in light of ERISA's intended protections. In that realm, this Note argues that, based on the existence of alarming anecdotal evidence that anti-assignment provisions *may* operate to the detriment of employees and their beneficiaries, Congress should conduct an in-depth empirical examination of this problem. This Note does not speculate on what that empirical evidence, developed as part of these efforts, will reveal. Instead, this Note outlines plausible ERISA amendments should that empirical research indicate a need for intervention, as well as interim solutions that could minimize ongoing adverse effects.

The impacts of anti-assignment provisions on out-of-network providers and insurers, as detailed in Part II.A.2, demonstrate the provisions' unequivocal significance.[251] Most notably, anti-assignment provisions have essentially stripped health care providers of the opportunity to enforce terms directly against an insurer and to bring suit directly against the insurance companies when payment issues arise.[252] As discussed above, not only does this impact the provider but that provider's burden can impact the ability of

247. *See supra* note 245 and accompanying text.

248. *Compare* Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341 (8th Cir. 1991) (finding mandated assignment to be preempted by ERISA), *and* St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc., 49 F.3d 1460 (10th Cir. 1995) (finding the same), *with* La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys., 461 F.3d 529 (5th Cir. 2006) (finding that a similar statute is not preempted).

249. *See supra* Part I.B.2.

250. Fuse Brown, *supra* note 1, at 139.

251. *See supra* Part II.A.2.

252. *See supra* Part II.A.2.

an insured to receive out-of-network care.[253] This issue is particularly pronounced in the context of ERISA, federal legislation seemingly designed to protect against such detriments.[254]

However, the simple fact that these provisions *may* be problematic does not necessarily command federal intervention. Instead, this Note proposes a deliberate congressional review in pursuit of comprehensive empirical evidence to help determine whether the impact of anti-assignment provisions on employees and their beneficiaries warrant action. Part III.A identifies immediate steps that Congress could take to better understand the effects of anti-assignment provisions in the context of ERISA's stated purpose and why this assessment is important. Part III.B suggests possible long-term changes to ERISA that may be warranted depending on the investigatory results. However, just because Congress must first take action to *understand* the issue does not mean changes cannot be made in the short term. Part III.C identifies interim solutions that could be utilized while Congress takes up this research endeavor, including utilizing power of attorney, establishing standard form contractual agreements for specialized out-of-network care, and encouraging employers to negotiate health plans for employees that do not include anti-assignment provisions.

A. Why Congressional Study Is Needed

Before approaching the question of *whether* Congress should take action, it is critical to understand *why* Congress is the most reasonable and logical actor, as suggested by this Note, to effectuate any needed change. The rationale has three components.

First, ERISA, the relevant law that has created many of these issues in the first place because of its standing requirement[255] and preemption power,[256] is a *federal* law.[257] Accordingly, Congress is tasked with proposing and passing any related amendments or new legislation.[258] Further, Congress has been recognized as having the institutional competence to study and act on important policy issues such as the one described by this Note.[259] As Justice Breyer has noted, "[w]here a legislature has significantly greater institutional expertise . . . the Court in practice defers to empirical legislative judgments."[260] This is because "Congress is far better positioned to gather

253. *See supra* text accompanying notes 200–03.
254. *See supra* Part I.A.
255. *See supra* text accompanying notes 34–36.
256. *See supra* text accompanying notes 39–46.
257. *See supra* text accompanying notes 17–18, 22.
258. *See* U.S. CONST. art. I, § 1, cl. 8. *See generally Enactment of a Law*, CONGRESS.GOV, https://www.congress.gov/help/learn-about-the-legislative-process/enactment-of-a-law [https://perma.cc/3F68-64RW] (last visited Mar. 16, 2021).
259. *See infra* text accompanying notes 260–61.
260. Nixon v. Shrink Mo. Gov't PAC, 528 U.S. 377, 402 (2000) (Breyer, J., concurring).

data, solicit and respond to the views of its constituents, and craft a solution that takes such policy considerations into account."[261]

Second, as discussed in Part II.A.2, federal courts have consistently and unequivocally held that unambiguous, private, and freely negotiated anti-assignment provisions are enforceable and not void as contrary to public policy, and there is no indication that the Supreme Court will act to the contrary.[262]

Third, while ERISA could be modified through executive branch action—by DOL rulemaking[263]—as opposed to congressional action, a closer look demonstrates that the latter is the more effective option.[264] DOL's substantive authority to regulate aspects of employee health plans—including network adequacy, transparency, and consumer financial protection—is established in large part by the Affordable Care Act—a bill that has come under judicial and political scrutiny.[265]

Because ERISA's text, the critical starting point, does not immediately make clear that such intervention is warranted,[266] determining this question depends on policy arguments about whether the reality of the current situation aligns with ERISA's stated purpose of promoting the interest of those insured in employer-sponsored health plans.[267] The sound and persuasive arguments opposing anti-assignment provisions, outlined throughout Part II.B, demonstrate an unavoidable plausibility that federal intervention may be warranted. However, the position that anti-assignment clauses actually *benefit* individuals in accessing affordable health care is "a proposition accepted by a variety of federal and state courts."[268]

Critically, the lack of a clearly correct answer to the situation is exacerbated by a notable failure of those contesting anti-assignment provisions to provide empirical evidence that supports the need for action. Policy arguments presented to courts have instead been predicated on generalities and merely anecdotal evidence,[269] which is helpful, yet only goes

261. Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 452 (3d Cir. 2018).

262. *See supra* text accompanying notes 142–44; *cf.* William N. Eskridge Jr., *Overriding Supreme Court Statutory Interpretation Decisions*, 101 YALE L.J. 331, 338 (1991) ("Congress frequently overrides or modifies statutory decisions by lower federal courts as well as those by the Supreme Court."); Gregory Koger, *How a Democratic Congress Can Push Back Against the Supreme Court*, VOX: MISCHIEFS OF FACTION (Nov. 12, 2018), https://www.vox.com/mischiefs-of-faction/2018/11/12/18080622/democratic-congress-against-supreme-court [https://perma.cc/BJV4-TPY4] ("Congress, however, can diminish the effect of . . . judicial policymaking by actually passing laws on several fronts . . . .").

263. Fuse Brown, *supra* note 1, at 194–97; *see supra* note 212.

264. *See supra* text accompanying notes 255–61.

265. Fuse Brown, *supra* note 1, at 196–97.

266. *See Am. Orthopedic*, 890 F.3d at 451 ("In short, the text of ERISA . . . is inconclusive on the question we address today."); *supra* Part II.B.1.

267. *Am. Orthopedic*, 890 F.3d at 451 ("Because ERISA does not clearly prohibit anti-assignment clauses, we confront a statutory gap yet to be filled . . . . To do so, we 'look to the provisions of the whole law, and to its object and policy.'" (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51 (1987))).

268. *Id.* at 452.

269. *See id.* ("Yet . . . neither party cites to authoritative empirical data.").

so far. Judge Cheryl Ann Krause of the Third Circuit emphasized this view, noting that "the parties' respective policy arguments are only as persuasive as the empirical data that support them."[270] Instead, however, sides advocating the conflicting positions "would have us deduce whether anti-assignment clauses promote or impede the goals of ERISA on the basis of their dueling economic arguments and without pointing us to any congressional findings or hearings on the subject."[271]

Contrary to the approach of those parties, any proposal to amend ERISA must be preceded by congressional facilitation of empirical data development, which would validate or invalidate the need for action. In undertaking this research endeavor, Congress should develop comprehensive empirical data that compares health care services in employer-sponsored health plans with anti-assignment provisions and those without such provisions.

More specifically, Congress should establish and investigate metrics that measure access to health care, with a focus on financial ramifications. As previously discussed, this is an indicator accepted by numerous courts as determinative of whether anti-assignment provisions achieve ERISA's intended purpose.[272] These research efforts could be achieved by drawing heavily on the DOL's authorization to promulgate rules and regulations requiring ERISA-governed health plans to submit certain data about health care claims.[273]

Potential metrics to consider assessing include, but are not limited to: (1) the average cost that an insured incurs when receiving out-of-network care where the insured's plan includes an anti-assignment provision; (2) the difference between the average amount advanced to the provider and the amount reimbursed by the insurer; (3) the frequency with which anti-assignment provisions result in unanticipated medical bills for insureds seeking out-of-network care; (4) the average amount of such bills; and (5) the difficulty, if any, for an insured with an anti-assignment provision in a health plan to obtain out-of-network care.

Even if anecdotal evidence unequivocally demonstrated the need for remedial action, empirical evidence would still likely be needed to succeed in the legislative process. Designing and executing a legislative solution is not a simple task given the extremely difficult process required to turn proposed legislation into actual law.[274] Further, there is no reason to think

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270. *Id.*

271. *Id.*

272. *See id.* at 451; *see also supra* text accompanying notes 191, 268.

273. "[This] statutory authority . . . is derived from Public Health Service Act (PHSA) section 2715A, which authorizes collection of data on health care costs and payments, and section 2717, which authorizes collection of data on health care quality." Fuse Brown, *supra* note 1, at 196.

274. *See generally* Andrew Rudalevige, *Why Does Congress Have Such a Hard Time Passing Laws?: Let's Blame the Constitution.*, WASH. POST: MONKEY CAGE (July 11, 2017), https://www.washingtonpost.com/news/monkey-cage/wp/2017/07/11/why-does-congress-have-such-a-hard-time-passing-laws-lets-blame-the-constitution [https://perma.cc/HHV7-2CHU].

sweeping changes to ERISA are feasible in the near term given that Congress's recent effectiveness at passing legislation has been historically subpar.[275] Congressional findings developed through hearings and other research tools may help the likelihood of bipartisan success on a legislative amendment pertaining to healthcare, one of the most hot button areas of policy today.[276]

B. Options for Potential ERISA Amendments in the Long Term

While this Note does not presuppose that Congress will find compelling evidence that ERISA needs to be amended, or even that anti-assignment provisions are detrimental to our healthcare system, there are several steps Congress could take should it find empirical evidence demonstrating that anti-assignment provisions are, in fact, damaging. Depending on the outcome of the research inquiry, a number of options stand out as potentially optimal paths forward if a long-term amendment is a prudent course of action. Part III.B proposes three revisionary options Congress could pursue and explores the strengths and weaknesses of each option. Part III.B.1 outlines mandatory assignment of benefits. Part III.B.2 highlights the possibility of tapering ERISA's broad preemption. Part III.B.3 explains the potential for allowing statutory standing for providers.

1. Mandatory Assignment of Benefits

The most obvious approach to amending ERISA in this context is a fairly simple one: mandating the right to assign the benefits that individuals are entitled to under employee welfare benefit plans. Though this may seem relatively innocuous on the surface, it is anything but. To the contrary, there could, and likely would, be a significant risk of sharp increases in insurance premiums because, as previously discussed, insurers have used anti-assignment clauses as a way to induce providers to come in network and control costs.[277] If assignment is mandated, providers likely would have less incentive to come in network and insurers would be susceptible to unforeseen rates charged by out-of-network providers.[278]

However, mandatory assignment of benefits laws are not unheard of—rather, they have been enacted on the state level in regulating non-ERISA-governed health plans.[279] Accordingly, if Congress found evidence, as part of its larger studies of anti-assignment provisions, that state laws mandating

275. *See generally* Derek Willis & Paul Kane, *How Congress Stopped Working*, PROPUBLICA (Nov. 5, 2018), https://www.propublica.org/article/how-congress-stopped-working [https://perma.cc/3AA4-FDHJ].

276. *See Election 2020: Voters Are Highly Engaged, but Nearly Half Expect to Have Difficulties Voting*, PEW RSCH. CTR. (Aug. 13, 2020), https://www.pewresearch.org/politics/2020/08/13/important-issues-in-the-2020-election [https://perma.cc/LRA3-QCVH] (identifying health care as the second highest topic considered "very important" by registered voters ahead of the 2020 election).

277. *See supra* text accompanying note 135.

278. *See supra* text accompanying note 193.

279. *See supra* text accompanying notes 234–35.

assignment of benefits did not lead to a hike in premiums, a federal adaptation of such an approach could be a feasible option. Additionally, advocates against anti-assignment provisions persuasively contend that mandating assignment is not as drastic as it may seem at first. For example, a spokeswoman for the Florida Medical Association explained that "the law would merely 'change the address on the [reimbursement] check,' meaning that instead of going to a patient, the check would be going to the physicians."[280]

Moreover, despite resistance from insurers, a study conducted on mandating assignment has demonstrated that "insurance companies would continue to earn substantial profits even if such an assignment mandate were in place."[281] Most importantly, effective mandatory assignment of benefits laws could lower the likelihood of an insured in an employer-sponsored health plan becoming a victim of balance billing,[282] thus furthering ERISA's intended protections.[283]

2. Tapering the Breadth of ERISA's Preemption

An alternative approach is to amend ERISA's text by tapering the breadth of its preemption powers. As discussed above, sections 502(a) and 514(a) both work to expressly displace state laws that impact employee welfare benefit plans, including health plans.[284] This preemption leaves state law that seeks to protect consumers of health care ineffective for those enrolled in ERISA-governed plans.[285] To taper ERISA's preemption would instead allow state legislatures to evaluate and implement the optimal governance for their constituencies.[286]

Congress could amend the aforementioned sections of ERISA to reflect an intent of conflict preemption, instead of the existing express preemption.[287] Under conflict preemption, "preemption occurs [only] when compliance with both federal and state regulations is a physical impossibility . . . or when state law poses an 'obstacle' to the accomplishment of the 'full purposes and objectives' of Congress."[288] This change could help achieve promotion of

280. Yusaf, *supra* note 4, at 118–19 (quoting Brandon Larrabee, *New Law Allows Out-of-Network Doctors to Be Paid Directly by Insurance Companies*, JACKSONVILLE.COM (June 11, 2009, 12:01 AM), https://www.jacksonville.com/article/20090611/NEWS/801233116 [https://perma.cc/9VPQ-N7QC]).

281. *Id.* at 127.

282. *See supra* text accompanying note 105.

283. Yusaf, *supra* note 4, at 126; *see supra* text accompanying note 108.

284. *See supra* text accompanying notes 43–47.

285. *See* Fuse Brown, *supra* note 1, at 194 ("In the context of consumer financial protection, ERISA preemption excludes from protection a large and growing number of consumers who[] are insured by self-funded employer health plans."); *see also supra* text accompanying notes 48–52.

286. *See* Fuse Brown & McCuskey, *supra* note 26, at 415; *see also supra* text accompanying note 50.

287. *See supra* Part I.A.

288. *See* SYKES & VANATKO, *supra* note 40, at 2 (footnote omitted) (first quoting Fla. Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142–43 (1963); and then quoting Hines v. Davidowitz, 312 U.S. 52, 67 (1941)); *see also* Fuse Brown, *supra* note 1, at 197 ("Under

the interest of participants and beneficiaries in employee welfare benefit plans by allowing state insurance and consumer financial protection laws to take effect for those in ERISA-related plans.[289] Because such state laws intend to foster and facilitate, rather than conflict with, the stated intentions of ERISA, they would likely not be preempted under a conflict preemption scheme.[290] For example, whereas currently, some state mandatory assignment of benefits laws are inapplicable to ERISA-governed plans due to preemption,[291] if these laws were given effect, anti-assignment clauses and their respective effects would become irrelevant because assignment would be mandatory.

Though, at first glance, returning the power to regulate a type of employee benefit plan to the states may seem inapposite to an intended federal "uniform regulatory regime,"[292] ERISA's legislative history, detailed in Part I.A, actually suggests Congress was far more concerned with regulating pension plans than welfare plans, including health plans.[293] Thus, it is plausible that allowing state laws to take effect with respect to a type of *welfare* plan, as opposed to a *pension* plan, does not run contrary to the true core of ERISA's original intentions.[294]

Additionally, a narrower view of preemption does have some basis in Supreme Court precedent.[295] The Court's approach to ERISA preemption is to take a narrower view than the broadest feasible interpretation of the fairly vague statutory text, specifically around ERISA's preemption powers.[296] If Congress were to transition ERISA's text to reflect conflict preemption rather than express preemption, it would merely be moving in the same direction that the Court has since ERISA's inception.[297]

3. Granting Statutory Standing to Out-of-Network Providers

An additional, though less significant, change would be to amend ERISA to grant statutory standing to providers. Instead of section 502 granting the right to sue to participants and beneficiaries only, Congress could instead add out-of-network providers to that list. Under this approach, while insureds

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conflict preemption, state laws are only preempted if they conflict with federal law, as opposed to ERISA's express preemption scheme which preempts all state laws if they relate to employee benefit plans, whether or not they conflict with ERISA.").

289. *See supra* text accompanying notes 50, 244–45, 286–87.

290. *See supra* Part I.A.

291. *See supra* note 248 and accompanying text.

292. Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004).

293. *See supra* notes 25–27 and accompanying text.

294. *See supra* text accompanying notes 24–27.

295. *See, e.g.*, Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016); N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96 (1983).

296. *See Travelers Ins. Co.*, 514 U.S. at 655–56 ("The governing text of [the] ERISA [preemption clause] is clearly expansive. . . . [But] [i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" (fifth alteration in original) (quoting HENRY JAMES, RODERICK HUDSON xli (Oxford Univ. Press 1980))).

297. *See supra* notes 295–96 and accompanying text.

would still be unable to assign their claims to providers where a valid anti-assignment provision exists, a provider could seek legal redress against insurance companies for nonpayment. Meanwhile, insurers would still maintain significant existing incentives for providers to come in network.[298] In addition to the safety net that being able to bring suit gives to providers, this model could also help promote uniform regulation because providers would not be forced into the work-around of suing under claims of disjointed state law but rather could consistently use ERISA.[299]

Though the provider would receive the protection of the right to pursue litigation, the grant of statutory standing could help achieve ERISA's stated purpose by actually promoting the interests of the employees enrolled in employer-sponsored health plans. Employees would likely continue to benefit financially with respect to their health plan premiums, which would continue to be low because the providers would still be incentivized to come in network.[300] However, for providers not participating in the network, treating out-of-network patients would become more palatable because the out-of-network provider would retain the ability to sue the insurance company directly should any issues arise.[301] Lastly, because providers would be able to file such suits, patients would incur far less risk of assuming unknown costs.[302]

This approach essentially serves as a compromise. The ERISA-governed insurance market following this amendment would be similar to current anti-assignment provisions. Anti-assignment provisions would continue to be effective and their intentions would be achieved, for the most part, as the advantages of coming in network would continue to exist.[303] However, out-of-network providers would simply have an extra layer of protection for the most egregious situations warranting litigation, such as when insurers underpay the provider to a severely problematic degree for services rendered.

C. Proposed Interim Solutions to Mitigate Anti-assignment Provisions

As congressional development of findings related to anti-assignment provisions would not occur overnight, there are interim steps that could mitigate the existing effects outlined above. Part III.C argues that, until Congress decides whether amendment of ERISA is warranted—and even for the long term if no amendment is enacted—ERISA's purpose will be furthered by the use of such interim solutions. Part III.C.1 outlines the possibility of providers using power of attorney to bring legal claims against insurers on behalf of patients. Part III.C.2 encourages providers to develop and implement the consistent use of standard form contracts to govern the

298. *See supra* note 135 and accompanying text.

299. *See supra* text accompanying notes 206–08, 228. *But see infra* Part III.C.2 (discussing the plausible perspective that the duties established in such ad hoc arrangements are distinct from the ERISA-governed plan terms).

300. *See supra* text accompanying notes 83–86, 135–37.

301. *See supra* text accompanying notes 195, 202–03.

302. *See supra* text accompanying note 161.

303. *See supra* note 135 and accompanying text.

provision of out-of-network care. Part III.C.3 suggests employers take initiative to protect their employees by negotiating employee health plans that do not include anti-assignment provisions.

1. Out-of-Network Provider Use of Power of Attorney

Where an allegedly harmed provider does not have standing to bring a claim against an insurer due to an anti-assignment provision,[304] use of a power of attorney (POA) may allow the provider to pursue claims on the insured's behalf.[305] POA is "an instrument in writing by which one person, as principal, appoints another as his or her agent and confers upon the agent the authority to perform certain specified acts."[306] POA does not transfer an ownership interest in a claim,[307] as assignment does,[308] but rather grants authority to the agent to act "on behalf of the principal."[309]

Though POA is not a common avenue of relief in the anti-assignment provision context, at least one court of appeals has endorsed the feasibility of its use, noting that an insured "may confer on his agent the authority to assert [a] claim on his behalf, and the anti-assignment clause no more has power to strip [the provider] of its ability to act as [the insured's] agent than it does to strip [the insured] of his own interest in his claim."[310] Put differently, because the claim is not being transferred to another individual, but instead simply pursued by another party on the original party's behalf, the anti-assignment provision has no impact. If it did, it would amount to completely barring suit by the insured individual in the first place.

Accordingly, as Congress develops greater insights into anti-assignment provisions, providers facing litigation-worthy underpayment should, in the interim, seek to use POA to enforce the terms of out-of-network patients' insurance plans in court. While this is not a perfect solution because the provider still does not technically have ownership of the claim and the patient continues to serve as the financial intermediary, it is likely more effective than suing the patient to recover lost fees or simply accepting the status quo.

2. Consistent Use of Standard Form Contracts for Specialized Out-of-Network Care

As discussed above, one alternative to relying on ERISA-related remedies for a provider, where possible, is to proactively establish a separate

304. *See supra* Part I.C; text accompanying notes 158–59.

305. *See* Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield, 890 F.3d 445, 455 (3d Cir. 2018).

306. 3 AM. JUR. 2D *Agency* § 20 (2020) (footnote omitted).

307. W.R. Huff Asset Mgmt. Co. v. Deloitte & Touche LLP, 549 F.3d 100, 108 (2d Cir. 2008).

308. *See supra* text accompanying note 127.

309. Villanueva Compania Naviera v. Bethlehem Steel Corp. (*In re* Complaint of Bankers Tr. Co.), 752 F.2d 874, 881 (3d Cir. 1984).

310. *Am. Orthopedic*, 890 F.3d at 455.

contractual agreement with an insurer before rendering out-of-network care.[311] At first glance, suing under disjointed state contract causes of action may appear to run contrary to ERISA's desired uniform governance. However, a number of courts have found to the contrary.[312] The key distinction is that the relevant obligations in the contract law causes of action context do not arise from ERISA-governed plans but rather from independent contractual obligations.[313] "In these disputes, the provider is 'not arguing about plan terms. It is not seeking to recover plan benefits . . . .'"[314] Rather, the provider "'is bringing state-law claims based on the alleged shortcomings in the communications between it and' the insurer or the plan."[315]

However, while this use of contract law may not necessarily contradict ERISA's intended purpose, the consistency of using a standard form contract, or lack thereof, has hampered its effectiveness as a work-around.[316] As eloquently explained by the Third Circuit:

> It is odd indeed that a pre-service agreement that sets forth the services to be provided alongside the dollar amounts to be paid is not yet common practice for out-of-network providers, particularly where a given provider operates as a large-scale, sophisticated business entity, as it would provide both parties with clarity and avoid the thicket of issues we find ourselves in today.[317]

As discussed above, without a standard form, certain terms within the ad hoc contractual agreement between an insurer and provider may default back to the terms of the insured's health care plan.[318] Where this occurs, preemption prohibits providers from bringing suit due to the impermissible "reference to" the plan.[319]

Accordingly, providers should work toward establishing and instituting effective standard form contracts to govern out-of-network service provisions as appropriate and, to avoid any preemption, providers should ensure that these agreements do not default to ERISA-plan-related terms.[320] While these are not feasible in all situations,[321] effective standard forms will likely minimize the potential of a provider declining to provide specialized

311. *See supra* Part II.B.3.

312. *See* Franciscan Skemp Healthcare, Inc. v. Cent. States Bd. Health & Welfare Tr. Fund, 538 F.3d 594, 599 (7th Cir. 2008) (surveying cases identifying that common-law contractual causes of action about independent agreements are distinct from those specifically revolving around the terms of an ERISA-governed plan).

313. Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc., 944 F.2d 752, 756 (10th Cir. 1991) ("An action brought by a health care provider to recover promised payment from an insurance carrier is distinct from an action brought by a plan participant against the insurer seeking recovery of benefits due under the terms of the insurance plan.").

314. Brief for the Secretary of Labor, *supra* note 213 at 18 (quoting *Franciscan Skemp Healthcare*, 538 F.3d at 601).

315. *Id.* (quoting *Franciscan Skemp Healthcare*, 538 F.3d at 601).

316. *See* Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 229 (3d Cir. 2020).

317. *Id.* at 229 n.14.

318. *See supra* text accompanying notes 220–22.

319. *See supra* text accompanying notes 220–22.

320. *See supra* text accompanying notes 220–22.

321. *See supra* text accompanying notes 225–26; Part I.B.2.

out-of-network care as—in a last resort situation—providers' lawsuits would not face the risk of preemption that otherwise exists.[322] Therefore, the chances of a provider failing to receive adequate compensation would be inherently lowered.

3. Employer Negotiation with Health Insurers

The third and final interim solution that could be deployed to combat the impact of anti-assignment provisions is effective bargaining by employers on their employees' behalves. Courts assessing challenges to the validity and enforceability of anti-assignment provisions have reiterated regularly that they are pieces of private, freely-negotiated contracts.[323] Employers—the parties responsible for bargaining with insurers over the terms of the health plans offered to employees—should take some responsibility for promoting the interests of those employees when negotiating ERISA-governed health plans.[324] Though it may seem that the highly profitable U.S. health insurance companies can afford to employ a "take it or leave it" attitude when offering terms,[325] in reality, employer-based health plans are the largest source of coverage in the United States[326] and "[e]mployers, especially large employers, are usually able to obtain more favorable pricing and coverage than individuals can,"[327] signaling their bargaining power.

While business leaders may be unfamiliar with the minutiae of health insurance contracts and see little value in directing significant attention to the topic, it actually makes good financial sense "to understand the health care benefits business," as "[e]mployee health benefits consume more than $15 million annually per 1,000 employees."[328] Additionally, more than half of U.S. adults receiving health insurance coverage from their employers have indicated that it is a "key factor" in whether they stay at their jobs.[329]

Accordingly, if an employer believes that employees participating in a health plan it offers have faced issues as a result of certain aspects of the contract negotiated on the employees' behalves, such as an anti-assignment provision, the employer should work diligently to use its bargaining power

322. *See supra* text accompanying note 317.

323. *See supra* note 144 and accompanying text.

324. *See* Vivian S. Lee, *U.S. Health Care Is in Flux. Here's What Employers Should Do.*, HARV. BUS. REV. (June 15, 2020), https://hbr.org/2020/06/u-s-health-care-is-in-flux-heres-what-employers-should-do [https://perma.cc/H287-YHAN] ("[E]mployers should shop and negotiate for health care solutions with the same rigor they shop for their business needs. They should challenge vendors to demonstrate the cost-effectiveness of their programs to produce better health and improve productivity, presenteeism, and quality of life for their employees.").

325. *See, e.g.*, Reed Abelson, *Major U.S. Health Insurers Report Big Profits, Benefiting from the Pandemic*, N.Y. TIMES (Aug. 5, 2020), https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html [https://perma.cc/T77C-KCNA].

326. KONGSTVEDT, *supra* note 22, at 38.

327. *Id.*

328. Lee, *supra* note 324.

329. Stephen Miller, *Employees Are More Likely to Stay If They Like Their Health Plan*, SOC'Y FOR HUM. RES. MGMT. (Feb. 14, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-benefits-foster-retention.aspx [https://perma.cc/QT4S-8XX3].

to negotiate such provisions out of the contract. Employees, in turn, should proactively inform the responsible individuals at their companies about any hardship that they have experienced, both generally in utilizing their health plans and specifically those that arise due to anti-assignment provisions. Such combined advocacy efforts by both the employer and employee may help to mitigate the ramifications resulting from anti-assignment provisions detailed throughout this Note.

CONCLUSION

The anti-assignment provision has become a critical part of health insurers' attempts to minimize costs associated with the provision of health care. Despite the urgency with which politicians and their constituencies discuss healthcare today, anti-assignment provisions have failed to gain the notoriety they warrant. This failure to acknowledge and investigate their importance has led to the glaring lack of data and findings on their impacts, leaving merely anecdotal evidence in arguments about anti-assignment provisions.

This pitfall is especially critical in the context of employee health plans given ERISA's purported intention to protect employees and their beneficiaries participating in such plans. While ERISA's text is unclear about the right to assign benefits due under such health plans and policy arguments are persuasive in both directions, this Note ultimately contends that the lack of clarity can only be resolved through the development of sufficient empirical data. These findings, in turn, will guide Congress toward a decision on whether or not an amendment to ERISA, such as the feasible avenues outlined above, is warranted to address the effects of anti-assignment provisions.