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WHO IS PROVIDING FOR THE PROVIDERS?

Ryan Savercool

New Jersey’s health insurance industry needs reform. The parties involved: the subscribers to health care plans, the health care providers and the insurers, have a significant stake in whether certain changes are instituted. New Jersey legislators have introduced two new bills that will dramatically reform the system in ways that both protect patients from surprise bills and providers from being under-reimbursed by insurers when administering out-of-network care. In tandem, the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act (“The Out-of-network Act”) and Health Care Consumer Cost Transparency Act (“The HPI Act”) create a uniform system to determine health care costs and resolve disputes related to out-of-network emergency and incidental care.

The proposed changes have been subject to several years of polarized political debate and commentary from all of the interested parties. The most recent versions of the bills had gained momentum but were tabled at the end of the year. However, if the state is ever to effectuate the changes proffered, a potentially overlooked legal issue must be addressed—whether subscribers

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3 Id.


should be able to assign their health plan benefits to out-of-network providers, despite the presence of a valid anti-assignment provision in the plan. Currently, these anti-assignment provisions are enforceable because of the public interest they promote in containing health costs.\(^6\) However, due to considerable changes in the healthcare landscape, the court’s analysis of assignment of benefits to out-of-network providers may warrant revision.

In Parts I and II, this note will provide a general overview of how the insurance industry operates and discuss how New Jersey courts approach assignment and anti-assignment provisions in the health insurance context. Next, in Part III, this note will outline the details of the two bills and the changes they propose. In Part IV, this note will analyze the current perspectives of subscribers, out-of-network providers and insurers, concluding that the reforms will better serve each parties’ interests than the status quo. Finally in Part V, this note will revisit the analysis of *Somerset Orthopedic Associates, P.A. v. Horizon Blue and Cross Blue Shield*. If the proper action is taken by both the Legislature and the Judiciary, New Jersey’s administration of health care benefits can be significantly improved. Accordingly, two significant changes should occur: (1) these bills or analogous legislation should be passed, and (2) subscribers should be able to assign to out-of-network providers the benefits of their insurance plans because the public policy behind anti-assignment provisions is no longer sound for out-of-network emergency and incidental care.

**Part I: General Overview of the Health Insurance Landscape**

The current and arguably dysfunctional insurance system spawned from the enactment of the Health Maintenance Organization Act of 1973.\(^7\) The intentions of the act were sound, as it was

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a response to increasing health care costs and a lack of primary care services. In its most basic form, the managed-care model allows persons to subscribe to health insurance plans to obtain certain benefits in consideration for a periodic premium. Insurers act as “gatekeepers” and rely on “closed system[s] of providers to contain costs.” These benefits include access to a designated primary care physician, access to a set of other cost-restricted providers, and the ability to be relieved any direct financial obligation to the provider when receiving certain health care services. To effectuate these benefits for consumers, insurance carriers contract with providers to create a network of providers who agree to accept reduced set-fee amounts for services rendered, in return for a higher volume of patients. State law now governs managed care models and New Jersey has developed a complex statutory regime governing this area.

Variants of the HMO exist such as preferred provider organizations (PPO), which allows subscriber to go outside the established network of providers but at the cost of higher premiums in consideration for the out-of-network services. Additionally, providers, for a variety of reasons, may choose to remain “out-of-network.” Certain providers may find reimbursement for services to be too low, some may wish to remain more autonomous, and others may wish to run a simpler practice and avoid the tedious billing requirements imposed by the carrier.

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11 Yusaf, supra note 7, at 88, 90.
13 See N.J.A.C. 11:24-1.1 to 18.4 (establishing HMOs).
14 Lucas & Williams, supra note 11, at 135.
16 Ibid.
One of the primary benefits of the contractual relationship between the providers who choose to join an insurer’s network is the right to receive payment directly from the insurer via the assignment of subscriber’s benefits.\textsuperscript{17} This relieves the subscriber of “any further financial burden, and in turn requires [the insurer] to pay each participating provider directly . . . doubtless encouraging] greater participation in the network.”\textsuperscript{18} To police this benefit, contracts between subscribers and insurers often include anti-assignment provisions that prohibit the assignment of benefits to providers who remain out-of-network.\textsuperscript{19} Thus, when a subscriber visits an out-of-network provider, the insurer directly pays the subscriber, who in turn, reimburses the provider. These anti-assignment provisions have been held to be valid because they presumably contain health costs.\textsuperscript{20}

\textbf{Part II: Assignment Law, Somerset Orthopedic Associates, and Subsequent Statutory Changes and Interpretation}

Before a more detailed examination of the down-stream consequences that anti-assignment provisions have on the health care delivery system, a short explanation of New Jersey’s common law principles regarding assignment is in order. Public policy generally supports the rule that choses in action are freely assignable, but this rule is not absolute.\textsuperscript{21} In assessing the validity of an anti-assignment provision in a contract, New Jersey has adopted the rules advocated by the Restatement (Second) of Contracts.\textsuperscript{22} Section 322 of the Restatement posits “that contractual

\textsuperscript{17} \textit{N.J.S.A.} 17:48E-10(b) (“A participating provider of health care services is one who agrees in writing to render health care services to or for persons covered by a contract or contracts issued by a health service corporation in return for which the health service corporation agrees to make payment directly to the participating provider.”)


\textsuperscript{19} \textit{Somerset Orthopedic Assocs.}, 785 A.2d at 461.


provisions prohibiting or limiting assignments operate only to limit the parties’ right to assign the contract, but not their power to assign, unless the parties manifest with specificity an intent to the contrary.\textsuperscript{23} Section 317 recognizes the validity of assignments, but specifically identifies exceptions that limit the assignability of contractual rights.\textsuperscript{24}

A contractual right can be assigned unless: (a) the substitution of a right of the assignee for the right of the assignor would materially change the duty of the obligor, or materially increase the burden or risk imposed on him by his contract, or materially impair his chance of obtaining return performance, or materially reduce its value to him, or (b) the assignment is forbidden by statute or is otherwise inoperative on grounds of public policy, or (c) assignment is validly precluded by contract.\textsuperscript{25}

Thus, the overall framework for analyzing an anti-assignment provision is to look to the specific language of the clause to ensure that the parties manifested specific intent to limit the power of an assignment, then to determine whether any of the exceptions to the rule in favor of the provision’s enforcement.\textsuperscript{26} Regarding the first inquiry, it is standard that most insurance plans contain language manifesting the express intent to limit the power of an assignment of benefits.\textsuperscript{27} Thus, whether an anti-assignment provision is enforceable turns on whether any of the three exceptions apply.

In \textit{Somerset Orthopedic Associates}, the Appellate Division of the New Jersey Superior Court upheld the validity of anti-assignments clauses, noting that other courts have concluded that these clauses “are valuable tools in persuading health care providers to keep their costs down’ and

\textsuperscript{23} Owen, 771 A.2d at 1218.
\textsuperscript{24}Restatement (Second) of Contracts § 317 (1981).
\textsuperscript{25} Ibid.
\textsuperscript{26} See Owen, 771 A.2d at 1219-20.
\textsuperscript{27} For example, New Jersey has codified the content of individual and small employer reform contracts with standard language typical of anti-assignment clauses: “No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our discretion, pay a Provider directly for services rendered to You.” N.J.A.C. 11:20-App. et. seq.
as such override the generally policy favoring the free alienability of choses in action."28 “[If the patient could assign his or her rights, it would undercut the pre-arranged costs with in-network providers that are relied upon by non-profit health services corporations in deciding the premium amount.”29

The court further grounded its decision by looking to overall statutory scheme under which Horizon, the defendant in the action, was established.30 Horizon is a health service corporation organized under the Health Service Corporations Act and is distinct from ordinary health insurers who act to only indemnify subscribers.31 “[Horizon’s] purpose was to ‘satisfy the needs of the hospitals and the community as a whole through partnership between hospitals and a non-profit prepayment plan.”32 “If there are no physicians participating in the medical service corporation’s plan . . . subscribers [would] be deprived of the protection which they might reasonably have expected [] be provided.”33 With the passage of the Health Service Corporation Act, “Horizon continue[d] to carry out the essentially public mission entrusted to its predecessor corporations of providing available and affordable health insurance to a broad-based community.”34

The court found that the right of the subscriber to choose a physician was preserved since the subscribers may choose to visit an out-of-network subscriber so long as the patient understands

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29 Somerset Orthopedic Assocs., P.A., 785 A.2d at 461.
30 Id. at 462.
31 Id.; See Group Health Ins. of N.J. v. Howell, 193 A.2d 103, 111-12 (1963) (“The basic distinction between medical service corporations and ordinary health and accident insurers is that the former undertake to provide prepaid medical services through participating physicians, thus relieving subscribers of any further financial burden, while the latter only undertake to indemnify an insured for medical expenses up to, but not beyond, the schedule of rates contained in the policy.”)
32 Somerset Orthopedic Assocs., P.A., 785 A.2d at 462 (internal citations omitted).
33 Somerset Orthopedic Assocs., P.A., 785 A.2d at 463 (quoting Group Health Ins. of N.J. v. Howell, 13 A.2d 103 (1963)).
34 Somerset Orthopedic Assocs., P.A., 785 A.2d at 463 (citing N.J.S.A. 17:48E—3(d)) (alteration in original).
that she would be reimbursed directly and responsible for payment to the provider.\textsuperscript{35} At the same
time, the anti-assignment clauses prevented the out-of-network providers from realizing the
benefits of being in-network without the contractual constraint.\textsuperscript{36} This enabled Horizon to control
costs and provide affordable coverage based on growth of the network by inducing providers to
join with the anti-assignment clause.\textsuperscript{37} The court deferred heavily to legislative judgments made
at the time in holding that the “anti-assignment clauses comport with both the statutory language
and the legislative intent of affording health care coverage while containing costs.”\textsuperscript{38}

Since the Appellate Decision rendered its decision, the health care industry has grown more
dysfunctional, and there may have been a shift in the Legislature’s feelings regarding whether the
constraints imposed on out-of-network physicians should be lifted in certain contexts. “As the
economy worsens and reimbursements drop, managed care organizations and providers clash more
often.”\textsuperscript{39} Thus, providers, frustrated with unacceptable contract terms, are retreating from MCOs
and going out-of-network.\textsuperscript{40}

Further, certain physician practices by their nature are susceptible to high levels of out-of-
network physicians.\textsuperscript{41} When a subscriber incidentally receives out-of-network care at a hospital,
for example from a radiologist prior to a procedure, it is plausible that the radiologist does not
know the insurance status of the patient and may be required to bill the patient directly for the
procedure.\textsuperscript{42} When receiving the bill, the patient is barred by her anti-assignment provisions from

\textsuperscript{35} Id.
\textsuperscript{36} Id. at 464.
\textsuperscript{37} Id.
\textsuperscript{38} Id. at 465.
\textsuperscript{39} Lucas & Williams, supra note 11, at 134.
\textsuperscript{40} Ibid.
\textsuperscript{41} See id. at 137 (“If the emergency department physician is contracted, the on-call specialist or the hospital-based
anesthesiologist, radiologist, or pathologist may not be. Accordingly, an enrollee may access the care of a
nonparticipating provider without doing anything ‘wrong.’”).
\textsuperscript{42} Kelly A. Kyanko, et al., Out-of-Network Physicians: How Prevalent are Involuntary Use and Cost
Transparency?, 48 Health Services Research 3 (June 2013) (Neither side reportedly knows)
assigning her benefits to the provider who may want to have the insurer collect and dispute her reimbursement directly. Consequent of, if a subscriber is subsequently reimbursed for out-of-network care at an exceedingly low rate, she may not be able to satisfy the remainder of the bill to the provider. If the provider and subscriber cannot complete the transaction, only the subscriber can enforce her right to a reasonable reimbursement in courts. Thus, providers must necessarily rely on the subscriber to enforce her benefit in order for the provider to get paid for their service. Over the years, providers have attempted to have the courts revisit this issue, but without success.

Additionally, despite a subscriber’s efforts to visit an in-network provider or facility in order to take advantage of the set-costs, emergencies and situations frequently arise that force a subscriber to visit out-of-network physicians. In these instances, subscribers to health plans are statutorily protected from being subject to the entire out-of-network bill by limiting the liability of the subscriber to the copayment, deductible or coinsurance of in-network services. This creates a problem for out-of-network providers who are seeking to be compensated for their services.

Providers will often seek from the full amount the provider elects to charged, generally referred to

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43 See Somerset Orthopedic Assocs., 785 A.2d at 460 (“Horizon, relying on the anti-assignment clause in its subscriber contracts, refuses to pay plaintiffs directly, but instead sends payment to the subscriber.”).
44 See Roni Caryn Rabin, Report Faults High Fees for Out-of-Network Care, N.Y. Times (Jan. 31, 2013) (“The [insurance] industry’s own report suggest that using Medicare rates as a benchmark will lead to patients’ picking up much more of the cost for out-of-network care, whether they carefully select a specialist or, as in the case of . . . many others, have no choice in the matter.”).
46 See Lucas & Williams, supra note 11, at 137 (“If an enrollee require emergency care . . . emergency medical transport or a private party will take the enrollee to a hospital emergency department without regard to whether the hospital has a contract with the enrollee’s payor.”)
47 N.J.A.C. 11:22-5.8(b)(1) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is a network provider to the subscriber’s copayment or coinsurance so long as the subscriber and provider have complied with all required preauthorization or notice requirements); N.J.A.C. 11:22-5.8(b)(2) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is out-of-network to the subscriber’s copayment or coinsurance).
as “billed charges.”48 Given the lack of privity, however, insurers have the upper-hand in the bargaining process since they are the ones who deal out the payments. Thus, insurers may reimburse out-of-network providers at an amount similar to the in-network rate—a rate that these providers expressly did not agree to accept.49 This out-of-network rate is usually referred to the “usual, customary, and reasonable charge (UCR)—a concept that generally embodies payment of an amount that a health plan determines is usual for a particular procedure, charged by a majority of physicians with similar training and experience within the same geographic area.”50 Although seemingly cognizant of an individual provider’s circumstances, the uneven bargaining power favors insurers, as they ultimately determine what a provider and her services are worth.

On the other hand, if insurers do comply with providers’ billing for emergency services at the providers’ suggested rate, the burden may fall onto subscribers.51 Insurers have the ability to spread out the costs among the plan subscribers to protect the bottom line. Thus, it is conceivable that insurers simply may raise premiums in light of their subscribers receiving incidental out-of-network care at no fault of their own.52 The proposed bills address these issues and warrant revisiting the validity of anti-assignment clauses.53

48 Lucas & Williams supra note 11, at 137.
49 See Aetna Settlement; but see OLS Legislative Fiscal Estimate of Act (“The rule does not limit the amounts that providers can charge the [insurers] . . . which currently must pay up to the billed charges, if a lower amount cannot be negotiated.”)
50 Lucas & Williams, supra note 11, at 137.
51 See Alan D. Lash, et al., The Battle Rages On: Recent Developments in Reimbursement of Non-participating Emergency Service Providers, 22 No. 2 Health Law. 30, 30 (Dec. 2009) (stating that insurers argue that they should set the rates to avoid “windfall” reimbursements to providers, to prevent providers from setting arbitrary rates and higher health costs due to smaller networks).
52 Andrew Kitchenman, Easy Access to Info on Costs of Medical Procedures Remains Key Provision of Bill, NJ Spotlight (June 2, 2015) available at http://www.njspotlight.com/stories/15/06/01/easy-access-to-info-on-costs-of-medical-procedures-remains-key-provision-of-bill/
53 Compare N.J.A.C. 11:24-5.3 (2008) (“Carriers shall reimburse hospitals and physicians” for “trauma services at any designated Level I or II trauma center as medically necessary.”) with Somerset Orthopedic Assocs., 785 A.2d at 465 (“[T]he anti-assignment clause in Horizon’s subscriber contracts is valid and enforceable to prevent assignment by subscribers of policy benefit payments...”). If an insurer receives a large bill from a patient who received emergency care from an out-of-network doctor, it is unclear whether the insurer can rely on the anti-assignment provision to prevent the provider from challenging the reimbursement amount. One can argue that this statute would assign the right to collect payment but not allow the
Part III: The HPI and Out-of-Network Bills

On May 14, 2015 Senators Joseph Vitale and Loretta Weinberg introduced a bill with aims of resolving health care billing disputes, containing rising costs and increasing transparency in pricing. The reforms addressed surprise out-of-network charges in emergency room procedures, and reports from providers that inadequate reimbursements from insurers has resulted in increased financial stress, low morale and reduced quality of care being provided to patients. The bill aimed to establish a Healthcare Price Index ("HPI"), which would collect health care data to aid seeking solutions to the problems by creating:

A more complete picture of how much health care costs, how much providers receive for the same or similar services, the resources used to treat patients, and variations across the State, and among providers in the total cost to treat an illness or medical event. In turn, businesses, consumers, provider, and policymakers can use the non-proprietary information to make better-informed decisions about cost-effectiveness and the quality of care.

Concerns about cost, administrative feasibility and efficiency, and minimum protections for subscribers, however, doomed the original bill.

In its place with substantial the same language, the Out-of-network Act seeks to place limits on out-of-network billing in two situations: "(1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) [if a covered person

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\(^{55}\) Id. at 2(a).

\(^{56}\) Id. at 2(c),(e).

\(^{57}\) Id. at 2(i).

receives] inadvertent out-of-network services." The bill defines inadvertent out-of-network services as covered services provided by an out-of-network provider at an in-network facility, where in-network services are unavailable for any reason. The bill protects patients receiving medically necessary services by prohibiting an out-of-network provider from billing the patient "in excess of the lowest deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person’s health benefits plan." Further, the bill provides in the event of inadvertent out-of-network services or emergency care, "the benefits that the covered [subscriber] receives for health care services shall be assigned to the out-of-network health care provider, which requires no action on the part of the covered person." This assignment of benefits permits providers to bill and to be paid directly by insurers.

With respect to the remainder of the provider’s bill, the insurer and the provider have thirty days to agree on an amount before one party can initiate a new binding arbitration process. The parties shall each propose an amount that the arbitrator shall choose as final. The arbitrator shall consider various relevant factors which include provider’s experience, usual charge, the case and patient’s complexity. Further, the arbitrator may consider the average in-network payment, the average out-of-network payment, the average accepted reimbursement, the Medicare rate, and any non-affiliated UCR commercial database. After the arbitrator selects an amount, the parties have

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60 Id.
61 Id.
62 Id. at 6.
63 Id.
64 Id. at 5.
65 Id. at 6.
66 Id. at 6-7.
67 Id. at 7.
the option of invoking a further non-binding peer-review process with oversight provided by the Board of Medical Examiners.68

Initially, the original act sought to carry out this above provisions through the HPI and other “policies and procedures for the collection, processing, storage, and analysis of health care data.”69 The HPI was intended to serve as an objectively reliable and comprehensive source of health information.70 Its goal was to provide a list of median paid in-network claims to create a “reasonable and clearly defined payment range . . . for any amount billed by an out-of-network health care provider and reimbursed by a carrier for out-of-network services provided on an emergency or urgent basis and as inadvertent out-of-network services.”71 In the arbitration process, providers would be required to submit bills between 75% and 250% of the median HPI amount.72 This ultimately was part of the initial bill’s failure because providers were concerned with having a statutory cap on amounts payable.73

In its revised form, the HPI Bill promotes a database similar to “all-payer claims databases” that have been established in other states and is decoupled from the Out-of-network Act.74 Instead, the HPI will be used as an objective and reliable benchmark for consideration in arbitration, for research and for transparency moving for consumers moving forward.75 The HPI will no longer

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68 Id. at 5, 7.
70 Id.
71 Id.
72 Id.
74 Office of Legislative Services, A952 Legislative Fiscal Estimate, 216th Leg. (N.J. 2016).
be a dispositive factor in the arbitrator’s decision but once rolled out, it will be the most reliable source for information regarding reasonable reimbursements.\textsuperscript{76}

**Part IV: Passage of the Act from the Perspective of Subscribers, Providers and Insurers**

Passage of these bills may preempt *Somerset Orthopedic Associates*, because the Out-of-network Act operates on the premise that an out-of-network provider can directly bill an insurer and enforce both its own and subscribers’ rights.\textsuperscript{77} While statutory protections are in place that already require the provider to bill the insurer directly, there currently is no enforcement mechanism to ensure responsible reimbursement.\textsuperscript{78} These bills provide for a uniform system that will give providers a means of leveraging their position without being encumbered by anti-assignment provisions. This is the proper course of action because: (1) the Out-of-network Act eliminates the practice of balance billing when surprise charges arise from incidental out-of-network care by setting maximum amount of charges to a subscriber; (2) the HPI and arbitration scheme will create a uniform system of enforcement that better protects providers from negative reimbursement decisions made by insurers; and (3) the changes will not overly burden insurers because of the narrow application of the bill to incidental out-of-network care and emergency care.

In sum with the passage of these bills, the public policy analysis conducted by the Appellate Division in *Somerset Orthopedics* may warrant revision.

**1. Protections to Subscribers: Balance Billing**

From research completed by the American Health Insurance Plans (AHIP), a national association of over 1300 insurance companies, out-of-network providers are responsible for bills

\textsuperscript{76} Id. at 3.


\textsuperscript{78} Lucas & Williams, *supra* note 11, at 137-38.
to subscribers that range from more than ten to one hundred times what Medicare would reimburse for the same service in a particular region.\textsuperscript{79} Consumers incur these huge bills when out-of-network providers balance bill, and charge subscribers the difference between their insurer’s reimbursement and the provider’s billed charge.\textsuperscript{80} Balance billing is a phenomenon that is generally an issue only in the HMO context because subscribers’ financial responsibility is set term in contract.\textsuperscript{81} However, because out-of-network providers lack privity of contract with the insurance companies, the parties often do not agree on what a fair value is for their services, and thus, may subject HMO subscribers to certain additional costs.\textsuperscript{82} When an insurer insufficiently reimburses an out-of-network provider, the provider turns around and tries to collect what she believes she is owed from the patient.\textsuperscript{83}

Balance billing is nearly categorically prohibited by in-network physicians.\textsuperscript{84} Further, emergency room patients are statutorily protected against balance billing.\textsuperscript{85} Therefore, this problem only arises in the case of when a subscriber undergoes incidental out-of-network care.\textsuperscript{86} For example, the AHIP reports that the highest reported maximum out-of-network charge billed to a patient for critical care in New Jersey was $27,310, more than ninety-three times what Medicare would have paid for the procedures.\textsuperscript{87} Out-of-network providers are often forced to rely on balance-billing since the insurers are in charge of setting costs, but it is the subscribers who

\textsuperscript{80} Id. at 2; see Hammond, \textit{supra} note 15, at 447.
\textsuperscript{81} Lucas & Williams, \textit{supra} note 11, at 136.
\textsuperscript{82} Id. at 147.
\textsuperscript{83} Id.; Yusaf, \textit{supra} note 7, at 90.
\textsuperscript{84} Hammond, \textit{supra} note 15, at 470.
\textsuperscript{85} See N.J.A.C. 11:22-5.8(b)(1).
\textsuperscript{86} Hammond, \textit{supra} note 15, at 470.
\textsuperscript{87} America’s Health Insurance Plans, Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability, at 5.
receive the brunt of the harm from this process. Doctors have protested the AHIP findings and have asserted that insurers have “effectively shifted the cost of out-of-network care onto patients by changing reimbursement formulas.” “Instead of the rates commercial insurers usually pay doctors, insurers are increasingly basing their out-of-network payments on Medicare rates, [which are] usually far lower.” Currently, many health plans with policies that cover out-of-network providers only do so at a percentage of Medicare’s determined reimbursement. Providers have claimed these reimbursements are effectively worthless and render subscribers responsible for the nearly the whole cost of their medical treatment. For example, the New Jersey Department of Banking and Insurance issued an Administrative Order requiring Aetna to repay out-of-network providers for under-reimbursed charges. Prior to the order, Aetna paid out-of-network providers only 125% of what Medicare paid for the same claims. The Department “concluded that Aetna was required to pay the non-participating provider a benefit large enough to insure that the non-participating provider would not balance bill the patient for the difference between the provider’s billed charges and Aetna’s payments.”

Patients in the face of an emergency, often have no choice in selecting a physician when they rush to a hospital to seek medical attention. When someone needs immediate medical attention and goes to an in-network hospital, the question of whether or not a privately contracted

88 Yusaf, supra note 7, at 85, 93-95.
90 Id.
91 Id.
92 Id.
93 Yusaf, supra note 7, at 124, Order Number A07-59. State of New Jersey Dept. of Banking and Insurance in the Matter of Aetna
94 Yusaf, supra note 7, at 124.
95 Ibid. (citing Lash, supra note 51, at 31).
physician who may not be part of the subscriber’s network administering care during a complex procedure is not a family member’s immediate concern. When a patient arrives at an in-network hospital, a patient cannot adequately protect herself from receiving expensive, incidental care from out-of-network emergency room doctors, anesthesiologists, radiologist and pathologists. Exacerbating this issue, New Jersey has promulgated an extensive list of rules required for hospital licensure which includes requiring that special physician groups conducting majority of their practice on-site including radiology, anesthesia, pathology, and emergency medicine. Consultation prior to surgery by anesthesiologists, imaging by radiologists and emergency treatment in these hospitals are performed by contracted, for-profit physician groups for whom without, hospitals would operate less efficiently resulting in lower quality patient care. Thus, it may be inevitable that a hospital visit may result in incidental out-of-network care.

Anti-assignment provisions requires out-of-network providers to collect directly from the patient. If anti-assignments are presumptively valid then insurers have completed their end of the transaction after issuing a reimbursement, leaving the provider and patient to work out the remainder of the bill between themselves. If the reimbursement is inadequate, then the subscriber may not be able to foot the remainder of the bill. When faced with an unexpected and large bill, it is not uncommon to find patients unable to pay. This forces providers to turn unpaid bills over

97 Id. See Jeffery Gold et al., Reimbursement for Emergency and Non-Emergency Services Provided by Out-of Network Physicians: The Issue of Balance Billing 8 ABA Health eSource 3 at 1 (Nov. 2011) (“Certain emergency services, or indeed all professional services in the emergency department, may be provided by out-of-network . . . physicians. Frequently, these are services where call coverage may be difficult to obtain . . . or where some history of unhappiness around rates that a health plan pays in-network has resulted in physicians dropping out of the plan’s network.”)
98 See N.J.A.C. 8:43G-1.1; N.J.A.C. 8:43G-2.12.
99 See Belmar v. Cipolla, 96 N.J. 199, 203-04 (1984) (Affirming the right of a non-profit hospital to enter into an exclusive contract to provide all of the anesthesiological services at the hospital reducing the burden of the hospital administration).
to debt collectors which can have a direct impact on all aspects of a patient’s life, if the debt collection proceedings result in judgments issuing liens or wage-garnishment. If a subscriber has viable claim against the insurer for these derivative consequences, the anti-assignment provision bars the provider from asserting the subscriber’s rights in an action against the insurer.

The Out-of-network Act resolves the issue of balance billing for subscribers by essentially barring the practice. An out-of-network provider will no longer be able to bill a patient in excess of what would be her standard co-payment would be. This ensures that subscribers will generally always know the maximum amount they will responsible for while receiving complex treatment at the hospital. The bills accomplish this feat by reworking the privity relationship between the parties in the transaction. The Out-of-network Act limits the subscriber’s—not the insurer’s role—in the transaction, setting a maximum cap on the amount billable to the subscriber in incidental care situations. While the subscriber initiates the transaction, the completion of the transaction that is left to the more sophisticated parties—the providers and insurers. The Out-of-network Act and valid assignment of benefits prevents surprise charges and the detrimental effects by limiting the subscribers’ responsibility. Thus, if a dispute goes to arbitration, the provider can raise claims on behalf of subscribers in order to receive the best reimbursement. Accordingly, passage of the Out-of-network Act properly protects subscribers from harm faced in the current landscape.

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103 Id.
104 Id. at 5-6.
105 Id. at 5-6.
2. Protections to Providers

Few would contest the proposition that providers seek to get paid for their services. However, providers face different challenges when attempting to be reimbursed by patients or insurers. Many of the same harms that balance billing imposes on subscribers are felt by providers as the uncertainties in collecting fees and the costs of doing so further drive up the costs of the physician’s practice.\(^{106}\) Beyond balance-billing the patient, there are two ways that a provider enforce payment from insurers: (1) on their own behalf—asserting various common law doctrines involving implied contracts or from the perspective of a third-party beneficiary; and (2) derivatively on behalf of the patient, as an assignee of benefits.\(^{107}\)

A. Balance Billing and Reimbursement

From the provider’s perspective, “[s]ometimes balance billing represents a sincere attempt to collect what the provider believes it is owed; other times it is a tool.”\(^{108}\) “The provider believes that the balance bill will cause the patient to complain to his or her carrier and demand that the provider's charges be paid.”\(^{109}\) However, in New Jersey, the reimbursement schedule set by the insurers often becomes the de facto price for a provider’s services because of the “economic reality that the pervasive insurance plan exercises extensive market power over the affected physician[s].”\(^{110}\) Thus, an out-of-network provider has no option but either to accept a unbargained-for reimbursement—from the party who has the means to pay—or the bill the patient directly. When the subscriber cannot pay, the provider may have to engage other legal or judicial means to procure payment, such as obtaining a lien on an individual’s property, attaching or seizing

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\(^{106}\) See Hammond, supra note 15, at 475 (noting that physicians may risk alienating patients by engaging in balance billing).

\(^{107}\) See Hyman, supra note 1, at 34 (finding that providers often rely on negligent misrepresentation, equitable estoppel and promissory estoppel in order to enforce their rights).

\(^{108}\) Lucas & Williams, supra note 11, at 147.

\(^{109}\) Ibid.

\(^{110}\) Hammond, supra note 15, at 474.
personal property, commencing a civil suit, or garnishing an individual’s wages.\footnote{See Rachel Weisblatt, Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions to Regulate Tax-Exempt Hospitals, 55 B.C. L. Rev. 687, 696-97 (2014) (discussing the means available to charitable hospitals to remain tax-exempt but collect debts).} These practices are time-consuming and costly for providers, and thus, many providers refer or sell their debts to third parties to assist with collection practices, further reducing the amount the provider will ultimately collect.

Moreover, in the case of emergency care, the provider cannot utilize balance-billing and is forced to deal with the insurer directly.\footnote{See N.J.A.C. 11:22-5.8(b)(1) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is a network provider to the subscriber’s copayment or coinsurance so long as the subscriber and provider have complied with all required preauthorization or notice requirements); N.J.A.C. 11:22-5.8(b)(2) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is out-of-network to the subscriber’s copayment or coinsurance).} However, due to the lack of privity, the provider is placed in a position of significantly unequal bargaining power.\footnote{Yusaf, supra note 7, at 124-25.} As mentioned above, the New Jersey Department of Banking and Insurance has intervened in the past to address inadequate reimbursement for providers.\footnote{See N.J. Dept’ of Banking & Ins. Order No. A07-59, available at: http://www.state.nj.us/dobi/pressreleases/pr070725_ordera07_59.pdf.} The Department ordered Aetna to reprocess claims for emergency care in order to satisfy the provider’s billed charges.\footnote{See Lash, supra note 51, at 31.} Aetna challenged the Department’s order, prompting the parties to enter into a Settlement Agreement.\footnote{Id.} The final settlement, however, expressly stated that the payments of providers’ full charges “do not establish and are not intended to establish generally the level of payment to be paid to out-of-network providers in these circumstances.”\footnote{Id.} Accordingly, the settlement arguably is limited to a one-time punishment and may only serve as a deterrent. Aetna expressly denied making any dispositive concessions, and thus, insurers did not give away control over reimbursement calculations.

\footnote{See Rachel Weisblatt, Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions to Regulate Tax-Exempt Hospitals, 55 B.C. L. Rev. 687, 696-97 (2014) (discussing the means available to charitable hospitals to remain tax-exempt but collect debts).}
\footnote{See N.J.A.C. 11:22-5.8(b)(1) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is a network provider to the subscriber’s copayment or coinsurance so long as the subscriber and provider have complied with all required preauthorization or notice requirements); N.J.A.C. 11:22-5.8(b)(2) (limiting a HMO subscriber’s liability in a hospitalization at a network hospital where the admitting physician is out-of-network to the subscriber’s copayment or coinsurance).}
\footnote{Yusaf, supra note 7, at 124-25.}
\footnote{See Lash, supra note 51, at 31.}
\footnote{Id.}
\footnote{Id.}
Beyond the use of Medicare rates as a reimbursement mechanism, several recently settled class actions against insurers highlight other transparency issues surrounding UCR calculations.\textsuperscript{118} In a settlement this summer, “Horizon Blue Cross Blue Shield of New Jersey [] agreed to amend its out-of-network payment procedures by discontinuing use of an allegedly faulty charging database [by] providing more transparency for the basis of its payment decisions to its subscribers and health care providers.”\textsuperscript{119} The underlying claims were that Horizon underpaid benefits owed “by calculating allowable payments with the assistance of . . . databases that artificially suppressed chargeable amounts through flawed and incomplete data and invalid geographic comparisons.”\textsuperscript{120} These transparency issues regarding the calculation of reimbursement are suggestive that balance-billing is a seemingly more-desirable alternative than dealing with insurers. However, the side effects arising from the collection efforts require providers to shift a portion of their focus away from their practice to ensure compliance with various regulatory agencies and to avoid further disputes with patients.

The Out-of-Network Act and HPI Act will resolve a majority of these issues by absolving providers’ reliance on the practice of balance-billing and fixing the transparency issues. First, the Out-of-network Act gives providers leverage in dealings with the insurance company. In the arbitration proceedings, providers may propose their billed charge supported directly by one’s experience, and the complexity of the case.\textsuperscript{121} Once the HPI database has a sufficient number of data points, arbitrators will be able to determine whether the provider’s specific case merits favorable treatment, and eventually, the arbitration process will only be used as a last resort.

\textsuperscript{118} Matthew Loughran, *Horizon’s Ingenix Settlement Approved, Class Members Obta

\textsuperscript{119} Id.

\textsuperscript{120} Id.

because the parties can confer with the HPI database in their initial negotiations. Furthermore, the HPI database resolves the transparency issues that prompted the litigious settlements. To create the database, the Department of Banking and Insurance is to select a neutral party to oversee the collection of the data. This is in direct contrast to the current system, where the commercial database were discovered to have been run by parties with perverse incentives. Lastly, providers themselves will be faced with less billing disputes because indigent subscribers are removed from the equation. With a straightforward dispute-resolution procedure, providers will be able to focus predominately on their practice and have increased confidence in the new system.

B. Direct Suits

Currently, if a provider does not choose to seek payment from the patient directly, the provider may attempt to initiate an action against the insurer. But when a provider is inhibited by an anti-assignment provision, she may face various obstacles in finding a basis for her injury without being able to derivatively assert the rights of the subscriber. An out-of-network provider may sue an insurer directly based on theories of negligent misrepresentation, equitable estoppel and promissory estoppel. Unfortunately given the low probability of success and the costs of litigation, individual providers are often unable to properly assert their rights in court.

124 See In re Wellpoint, Inc., Out-of-Network UCR Rates Litig., 865 F. Supp. 2d 1002, 1017 (C.D. Cal. 2011). The faulty UCR database, Ingenix, “is a wholly owned subsidiary of [UnitedHealth Group, Inc.]” which spawned from the Health Insurance Association of America’s prior database of UCR charges. Id. The database was criticized for only utilizing four data points to calculate UCR charges of which high value charges were “scrubbed” from the database. Id.
126 See Hyman, supra note 1, at 37.
127 Id. at 39.
128 See Yusaf, supra note 7, at 92.
A negligent misrepresentation claim "may exist when a party negligently provides false
information."\textsuperscript{129} "A negligent misrepresentation constitutes an incorrect statement, negligently
made and justifiably relied on, and may be the basis for recovery of damages for economic loss
sustained as a consequence of that reliance."\textsuperscript{130} If insurers "fail to act reasonably in making
representations concerning insurance coverage, financial harm will likely be inflicted on the
medical companies that provide treatment in reliance upon promises of payment."\textsuperscript{131} Given
Horizon's faulty UCR data settlement, it appears that providers would be able to assert facts that
plausibly support a claim under this theory. However, the complexity of the litigation surrounding
the UCR data would likely prove to be too costly and lengthy to pursue. In approving the
settlement, the District Court noted that, "[t]he complexity of this action militates strongly in favor
of approving the settlement" because of the "probable costs, in both time and money, of continued
litigation."\textsuperscript{132} The District Court noted that "the Third Circuit has expressed the view that
'extensive pretrial motions addressing complex factual and legal questions, and ultimately a
complicated lengthy trial' weigh in favor of approving a class action settlement."\textsuperscript{133} Given the
complexity of these allegations, an individual plaintiff would not likely have the resources to
litigate on her own behalf, and in light of these settlements, meeting the requirements for class
certification pose even higher obstacles.

An equitable estoppel claim arises from "the effect of the voluntary conduct of a party
whereby he is absolutely precluded, both at law and in equity, from asserting rights which might

\textsuperscript{129} Singer v. Beach Trading Co., Inc. 876 A.2d 885, 890-91 (N.J. Sup. Ct. App. Div. 2005) (internal citations and
quotations omitted).
\textsuperscript{130} Ibid.
\textsuperscript{132} McDonough v. Horizon Healthcare Serv., Inc. d/b/a Blue Cross Blue Shield of New Jersey, Inc. Settlement
\textsuperscript{133} Id.
perhaps have otherwise existed . . . as against another person, who has in good faith relied upon such conduct, and has been led thereby to change his position for the worse. . . .”

134 Equitable estoppel requires detrimental reliance.135 A provider pleading this claim would likely struggle to establish that she changed her position. In the emergency context, the provider cannot deny treatment to the payment on account of her ability to pay, and thus cannot claim any reliance.136 Further, the provider’s reliance is on the insurer to reimburse the subscriber at a rate that is sufficient to give the provider an adequate opportunity to be paid in whole by the patient. A subscriber’s inability to pay likely disrupts the chain of causation for the provider to successfully plead such a claim.

A claim based on the theory of promissory estoppel does not facially seem meritorious to warrant a provider filing a direct complaint against an insurer. The elements of promissory estoppel are: “(1) a clear and definite promise by the promisor; (2) the promise must be made with the expectation that the promisee will rely thereon; (3) the promisee must in fact reasonably rely on the promise, and (4) detriment of a definite and substantial nature must be incurred in reliance on the promise.”137 A provider would face issues in providing any evidence of a clear and definite promise from the insurer that she would be made whole by a reimbursement. Additionally, for the same reasons as why an equitable estoppel claim would fail, this theory is flawed as well.

The Out-of-network Act’s arbitration scheme provides the means for a provider to raise grievances with inadequate reimbursement. Some may argue that the return on a provider’s investment in bringing a claim in the arbitration system may result in a smaller reimbursement than traditional litigation. However, the Act likely will result in a net benefit for providers because

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135 Id. at 857.
136 See N.J.A.C. 11:22-5.8(b)(1), (2).
it at least guarantees some amount, rather than losing a claim on summary judgment after investing money in bringing a suit.

C. The benefit of ERISA’s uniformity can be achieved through the bills.

Out-of-network providers should be able to enforce their patients’ rights in a single, uniform system, which is predicated on permissible assignment of benefits. The ERISA scheme provides for an example of the benefits of having a uniform system, and the Out-of-network Act would accomplish much of the same.

ERISA provides for a uniform regulatory system over employee benefit plans and serves as an “integrated enforcement mechanism” to allow a participant to recover benefits due, enforce her rights under the terms of the plan and clarify her future rights and benefits due under the terms of the plan.138 To promote a uniform enforcement system, suits against insurance companies for the denial of benefits are preempted by ERISA, “even when the claim is couched in terms of common law negligence and breach of contract.”139 For example, where a denial or cancellation of a claim could have been characterized as a negligence claim, the Eight Circuit viewed the claim as an improper processing of medical benefits, and therefore preempted by ERISA.140 Congress sought to create a uniform enforcement mechanism because it was concerned “that owing to the inadequacy of current minimum [financial and administrative] standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered.”141

The enforcement scheme was introduced to “provide each individual participant with a remedy in

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141 § 2, 29 U.S.C. § 1001(a) (alteration in original).
the event that promises made by the plan were not kept.”¹⁴² The Third Circuit has recognized the right of a provider to assert ERISA claims on behalf of participants.¹⁴³ The court recognized important policy concerns that accompany allowing a provider to enforce a plan participants’ rights.¹⁴⁴

[T]he assignment of ERISA claims to providers serves the interests of patients by increasing their access to care: Many providers seek assignments of benefits to avoid billing the beneficiary directly and upsetting his finances and to reduce the risk of non-payment. If their status as assignees does not entitle them to federal standing against the plan, providers would either have to rely on the beneficiary to maintain an ERISA suit, or they would have to sue the beneficiary. Either alternative, indirect and uncertain as they are, would discourage providers from becoming assignees and possibly from helping beneficiaries who were unable to pay them “upfront.” The providers are better situated and financed to pursue an action for benefits owed for their services.¹⁴⁵

The court further reasoned that if providers could not advocate for their patients’ rights, providers would be less likely to accept their claims in exchange for services when an insurer has denied coverage.¹⁴⁶ Just recently, the Third Circuit held that an assignment of benefits, regardless of the specificity of the language, necessarily includes the right to enforce the benefits beyond simply receiving payment.¹⁴⁷ The court reasoned that “[i]t does not seem that the interests of patients or the intentions of Congress would be furthered by drawing a distinction between a patient’s assignment of her right to receive payment and the medical provider’s ability to sue to enforce that right.”¹⁴⁸ The value of the assignments, the court continued, “lies in the fact that providers, can treat patients without demanding they prove their ability to pay up front.”¹⁴⁹ Thus,

¹⁴⁴ Id. at 179.
¹⁴⁵ Id. (citing Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286, 1289 n. 13 (5th Cir.1988), abrogated on other grounds by Access Mediquip, L.C.C. v. UnitedHealthcare Ins. Co., 698 F.3d 229 (5th Cir.2012)).
¹⁴⁶ Id.
¹⁴⁸ Id. at 373.
¹⁴⁹ Ibid.
the assignment of claims supports ERISA’s goals of ensuring that plan participants receive their benefits owed.

The federal government’s interest in securing benefits and increasing access to care for those that are enrolled in employee benefit plans should be extended to citizens who are enrolled in state-enforced HMO plans. Currently, the out-of-network provider is forced to either rely on the patient to maintain a suit or they may have to sue the patient itself. The two proposed bills will provide for a centralized and uniform dispute resolution system that accomplishes the goals underlying the ERISA scheme. By limiting subscriber responsibility, the Out-of-network Act places the better positioned parties in charge of negotiation because “an assignment will transfer the burden of bringing suit from [HMO subscribers] to providers.”

Thus, in the uniform system with further statutory protections, subscribers can be confident that they will not be subject to surprise charges and providers can be assured that they will have a voice in disputes.

3. The Act’s Impact on Insurers

Insurers have an interest in retaining the status quo because if subscribers were allowed to assign their benefits to an out-of-network provider, then the insurer’s network and cost-saving protocols would be undermined. However, in light of the limits imposed by the Act, the assignment of benefits from the subscriber to the provider does not “materially change the duty of the [insurer], or materially increase the burden or risk imposed . . . [or] materially reduce its value to [the insurer].” First, the Act is only implicated in a small subset of situations, where there already exists substantial regulation. Statutory protections in the emergency room context already provide that the reimbursement for the provider is to be determined between the insurer

150 Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997).
151 See Somerset Orthopedic Assoc., P.A., 785 A.2d at 463.
152 Restatement (Second) of Contracts § 317 (1981).
153 See N.J.A.C. 11:22-5.8(b)(1), (2).
and provider. Further, the Act in some sense actually benefits insurers by limiting their liability to exorbitant charges from providers because the arbitrator may select the insurer’s proffered reimbursement. Additionally, the arbitration system is likely to be less costly than unanticipated and lengthy litigation.

PART V: Revisiting Somerset Orthopedics Associates & Concluding Thoughts

1. The Public Policy Arguments Underlying Somerset Orthopedic are not supported by the issues raised in emergency care and incidental care

Somerset Orthopedics Associates was deferential to then-existing legislative judgments. However, the Legislature has promulgated various new protections for subscribers that are seemingly inconsistent with the Appellate Division’s analysis. First, the Appellate Division found persuasive that anti-assignment “clauses valuable tools in persuading health care providers to keep their costs down and as such override the general policy favoring the free alienability of choses in actions.” This is accomplished by pressuring providers to join the network in acceptance of the fees set by the insurer. However, this argument has been undermined in practice. By enforcing anti-assignment provisions and pressuring providers to join networks, insurers have been implicitly able to set fee-schedules at exceedingly low amounts, which providers have accepted in light of difficulties in billing patients directly. Since the insurers have abused this tool of persuasion to get providers to join their network, certain profitable—and more importantly, necessary physician practices—have eschewed the system because of reimbursements that they

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154 Ibid.
155 Lucas & Williams, supra note 11, at 137.
158 Somerset Orthopedic Assocs., P.A., 785 A.2d at 461 (collecting other state courts upholding provisions).
159 See Obstetricians-Gynecologists, P.C. v. Blue Cross & Blue Shield of Nebraska, 361 N.W.2d 550, 556 (1985)
have found to be unsatisfactory in order to maintain their practice. Thus in response to groups of providers being outside of the network, incidental out-of-network care has become an issue, and subscribers to health plans are harmed because they are not getting adequate relief from insurers for out-of-network reimbursement.

Next, the Appellate Division found that "if a patient could assign his or her rights to payment to outside medical providers, it would undercut the pre-arranged costs with in-network providers that are relied upon by non-profit health services corporations in deciding the premium amount." As a facial matter this premise is correct, but because of the statutory provisions limiting the subscriber's responsibilities, providers billing insurers at egregious amounts has resulted in insurers raising premiums. Additionally, the Act protects the sanctity of in-network rates because arbitrators can consider the average in-network rate, out-of-network rate and accepted reimbursements. Given the factors provided in determining which arbitration amount is to be selected, insurers may profit from the system.

2. Passage of the Act

The Out-of-network Act and HPI Act provide three great solutions to the pervasive issues surrounding the pricing of health care. First, the acts reduce subscriber liability for emergency room care and for incidental out-of-network care. This is a desirable outcome because in the third-party payer system the more sophisticated parties, the providers and insurers, should be the parties negotiating reimbursement. Second, the arbitration system resolves the loophole in the statutory scheme that limits subscriber liability in emergency room payments by giving the provider and

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160 Somerset Orthopedic, 785 A.2d at 461.
insurer a more direct and complete avenue to complete the transaction and resolve any disputes. The arbitration system provides oversight and reins back both parties from acting egregiously. Finally, the HPI database will provide for more accountability in billing and reimbursement by giving providers and insurers a range of reasonable charges, provide for more transparency by providing access to what are currently unknown reimbursement formulas and decisions, and ultimately will contain health costs and reduce transaction costs with objective information. The Act’s uniform scheme can be properly implemented and will benefit all parties involved.

3. **Invalidation of anti-assignment provisions**

If the Out-of-network Act is going to be properly implemented, then the standard boiler-plate anti-assignment provisions found in health plans must not be enforceable in all circumstances. In the event of inadvertent out-of-network care, the insurer must ensure that the subscriber does not pay more than she would for covered services. If the arbitration process is to function properly, an assignment of benefits is necessary to allow any reimbursement to be paid directly to the provider at the conclusion of arbitration, because otherwise the provider has no incentive to arbitration on behalf of the patient or itself. Additionally, an assignment will allow the provider to properly advocate for herself and on behalf of the patient, by requiring the insurer to provide a written explanation of subscriber’s benefits specifying the proposed reimbursement.

As aptly stated by the Legislature, “[t]he health care delivery system in New Jersey needs reforms that will increase transparency in pricing for health care services, enhance consumer protections, create a system to resolve certain health care disputes, contain rising costs, and measure success with respect to this goals.”162 The two bills accomplish these goals. Accordingly,

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the courts should revisit the issue of anti-assignment provisions given the Legislature’s new stance. Because the court does “not go behind such legislative judgments,” the public policy argument in favor of anti-assignment provisions has been overridden.\textsuperscript{163}