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United States District Court, D. New Jersey.

ATLANTIC SHORE SURGICAL ASSOCS., PC,
Plaintiff,
v.
AETNA LIFE INS. CO., et al, Defendants.

Civil Action No. 20-15622 (MCA) (MAH)
|
Filed 04/12/2021

REPORT AND RECOMMENDATION

Michael A. Hammer United States Magistrate Judge

I. INTRODUCTION

***1** This matter comes before the Court by way of Plaintiff Atlantic Shore Surgical Associates, PC ("Atlantic Shore")'s motion to remand to the Superior Court of New Jersey, Law Division, Essex County pursuant to 28 U.S.C. § 1447(c). *See* Motion to Remand, D.E. 5. Defendants oppose the motion. D.E. 9, 10, 11, 24. The Honorable Madeline Cox Arleo, U.S.D.J., referred this motion to the Undersigned for a Report and Recommendation. L. Civ. R. 72.1(a)(2). The Undersigned has considered the matter without oral argument. Fed. R. Civ. P. 78. For the reasons set forth herein, the Undersigned respectfully recommends that the District Court grant Atlantic Shore's motion to remand, deny Atlantic Shore's informal application for fees and costs, and deny the Aetna Defendants' motion to strike.

II. BACKGROUND[1]

Atlantic Shore is a medical practice in New Jersey, specializing in general and bariatric surgery. Compl., D.E. 1-1, ¶ 1. Atlantic Shore alleges that at all relevant times, it was an out-of-network, or non-participating, healthcare provider that provided emergency and pre-approved medically necessary services to fifteen patients[2] covered by healthcare plans sponsored, funded, operated, controlled, administered and/or underwrote by Defendants Aetna Life Ins. Co., Aetna Health, Inc., Aetna Health Ins. Co. ("the Aetna Defendants); Blinds-to-Go (US), Inc. ("Blinds-to Go"); CommVault Sys., Inc. ("CommVault"); Rock Brook Consulting Gr., P.A. ("Rock Brook"); Walmart, Inc. ("Walmart"); National Railroad Passenger Corp. d/b/a Amtrak ("Amtrak"); Expeditors International of Washington ("Expeditors International") (collectively "the Plan Sponsors Defendants"); 1199SEIU National Benefit Fund ("The Fund"); and ABC Corps. 1-100. *Id.*, ¶¶ 2-13.

***2** Atlantic Shore asserts that the Aetna Defendants "intentionally and deliberately administer[ed] the plan(s) in a self-serving/self-dealing manner to lower the reimbursement for out-of-network services...." *Id.*, ¶ 40. Atlantic Shore maintains that "[a]s a matter of routine business practice, Plaintiff Atlantic Shore engaged in regular communications and discussions with defendants and/or their agent(s) regarding coverage, reimbursement and other issues" which gave rise to a course of dealings between the parties. *Id.*, ¶¶ 43, 44. Atlantic Shore argues that through their course of dealings the Aetna Defendants knew their insureds must be held harmless for emergency services under New Jersey law, and must pay Atlantic Shore its usual, customary and reasonable ("UCR") billed charges, minus copay, coinsurance or deductible. *Id.*, ¶¶ 23-39. Atlantic Shore maintains that "[D]efendant(s) refused to pay Atlantic correctly for the surgical and medical services plaintiff provided to the patients ..., contrary to the pre-approvals and/or the patient's health benefit plans...." *Id.*, ¶ 68. Atlantic Shore further avers that the Aetna Defendants underpaid plan benefits even though the claims were all preauthorized pursuant to the terms of the plans and the Aetna Defendants indicated that the claims were covered under the terms of each of the plans at issue. *Id.*, ¶¶ 77-78.

On October 2, 2020, Atlantic Shore filed an action against Defendants, in the Superior Court of New Jersey, Law Division, Essex County, alleging eight causes of action based solely on New Jersey state law. *Id.*, D.E. 1-1. The eight causes of action are: (1) breach of implied contract; (2) breach of the covenant of good faith and fair dealing; (3) unjust enrichment and quantum meruit; (4) promissory estoppel; (5) negligent misrepresentation; (6) tortious interference with economic advantage; (7) violations of New Jersey Regulation Governing Payment for

Emergency Services Rendered by an Out-of-Network Provider; and (8) violations of the Healthcare Information Networks and Technologies Act ("HINT") and the Health Claims Authorization, Processing and Payment Act ("HCAPPA"). *Id.*, Counts I-VIII.

On November 6, 2020, the Aetna Defendants removed this lawsuit to federal court based on federal question jurisdiction pursuant to 28 U.S.C. § 1441(a) and 28 U.S.C. § 1331, arguing that Atlantic Shore's state law claims are completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.*, as amended ("ERISA") and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14. Notice of Removal, Nov. 6, 2020, D.E. 1, ¶ 4. The Aetna Defendants also removed based on the Federal Officer Removal Statute under 28 U.S.C § 1442(a)(1). *Id.* All Defendants consented to removal of this action. *See* Notice of Removal, D.E. 1, ¶ 6; *see also* Exh. B to Notice of Removal, Email from Suzanne Metzger consenting to removal on behalf of 1199SEIU National Benefit Fund, D.E. 1-2.

On December 28, 2020, Atlantic Shore filed the instant motion to remand, arguing that ERISA does not govern this action because it is a healthcare reimbursement dispute containing only state-law claims "arising from the statements and course of dealings between plaintiff-medical provider and defendants." Pl. Br. in Supp., Dec. 28, 2020, D.E. 5-3, at 1. On February 16, 2021, Defendant 1199SEIU National Benefit Fund[3] ("The Fund") filed an opposition to the motion and on February 18, 2021, the Aetna Defendants and the Plan Sponsors Defendants filed their opposition to the motion, arguing, *inter alia*, that Plaintiff's claims are completely preempted under ERISA. Opp. Br., D.E. 9, 10, 11, 24. On March 11, 2021, Atlantic Shore filed its reply brief in further support of its motion. Reply Br., Mar. 11, 2021, D.E. 27. On April 1, 2021, the Aetna Defendants filed a motion to strike the Reply Certification of Eric D. Katz, counsel for Atlantic Shore.[4] Mot. to Strike, Apr. 1, 2021, D.E. 28.

III. ANALYSIS

***3** A decision to remand is dispositive. *In re U.S. Healthcare*, 159 F.3d 142, 146 (3d Cir. 1998) ("[A]n order of remand is no less dispositive than a dismissal order of a federal action for lack of subject matter jurisdiction where a parallel proceeding is pending in the state court."). Accordingly, this Court addresses Plaintiff's motion via Report and Recommendation.

Removal of a civil case to a federal court is governed by 28 U.S.C. § 1441. A defendant may remove an action brought originally in state court only if the plaintiff could have filed the complaint within the original jurisdiction of the federal court. 28 U.S.C. § 1441(b); *see also* 28 U.S.C. § 1441(a) ("Except as otherwise provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant ... to the district court of the United States ..."). A federal court lacking subject matter jurisdiction over a case must remand the matter back to state court. 28 U.S.C. § 1447(c); *see* *Farina v. Nokia, Inc.*, 625 F.3d 97, 114 (3d Cir. 2010) (noting that a federal court cannot proceed without subject matter jurisdiction, nor can a party waive such jurisdiction).

As the party asserting federal jurisdiction by way of removal, the defendant bears the burden of establishing that subject matter jurisdiction exists at all stages in which the case is properly before the federal court. *Samuel–Bassett v. KIA Motors Am., Inc.*, 357 F.3d 392, 396 (3d Cir. 2004). Section 1441 is to be construed strictly; all doubts must be resolved in favor of remand. *Id.*; *see also* *Batoff v. State Farm Ins. Co.*, 977 F.2d at 851 ("[R]emoval statutes are to be strictly construed against removal and all doubts should be resolved in favor of remand.") (citations omitted) (internal quotations marks omitted); *Abels v. State Farm Fire & Cas. Co.*, 770 F.2d 26, 29 (3d Cir. 1985) ("Because lack of [federal] jurisdiction would make any decree in the case void and the continuation of the litigation in federal court futile, the removal statute should be strictly construed and all doubts should be resolved in favor of remand.") (citations omitted).

A party may move to remand an action back to state court based on an alleged defect in the removal procedure, or lack of subject matter jurisdiction. 28 U.S.C. § 1447(c). Section 1447, which sets forth the procedures for moving to remand, provides in pertinent part:

> A motion to remand the case on the basis of any defect other than lack of subject matter jurisdiction must be made within 30 days after the filing of the notice of removal under section

> 1446(a). If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded.

28 U.S.C. § 1447(c). A defect is deemed jurisdictional in nature " 'only if the case could not initially have been filed in federal court.' " *Farina*, 625 F.3d at 114 (quoting *Ariel Land Owners, Inc. v. Dring*, 351 F.3d 611, 614 (3d Cir. 2003)).

A. ERISA Preemption[5]

***4** In determining whether an action should be remanded to state court, "a district court must focus on the operative complaint at the time the petition for removal was filed." *Group Hospitalization & Med. Servs. v. Merck-Medco Managed Care, LLP*, 295 F. Supp. 2d 457, 461-462 (D.N.J. 2003). District courts have federal question subject matter jurisdiction over "all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. In order for a claim to arise under federal law, the "well-pleaded complaint" must establish "either that federal law creates the cause of action or that the plaintiffs[']right to relief necessarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 27-28 (1983).

An exception to the well-pleaded complaint rule is the doctrine of complete preemption, which " 'operates to confer original federal jurisdiction notwithstanding the absence of a federal cause of action on the face of the complaint.' " *N.J. Carpenters and the Trs. Thereof v. Tishman Constr. Corp.* 760 F.3d 297, 302 (3d Cir. 2014) (quoting *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 160 (3d Cir. 1999)). Section 502(a) of ERISA provides in pertinent part that "[a] civil action may be brought ... by a participant or beneficiary ... for relief provided for in subsection (c) of this section, or ... to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights for future benefits under the terms of the plan." 29 U.S.C. § 1132(a). The Supreme Court has recognized the "complete preemption" doctrine in claims pursuant to § 502(a). *See* *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). "ERISA's civil enforcement mechanism, § 502(a), 'is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule,' and permits removal." *N.J. Carpenters*, 760 F.3d at 303 (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004)). Accordingly, where § 502(a) preempts a plaintiff's claims, federal jurisdiction is proper.

Section 502(a) completely preempts state law claims where: (1) the plaintiff could have brought the action under § 502(a); and (2) no independent legal duty supports the plaintiff's claims. *See* *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir. 2004); *see also* *Davila*, 542 U.S. at 209. Complete preemption requires the defendant to satisfy both prongs of the test. *N.J. Carpenters*, 760 F.3d at 303.

1. Atlantic Shore Could Not Have Brought Its Claims Under ERISA § 502(a)

a. Standing

The first prong, *i.e.*, whether the plaintiff could have brought the action under § 502(a), requires a court to resolve two issues. The first issue under Prong I regards standing, specifically "whether the plaintiff is the type of party that can bring a claim pursuant to" § 502(a). *Progressive Spine & Orthopaedics, LLC v. Anthem Blue Cross Blue Shield*, No. 17-536, 2017 WL 4011203, at *5 (D.N.J. Sept. 11, 2017). The second issue under Prong I is "whether the actual claim that the plaintiff asserts can be construed as a colorable claim for benefits pursuant to" § 502(a). *Id.* As to standing, a claim is subject to ERISA preemption if it is brought by a beneficiary or participant[6] "to recover benefits due to him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Additionally, a healthcare provider may have derivative standing by virtue of an assignment by a beneficiary or plan participant. *North Jersey Brain & Spine Center v. Aetna, Inc.*, 801 F.3d 369, 372 (3d Cir. 2015).

***5** There is no dispute that Atlantic Shore is neither a plan participant nor a beneficiary. Thus, Atlantic Shore does not have standing in its own right to bring a claim

pursuant to § 502(a). The parties disagree over whether the patients on the DCL assigned their legal rights under the plans to Atlantic Shore. The Aetna Defendants argue that Atlantic Shore obtained assignments of benefits, and thus has standing to bring its claims under ERISA, thereby satisfying the first element of the *Davila/Pascack* test. Opp. Br., Feb. 18, 2021, D.E. 11, at 12-14. Atlantic Shore contends that it lacks derivative standing because Aetna has produced no proof of valid, executed assignments, or even that there is no anti-assignment provision.

The United States Court of Appeals for the Third Circuit's decision in *North Jersey Brain & Spine Center v. Aetna Inc. ("NJBSC")* guides this Court's analysis. 801 F.3d 369 (3d Cir. 2015). In that case, NJBSC treated members of an ERISA-governed healthcare plan administered by Aetna. The member-patients had executed authorizations assigning to NJBSC "all payments for medical services rendered to myself or my dependents." *NJBSC*, 801 F.3d at 370-71. NJBSC also retained the right to bill the member-patients for any portion of the services not covered by insurance. *Id.* at 371. After rendering services, NJBSC sued Aetna. NJBSC claimed that Aetna refused to pay or had underpaid for the services NJBSC had rendered.

At issue before the Third Circuit was what type of assignment was sufficient to confer derivative standing on the provider. NJBSC argued that simply assigning the right to payment sufficed, while Aetna contended the patient must assign "not just the right to payment but also the patient's legal claim to that payment if a provider is to file suit." *Id.* at 372. Reasoning that "[a]n assignment of the right to payment logically entails the right to sue for non-payment[,]" the Third Circuit held that "as a matter of federal common law, when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA § 502(a)." *Id.*

In this case, Atlantic Shore contends that the Aetna Defendants have failed to provide proof that Atlantic Shore has "executed, valid and enforceable assignments." Pl. Br. in Supp., Dec. 28, 2020, D.E. 5-3, at 7-8. In fact, Atlantic Shore maintains that Defendants have failed to meet their burden that there was a valid assignment because they failed to attach to their Notice of Removal even one assignment for any of the fifteen patients. *Id.* at 8-10. Atlantic Shore also argues that Defendants fail to establish that there was no anti-assignment clause that precluded any derivative assignment in the plan contracts. *Id.* at 10. Atlantic Shore alleges that Aetna's contracts routinely contain an anti-assignment provision and the Aetna Defendants' failure to provide proof that the contracts with the patients on the DCL did not contain an anti-assignment provision is fatal to their attempt to remove this action. *Id.*

The Aetna Defendants respond that Atlantic Shore has valid assignments for each of the patients. The Aetna Defendants argue that the standard HCFA-1500 health insurance claim forms that Atlantic Shore submitted to Aetna for reimbursement for services provided demonstrate that the patients have assigned their rights to Atlantic. Opp. Br., Feb. 18, 2021, D.E. 11, at 12. Box 13 of these forms provides:

> 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
>
> SIGNATURE ON FILE
>
> SIGNED

Id.; *see also, e.g.*, D.E. 24-71, Exh. 28, HCFA-1500 health insurance claim forms. The Aetna Defendants also maintain that when Atlantic Shore appealed decisions, Atlantic Shore submitted Aetna appeal forms indicating that an assignment of benefits had been attached to the form. *Id.*, *see also, e.g.*, D.E. 24, Exh. 33, Untitled. Therefore, the Aetna Defendants argue that the patients on the DCL have assigned their rights to their medical benefits to Atlantic Shore, and Atlantic Shore has derivative standing. Opp. Br., Feb. 18, 2021, D.E. 11, at 12-13.

***6** The Aetna Defendants have failed to establish that Atlantic Shore has a single valid assignment for any of the fourteen patients on the DCL. The Aetna Defendants have submitted more than 1500 pages of documents as part of their opposition papers. However, the Defendants provide nothing to establish that Atlantic Shore has assignments from any of the fourteen patients such that this Court could find that Atlantic Shore has derivative standing to bring ERISA claims. Indeed, the Aetna Defendants do not provide a **single** assignment. *See North Jersey Brain & Spine Ctr. v. Aetna, Life Ins. Co.*, No. 15-1544, 2017 WL 659012, at *4 (D.N.J. Feb. 17, 2017), *Report and Recommendation*, 2017 WL 1055957 (D.N.J. Mar. 20, 2017) ("Aetna has failed to submit documents establishing assignments with respect to the other four patients involved in this case. Thus, Aetna has failed to demonstrate, at least with respect to four of the patients, valid assignments that would confer standing on NJBSC to bring any claims it may possess as an assignee under §

502(a).”). Instead, the Aetna Defendants rely on Health Insurance Claim forms and Appeal forms to establish that Atlantic Shore has valid assignments.

The Aetna Defendants’ arguments are unavailing for several reasons. The Aetna Defendants rely heavily on the HCFA-1500 forms and appeal forms to establish that Atlantic Shore has valid assignments from the Plan beneficiaries. But those forms establish little by way of assignment. Moreover, the standardized HCFA-1500 forms on which the Aetna Defendants ask, in Box 27, whether the patient/beneficiary will “ACCEPT ASSIGNMENT? (For govt. claims, see back).” The patient/beneficiary must check either “yes” or “no.” The “yes” box is not checked on any of the forms, and the “no” box is checked on at least one such form. Decl. of Elizabeth C. Petrozelli, D.E. 24-71 & 24-73, Exh. 28 & 30, HCFA-1500 health insurance claim forms. Even if the “yes” box had been checked, this Court is not persuaded that simply checking a box on a standardized form confers derivative standing on Atlantic Shore. *See N.J. Spinal Med. & Surgery PA v. IBEW Local 164*, No. 11-5493, 2012 WL 1988708, at *2 (D.N.J. May 31, 2012) (court stating that it “is not convinced that ... by marking box 27 ‘acceptance of assignment’ on the Health Insurance Claim Form, Plaintiff has accepted an assignment”). Courts in this District have consistently found that the type of forms on which the Aetna Defendants rely to confer derivative standing on Atlantic Shore alone are insufficient to establish standing. *See NJBSC v. United*, Civ. No. 18-15631, 2019 WL 6317390, at *4 n.3 (D.N.J. Nov. 25, 2019), *Report and Recommendation adopted*, 2019 WL 6721652 (D.N.J. Dec. 10, 2019) (expressing doubt regarding “notion that annotations on a standardized health insurance claim form sufficiently establish...standing”); *Brainbuilders v. Optum Inc.*, Civ. No. 18-638, 2019 WL 2315389 (D.N.J. May 31, 2019) (same), *adopting Report and Recommendation*, 2019 WL 2618112 (D.N.J. Feb. 4, 2019); *Peterson v. Cigna Health and Life Ins. Co.*, 18-4764, 2018 WL 3586273, at *3, n.4, n.5 (D.N.J. July 25, 2018) (“Court will not assume that an assignment exists based on the [forms] alone”; “Without evidence of an assignment, there is a ‘grave doubt that Plaintiff would have standing’ ”); *N.J. Spinal v. Aetna Ins.*, Civ. No. 09-2503, 2009 WL 3379911, at *3-4 (D.N.J. Oct. 9, 2009) (forms “fail[ ] to establish the existence of a valid assignment”). Therefore, based on the record before it, this Court cannot conclude that Atlantic Shore has valid assignments from any of the fourteen patients such that Atlantic Shore has derivative standing to pursue claims on behalf of any of its patients on the DCL. *See* *Pascack*, 388 F.3d at 404 (“the absence of an assignment is dispositive of the complete pre-emption question”).

Even if this Court were to find that Defendants produced sufficient evidence to establish the existence of assignments from each of the fourteen patients, Defendants fail to demonstrate that they were valid assignments. Much like the assignments themselves, there is little in the record to show that the Aetna Defendants’ contracts with their insureds did not have anti-assignment provisions. To the contrary, each of the Summary Plan Descriptions (“SPD”) that the Aetna Defendants have submitted for the fourteen patients indicates that assignments were expressly prohibited.[7] *See* Reply Cert. of Eric D. Katz, D.E. 27-1, ¶ 2a-m. By way of example, the SPD related to Defendant CommVault and patient M.C. contains the following prohibition:

> ***7 Assignments**
>
> Coverage and your rights under this plan may not he assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Id., ¶ 2a; Decl. of Elizabeth C. Petrozelli, Exh. 11, D.E. 24-51, at 9. Many of the SPDs contain the same or similar language, while others contain different anti-assignment provisions. For example, some clauses permit some form of assignment with written consent, *id.*, ¶ 2g; others specifically forbid assignments to out-of-network providers. *Id.*, ¶ 2g, h. Yet, the Aetna Defendants fail to provide any other evidence which would support a finding that Atlantic Shore has valid assignments. For instance, the Aetna Defendants do not attach a single document to show they have given their written consent to assignment. There is nothing in the record to establish that despite these anti-assignment provisions, Atlantic Shore has valid assignments for each of the fourteen patients on the DCL. The law is clear in the Third Circuit that anti-assignment provisions in ERISA-governed health plans are enforceable. *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, No. 17-1663, 2018 WL 2224394, at *1 (3d Cir. May 16, 2018); *see also Emami v. Quinteles IMS*, No. 17-3069, 2017 WL 4220329, at *2 (D.N.J. Sept. 21, 2017) (finding anti-assignment provision “clear and unambiguous” and “valid and enforceable”); *Neurological Surgery Assocs. P.A. v. Aetna Life Ins. Co.*, No. 12-5600, 2014 WL 2510555, at *2-4 (D.N.J. June 4, 2014) (concluding that “a provision requiring that coverage may be assigned only with Defendant’s consent” is “valid and enforceable”). Therefore, the Aetna Defendants cannot now be heard to claim that these anti-assignment provisions do not prohibit the patients on the DCL from assigning their rights to Atlantic Shore.

Apparently seeking to shrug their burden of

demonstrating that Atlantic Shore has valid assignments, the Aetna Defendants argue that "four (4) of the claims at issue were submitted by Plaintiff pursuant to assignments of benefits under Plans that do not contain anti-assignment provisions." Opp. Br., Feb. 18, 2021, D.E. 11, at 14. Defendants point to the SPD for the patients covered by the Walmart and Blinds-to-Go plans. Decl. of Elizabeth C. Petrozelli, Feb. 19, 2021, D.E. 24 & 24-13-23, ¶4, Exhs. 5 & 6. But these plans clearly contain anti-assignment provisions. *Id.*, D.E. 24-14, at 206, 210; D.E. 24-21, at 85. Further, the Aetna Defendants fail to produce any other evidence to establish that the anti-assignment provisions are inapplicable here and that Atlantic Shore has valid assignments. *See, e.g.*, n.7, *supra*. Therefore, the Court finds that Defendants have failed to establish that any of the patients on the DCL validly assigned their rights to Atlantic Shore, sufficient to confer derivative standing on Atlantic Shore.

b. Colorable Claim for Benefits

***8** Even if this Court were to find that Atlantic Shore has standing, that alone does not necessarily convert a state-law cause of action into a federal claim. Indeed, even where a plaintiff " 'ha[s] received a valid assignment and could have filed under ERISA, the mere existence of an assignment does not convert [the plaintiff's] state law' claims into an ERISA claim for benefits." *Atlantic Shore Surgical Associates v. Local 464*, Civ. No. 17-12166, 2018 WL 3611074, at *3 (D.N.J. Jul. 27, 2018) (citation omitted). Therefore, the Court must next consider whether Atlantic's claims "can be construed as a colorable claim for benefits" under § 502(a).

Section 502(a) recognizes the participant's or beneficiary's right to sue "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a). *See also Emergency Physicians of St. Clare's v. United Health Care*, No. 14-404, 2014 WL 7404563, at *5 (D.N.J. Dec. 29, 2014) ("an action must be 'a suit complaining of denial of coverage for medical care' ") (quoting *Aetna*, 542 U.S. at 210).

As noted earlier, the Complaint alleges claims for: (1) breach of implied contract; (2) breach of the covenant of good faith and fair dealing; (3) unjust enrichment and quantum meruit; (4) promissory estoppel; (5) negligent misrepresentation; (6) tortious interference with economic advantage; (7) violations of New Jersey Regulation Governing Payment for Emergency Services Rendered by an Out-of-Network Provider; and (8) violations of New Jersey HINT & HCAPPA. *See* Compl., D.E. 1-1. Atlantic Shore's claims do not seek coverage under a particular health care plan. Instead, Atlantic Shore disputes the amounts it has received in payment. Atlantic Shore maintains that it is entitled to greater reimbursement based on an implied contract that was created during its dealings with the Aetna Defendants. *Id.*, at ¶¶ 23-39. In short, Atlantic Shore challenges the amount of reimbursement, not the provision of benefits under any of the plans. Accordingly, Atlantic Shore contends that its claims are independent of the plans.

The Aetna Defendants contend that Atlantic Shore's claims are within the scope of ERISA because Atlantic Shore's Complaint "alleges that Aetna underpaid/denied claims for medical expenses related to treatment provided to [fourteen patients], whose claims ... at issue in this matter, are participants or beneficiaries of ERISA governed health Plans," and that Atlantic Shore should have been paid an amount deemed reasonable and customary. Opp. Br., Feb. 18, 2021, D.E. 11, at 9. Defendants argue that Atlantic Shore's claims fall within ERISA preemption because "none of Plaintiff's state law claims are predicated on a legal duty that is independent of ERISA. All Plaintiff's claims require construction or interpretation of the Plans and do not seek to enforce obligations independent of the Plans." *Id.*, at 26.

The Third Circuit has distinguished disputes concerning the amount of reimbursement from those related to the right to reimbursement. In *Pascack Valley Hospital*, the Third Circuit held that ERISA does not preempt disputes regarding the amount of payment made to a provider. 388 F.3d 393, 403-04 (3d Cir. 2004). The Third Circuit reasoned that the provider had an independent breach-of-contract action against the insurer because "the dispute here is not over the right to payment, which might be said to depend on the patients' assignments to the Hospital, but the amount, or level, of payment...." *Id.* (quotation marks and alterations omitted); *see also CardioNet, Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014) (holding that claims "seeking coverage under a benefit plan, and claims seeking reimbursement for coverage provided" are distinguishable and ERISA does not preempt the latter). Accordingly, courts within this district have consistently held that § 502(a) does not preempt a dispute over the amount of payment to the provider. *See, e.g.*, *E. Coast Advanced Plastic Surgery v. Amerihealth*, No. 17-8409, 2018 WL 1226104, *3 (D.N.J. Mar. 9, 2018) (remanding claims sounding in implied-in-fact contract for inadequate reimbursement because "[d]isputes over the amount of

reimbursement are not preempted by ERISA"); *Emergency Physicians of St. Claire's,* 2014 WL 7404563, at * 5 (relying on *Pascack Valley* and *CardioNet* to hold that ERISA "does not [ ] preempt claims over the amount of coverage provided, which includes disputes over reimbursement.").

***9** In a case rather similar to this matter, the Court determined that because Plaintiff alleged that it had engaged in a course of dealing with defendants for a certain reimbursement rate that established an implied contract, and the insurer-defendants breached that implied contract by failing to remit reimbursement at the proper rate, plaintiff's claims did "not challenge the type, scope or provision of benefits under" an ERISA plan. *North Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, No. 18-15631, 2019 WL 6317390, (D.N.J. Nov. 25, 2019), *Report and Recommendation adopted*, 2019 WL 6721652 (D.N.J. Dec. 10, 2019). The Court found that plaintiff "dispute[d] the amount of reimbursement" pursuant to an allegedly enforceable contract implied-in-fact, arising out of an established course of dealing. *Id.* at *5 (citations omitted). The plaintiff in In *North Jersey Brain & Spine Ctr.* was an out-of-network provider that provided both emergency and pre-approved medical services to twenty-seven patients "covered by healthcare plans sponsored, funded, operated, controlled, and/or administered" by health-insurance companies. The plaintiff sued those health-insurance companies for, among other things, breach of implied contract, breach of the covenant of good faith and fair dealing, and unjust enrichment. *Id.* at *1. Plaintiff asserted that it had a course of dealing with defendants in which defendants promised a certain reimbursement rate, and the defendants had breached that implied contract by reimbursing plaintiff below the established rate. *Id.* The Court reasoned that plaintiff's claims were not colorable under ERISA because "plaintiff's claims are related to the amount of payment received, premised on implied agreements and representations that allegedly arose in the course of dealings between the parties, and not claims seeking coverage under a given health plan." *Id.* at *5. The absence of an express agreement between the parties did not change the Court's finding. *Id.* Other courts within this District have similarly held that ERISA did not preempt the state-law claims where the plaintiff did not challenge the right to reimbursement, but instead the amount of reimbursement. *See*, e.g., *MHA, LLC v. Empire Healthchoice HMO, Inc.*, No. 17-6391, 2018 WL 549641, at *3 (D.N.J. Jan. 25, 2018) (out-of-network healthcare provider's claims were not colorable under ERISA because plaintiff challenged the amount of reimbursement and not "the type, scope or provision of benefits under" defendants' healthcare plans); *North Jersey Brain & Spine Ctr.*, 2017 WL 659012, at *4 (finding that plaintiff did not contend that it was due any additional money under the patients' ERISA plans but was due additional money separate and apart from the plans because of its alleged contract with Aetna).

In this case, Atlantic Shore challenges the amount of reimbursement based on an alleged implied-in-fact contract, not the provision of benefits under the ERISA plans. Atlantic Shore contends that the parties' course of dealings, Aetna's authorization of surgical services as the plan administrator, and Aetna's representations that pre-authorization was not necessary, gave rise to an implied-in-fact contract that entitled Atlantic Shore to reimbursement according to usual and customary rates. *See* Compl., D.E. 1-1, at ¶¶ 20-30. The Court cannot discern, nor have the Aetna Defendants explained, how interpretation of the plans is necessary to resolve these claims. Instead, the allegations make clear that Atlantic Shore is alleging underpayment. It is asserting rights pursuant to an implied-in-fact contract between itself and the Aetna Defendants, wholly separate from the plans. Atlantic Shore does "not challenge the type, scope or provision of benefits under" an ERISA plan. Rather, Atlantic Shore "dispute[s] the amount of reimbursement" pursuant to what it claims is an allegedly enforceable implied-in-fact contract arising out of an established course of dealing. *North Jersey Brain & Spine Ctr.*, 2019 WL 6317390 at *5 (citations omitted). Thus, Atlantic Shore's claims are not preempted by ERISA because they do not require either construction of, or reference to, an ERISA plan. *Id.*; *See also E. Coast Advanced Plastic Surgery v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 18-7718, 2018 WL 6185544, at *5 (D.N.J. Sept. 17, 2018) (finding that "interpretation of the Plan is not necessary to adjudicate [plaintiff's] underpayment claims, and that they are not colorable claims under § 502(a)."), *Report and Recommendation adopted*, 2018 WL 6178869 (D.N.J. Nov. 26, 2018); *E. Coast Advanced Plastic Surgery*, Civ. No. 17-8409, 2018 WL 1226104, at *3; *see also Thomas R. Peterson, M.D. PC v. Cigna Health & Life Ins. Co.*, Civ. No. 18-4764, 2018 WL 3586273, at *4 (D.N.J. July 25, 2018) ("ERISA does not pre-empt disputes over the amount of reimbursement."); *Emergency Physicians of St. Clare's*, 2014 WL 7404563, at *5 ("ERISA does not, however, preempt claims over the *amount* of coverage provided, which includes disputes over reimbursement."). The Court is satisfied that interpretation of the plans is not necessary to adjudicate Atlantic Shore's underpayment claims, and Atlantic Shore's claims are not the types of claims that are colorable under § 502(a).

Having found that the Aetna Defendants[8] have not met

their burden of proof under the first prong of the *Pascack/Davila* test, *i.e.*, they have failed to demonstrate that Atlantic Shore has derivative standing to assert their claims under ERISA and that Atlantic Shore's claims can be construed as colorable claims for benefits under § 502(a), the Court need not reach the second prong.

B. Federal Officer Removal Jurisdiction

***10** The Aetna Defendants also contend that this Court has jurisdiction over this case pursuant to the federal officer removal statute, 28 U.S.C. § 1442(a)(1). The Aetna Defendants aver that "the federal officer removal statute applies to disputes over the coverage of benefits and reimbursement under FEHBA plans between national insurers, like Aetna, contracting under FEHBA and healthcare providers. Here, Aetna insures and administers the FEHBA Plan at issue and thus, Plaintiff's dispute over reimbursement related to the FEHBA Plan was properly removed to this Court under the federal officer removal statute." Opp. Br., Feb. 18, 2021, D.E. 11, at 4. The Aetna Defendants argue that Atlantic Shore's claim with respect to the services it provided to W.B. "falls squarely within the scope of the federal officer removal statute because it is intimately related to the provision of benefits under the terms of the Plan promulgated by the OPM, the terms of the contract, and thus was done under the direct control of a federal agency. Aetna is a 'federal officer' under § 1442." *Id.*, at 30.

Atlantic Shore argues that the Aetna Defendants have failed to provide a single document or affidavit to support removal under the federal officer removal statute. Reply Br., Mar. 11, D.E. 27, at 10. Atlantic Shore contends that "Aetna is also playing games by hiding which specific Aetna entity contracted with the OPM. The SPD says 'Aetna Health, Inc.' (Reply Cert. ¶ 2(e), *see* Ex. E), but that entity is not a party here. Accordingly, the Aetna defendants here-- apparently middleman—cannot invoke federal officer jurisdiction...." *Id.* (quoting *Administrator Ad Prosequendum for Estate of Saravia v. Bayonne Dry Dock & Repair Corp.*, No. 20-9174, 2020 WL 5887580, at *3–4 (D.N.J. Oct. 5, 2020)). Atlantic Shore also maintains that the Aetna Defendants have neglected to carry their "special burden" to establish that OPM exercised "direct and detailed control" over Aetna in preauthorizing services for W.B. and that they preauthorized services for W.B. at the direction of official federal authority. Reply Br., Mar. 11, D.E. 27, at 13.

Section 1442 (a)(1) provides federal jurisdiction over claims against the "United States or any agency thereof or any officer (or any person acting under that officer) of the United States or any agency thereof sued in an individual capacity for any act under color of such office." 28 U.S.C. § 1442(a)(1). A defendant seeking removal pursuant to § 1442(a)(1) must demonstrate that: "(1) it is a "person" within the meaning of the statute; (2) the plaintiff's claims are based upon the defendant's conduct "acting under" a federal office; (3) it raises a colorable federal defense; and (4) there is a causal nexus between the claims and the conduct performed under color of a federal office." *Feidt v. Owens Corning Fiberglas Corp.*, 153 F.3d 124, 127 (3d Cir. 1998).

Defendants bear the burden of establishing that this Court has jurisdiction pursuant to section 1442(a)(1). *Orthopedic Specialists of New Jersey PA v. Horizon Blue Cross/Blue Shield of New Jersey*, 518 F.Supp.2d. 128, 133 (D.N.J.2007). When a private party seeks removal under § 1442(a)(1), that party " 'bear [s] a special burden of establishing the official nature of [its] activities.' " *See id.* (quoting *N.J. Dept. of Envtl. Protection v. Exxon Mobil Corp.*, 381 F. Supp. 2d 398, 403 n.5 (D.N.J.2005)). The "special burden" is necessary because "the policy reasons for generally favoring removal and the existence of federal jurisdiction under section 1442 are not applicable" to private parties. *Id.* (citing *Exxon Mobil*, 381 F. Supp. 2d at 403 n. 5).

As an initial matter, this Court finds that Atlantic Shore correctly asserts that the party to the plan that covers W.B. is Atlantic Health Inc. (New Jersey) and is not a party to this action. *See* Decl. of Elizabeth C. Petrozelli, D.E. 24, ¶ 4., Exh. 2, D.E. 24-6; *see* Reply Cert. ¶ 13, Exh. E, Aetna Organizational Chart, D.E. 27-1, at 53. Here, it is completely unclear who contracted with the OPM, as the Aetna Defendants are silent on this issue and have provided no document to indicate which Aetna entity interacted with OPM, or the extent of this relationship, interaction or control. It appears from the record before the Court--specifically, the SPD that covers W.B. and the organizational chart provided by Defendants--that the Aetna Defendants may in fact be middlemen who are not entitled to federal officer removal. *See* *Saravia*, No. 2020 WL 5887580, at *3–4 (federal officer removal jurisdiction was unavailable to "middleman" defendant who lacked direct relationship with the Government). Nonetheless, assuming *arguendo* that the Aetna Defendants named in this action are eligible to assert federal officer removal jurisdiction, they must satisfy each of the *Feidt* factors.

***11** With respect to the first factor--whether the Aetna

Defendants qualify as a "person" under § 1142(a)(1)--Atlantic Shore does not dispute that the Aetna Defendants qualify as a "person" within the meaning of the statute. For purposes of the federal officer removal statute, most courts have determined that a corporation qualifies as a person. *See* *Orthopedic Specialists*, 518 F.Supp.2d at 134. Therefore, for purposes of this motion, the Court finds that the Aetna Defendants qualify as a person.

The second prong requires the Court to ascertain whether "the plaintiff's claims are based upon the defendant's conduct 'acting under' a federal office...." *Feidt*, 153 F.3d at 127. To demonstrate this prong, the private party seeking removal "must demonstrate that it performed the *complained-of activity* at the direction of official federal authority." *Orthopedic Specialists*, 518 F. Supp. 2d at 134 (emphasis in original) (citation omitted). Specifically, the private party must show that it took the action in question under the "direct and detailed control" of a federal officer. *Id.* (citation omitted). "Conversely, if a private party only establishes that the acts in question 'occurred under the general auspices of federal direction,' removal is improper." *Moore v. Turner Constr. Co.*, Nos. 07-5658, 08-867, 2008 WL 4723017, at *5 (D.N.J. Oct. 24, 2008) (quoting *Good v. Armstrong World Industries, Inc.*, 914 F. Supp. 1125, 1128 (E.D. Pa. 1996)).

To satisfy the second prong, the Aetna Defendants are required to show that their preauthorization of the services rendered to W.B., and underpayment of Atlantic Shore's claim with respect to W.B., were the result of a direct order from, or that the Aetna Defendants were acting under, a federal officer. On this prong, the Court finds that the Aetna Defendants have completely failed to set forth any evidence to carry their "special burden" to establish that OPM exercised "direct and detailed control" over Aetna in preauthorizing services for W.B. The Notice of Removal provides a general description of OPM's regulatory control over health benefits contracts under FEHBA, but then simply states that Defendants are "administering the terms of a federal government contract or federal program under the direct and detailed supervision of a federal agency." Notice of Removal, D.E. 1, at ¶ 23. The Notice of Removal lacks the requisite factual allegations to demonstrate that OPM exercised any control over the Aetna Defendants in preauthorizing services for W.B., or in making decisions regarding W.B. The Notice of Removal does not explain precisely how the Defendants' contract with OPM, or the statutory and regulatory framework, bears on the Aetna Defendants' coverage decisions. It also does not assert that OPM authorized or required the Aetna Defendants to preauthorize services for W.B. but then underpay or deny reimbursement for those services.

Moreover, Atlantic Shore's claims do not arise from the OPM's guidelines or supervision over the Aetna Defendants. Instead, as alleged in the Complaint, Atlantic Shore's claims arise from the alleged course of dealing between the parties, and Atlantic Shore's claims that the Aetna Defendants failed to pay Atlantic Shore its usual and customary rate. Such a claim is unrelated to the provision of benefits under the terms of a plan over which OPM may have some oversight. Atlantic Shore's promissory estoppel claim (Count Four of the Complaint) perhaps best explains the lack of relationship between the plan and Atlantic Shore's claims. In Count Four, Atlantic Shore alleges that the Aetna Defendants preauthorized services for W.B., that Atlantic Shore relied on the preauthorization, and that the Aetna Defendants then failed to pay Atlantic Shore the appropriate amount. Compl., ¶¶ 74-82. To establish federal officer jurisdiction, the Aetna Defendants must show that OPM exercised "direct and detailed" control over the Aetna Defendants when they both preauthorized the services for W.B. and then underpaid the resulting claim. However, the Aetna Defendants have failed to demonstrate any such control by OPM.

***12** Neither of the cases on which the Aetna Defendants rely alter the Court's analysis. First, the decisions were rendered by the Eighth and Eleventh Circuits, and therefore are not controlling. *See* Opp. Br., Feb. 18, 2021, D.E. 11, at 27 (relying on *Jacks v. Meridian*, 701 F.3d 1224 (8th Cir. 2012); *Anesthesiology Associates of Tallahassee, Fla., P.A. v. Blue Cross Blue Shield of Fla., Inc.*, No. 03-15664, 2005 WL 6717869 (11th Cir. 2005)). But more importantly, both cases are inapposite here. The issue before the Court in *Jacks* was not pre-authorization of procedures, as is the case here. Rather, *Jacks* involved subrogation in a plan beneficiaries' class action. 701 F.3d at 1227-28. Further, the court in *Jacks* observed that "not all relationships between private entities or individuals and the federal government suffice," and the party asserting federal officer jurisdiction must demonstrate "an unusually close [relationship] one involving detailed regulation, monitoring, or supervision." *Id.* at 1231. The *Jacks* court also recognized that other courts, including courts within this District, have "diverging views as to whether the federal officer removal statute applies to...employee members and...carriers contracting under...FEHBA." *Id.* at 1232.

The Eleventh Circuit's decision in *Anesthesiology*

Associates is similarly distinguishable. That matter concerned an actual assignment of rights under health plans covered by ERISA and FEHBA, neither of which applies here. 2005 WL 6717869, at *1. *Anesthesiology Associates* involved the right to the provision of benefits based on the terms of the plan, not one concerning the amount of reimbursement based on an alleged course of dealings between the parties and a prior preauthorization, as is the case here. *Id.*, at *2. In sum, neither *Jacks* nor *Anesthesiology Associates* is particularly persuasive in this case. Accordingly, the Aetna Defendants have failed to meet their burden to show that they or their employees were acting under federal direction, or that § 1442(a)(1) is a valid source of federal jurisdiction.[9]

C. Diversity of Citizenship

In their opposition to Atlantic Shore's motion to remand, the Aetna Defendants argue for the first time that the action is properly here on the basis of diversity jurisdiction, and that the plan sponsors were fraudulently joined to avoid diversity jurisdiction, but they are not proper defendants and the claims against them are frivolous. Opp. Br., Feb. 18, 2021, D.E. 11, at 4-5, 31-32. Atlantic Shore contends that the Aetna Defendants waived this argument because they failed to raise diversity jurisdiction as a ground for removal in their Notice of Removal. Reply Br., Mar. 11, 2021, D.E. 27, at 15 (citing *State Farm Indemnity v. Fornaro*, 227 F. Supp. 2d 229, 240-41 (D.N.J. 2002)).

The Third Circuit has held that a defendant "may not rely on an entirely new basis for removal not set forth in the removal petition." *MHA LLC v. HealthFirst Inc.*, 629 Fed. Appx. 409, 412 (3d Cir. 2015). Consistent with the Third Circuit's instruction in *MHA LLC*, courts within the Third Circuit have generally held that a defendant opposing remand cannot rely on jurisdictional grounds that were not plead in the notice of removal. *See Gosch v. International Chapter of Horseshoers and Equine Trades, Local 947*, 200 F. Supp. 484, 494-95 (M.D. Pa. 2016) ("The time for Defendant to substantively amend the notice of removal and assert new jurisdictional bases has lapsed. At no point did Defendant amend (or seek to amend) the notice of removal to include as grounds that ... the Court has diversity jurisdiction .... In this vein, the Court will not consider either proposition although they were raised and addressed in the parties' briefs regarding Plaintiff's motion to remand."). *See also Fornaro*, 227 F. Supp.2d at 240-41 (rejecting litigant's belated effort to raise diversity jurisdiction as basis for removal where not plead in notice of removal).

***13** Here, the Aetna Defendants were served a copy of the Summons and Complaint on October 7, 2020. Notice of Removal, Nov. 6, 2020, D.E. 1, ¶ 2. Therefore, the thirty-day period for removal expired after November 6, 2020. *Id.*, ¶ 6; *see also* Exh. B to Notice of Removal, email from Suzanne Metzger consenting to removal, D.E. 1-2. The Notice of Removal stated that the grounds for removal were "federal question subject matter jurisdiction under 28 U.S.C. § 1441(a) and the Federal Officer Removal Statute under 28 U.S.C § 1442(a)(1)." Notice of Removal, Nov. 6, 2020, D.E. 1, ¶ 4. No Defendant filed an amended notice of removal. The Aetna Defendants raised diversity jurisdiction for the first time in their February 18, 2021 opposition brief.[10] The Aetna Defendants do not explain why they did not include diversity jurisdiction in the Notice of Removal, much less assert that they could not have plead it earlier. Therefore, the Undersigned recommends that the District Court conclude that the Aetna Defendants cannot now raise, in their brief in opposition to remand, rather than a timely filed notice of removal, diversity jurisdiction as an alternate basis to deny remand.

For the foregoing reasons, the Undersigned respectfully recommends that the District Court grant Atlantic Shore's motion to remand.

D. Plaintiff's Informal Application for Costs and Fees

"An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal." 28 U.S.C. § 1447(c). An award of costs and fees is proper "where the removing party lacked an objectively reasonable basis for seeking removal." *Id.* A Court "has broad discretion and may be flexible in determining whether to require the payment of fees under [28 U.S.C. §] 1447(c)." *Mints v. Educ. Testing Serv.*, 99 F.3d 1253, 1260 (3d Cir. 1996). Although the United States Court of Appeals for the Third Circuit has found "no need to establish definitive criteria" for awarding fees and costs under this statute, a court can consider whether the notice of removal raised difficult issues or whether it was "frivolous" or "insubstantial." *Id.* at 1260–61. Bad faith need not be present to award fees. *Id.* at 1260. Ultimately, in deciding whether to award fees, the Court "must weigh

the circumstances of the case before it." *Siebert v. Norwest Bank Mn.*, 166 F. App'x 603, 607 (3d Cir. 2006) (citing *Mints*, 99 F.3d at 1260.)

In its reply, Atlantic Shore suggests that the Court should assess costs and attorney fees because Defendants' "knee-jerk" removal was frivolous and nothing more than a delay tactic, and that the imposition of fees and costs will serve as a future deterrent. *See* Reply Br., Mar. 11, 2021, D.E. 27, at 2; *see also* Reply Cert. ¶ 4 ("Atlantic acknowledges that it did not formally move for an award of attorneys' fees and costs .... However, the Court has discretion to *sua sponte* award fees."). Although the Court has rejected Defendants' arguments for removal, the Court cannot conclude that Defendants' removal was objectively unreasonable. Furthermore, the award of attorney's fees is a discretionary matter. Accordingly, this Court in its discretion recommends that the District Court decline to assess costs and fees.

IV. CONCLUSION

For the reasons set forth above, the Undersigned respectfully recommends the District Court grant Atlantic Shore's motion to remand, deny Atlantic Shore's informal application for costs and fees, and deny the Aetna Defendants' motion to strike. The parties have fourteen days to file and serve objections to this Report and Recommendation. *See* 28 U.S.C. § 636; L. Civ. R. 72.1(c)(2).

All Citations

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Footnotes

1 Because the Court writes for the parties, the Court briefly summarizes the pertinent facts. The Court also assumes as true the factual allegations in the Complaint for purposes of this motion. *See* *Batoff v. State Farm Ins. Co.*, 977 F.2d 848, 851-52 (3d Cir. 1992).

2 The patients listed in the Complaint on the Disputed Claims List ("DCL") are identified as: M.C., P.S., J.M., C.F., W.B., G.B., N.C., N.H., M.H., J.Z., L.M., M.D., R.S., D.R., and Z.P. Compl., D.E. 1-1, ¶ 19. Three of these patients, D.R. G.B. and M.H, were participants in the Walmart, Inc. Group Health Plan. Decl. in Opp.., Feb. 19, 2021, D.E.24, Decl. of Elizabeth C. Petrozelli, at ¶ 4. Therefore, there are only thirteen plans at issue before this Court. Twelve of the thirteen plans before the Court are employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 (as amended), 29 U.S.C. § 1001, *et. seq.* ("ERISA"). Opp. Br., Feb. 18, 2021, D.E. 11, at 1. The remaining plan, which covers patient W.B., is governed by the Federal Employees Health Benefits Act of 1959 ("FEHBA"), 5 U.S.C. §§ 8901-14. *Id.* While Defendants argued complete preemption under FEHBA as a ground for removal of Atlantic's claim as to W.B. in its Notice of Removal, the Aetna Defendants seem to have abandoned this basis for removal in their opposition brief as they do not address it. Notice of Removal, Nov. 6, 2020, D.E. 1, ¶¶ 15-19; Opp. Br., Feb. 18, 2021, D.E. 11. Because the Aetna Defendants fail to argue in their opposition that this claim was removable based on FEHBA, the Court finds that the Aetna Defendants waive FEHBA as a basis for removal. *See* *Krys v. Aaron*, 112 F. Supp.3d 181, 197 n.18 (D.N.J. 2015) ("passing reference ... will not suffice"). Nonetheless, the Court finds that removal pursuant to FEHBA was improper because Atlantic's claims raise only state law issues and fail to raise any substantial federal question. *See* *Empire v. McVeigh*, 547 U.S. 677, 697 (2006); *Goepel v. Nat'l Postal*, 36 F.3d 306, 316 (3d Cir. 1994).

3 Patient J.Z., one of the fifteen patients listed on the DCL, is allegedly a participant of the Fund's plan. The Fund's arguments in support of removal and in opposition to remand will be considered in footnote 6, *infra*.

4 Defendants' motion to strike is more properly characterized as an unauthorized sur-reply. Defendants attempt to argue the contents of the relevant Summary Plan Descriptions ("SPDs"), and whether the SPDs contained anti-assignment provisions. Defendants certainly could have addressed this very issue in their opposition to the

motion to remand, but did not. Instead, Defendants' initial opposition papers simply attached hundreds of pages of SPDs to their opposition. Their opposition neither pointed to the specific language of any anti-assignment provision, nor explained the significance of any of the anti-assignment provisions or exceptions thereto. Moreover, as explained more fully *infra*, the Aetna Defendants failed to produce even a single valid assignment.

The Defendants also advance two reasons that the Court should strike Mr. Katz's certification, neither of which is availing. First, Defendants object that Mr. Katz's certification contains legal and factual arguments, and is not restricted to statements of facts that are within Mr. Katz's personal knowledge as required by L. Civ. R. 7.2(a). The Court disagrees. The pertinent part of Mr. Katz's certification (i) states that each plan contains an anti-assignment provision, (ii) quotes the specific language of each of the plan's anti-assignment provisions, and (iii) provides the citation in the record for where the specific SPD language can be found. The Court cannot find that Mr. Katz's certification contains impermissible legal and factual arguments.

Second, Defendants contend that the Court should strike Mr. Katz's certification because it improperly requests attorney's fees, when the time to do so was in Atlantic Shore's original motion. Defendants are correct in their assertion that any request for fees and costs should have been made in the original motion. But since the Court recommends denial of Atlantic Shore's informal request for fees and costs, for the reasons set forth herein, this objection requires no further consideration.

[5] This section addresses fourteen of the fifteen patients on the DCL: M.C., P.S., J.M., C.F., G.B., N.C., N.H., M.H., J.Z., L.M., M.D., R.S., D.R., and Z.P., as they were all covered by plans governed by ERISA. The Court will deal with removal of Atlantic Shore's claims with respect to patient W.B. who was covered under an FEHBA plan, *infra*, in the section dealing with federal officer removal.

[6] A "participant" is

> any employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7). A "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

[7] That there were some exceptions to these anti-assignment provisions, as the Aetna Defendants now argue in their motion to strike, does not change this Court's analysis. The Aetna Defendants have failed to provide this Court with any evidence to establish that there was even a single valid assignment. *See* Mot. to Strike, Apr. 1, 2021, D.E. 28, at 2, 5. Moreover, the language on which the Aetna Defendants rely to show that assignments were permissible in at least some of the plans is far from clear. For example, the Aetna Defendants indicate that the Walmart SPDs permitted assignment to non-network healthcare providers. *Id.* However, the non-assignment provision indicates that it does not apply to a "non-network physician or health care provider **who accepts assignments**." *Id.*; *see also* Reply Cert. of Eric D. Katz, D.E. 27-1, ¶ 2f. Again, the Aetna Defendants provide the Court with no evidence to demonstrate that Atlantic Shore accepted assignments.

[8] For these same reasons, the Court finds that Defendant 1199SEIU National Benefit Fund ("the Fund") has failed to carry its burden of demonstrating that Atlantic Shore's claims are completely preempted by ERISA. The Fund argues that Atlantic Shore "has derivative standing as an assignee of J.Z.'s rights to benefit payments; ergo, Plaintiff's complaint is completely preempted by ERISA and this court has jurisdiction over this matter." Fund Opp. Br., Feb. 16, 2021, D.E. 9, at 9. The Fund argues that is an undisputed fact that Atlantic Shore has an assignment of benefits from J.Z., but the Fund fails to provide any proof to establish that Atlantic Shore has a valid assignment. *Id.* Indeed, the SPD on which the Fund relies contains an anti-assignment provision. Reply Cert. of Eric D. Katz, D.E. 27-1, ¶ 2i; Affirmation of Suzanne Metzger, Feb. 16, 2021, D.E. 10, ¶ 5, Exh. B, D.E. 10-2, at 147, 160, 164. Moreover, the Fund fails to establish that Atlantic Shore's claims are colorable claims for benefits under § 502(a).

[9] Because the Court finds that the Aetna Defendants are unable to carry their burden of demonstrating that the OPM exercised "direct and detailed control" over the Aetna Defendants and their employees in preauthorizing services

for W.B., prong two of the *Feidt* analysis, the Court need not reach prongs three and four.

[10] Defendant 1199SEIU Greater New York Benefit Fund has not raised diversity jurisdiction in its opposition to Plaintiff's motion to remand.

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