2022 WL 1236070 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division,
Essex County-Civil Part.
Essex County

ATLANTIC SHORE SURGICAL ASSOCS., P.C., Plaintiff,
v.
AETNA LIFE INS. CO., Aetna Health, Inc., Aetna Health Ins. Co., Blinds-To-Go (US), Inc., Commvault Sys., Inc., Rock Brook Consulting Gr., P.A., Walmart, Inc., 1199Seiu National Benefit Fund, National Railroad Passenger Corp. d/b/a Amtrak, Expeditors International of Washington, and ABC Corps. 1-100, Defendants.

No.
ESX
-
L
-
6558
-
20
.
April 22, 2022.

***1** CIVIL ACTION

Order

Michael H. Bernstein, NJ Attorney ID No.: 128702014, Matthew P. Mazzola, NJ Attorney ID No.: 253252017, Robinson & Cole LLP, 666 Third Avenue, 20th Floor, New York, New York 10017, Telephone: (212) 451-2900, Facsimile: (212) 451-2999, for defendants Aetna life Ins. Co., Aetna Health, Inc., Aetna Health Ins. Co., Blinds-To-Go (US), Inc., Commvault Sys., Inc., Rock Brook Consulting Gr., Br. P.A., Walmart, Inc., National Railroad Passenger Corp. d/b/a/ Amtrak, Expeditors International of Washington.

Keith E. Lynott, Judge.

THIS MATTER having been opened to the Court by Robinson & Cole LLP, attorneys for Defendants Aetna Life Ins. Co., Aetna Health, Inc., Aetna Health Ins. Co. (collectively, "Aetna Defendants"), Blinds-To-Go(US), Inc., Commvault Sys., Inc., Rock Brook Consulting Gr., P.A., Walmart, Inc., Railroad Passenger Corp. d/b/a Amtrak, and Expeditors International of Washington (collectively, the "Plan Sponsors"), for an Order (i) dismissing the Third, Seventh and Eight Counts of Plaintiff's Complaint against the Aetna Defendants with prejudice; and (ii) dismissing Plaintiff's Complaint in its entirety and with prejudice as against the Plan Sponsors; the Court having considered Aetna Defendants and Plan Sponsors' motion papers; and for good cause shown;

IT IS on this 22nd day of April 2022:

ORDERED that the motion to dismiss (i) the Third, Seventh and Eight Counts of Plaintiff's Complaint as against the Aetna Defendants and (ii) Plaintiff's Complaint as against the Plan Sponsors is hereby denied for the reasons set forth in the accompanying Statement of Reasons; and it is further

ORDERED that a copy of this Order shall be deemed served upon all counsel upon e-filing by the Court.

<<signature>>

J.S.C.

☑ Opposed

_____ Unopposed

Statement of Reasons

In this action, Atlantic Shore Surgical Associates, PC ("Atlantic"), a medical and surgical practice alleges underpayment of charges for emergency medical services rendered to numerous patients. The Defendants move to dismiss, in whole or in part, the Plaintiff's Complaint pursuant to R. 4:6-2(e).

Specifically, the Defendants Aetna Life Insurance Co., Aetna Health, Inc., and Aetna Health Insurance Co. (collectively, "Aetna"), and Blinds-to-Go (US), Inc., Commvault Sys., Inc. Rock Brook Consulting Group, P. A., Walmart, Inc., National Railroad Passenger Corp. d/b/a Amtrak and Expediters International of Washington (collectively, the "Plan Sponsors") move to dismiss the Complaint in its entirety as to the Plan Sponsors and the Third, Seventh and Eighth Counts of the Complaint as to Aetna. In addition, the Defendant 1199SEIU National Benefit Fund ("NBF") moves to dismiss the Complaint in its entirety.

For the reasons set forth herein, the Court denies these motions. It concludes that, under the liberal rules governing the adjudication of a motion to dismiss, the Complaint states viable causes of action against all of the Defendants.

I

As these are motions to dismiss pursuant to R. 4:6-2(e), the Court is required to examine the Plaintiff's Complaint through a liberal and hospitable lens. Printing Mart-Morristown, Inc. v. Sharp Elecs. Corp., 116 N. J. 739, 746 (1989). It must conduct an exacting review of the pleading to determine if it is possible to discern the "fundament" of a cause of action from even an "obscure statement" of the claim. Ibid.

The Court accepts as true (solely for purposes of the motion) the factual averments of the Complaint, though it is not required to accept conclusory factual assertions or legal contentions. Ibid. The Court must confer on the Plaintiff the benefit of all reasonable inferences to be drawn from the facts alleged. Ibid.

***2** The Court is not concerned at this juncture with the Plaintiff's ability to prove its claims. Ibid. Instead, its function on a motion to dismiss is to consider the legal sufficiency of the factual allegations and determine whether such alleged facts, if ultimately proven, would entitle the Plaintiff to relief. Ibid.

Ordinarily, the Court confines its examination of the record on a motion to dismiss to the Complaint and it does not examine extrinsic materials. Rieder v. State, 221 N.J. Super. 547, 552 (1987). An exception exists for documents attached or referred to in the Complaint, matters of public record and extrinsic materials that are integral to the Plaintiff's claims even if not specifically referred to the pleading. Banco Popular North Am. v. Gandi, 184 N. J. 161, 183 (2005).

New Jersey courts grant motions to dismiss only in rare instances. 116 N. J. 747. When they do so, they ordinarily grant the motion without prejudice to the right of the Plaintiff to re-plead to address any deficiency identified in the motion practice. Ibid.

II

The Court draws the relevant facts from the Complaint, accepted as true for purposes of this motion only.

Atlantic is a medical practice specializing in surgical treatment, including general and bariatric surgery. It alleges it was at all relevant times an out-of-network provider and "rendered emergency and/or preapproved, medically necessary surgical and related medical services to patients who are entitled to health benefits under plans sponsored, funded, operated, controlled and/or underwrote [sic] by defendants."

Aetna is an insurer licensed to conduct insurance business in New Jersey. According to the Complaint, it sponsored, funded, operated, controlled, administered and/or underwrote health plans for 15 patients identified (via initials) on a Disputed Claims List in the Complaint. The remaining Defendants sponsored, funded and/or administered plans relating to one or more of these patients. The Complaint alleges that Aetna acted as an agent of these Defendants when functioning as administrator of the respective plans.

The Plaintiff alleges that, as to the 15 patients, it performed emergency services for which it was grossly underpaid. Atlantic asserts it performed some of these services following preauthorization by a Defendant and in some cases after being advised by a Defendant that preauthorization was not necessary. As to still other patients, the Complaint alleges it performed emergency services without preauthorization or specific acknowledgment that such authorization was not required and was subsequently underpaid for the same. The Complaint identifies the patients by initials, with dates of service and the amount claimed to be owed.

As to the services for which the Plaintiff contends it obtained preauthorization from the Defendants or representations that such preauthorization was not required, the Complaint alleges that Atlantic relied upon or was to render services "with the expectation to be reasonably compensated consistent with the statements, representations and conduct of Aetna." The Plaintiff alleges that retroactive withdrawals of preauthorization were illegal.

The Complaint avers that the Plaintiff was obligated under New Jersey law to provide emergency services to patients presenting for such treatment, regardless of ability to pay. The Plaintiff alleges the Defendants were aware of this obligation and of a corollary obligation imposed on them to pay providers their usual, customary and reasonable ("UCR") charges for such emergency services in order to hold patients harmless against the cost of the same, save for applicable deductibles and co-pays. It refers to such requirements as State Insurance Mandates. The UCR is the charge rendered by the provider in the free market without an agreement with the payor for a reduced charge and reasonably charged in the geographic marketplace by providers with similar training and experience.

***3** The Plaintiff asserts the Defendants have an "established course of dealings regarding the payment of emergency services." The Complaint alleges the Defendants, through Aetna, represented to the public, including the Plaintiff, their acknowledgment of obligations to pay providers' UCR charges in respect of emergency services. According to the Complaint, the Defendants issued "correspondence and literature" acknowledging and declaring an intention to comply with legal mandates regarding reimbursement of providers for emergency services or otherwise issued documents and were engaged in conduct "consistent with Atlantic's understanding that the State Insurance Mandates must be followed so that the Patients are held harmless when they receive emergency surgery and treatment."

The Complaint alleges, as "[a]nother example of the course of dealings", that the Defendants issued payments "close or consistent" with requirements of law and/or the Plaintiff's UCR charges via application of Aetna's "'nonparticipating balance bill work flow' program, 'network exception' practices, or the practice of paying the defendants a 'negotiated amount'" in circumstances in which Atlantic was the only "on-call physician at a hospital" and no in-network physician was available to respond to the emergency. More generally, according to the Complaint, Aetna has stated it reimburses for emergency services based on its corporate "payment policies." The Plaintiff alleges that the Defendants also represented to Atlantic that they derived the UCR based on an external database.

The Plaintiff alleges that, despite such acknowledgments by the Defendants and the "course of dealings with Atlantic," the Defendants ignored the emergent nature of the services provided to the patients identified in the Complaint and exposed such patients to "balance bills" in respect of such services. The Complaint avers that the amounts paid in relation to the subject patients do not correspond to any valid determination of UCR and that the Defendants so conceded and/or engaged in

"inconsistent, irreconcilable representations" concerning the basis and standard for payment.

The Complaint avers that Atlantic reasonably relied on prior payments based on Aetna's internal policies, "'nonparticipating balance bill workflow' program," "network exception policy" and/or "negotiated amount' practices." It alleges the Defendants have engaged in bait and switch tactics in their use of these programs.

The Plaintiff asserts that it submitted full documentation for each of the subject claims for payment in accordance with all applicable requirements, including time frames imposed by law. It asserts that, "[e]ven though the services rendered by Atlantic were emergency and/or pre-approved, medically necessary surgical care … defendants systematically failed to issue proper reimbursement for the services rendered by Atlantic" to the 15 identified patients. The Plaintiff asseverates that the Defendants also failed to comply with New Jersey's "Prompt Pay" laws resulting in an obligation for interest as prescribed by law.

The Plaintiff asserts that it has exhausted administrative remedies provided by the Defendants and that the prescribed appeal process is illusory and futile. Atlantic avers that Aetna rejected appeals without any explanation and/or claimed the same were untimely when they were not.

The Plaintiff alleges that, to avoid balance billing patients, Atlantic engaged in communications with the Defendants' representatives regarding the subject claims, but it received no response. They assert the Defendants issued gross underpayments, which payments were unlawful as the Defendants failed to pay the proper amounts required by statute, regulation and common law. The Plaintiff alleges that the Defendants intentionally manage the subject healthcare plans in a self-dealing self-serving manner to increase profits by underpaying out-of-network providers to discourage patients from engaging such providers even though the patients paid premiums for access to such providers.

***4** The Plaintiff asserts that Aetna was a de jure or de facto fiduciary of the patients' health care plans and bears fiduciary-based liability. The Plaintiff asserts that the Defendants interacted directly with Atlantic in communications regarding coverage and reimbursement, as well as claims processing, including issuance of Explanations of Benefits and other statements. Atlantic alleges that it relied on the Defendants' "conduct and the parties' course of dealings."

Atlantic avers that its claims arise under state statutory, regulatory and common law, and not any federal law. It alleges that it has proceeded entirely on its own behalf and not via Assignments of Benefits obtained from the subject patients. It contends that the Defendants admit determining payment on the basis of corporate policies and not on the terms of any health care plan. It asserts its rights to additional reimbursements in relation to the subject claims arise from New Jersey laws, statutes and regulations governing "Prompt Pay" and reimbursement of out-of-network providers rendering emergency services, as well as "pre-authorizations and/or pre-certifications and/or payment verifications provided by defendants to plaintiff to induce plaintiff to render surgical and medical services with the promise of coverage and payment."

Atlantic asserts its action relates to alleged failure to provide the proper amount of payment, as opposed to alleged failure to comply with the terms of any health care plan. It contends "[t]here is no dispute that defendants' plans provide benefits for emergency medical services, referenced in the [Disputed Claims List in the Complaint] as demonstrated by the conduct of the defendants in issuing partial payments."

The Complaint sets forth eight Counts. These Counts purport to state claims for relief for breach of implied contract, breach of the covenant of good faith and fair dealing, unjust enrichment and quantum meruit, promissory estoppel, negligent misrepresentation, tortious interference with prospective economic advantage, and violations of regulations in respect of which the Plaintiff claims the right to pursue a private cause of action.

The First Count purports to state a claim for breach of an implied contract as between Atlantic and the Defendants. The Plaintiff alleges that the " Defendants indicated, by a course of conduct, dealings and the circumstances surrounding the relationship, to Atlantic that defendants would pay for surgical and medical services provided, including the emergency services provided by Atlantic to defendants' insureds" identified in the Complaint. It contends the Defendants "represent that their members and beneficiaries are covered for out-of-network emergency and/or pre-authorized care, and that they may go to any hospital emergency room when they need emergency care, and that they will only be responsible to pay the plan's copayments, coinsurance and deductibles at an in-network level when emergency services are rendered."

The Plaintiff's asseverates that the Defendants were paid premiums for out-of-network emergency care and the treatment provided by Atlantic was necessary to satisfy medical needs of the subject patients. The Complaint alleges that the Defendants know that Atlantic is required to provide emergency services to the Defendants insureds and indeed that Atlantic provided the only on-call surgeon available when the need for such services arose.

The Defendants, according to the Complaint, indicated "by a course of conduct, dealings and the circumstances surrounding the relationship, to Atlantic" that it would pay Atlantic's UCR amounts and would hold the insureds harmless. The Plaintiff asserts the Defendants also "indicated, by a course of conduct, dealings and the circumstances surrounding the relationship, to Atlantic that they would honor, inter alia, (a) their representations that the services rendered were pre-authorized, and (b) their indications that pre-authorization was not required."

***5** According to the Complaint, Atlantic performed under the implied contract by providing medically necessary surgical and medical services, including emergency services, to the subject patients and reasonably expected the Defendants to pay for the same. Atlantic alleges a reasonable person in the circumstances would know or should have known of Atlantic's expectation of payment. However, despite indicating by "a course of conduct, dealings, and the circumstances surrounding the relationship" that the Defendants would "properly and timely reimburse plaintiff for either its actual charges as an out-of-network provider or its UCR rates," the Defendants failed to do so, resulting in damages.

The Second Count purports to state a claim for breach of the implied covenant of good faith and fair dealing. The Plaintiff alleges the Defendants were required to act "in a manner that is consistent with the Plaintiffs reasonable expectations." It contends the "Defendants acted with an improper motive and injured plaintiffs rights and benefits under the contract." According to the Complaint, the Defendants thereby breached the covenant with acts and omissions that were wrongful and without justification and that denied the Plaintiff the "benefit of the bargain" intended by the implied contract.

The Third Count purports to state a claim for unjust enrichment and quantum merit. The Complaint alleges the Defendants have enriched themselves unjustly at the expense of Atlantic. It asserts the Defendants refused to pay "correctly" for services provided to patients contrary to pre-approvals and/or the benefits plans, all in contravention of common law, and statutory and regulatory obligations.

The Complaint alleges that the Defendants were paid premiums by plan members for out-of-network emergency and/or pre-authorized services and that, to satisfy obligations to provide such services, the Defendants "required services of Atlantic to render the surgical and medical services, including emergency care where applicable." The Complaint alleges that Atlantic conferred a benefit on the Defendants by providing such services, in circumstances in which its surgeons were the on-call emergency surgeons in the hospital at which the subject patients received treatment.

The Complaint asserts that Defendants unlawfully retained the benefit due to such services by grossly underpaying for the same. They have, according to the Complaint, been further unjustly enriched by reason of earning interest on retained amounts that they should have paid to Atlantic.

The Fourth Count purports to state a claim sounding in promissory estoppel. This Count alleges that the Defendants "made representations, or undertook conduct, that conveyed to Atlantic that reasonable coverage for surgical and medical services would be afforded to patients [identified on the Disputed Claims List], including by pre-authorizing and/or advising the pre-authorization was not necessary." The Defendants, so the Complaint avers, confirmed the services were covered by the applicable healthcare benefits plan and thereby conveyed that reasonable payment would be made for such services, based on "course of dealings, industry customs and regulatory context."

The Plaintiff alleges the Defendants reasonably expected, or reasonably should have expected, that Atlantic would rely upon pre-authorizations given prior to having its surgeons perform services and that the Plaintiff did reasonably rely on such pre-authorizations. The Complaint alleges that withdrawal of pre-authorizations is also contrary to law. Atlantic avers its reliance on the Defendants' promises caused it to suffer a detriment.

The Plaintiffs Fifth Count seeks to state a claim for negligent misrepresentation. It alleges that the Defendants negligently misrepresented that they would provide proper coverage to the subject patients and pay claims "correctly, including by way

of preauthorization, and/or advising that pre-authorization was not necessary." The Defendants then, according to the Complaint, refused proper payment of Atlantic's invoices.

***6** The Complaint avers that Atlantic reasonably relied on the representations that it would be reasonably compensated. It asseverates that such representations were false in that the Defendants materially misrepresented that Atlantic would be reasonably compensated, but that it was improperly underpaid for the services provided. It avers the withdrawal of pre-authorizations was unlawful.

The Sixth Count purports to state a claim for tortious interference with prospective economic advantage. According to the Complaint, the Plaintiff had a reasonable expectation of economic advantage or benefit with which the Defendants wrongfully interfered, resulting in damages.

The Seventh and Eighth Counts allege violations of New Jersey statutes and regulations governing payment for emergency services and or prompt payment of eligible claims for medical services. Specifically, the Plaintiff alleges in the Seventh Count that New Jersey law requires providers to render emergency care to patients regardless of ability to pay or source of payment; that insurance regulations obligate payors to determine coverage and pay promptly, to notify subscribers that they are entitled to have "'access"' to emergency services and to payment of benefits for emergency conditions; that an out-of-network provider of emergency services must be paid a sufficient amount for emergency services to ensure the patient is not "balanced billed" even if the payor must pay the provider the billed amount (less copayments, coinsurance and deductibles) that would apply to service by an in-network provider.

The Eighth Count asserts that applicable statutes and regulations obligate a payor to remit payment to a provider "for an 'eligible' non-capitated claim for medical services" within 30 or 40 days following receipt of the claim. In the alternative the rules require, according to the Complaint a statement of specific reasons for denial of payment. The Complaint alleges the Defendants, as a matter of practice and/or pattern, delayed payment of properly submitted claims, did not pay "correctly," and failed to pay interest as required by law.

The Plaintiff alleges that it has an implied private right of action to pursue civil monetary relief under both sets of statutory and regulatory provisions. It contends that as a result the Defendants are (i) obligated to pay Atlantic 100% of the Plaintiff's UCR charges for emergency services provided to the subject patients, less applicable copays, coinsurance and or deductibles (Seventh Count); and (ii) simple interest at a rate of 12% per annum as to overdue payments (Eighth Count). The Plaintiff alleges the Defendants violated these requirements of law, resulting in damages to Atlantic.

The Plaintiff claims entitlement to compensatory damages, interest, costs of suit and attorneys' fees. It demands trial by jury.

III

Motion to Dismiss of Aetna and the Plan Sponsors

Aetna and the Plan Sponsors move to dismiss all or portions of the Complaint for failure to state a claim pursuant to R. 4:6-2(e). Specifically, they seek dismissal of the Complaint in its entirety as to the individual Plan Sponsors only and of the Third, Seventh and Eighth Counts as against Aetna, as well as the Plan Sponsors.

These Defendants assert the claims against the Plan Sponsors fail as a matter of law. They contend that, although the Plaintiff asserts these Defendants are liable for the actions of Aetna alleged in the Complaint on the theory that Aetna acted at all times as their agent, the Complaint fails to allege sufficient facts to establish a principal/agent relationship among these parties.

***7** They contend as well that 14 of the 15 patient claims raised in the action relate to employee healthcare benefits plans governed by the federal Employee Retirement Income Security Act of 1974 (as amended), 29 U.S.C. § 1001, et seq. ("ERISA"). They assert that there can be no agency theory of liability applicable to the relationship between an employer

acting as plan sponsor of an ERISA-subject plan and a plan administrator such as Aetna.

Aetna and the Plan Sponsors also assert that the Complaint fails to reconcile its assertion of liability predicated on agency grounds with the contention pleaded in (indeed throughout) the Complaint that Aetna forged an implied contractual relationship with Atlantic that was wholly separate and apart from the healthcare benefits plans sponsored by the Plan Sponsors. These Defendants assert that the relationship between Aetna and the Plan Sponsors is entirely based on and tethered to the former's role as administrator or insurer of the latter's benefits plans. It follows, according to the Defendants, that there can be no agency relationship in relation to claims that Atlantic alleges arise from conduct of Aetna that occurred wholly outside the parameters of such plans.

Aetna and the Plan Sponsors seek dismissal of the Plaintiff's Third Count alleging unjust enrichment and quantum merit as against all of these Defendants. They assert that the Complaint fails to establish facts concerning any benefits conferred on these Defendants by the Plaintiff as a result of which Aetna and the Plan Sponsors have been unjustly enriched. They further argue that any such claim is subject to preemption under ERISA as to 14 of the 15 patient claims, citing in particular a recent decision to such effect of the United States Court of Appeals for the Third Circuit. See Plastic Surgery Center, P. A. v. Aetna Life Insurance Co., 967 F. 3rd 218 (3rd Cir. 2020). They contend the same claim asserted in respect of the 15th patient is likewise preempted by the Federal Employers Health Benefits Act of 1959, 5 U.S.C. §§ 8901-14 (the "FEHBA").

Aetna and the Plan Sponsors also seek dismissal of the Plaintiff's Seventh and Eighth Counts, asserting liability to the Plaintiff under New Jersey statutes and regulations dealing with providers' and insurers' obligations in respect of emergency medical services and prompt payment of provider claims. These Defendants assert there is no implied private right of action under such laws and regulations.

Aetna and the Plan Sponsors further contend that such laws and regulations by their express terms apply only to payors in connection with healthcare benefits plans. They point out that, in this case, the gravamen of the Plaintiff's claims is that Aetna and the Plan Sponsors failed to correctly pay reimbursement claims of Atlantic presented under a separate implied contractual agreement with the Plaintiff and not pursuant to the benefits plans themselves. In such circumstances, according to Aetna and the Plan Sponsors, the statutes and regulations on which Atlantic relies to establish its entitlement to relief simply do not apply. Finally, the movants assert that the claim of the Plaintiff predicated on such New Jersey statutes and regulations are preempted both by ERISA and the FEHBA.

The Court concludes that the Complaint adequately states claims against the individual Plan Sponsors that, if proved, would entitle the Plaintiff to relief as to some or all of them. Examined through the generous and hospitable lens required by Printing Mart, 116 N. J. 739, the Complaint lodges claims directly against the individual Plan Sponsors based on their own conduct and on a principal/agent theory.

***8** The movants overlook the fact that the Complaint alleges that the Plan Sponsors themselves engaged in a course of dealing that gave rise to an implied contract or contracts to bear the Plaintiff's UCR charges for emergency services performed by Atlantic that such Defendants then breached by failing to pay the reimbursement claims rendered to the subject patients in accordance with the terms of such contracts. Stated differently, one can readily read the Complaint to allege such contracts exist by virtue of actions taken by the Plan Sponsors, as well as by Aetna on their behalf.

The Complaint further alleges that at the Plan Sponsors negligently misrepresented to Atlantic that services to be rendered by it were preauthorized or that such authorizations were not needed. The Complaint likewise avers that the Plan Sponsors as well as Aetna negligently represented in a variety of communications that they would pay for emergency services in a manner that would protect the patients from balance billing or engaged in conduct that conveyed such assurances. Finally, the Complaint alleges that the Plan Sponsors together with Aetna made definite promises to bear the UCR charges of Atlantic, in each case inducing reliance by Atlantic.

In this regard, the Complaint, read liberally in the Plaintiff's favor, asserts that there were direct communications between Atlantic and some or all of the Plan Sponsors or other conduct undertaken by each of them. As a result of such allegations, it is possible to read the Complaint to allege a right to payment from the Plan Sponsors under the various theories based on their own conduct and not solely on the basis of an alleged principal/agent relationship.

At the same time, the Complaint also sets forth facts from which a factfinder could conclude that Aetna functioned as an agent of the Plan Sponsors and, in such capacity, bound them to implied contracts, misrepresented material matters concerning treatment and payment and/or made definite promises of payment, inducing reliance. The parties agree that a principal/agent relationship arises when the principal authorizes the agent to act on its behalf, the agent manifests consent to the relationship, the principal had the ability to exercise control over the agent and a third-party relied upon the agent's apparent authority to act for the principal. See Clients' Sec. Fund of the Bar of New Jersey v. Sec. Title and Guaranty Co., 134 N. J. 358, 369 (1993); Restatement (Second) of Agency, §§ 140, 212-214, 343.

The Complaint alleges that Aetna acted as an insurer and or administrator of the plans sponsored by the Plan Sponsors. One can reasonably read the Complaint to aver that the Plan Sponsors thereby empowered Aetna to act on their behalf in relation to interactions with Atlantic and had the right or ability to exercise control over its actions. The Complaint alleges that, in its capacity as insurer or administrator of the Plan Sponsors' healthcare benefits plans, Aetna undertook a course of dealing with the Plaintiff that gave rise to an implied contract that was then breached via the claimed underpayments as to the subject patients. It also alleges that, in such capacity, Aetna negligently misrepresented material facts and/or promised payment, expressly or via course of dealing, inducing reliance by Atlantic on Aetna's apparent authority to act in such manner on behalf of the Plan Sponsors as insurer or administrator of the Sponsors' plans.

One can readily read the Complaint to allege the elements of an agency relationship – authorization, acceptance, control and reliance. Whether the Plaintiff can prove such facts or not is not a basis for granting a motion to dismiss.

***9** Aetna and the Plan Sponsors assert that the Complaint cannot be read to establish an agency relationship as the Plaintiff contends Aetna acted to forge an entirely separate relationship with Atlantic that was wholly independent of the healthcare benefits plans themselves. They argue that the plans provided the only basis and authority for any agency relationship as between Aetna and the Plan Sponsors. They thus assert that any action taken by Aetna to establish a basis for medical services and payment for the same that was separate and independent of the benefits plans would perforce be outside the scope of Aetna's actual and apparent authority.

The Court concludes these are matters to be addressed not at the pleading stage, but after discovery, via subsequent motion practice and/or trial. It suffices for now to state that the Complaint alleges facts establishing an agency relationship in connection with which Aetna, on behalf of the Plan Sponsors and in its capacity as insurer or administrator, forged implied contracts, made promises or commitments to bear the billed cost of emergency services to patients sufficient to avoid balance billing and/or misrepresented an intention to do so. It is not by any means inconceivable in all the circumstances that the Plan Sponsors would empower Aetna to facilitate emergency services to subscribers in this manner, as the Complaint also alleges the Plan Sponsors accepted premiums to afford the subscribers, among other benefits, with access to emergency care. In any event, the Court cannot and should not render a determination as to whether the Plan Sponsors did or did not do so on a motion to dismiss.

Nor does the Court accept the moving Defendants' argument that ERISA somehow operates to vitiate or render inapplicable any principal/agent relationship as between any of the Plan Sponsors and Aetna. Even putting aside the question of whether the relevant plans are subject to ERISA, the Plaintiff has pleaded state law claims that are separate from and independent of the plans themselves and thus the purview of ERISA. Such claims, if successful, would be governed by state law principles, including principles relating to agency.

Finally, it is not at all clear that ERISA supplants entirely the principles of agency law as the source of liability for employer sponsors of ERISA-subject plans. See McMahon v. McDowell, 794 F. 2d 100, 109 (3rd Cir. 1986). Applying principles of agency law and respondeat superior to tax employers with liability for the acts of agents is consistent with the overall statutory purpose of ERISA of protecting employees and beneficiaries.

The Court finds that the Plaintiff has stated a viable claim for relief in Count Three that purports to allege a claim for unjust enrichment and/or quantum meruit. The case law dealing with these theories or remedies that both sound in quasi-contract establishes, at minimum, that the theories are consanguineous and even overlapping or coincident in appropriate cases. That said, the Court concludes these two theories are legally distinct with different elements.

Unjust enrichment requires a plaintiff to demonstrate that the defendant received a benefit from the plaintiff and that retention

of the benefit without remuneration would be unjust. Thieme v. Aucoin-Thieme, 227 N. J. 269, 288 (2016) (quoting Iliadis v. Wal-Mart Stores, Inc, 191 N. J. 88, 110 (2007)). The doctrine "also requires that [the] plaintiff show that it expected remuneration from the defendant at the time it performed or conferred a benefit on defendant and the failure of remuneration enriched defendant beyond its contractual rights." Ibid. (internal quotation marks omitted; quoting Iliadis, 191 N. J. at 110; quoting VRG Corp v. GKN Realty Corp., 135 N. J. 539, 554 (1994)).

***10** The Court disagrees with Atlantic's argument that New Jersey courts have in recent years made clear that a claim for unjust enrichment arises even if there is no benefit conferred on the defendant. According to Atlantic, this argument follows from the quoted language above ultimately from VRG Corp. to the effect that a claim for unjust enrichment arises when the plaintiff "conferred performed or conferred a benefit" on the defendant. 135 N.J. at 554. Atlantic asserts this formulation contemplates a claim when the plaintiff performed a service or conferred a benefit in respect of which the plaintiff expected to receive remuneration.

The Court concludes that this language refers – however awkwardly – performing or conferring a benefit. The Thieme court explicitly stated that unjust enrichment requires a showing of a benefit and then in the same paragraph referred to the text from VRG Corp. to the effect that a claim for unjust enrichment arises when the plaintiff "performed or conferred a benefit on defendant." 227 N. J. at 288. The court thus understood such quoted text to be in accord with its own statement of the elements of the claim. Had the Thieme court instead understood that the right to unjust enrichment exists when the plaintiff confers a benefit or performs a service, it surely would have said so.

At the same time, of course, it is certainly possible that the benefit conferred on a defendant could be a service performed by the plaintiff for which the plaintiff expects to be remunerated. In this respect, the theory of unjust enrichment overlaps with quantum meruit.

Quantum meruit is a quasi-contract theory that applies when a litigant performs a service for which he/she/it reasonably expects to be remunerated. This distinct – albeit related – theory requires the following showing: (i) the performance of services in good faith; (ii) the acceptance of the services by the person to whom they were rendered; (iii) an expectation of compensation therefor; and (iv) the reasonable value of the services. Starkey, Kelly, Blaney & White v. Estate of Nicolaysen, 172 N. J. 60, 68 (2002).

Contrary to the argument advanced by Aetna and the Plan Sponsors, the Plaintiff has stated a viable claim for unjust enrichment and quantum meruit. It alleges that, in performing emergency services for the subject patients, Atlantic conferred a benefit on not only the patients but also the Plan Sponsors, inasmuch as Atlantic enabled the latter to satisfy their legal and contractual obligations to ensure that plan beneficiaries receive emergency medical care when needed, including via out-of-network providers, in relation to which obligations the Plan Sponsors received premiums. The Complaint alleges that Atlantic provided such a benefit as the on-call emergency service provider at the time the subject patients sought treatment and, thus, that its affiliated physicians were the only medical professionals available to address the patients' emergency conditions.

The Complaint further avers that, in return for conferring such benefit, the Plaintiff expected remuneration in the form of payment of its UCR charges. It alleges that the retention of the payment due to Atlantic, and the earnings the Defendants realized thereon, would be unjust.

The Court is mindful that some other courts have held in comparable circumstances that there was no benefit conferred on the provider. Instead, according to such holdings, the benefit inured solely to the patient as the provider only received a bill for the services.

But this Court finds more persuasive -and more in line with New Jersey law - the holdings in such cases as El Paso Healthcare Sys. v. Molina Healthcare of N. M., Inc., 683 F. Supp. 2d 454, 461 (W. D. Tex. 2016), in which the court, addressing a claim sounding in quantum meruit, stated that "[w]hile it is true that the immediate beneficiaries of the medical services were the patients, and not Molina [a health maintenance organization], that company did receive a benefit of having its obligation to plan members and to the State, in the interests of the plan members, discharged." (Emphasis in original). The court stated that "Molina describes this benefit as 'incidental,' but the court finds the benefit is material due to the

aforementioned obligations." Ibid. It further observed that "[i]ndeed, Molina's very reason for existence is to ensure that such services are provided to plan members; seeing the core obligation fulfilled is hardly incidental." Ibid.

***11** The court reasoned that "[i]n sum, discharges were presented for the benefit of Molina, which enjoyed them and accepted them, and Molina even acknowledged as much when it tendered payment for them at a rate it determined to be proper." Id. at 462. Referring to the elements of the claim for quantum meruit, the court held that "[p]rongs two and three [requiring a benefit to be conferred upon and accepted by the defendants] have been fulfilled as well as one and four, even though Molina disputes this characterization of the facts." Ibid.

This Court is mindful that El Paso involved a managed care organization, which had certain obligations to the Medicaid program to deliver services to the enrolled patients. But as this Court has previously stated in other cases comparable to this one, it does not perceive a significant leap of logic to be required to find that a similar benefit accrued to Aetna and the Plan Sponsors here, at least given the facts alleged by Atlantic. The Complaint alleges the services provided were emergency services that the moving Defendants agreed to provide and/or were required to provide to their subscribers, in respect of which obligations the Defendants accepted premiums. According to the Complaint, the performance of such services by Atlantic enabled the Defendants to discharge such contractual and legal obligations to their beneficiaries.

The Court also finds that the Complaint states a viable claim for relief under the theory of quantum meruit. The Complaint alleges that the Plaintiff performed necessary medical services that, as noted, redounded to the benefit of Aetna and the Plan Sponsors. It further alleges that Atlantic expected remuneration, not only based on the services delivered to the subject patients, but on a course of dealing established with the Defendants in relation to other patients.

Aetna and the plan spent sponsors contend with the claim for unjust enrichment is preempted by § 514(a) of ERISA, 29 U.S.C. § 1144 ("the provisions of [ERISA] shall supersede any and all State laws insofar as they relate …to any employee benefit plan … Except … nothing in this chapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." Citing to Plastic Surgery, 967 F. 3d 218, Aetna and the Plan Sponsors contend the benefit alleged by the Plaintiff as the basis for its claim of unjust enrichment perforce arises from the existence of an ERISA-governed healthcare benefits plan.

The Supreme Court and numerous other courts have concluded that interpreting the statutory phrase "relate to" as used in § 514(a) to its literal extent would render the reach of the provision virtually limitless. Courts have concluded the phrase does not set forth a test for preemption, but merely identifies the field in which the principles of preemption operate. Cali Div. of Labor Sts. Enforcement v. Dillingham Constr., N.A., Inc., 519 U. S. 316, 336 (1997) (Scalia, J, concurring). For these reasons, the Supreme Court has rejected application of "uncritical literalism" to the phrase, instead requiring courts to go beyond the text and examine the objectives of the ERISA statute as the polestar for determining if Congress intended a state law to survive preemption scrutiny. Id. at 325; Board of Trs. of Oprt'g Engrs. 825 Fund Serv. Facilities v. L. B. S. Constr. Co., 148 N. J. 561, 568-570, 575 (1975); N.Y.S. Conf. of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U. S. 645, 655 (1995); Access Mediquip LLC v. United Healthcare Ins. Co., 662 F. 3d 376, 382 (5th Cir. 2011).

***12** In this regard, when Congress legislates in a field that has traditionally been an area of state regulation under the states' police power, the preemption inquiry "begins with the assumption that Congress did not intend to supersede the state statute." In Re Reglan Litig., 226 N.J. 315, 328-329 (2016). It is undeniable that healthcare regulation has traditionally been a central focus of state law. What is more, the purpose of ERISA in regard to healthcare benefits is to protect beneficiaries/patients. The Plastic Surgery court expressly recognized the importance of affording a state forum in order to protect the rights of patients. Plastic Surgery, 967 F. 3d at 238.

In St. Peters Univ. Hospital v. N. J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 456 (App. Div. 2013), the court concluded that preemption does not occur if the state law claim has only a "'tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability."' (quoting L.B. S. Constr., 148 N.J. at 569). The St. Peters court determined that "[a] state law claim relates to an employee benefits plan if 'the existence of an ERISA plan [is] a critical factor in establishing liability' and 'the trial court's inquiry would be directed to the plan."' Ibid (quoting L.B.S. Constr., 148 N.J. at 569).

Finally, preemption is a fact-sensitive affirmative defense. See R.F. v. Abbott Labs, 162 N.J. 596, 619 (2000) ("Determining whether federal law preempts state law is a fact sensitive endeavor … preemption is not to be lightly presumed"); Access Mediquip, 662 F. 3d at 378 (ERISA preemption is an affirmative defense which must be proven by the defendant at trial"). Given the nascent stage of these proceedings, the Court concludes it must approach with due caution a claim of preemption that is advanced prior to any discovery.

Here, Atlantic challenges whether the relevant plans of Aetna and the Plan Sponsors are even subject to ERISA in the first instance. It argues that, on the present motions, Aetna and the Plan Sponsors have relied on untested averments of a paralegal from Aetna's law department to establish ERISA applicability without submitting the plan documents themselves.[1]

Moreover, the Court finds that a motion to dismiss is not the appropriate juncture at which to address conclusively the issue of preemption that, under St. Peters, requires assessment concerning whether reference to an ERISA-subject plan is critical to establishing liability. As noted, the Plaintiff has pleaded state law claims that are, so they allege, wholly separate from and independent of the plans themselves. The Court finds that the Plaintiff is entitled to reasonable discovery to achieve full exposure of its claims – and the Defendants' preemption defense – and to develop a full record of relevant facts before the Court takes up an issue as complex and fact-sensitive as ERISA preemption. The Court reaches the same conclusion in respect of the question of preemption pursuant to the FEHBA.

The Court is mindful that the Plastic Surgery court, in a published decision issued after this Court last rendered an opinion on these matters, held that ERISA § 514(a) preemption applied to bar the plaintiff from pursuing a claim for unjust enrichment. 967 F. 3d at 242. The court found that, because the claimed benefit underpinning the claim of unjust enrichment in the first instance was the satisfaction of the defendant's obligation under the subject plan to afford coverage for emergency services, the claim for unjust enrichment perforce depended on the existence of an ERISA plan. Ibid. Although this finding may well carry the day here in relation to Atlantic's unjust enrichment claim, this Court, for the reasons noted, finds it is premature to address such issues on a motion to dismiss.[2]

***13** Even were the Court to agree with Aetna and the Plan Sponsors as to the persuasive force of Plastic Surgery as to the claim for unjust enrichment, the Third Count here also pleads a claim for quantum meruit. The Plastic Surgery court specifically observed, 967 F. 3d at 241, n. 27, that its rationale as to unjust enrichment likely did not apply to a claim sounding in quantum meruit. Thus, the Third Count would survive at this time even if the Court were to find the moving Defendants have submitted a ripe motion for preemption of the claim for unjust enrichment.

Aetna and the Plan Sponsors also seek dismissal of the Seventh and Eighth Counts that purport to state claims for relief under New Jersey laws and regulations - specifically N.J.A.C. 11: 24A-2.5(b)(2) and the "Prompt Pay" laws and regulations. They assert entitlement to dismissal on the basis that such requirements do not establish an implied private right of action; that such laws and any cause of action thereunder are preempted by ERISA; and, in all events, that such laws and regulations simply do not apply in the circumstances here.

As to the latter argument, the moving Defendants contend these statutory and/or regulatory enactments or promulgations do not apply because such provisions impose obligations on payors in connection with healthcare benefits plans. They contend the essential theory of the Plaintiff's Complaint is that Atlantic and Aetna and the Plan Sponsors forged arrangements outside the purview of the plans themselves. It follows, according to the movants, that statutory and regulatory provisions applicable in matters involving healthcare benefits plans cannot possibly apply when the parties were operating outside the purview of such plans.

The Court finds that the Plaintiff has pleaded a prima facie right to relief in the Seventh Count on the basis of an implied private right of action under the statutory and regulatory provisions obligating providers to perform emergency services and "carriers" performing under healthcare benefits plans to pay for such services in a manner such that the insureds are not balanced billed for the same. Likewise, the Plaintiff has stated a prima facie right to relief on the basis of an implied private right of action under the New Jersey "Prompt Pay" laws and regulations generally obligating an insurer under a healthcare benefits plan to timely pay or dispute a claim for reimbursement or to bear interest at 12% upon failure to do so.

In any event, the Seventh and Eighth Counts also plead that Atlantic and Aetna and the Plan Sponsors incorporated such

statutory and regulatory provisions, via a course of dealing, into the parties' implied contract as alleged in the First Count. The Complaint specifically cites to various pronouncements of Aetna by which it acknowledged its obligation to adhere to laws and regulations pertaining to payment for emergency services provided to insureds. The Seventh and Eighth Counts would thus survive scrutiny on a motion to dismiss as ancillary to the claim for relief stated in the First Count.

The Court may find that the Legislature intended to vest in a private litigant a right of action in connection with a statutory enactment if the litigant is within the class of intended beneficiaries of the law; there is evidence in the legislative text or history of an intention to create a private right of action; and a private right of action would advance the policies or objectives underpinning the law. _____ and its members under the HINT act for damages). Here, the regulatory provision (adopted by the agency on the basis of authority conferred by statute) obligating insurers to pay for emergency services in a manner as to hold insureds harmless from balance billing obligates the "carrier" to pay the provider. Thus, one could reasonably conclude that the legislative and regulatory authorities intended to include providers as well as the beneficiaries themselves within the protection afforded by the emergency room mandate.

***14** Such requirement also evinces an intention to enable providers to assert a direct private claim for payment in the event of non-compliance with the mandate to pay the insurer at a sufficient level to avoid a balance bill to the patient/insured. And an implied right private right of action - permitting the provider a cause of action to address non-payment or underpayment - would advance the manifest purpose of the emergency room mandate to ensure access to emergency medical services without risking a large financial burden by requiring insurers to pay the providers an amount sufficient to avoid balance billing directed to the patients/insureds.

A similar rationale supports a finding of an implied private right of action to enforce the "Prompt Pay" law. The applicable rules require the carrier to pay the provider promptly or dispute reimbursement claims of a provider and pay the provider interest if it fails to do so. The rules provide for any such interest paid to the provider to be credited against any statutory penalty imposed by the State. Such a legal requirement evinces an intent to benefit providers directly, as well as an intention to afford providers a right of action to collect interest in appropriate cases. Moreover, there can be little doubt that the objectives of such "Prompt Pay" requirements would be advanced by according to providers a direct right of action.

For these reasons, the Court as noted concludes the Plaintiff has established a prima facie right to relief under the cited statutory and regulatory provisions. In the circumstances, the Plaintiff is entitled, at minimum, to pursue discovery to develop a complete record before the Court were to issue a definitive ruling on the existence vel non of an implied private right of action.

The Court also concludes on this motion to dismiss that, were the Plaintiff to prove the facts alleged, the subject emergency room mandate and "Prompt Pay" requirements could apply to Aetna and the Plan Sponsors in the circumstances presented here. The Plaintiff alleges that Aetna and the Plan Sponsors recognized and accepted, through their course of dealing, a legal obligation to bear the Plaintiff's UCR charges for emergency services and to comply with the "Prompt Pay" laws and/or that Aetna, as an agent of the Plan Sponsors, committed the latter to comply with such laws and regulations. The Complaint refers to various documents and pronouncements of Aetna explicitly acknowledging the applicability of such laws and regulations governing payment for emergency services rendered to an insured/plan member. Put differently, a generous and hospitable reading of the Complaint requires the conclusion that the Plaintiff alleges that the Plan Sponsors, as well as Aetna, have recognized and acknowledged, directly or indirectly through Aetna as their authorized agent, that these laws and regulations do apply to them and their activities in relation to their subscribers.

As to the claim of preemption, the Court concludes the motion is premature. For reasons already noted, it finds in all the circumstances here than a motion to dismiss is not the appropriate juncture at which to adjudicate definitively a claim of ERISA preemption.

IV

Motion to Dismiss of the Defendant 1199 SEIU National Benefit Fund

The Defendant NBF asserts that it is a self-funded, multi-employer Taft-Hartley trust fund administered under ERISA, established by not-for-profit hospital employers for the benefit of employees. It moves to dismiss Atlantic's Complaint in its entirety.

As an initial matter, NBF alleges that, contrary to the allegations of the Complaint, the patient J.Z., identified as a plan beneficiary treated by an Atlantic-affiliated physician, was actually a participant in a different plan altogether than the NBF Plan. It asserts that the correct plan is the 1199 SEIU Greater New York Fund (the "GNY Fund"). It also contends such plan was established for employees of for-profit hospitals such as J.Z. It presents this motion to dismiss on the assumption that the claims of Atlantic in relation to J.Z. implicate the GNY Fund Plan and not the NBF Plan.

***15** NBF asserts there are actually two separate GNY Fund Plans – one for employees in New York and one for New Jersey employees. It contends that J.Z. is a participant in the GNY Fund Plan for New Jersey employees. It contends this fact is of significance here as it asserts this Plan does not provide for out-of-network benefits of any kind.

NBF further asserts, based on the allegations of the Complaint, that the alleged underpayment in relation to the subject patient J.Z. (the only patient in respect of whom the Complaint alleges liability as to NBF/GNY Fund) is for emergency services that were not pre-authorized. As a result, the movant contends that all the allegations of the Complaint relating to allegedly preauthorized services do not and cannot apply to it. As a result, NBF challenges the legal viability of the causes of action asserted against it as, it contends, the same rest in large measure on alleged preauthorizations.

NBF challenges the legal sufficiency of all the claims asserted against it. It contends that what it asserts are minimal facts pleaded in relation to J.Z. and NBF and/or the GNY Fund do not establish viable claims for breach of implied contract, breach of covenant, unjust enrichment or quantum meruit, negligent misrepresentation, promissory estoppel or tortious interference with prospective advantage. It asserts that the Seventh and Eighth Counts fail as there is no basis for the assertion of a private right of action and, in any event, the movant is not an insurer subject to either the emergency room mandate or "Prompt Pay" laws. Finally, NBF contends the Plaintiff's claims are preempted by ERISA inasmuch as NBF and the GNY Fund are self-funded, multi-employer trusts subject to ERISA.

The movant also asseverates that the Plaintiff's pleading is insufficiently definite as to the claims asserted against it. This is so, according to the movant, as the Plaintiff has chosen to combine its claims against NBF with factual averments and claims as to the other named parties without differentiation, resulting in a pleading that, it contends, is almost entirely irrelevant as to NBF. NBF further asserts that, because it and the GNY Fund are trusts, the action is improperly lodged in the Law Division and instead belongs in the Chancery Division.

The Court is unable to adjudicate on a motion to dismiss the assertions of NBF that it is not a proper party as (i) J.Z. was a participant in the GNY Fund; and (ii) the relevant fund does not provide any out-of-network benefits.[3] To determine these matters on a motion to dismiss would ignore the instructions of Printing Mart, 116 N.J. 739, and related cases to accept as true the allegations of the Plaintiff's Complaint and not to examine factual matters extrinsic to the Complaint (with limited exceptions). NBF relies on a SPD from 2011. The record also contains a 2017 SPD for the same Plan. Neither summary is or appears to be the plan summary in effect during the relevant year of 2016. Moreover, the present record does not contain the plan documents themselves. Nor has the Plaintiff had an opportunity to conduct discovery as to the same.

In any event, the Plaintiff argues that summary descriptions in the record contradict the assertion that the relevant Plan did not authorize any out-of-network services. The Court is not empowered to resolve such factual disputes on a motion to dismiss.

***16** Moreover, as discussed at length herein, the gravamen of the Plaintiff's Complaint is that the parties participated in a course of dealing by which they separately agreed on payment for emergency services – whether or not preauthorized – independent of the Plan documents themselves. The Plaintiff clearly asserts such claims against NBF and/or the GNY Fund as well as the other parties.

The Court finds that the Plaintiff has asserted facts establishing viable claims as against NBF for breach of contract, breach of covenant, unjust enrichment and quantum merit, negligent misrepresentation, promissory estoppel and tortious interference. The Complaint alleges the same essential facts as against NBF and/or the GNY Fund as it does in relation to Aetna and the

Plan Sponsors. The movant overlooks the fact that the Complaint, read liberally and generously as Printing Mart requires, alleges that NBF engaged in the same course of conduct – and/or that Aetna did so on its behalf – that the other Plan Sponsors and Aetna undertook when their subscribers presented as emergency room patients at hospitals served by Atlantic.

Specifically, the Complaint alleges that NBF – directly, or via Aetna acting as an agent – engaged in a course of dealing by which it established an agreement with Atlantic to pay the Plaintiff's UCR charges for the emergency services rendered to subscribers of NBF. It alleges such course of dealing is manifested in (i) direct communications with Atlantic – if not as to J.Z. specifically then as to other subscribers of NBF; and/or (ii) public pronouncements or disposition of other reimbursement claims by Aetna, which functioned at all times as an agent for whose conduct NBF is responsible.

This alleged course of dealing forms the essential basis for the Plaintiff's claims (pleaded in the alternative as permitted by the Court Rules) sounding in contract or quasi-contract. The Plaintiff alleges such course of dealing gave rise to an agreement-in-fact to pay for services rendered on an emergency basis and that NBF, or Aetna acting as its agent, breached such agreement in relation to the services rendered to the patient J.Z. The claim is not dependent upon preauthorization, even though the Plaintiff alleges such preauthorization in respect of certain patients of the other Plan Sponsors

Likewise, the Complaint alleges that the Plaintiff conferred a benefit on NBF via its performance of emergency services to a beneficiary of the subject plan and/or performed a service, in return for which it expected remuneration from NBF based upon the alleged course of dealing. The Complaint thus states a claim for unjust enrichment and/or quantum meruit as to NBF, just as it does in relation to the other Defendants. This is so even if though the Complaint does not allege that the services provided in respect of J.Z. were preauthorized.

The claim for promissory estoppel requires a showing of a clear and definite promise by the defendant intended to induce reliance on the same, reasonable reliance and substantial detriment. See Lobiodo v. O'Callaghan, 357 N.J. Super. 488, 499 (App. Div. 2003). Promissory estoppel is a principle that prevents a party from reneging on a promise even when an enforceable contract does not exist. It is a substitute for consideration necessary to establish an enforceable contract. Here, the facts alleged in the Complaint, considered as a whole, state a viable claim for promissory estoppel as against NBF in addition to the other Defendants.

***17** The Plaintiff alleges a clear and definite promise to pay the Plaintiff's UCR charges in respect of emergency services rendered to J.Z. via conduct in the form of a course of dealing by NBF and/or Aetna acting on its behalf by which NBF acknowledged an obligation to compensate Atlantic for out-of-network emergency services provided to its subscribers at the UCR rates and assured Atlantic that it would compensate for such emergency services in such manner. This conduct induced reliance on the part of Atlantic in the form of the emergency services provided to J.Z., NBF's (alleged) beneficiary.

It is true that, in respect of J.Z., the Complaint does not allege a promise of payment via a preauthorization communicated to Atlantic by NBF or Aetna acting on its behalf. But just as a binding contract can be formed by conduct of the contracting parties, there is no logical reason why a promissory estoppel cannot arise from conduct of a party that conveys a clear and definite promise intended to induce reliance.

The claim for negligent misrepresentation requires a plaintiff to establish the negligent provision of false information; that such plaintiff was a reasonably foreseeable recipient of such information; reasonable reliance on such false information; and resulting damages. Karu v. Feldman, 119 N.J. 135, 146-147 (1990). The cause of action encompasses not only spoken or written words, but also conduct that amounts to an assertion that is false or untrue. "[C]onduct asserting the existence of a fact constitute[s] a misrepresentation if the fact does not exist." Restatement (Second) of Torts, § 525, cmt b.

As the Restatement makes clear, conduct can give rise to a false misrepresentation. Here, the Complaint alleges a course of conduct by NBF or Aetna acting on its behalf, that negligently conveyed a present intention to bear the cost of UCR charges for out-of-network emergency services rendered by Atlantic to NBF subscribers. It avers that such conduct induced reliance by Atlantic through the emergency services provided to J.Z. and that NBF's assurances that it would pay Atlantic in such manner were false in that NBF failed to properly compensate Atlantic for its services.

The Court likewise concludes that the Complaint – examined through a prism that favors the Plaintiff – states a viable claim against NBF for tortious interference with prospective economic advantage. To state such a claim, a plaintiff must allege

facts establishing a protected interest, including a reasonable prospect of a future economic relationship or contract; interference with such interest by the defendant; malice – meaning an interference without justification; a reasonable likelihood that the interference resulted in the loss of the actual or prospective gain; and resulting damages. Printing Mart, 116 N.J. at 751.

Here, the prospective economic advantage alleged is the economic benefit to be derived from the patient/provider relationship allegedly existing between Atlantic and J.Z. who sought treatment from Atlantic. The Complaint – once again examined in the manner required by Printing Mart – alleges an interference with such relationship via underpayment of its reimbursement claim and that NBF acted contrary to an alleged course of dealing as to payment for emergency services without justification and for its own benefit, causing the Plaintiff harm in the form of loss of the reasonably expected full benefit of its provider/patient relationship.

For the reasons already set forth, the Court finds the Plaintiff has stated viable claims for private party relief under the emergency room mandate and "Prompt Pay" laws. It further concludes the Plaintiff has alleged facts that, despite its present claim that such laws and regulations do not apply to it, NBF has, via its own conduct and/or that of Aetna on its behalf, acknowledged the applicability of such laws and regulations in relation to the emergency medical treatment provided to J.Z. and the provider's charges for the same.

***18** The Court concludes it is premature to determine questions of ERISA preemption as to NBF (or the GNY Fund, as the case may be). The present record is incomplete and contested as to the applicability vel non of ERISA to the subject plan.

Even granting that such plan is established pursuant to ERISA, the question of preemption under ERISA § 514(a) requires the Court to determine whether the existence of an ERISA-subject benefits plan is a "critical factor" in establishing liability. Saint Peters, 431 N.J. Super. 446, 455-456. This is a fact-sensitive inquiry that requires a record inasmuch as the Plaintiff alleges its right to the relief sought under the various causes of action exists wholly independent of any healthcare benefits plan. The Complaint alleges facts supporting causes of action for breach of an implied contract that, the Plaintiff contends, is separate from and independent of any ERISA-subject plan. It asserts claims sounding in quasi-contract (unjust enrichment, quantum merit promissory estoppel) and tort (negligent misrepresentation and tortious interference) that, it alleges, are not grounded in any healthcare benefits plan and do not require the Court to examine the terms of any such plan. It contends that NBF also acted contrary to applicable laws and regulations that are independent of any such benefits plan; that establish independent duties and that relate to the rate and amount of payment, including for late payment, and thus to the cost of implementing a benefits plan and not to the nature or quality of the benefits to be provided.

In Plastic Surgery, 967 F. 3d 218, the court rejected preemption claims relating to the plaintiffs contract, quasi-contract and tort theories (save as discussed above for unjust enrichment). It did so on the basis of the plaintiffs contention that its claims were grounded in conduct independent of the terms of a healthcare benefits plan.

In this case, it remains to be seen whether the Plaintiff can establish entitlement to relief under such causes of action and/or whether the same are in fact independent of and do not require substantive reference to the NBF or GNY Fund plan. The Court only determines here that the Plaintiff is entitled to the benefit of discovery and to a more complete factual record as to its claims before the Court takes up and adjudicates a defense predicated on preemption.

The Court concludes the case against NBF is properly lodged in the Law Division and the Court has jurisdiction to address the claims asserted by Atlantic. The Plaintiff seeks monetary damages and does not allege a breach of trust as to NBF. To the extent the Plaintiff invokes the equitable authority of the Court, it is fully empowered to grant such equitable relief as it determines to be appropriate.

Finally, the Court concludes, for reasons already stated, that the Complaint alleges viable causes of action against NBF in a sufficiently clear and definite manner. There is no basis established on this record that the Complaint, as to NBF, contains inappropriate material. That the Plaintiff does not allege a preauthorization of services as to NBF does not mean there are no facts alleged as to this party to support the claims asserted or that NBF is unable to determine the basis for the action or the allegations it is required to answer.

Footnotes

[1] As to the motion of the Defendant NBF, discussed below, Atlantic also points out that Aetna and the Plan Sponsors have submitted a 2017 Summary Plan Description ("SPD") of the Fund's plan and the Fund itself has submitted a 2011 SPD. It observes no one has submitted the SPD for 2016 (the year in which the subject services were rendered) or the definitive plan documents.

[2] Notably, the Plastic Surgery court rejected the defendant's preemption claim in relation to other causes of action lodged by the plaintiff - e.g., breach of implied contract, and misrepresentation - which causes of action are substantially similar to those at issue here.

[3] The Plaintiff is free to seek leave to amend its Complaint to substitute the GNY Fund for NBF if it determines this is appropriate.