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NOT FOR PUBLICATION
United States District Court, D. New Jersey.

ESSEX SURGICAL, LLC, et al., Plaintiffs,
v.
AETNA LIFE INSURANCE CO., et al.,
Defendants.

Civil Action No. 23-03286-WJM-AME
|
Filed 12/31/2024

REPORT and RECOMMENDATION

ANDRÉ M. ESPINOSA United States Magistrate Judge

***1** This matter is before the Court on the motion by Plaintiffs Essex Surgical, Mark Drzala MD, PC; Mitchell Reiter MD, PC; and Kevin McCracken MD, PC to remand this action for lack of subject matter jurisdiction, or alternatively, to sever and remand. [*See* D.E. 18, 59]. Removing Defendants Aetna Life Insurance Company and Aetna Health Insurance Company (together, the "Removing Defendants") oppose the motion, arguing that federal question jurisdiction exists through ERISA pre-emption and that diversity jurisdiction exists because of the fraudulent joinder of certain non-diverse defendants. [D.E. 19, 60]. The Honorable William J. Martini, U.S.D.J., referred the motion for a Report and Recommendation pursuant to 28 U.S.C. § 636(b). This Court has reviewed the parties' written submissions and issues this Report and Recommendation without oral argument. *See* Fed. R. Civ. P. 78(b). For the following reasons, the Court respectfully recommends that Plaintiffs' motion be granted, and this matter be remanded to the Superior Court of New Jersey pursuant to 28 U.S.C. § 1447(c).

I. BACKGROUND

i. Facts and Procedural History

On May 8, 2023, Plaintiffs Essex Surgical, LLC ("Essex"); Mark R. Drzala MD, P.C., also doing business as New Jersey Spine Specialists, LLC ("Dr. Drzala"); Mitchell F. Reiter MD, P.C., also doing business as New Jersey Spine Specialists LLC ("Dr. Reiter"); and Kevin A. McCracken, MD, P.C., doing business as Orthopaedic & Spine Center of New Jersey, PA ("Dr. McCracken") (collectively, "Plaintiffs") filed a lawsuit in the Superior Court of New Jersey, captioned *Essex Surgical, LLC, et al. v. Aetna Life Ins. Co., et al.*, BER-L-002422-23. [D.E. 1-3 at 2-3, ¶¶ 1-4]. In their complaint (the "Complaint"), Plaintiffs plead claims against Defendants Aetna Life Insurance Company ("ALIC"); Aetna Health Insurance Company ("AHIC"); and Aetna Health, Inc. ("AHI") (collectively, the "Aetna Defendants"). [D.E. 1-3 at 4, ¶ 6]. The Complaint alleges that "[a]t all relevant times, [the Aetna Defendants] insured or administered insurance that covered Patients T.A., D.A., D.L., K.S., T.M., N.S. and D.P." (collectively, the "Patients"). [D.E. 1-3 at 4, ¶ 7].

Plaintiffs also plead claims against Defendants Insmed, Incorporated ("Insmed"); Schools Health Insurance Fund ("SHIF"); and Johnson & Johnson ("J&J") (collectively, the "Payor Defendants"). [D.E. 1-3 at 5-6, ¶¶ 10-12]. Insmed insured Patient K.S.; SHIF insured Patient N.S.; and J&J insured Patient D.P. [*Id.*].

Plaintiffs all maintain offices in New Jersey and are citizens of New Jersey. [D.E. 1-3 at 2-3, ¶¶ 1-4]. The Removing Defendants are Connecticut corporations that maintain their principal place of business in Connecticut. [D.E. 1 at 2, ¶ 5; D.E. 1-3 at 4, ¶ 6]. Defendant AHI is a New Jersey corporation with its "statutory home" in New Jersey and its "main administrative" office in Pennsylvania. [D.E. 1-3 at 4, ¶ 6]. The Complaint alleges that the Payor Defendants are all citizens of New Jersey. [D.E. 1-3 at 5-6, ¶¶ 10-12].

***2** According to the Complaint, the Aetna Defendants also maintained a "National Advantage Program" ("NAP"), through which they "entered into agreements with MultiPlan, Inc. to access and use MultiPlan's network of [healthcare] providers." [D.E. 1-3 at 18-19, ¶¶ 51-52]. Patients in the NAP "obtain[ ] discounts for out-of-network care from so-called 'NAP providers.' " [D.E. 1-3 at 19, ¶ 52]. Plaintiffs were not providers participating in the Aetna insurance network and were out-of-network with respect to Defendants. [D.E. 1-3 at 8, ¶ 23]. However, Plaintiffs maintained provider agreements with MultiPlan. [D.E. 1-3 at 8, ¶ 23; D.E. 1-3

at 19, ¶ 53]. The Complaint alleged that, due to Plaintiffs' out-of-network status, Plaintiffs contacted the Patients' insurance plans via the Aetna Defendants to obtain pre-authorization for surgical and medical services. [D.E. 1-3 at 9, ¶¶ 24, 26; D.E. 1-3 at 10, ¶ 28; D.E. 1-3 at 11, ¶ 30; D.E. 1-3 at 12, ¶¶ 32, 34; D.E. 1-3 at 13-14, ¶¶ 36-37]. Plaintiffs allege that they conducted such pre-authorization calls for each of the Patients and obtained oral pre-authorization from Defendants. [D.E. 1-3 at 14, ¶ 39].

According to the Complaint, "different Aetna Defendants take part in claims administration," including pre-authorization calls, and when the phone number for pre-authorization is dialed, "there is no indication which specific Aetna company or affiliate is processing the pre-authorization call." [D.E. 1-3 at 5, ¶ 8].[1] Instead, the caller speaks with an Aetna representative, who is part of the Aetna "Provider Services Team" or the Aetna "Provider Resolution Team," and receives a reference number for the call. [D.E. 1-3 at 5, ¶ 8]. Plaintiffs allege that, for each of these calls, Aetna representatives orally affirmed that Plaintiffs would be reimbursed at a certain percentage of the usual, customary, and reasonable rate for the services in question. [D.E. 1-3 at 9, ¶¶ 24, 26; D.E. 1-3 at 10, ¶ 28; D.E. 1-3 at 11, ¶ 30; D.E. 1-3 at 12, ¶¶ 32, 34; D.E. 1-3 at 14, ¶ 37]. None of the Aetna representatives' oral pre-authorizations referenced any MultiPlan rates. [*See id.*]. The Complaint alleges that in reliance on these oral pre-authorizations, Plaintiffs rendered surgical and medical services to each of the Patients.[2]

***3** Plaintiffs allege that, after they performed such surgical and medical services, they were reimbursed at rates lower than those relayed in the pre-authorization calls. [D.E. 1-3 at 9, ¶¶ 24-26; D.E. 1-3 at 10, ¶ 27-29; D.E. 1-3 at 11, ¶¶ 30-31; D.E. 1-3 at 12, ¶¶ 32-34; D.E. 1-3 at 13, ¶¶ 35-36; D.E. 1-3 at 14, ¶ 38]. As such, the Complaint alleges claims for breach of implied contract; breach of the covenant of good faith and fair dealing; *quantum meruit*; promissory estoppel; negligent misrepresentation; negligence; and tortious interference with economic advantage. [*See* D.E. 1-3 at 23-31, ¶¶ 72-127].

On June 14, 2023, the Removing Defendants removed this action to federal court on the basis of federal question jurisdiction, stating that the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq.* ("ERISA") provides complete pre-emption over Plaintiffs' claims. [*See* D.E. 1 at 3, ¶ 9]. Alternatively, the Removing Defendants assert that the federal court has subject matter jurisdiction through diversity jurisdiction, because non-diverse defendants AHI, Insmed, SHIF, and J&J were fraudulently joined, and therefore, the citizenship of these entities must be disregarded in determining complete diversity. [*See* D.E. 1 at 8; D.E. 1 at 9, ¶¶ 21-22].

On July 14, 2023, Plaintiffs voluntarily dismissed only the claims relating to the services Drs. McCracken and Drzala provided to Patient D.P., thereby voluntarily dismissing the claims against J&J. [*See* D.E. 17]. On that day, Plaintiffs moved to remand this case back to state court, arguing this Court lacks subject matter jurisdiction because ERISA does not pre-empt their claims and because no Defendant is fraudulently joined. [*See* D.E. 18]. Alternatively, Plaintiffs argue, if some of the claims are pre-empted by ERISA, the Court should sever and remand those claims. [*See* D.E. 18-1 at 47-48]. Defendants opposed Plaintiffs' motion. [D.E. 19].

On December 21, 2023, the Court ordered the parties to engage in limited fact discovery "to ascertain which of the claims concerning each Patient are arguably pre-empted by ERISA." [*See* D.E. 32 at 3, ¶ 9]. On March 27, 2024, Plaintiffs filed a motion to compel discovery pertaining to fraudulent joinder, and Defendants filed a motion for a protective order barring depositions. [D.E. 41]. The Court held a status conference on June 5, 2024, to address the parties' disputes. [D.E. 51]. Thereafter, on June 6, 2024, Plaintiffs voluntarily withdrew their motion to compel discovery without prejudice, which mooted Defendants' motion for a protective order, and the Court reinstated Plaintiffs' motion to remand. [D.E. 52 and 53]. On June 7, 2024, the Court ordered supplemental briefing on Plaintiffs' motion to remand. [D.E. 55]. That day, Plaintiffs Dr. McCracken and Dr. Drzala voluntarily dismissed with prejudice only the claims relating to the services they provided to Patient D.P., thereby dismissing with prejudice only Defendant J&J. [D.E. 56]. The Court ordered that voluntary partial dismissal with prejudice on June 10, 2024. [D.E. 57]. In addition to briefing on the original motion to remand, the parties provided supplemental briefing. [*See* D.E. 18, 19, 20, 59, 60, and 61].

ii. The Parties' Arguments

The Removing Defendants assert two grounds for federal subject matter jurisdiction. First, the Removing Defendants argue that federal question jurisdiction provides a basis for removal, because ERISA completely pre-empts Plaintiffs' claims under the two-pronged test in *Aetna Health, Inc. v. Davila, 542 U.S. 200, 210*

(2004), and articulated by the Third Circuit in *Pascack Valley Hosp., Inc. v. Loc. 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir.2004) (the "*Pascack* test"). [D.E. 1 at 3-4; D.E. 19 at 18 n. 9]. Under this test, a plaintiff must have been able to bring their claim under 29 U.S.C. § 1132(a)(1)(B) (hereinafter "ERISA 502(a)(1)(B)" or "ERISA 502(a)"). *Pascack*, 388 F.3d at 400. Second, no other legal duty can support the plaintiff's claim. *Id.* To demonstrate Plaintiffs could have brought their claims under ERISA 502(a), the Removing Defendants argue that Patient D.P.'s health benefits plan was governed by ERISA and provided a claim form for Patient D.P.; a form wherein Patient D.P. purportedly provided an assignment to Dr. McCracken; and letter wherein Dr. Drzala requested documents as an assignee under D.P.'s J&J Plan. [*See* D.E. 19 at 18; D.E. 1-7; D.E. 60-1; and D.E. 60-2]. The Removing Defendants assert that no other legal duty supports Plaintiffs' claims because the claims based on pre-authorization statements here are not independent of any ERISA plan. [D.E. 19 at 18 n. 9; D.E. 60 at 6].

***4** Plaintiffs, on the other hand, argue that complete ERISA pre-emption does not apply here, first, because Plaintiffs dismissed with prejudice the claims related to services provided to Patient D.P., and second, because the remaining insurance plans all contain anti-assignment clauses, which deprive Plaintiffs of standing to bring ERISA-based claims on behalf of the Patients. [D.E. 18-1 at 19; D.E. 59 at 7; D.E. 61 at 1-2]. Plaintiffs also argue the claims here are independent of any ERISA plans because they arose out of oral pre-authorizations with Plaintiffs as out-of-network providers, not from any ERISA plan. [D.E. 18-1 at 31; D.E. 59 at 7 n. 2].

Second and alternatively, the Removing Defendants assert that complete diversity exists between the parties under the fraudulent joinder doctrine. [D.E. 1 at 7]. Specifically, the Removing Defendants argue the Payor Defendants were fraudulently joined because the Master Services Agreements between the Payor Defendants and the Aetna Defendants made clear that the Aetna Defendants had no authority outside the scope of the insurance plans and either limited the scope of their relationship to issuance of claim payments or disclaimed agency relationships altogether. [D.E. 19 at 14-15].

The Removing Defendants assert that AHI was fraudulently joined because AHI did not insure or administer any of the insurance plans in question here, and therefore, has no connection to Plaintiffs' claims. [D.E. 19 at 16]. In support of this, the Removing Defendants offer the declaration of Elizabeth C. Petrozelli, a paralegal at Aetna Resources, LLC ("Petrozelli"), who certified that in her position, she has "become familiar with the systems utilized by Aetna affiliated entities ... for identifying the health plans and claims in which a member is enrolled," and that "[n]one of the plans at-issue in this case are administered, insured, or underwritten by [AHI]." [*See* D.E. 1-2 at ¶¶ 1-2, 4]. The Removing Defendants also argue it is insufficient for Plaintiffs to claim that "Aetna holds itself out to the public ... as a cohesive, integrated family of companies that operate together to insure, administer and process claims" and that the Aetna Defendants are "alter egos and/or agents of one another" to justify the propriety of joining AHI. [*See* D.E. 19 at 16-17].

Plaintiffs argue the Payor Defendants were not fraudulently joined because the Complaint alleges direct causes of action against them arising out of the parties' course of dealing. [D.E. 18-1 at 42; D.E. 59 at 8]. Plaintiffs additionally assert that a disclaimer of agency relationship is not dispositive, and claims against the Payor Defendants were colorable because the Aetna Defendants executed oral pre-authorizations with Plaintiffs as agents of the principal Payor Defendants. [D.E. 20 at 17-18; D.E. 18-1 at 42]. Concerning AHI, Plaintiffs argue that Aetna holds itself out as "a cohesive, integrated family of companies that operate together to insure, administer and process claims," supporting AHI's joinder, or, at a minimum, not rendering it "wholly insubstantial and frivolous" under the fraudulent joinder standard. [D.E. 18-1 at 44].

Finally, Plaintiffs argue that, if the Court concludes their claims are pre-empted by ERISA, the Court should isolate and sever the pre-empted claims from those that are not pre-empted and remand the non-pre-empted claims back to state court. [D.E. 18-1 at 47]. Defendants oppose that proposal, arguing the Court should sever the claims into six different actions for each individual patient and perform independent jurisdictional analysis for each. [D.E. 19 at 20; D.E. 60 at 7].

II. DISCUSSION

***5** An action may be removed from state court pursuant to 28 U.S.C. § 1441(a) only if that action could have originally been brought in federal court. In other words, Section 1441 authorizes removal "so long as the district court would have had subject-matter jurisdiction had the case been originally filed before it." *A.S. ex. rel. Miller v. SmithKline Beecham Corp.*, 769 F.3d 204, 208 (3d Cir. 2014). Because federal courts are courts of

limited jurisdiction and "possess only that power authorized by Constitution and statute," *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994), removal statutes must be strictly construed. *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100, 108-09 (1941); *see also* *Samuel-Bassett v. KIA Motors Am., Inc.*, 357 F.3d 392, 396 (3d Cir. 2004) (holding that "28 U.S.C. § 1441 is to be strictly construed against removal"). Where a case is removed to federal court under Section 1441, all doubts concerning subject matter jurisdiction must be resolved in favor of remand. *A.S.*, 769 F.3d at 208 (citing *Batoff v. State Farm Ins. Co.*, 977 F.2d 848, 851 (3d Cir. 1992)); *see also* 28 U.S.C. § 1447(c) ("If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded."). On a motion to remand, the removing party bears the burden of demonstrating there is federal subject matter jurisdiction. *Samuel-Bassett*, 357 F.3d at 396; *Boyer v. Snap-On Tools Corp.*, 913 F.2d 108, 111 (3d Cir. 1990).

A. Federal Question Jurisdiction Under Complete ERISA Pre-Emption

Defendants have not established that federal question jurisdiction exists in this matter. Defendants' removal notice asserts that ERISA is the original federal law that provides the grounds for removal to federal court. [D.E. 1 at 3-4, ¶¶ 9-10]. Specifically, Defendants argue that Plaintiffs' claims are completely preempted under ERISA 502(a). [*See* D.E. 1 at 4, ¶ 11; D.E. 60 at 5]. For the reasons explained below, Defendants have not demonstrated that Plaintiffs' claims are subject to complete ERISA 502(a) pre-emption.

A district court has original jurisdiction over claims "arising under the Constitution, treaties or laws of the United States." 28 U.S.C. § 1331. It is long settled "that a cause of action arises under federal law only when plaintiff's well-pleaded complaint raises issues of federal law." *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987); *see also New Jersey Carpenters & the Trs. Thereof v. Tishman Constr. Corp. of New Jersey*, 760 F.3d 297, 302 (3d Cir. 2014). A federal defense or expectation of such defense is insufficient to confer federal jurisdiction. *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 271 (3d Cir. 2001). If a well-pleaded complaint does not present federal question jurisdiction on its face but "falls within the narrow class of cases to which the doctrine of 'complete pre-emption' applies," however, it may still be removed. *Pascack*, 388 F.3d at 399 (citing *Aetna Health Inc. v Davila*, 542 U.S. 200 (2004)). "A federal court may look beyond the face of the complaint to determine whether a plaintiff has artfully pleaded his suit so as to couch a federal claim in terms of state law." *Pascack*, 388 F.3d at 400 (citing *Pryzbowski*, 245 F.3d at 274).

"ERISA provides for uniform federal regulation of pension benefit plans and welfare benefit plans." *New Jersey Carpenters*, 760 F.3d at 303. Congress's aim in enacting ERISA was to "ensure that benefit plan administration was subject to a single set of regulations and to avoid subjecting regulated entities to conflicting sources of substantive law." *Id.* As such, ERISA includes pre-emption provisions that are "intended to ensure that employee benefit plan regulation would be exclusively a federal concern." *Davila*, 542 U.S. at 208.

"ERISA creates two forms of pre-emption." *Somerset Orthopedic Assocs., P.A. v. Aetna, Inc.*, No. 19-12544, 2019 WL 13535769, at *7 (D.N.J. Oct. 24, 2019). The first is express pre-emption under Section 514(a), where ERISA preempts "any and all State laws insofar as they ... relate to any employee benefit plan covered under the statute." *Id.* A state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* (citing *Advanced Orthopedics & Sports Med. Inst. v. Empire Blue Cross Blue Shield*, No. 17-08697, 2018 WL 2758221, at *3 (D.N.J. June 7, 2018)). The second is under ERISA Section 502(a), a "civil enforcement mechanism ... 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. *Davila*, 542 U.S. at 209 (citing *Metro. Life*, 481 U.S. at 65-66). In other words, "state law causes of action that are within the scope of § 502(a) are completely pre-empted and therefore removable to federal court." *Pascack*, 388 F.3d at 400 (internal quotations omitted).

***6** The Third Circuit has held that ERISA 502(a) completely pre-empts a claim only if two conditions are both met, first, the plaintiff must have, at some point in time, been able to bring their claim under ERISA 502(a). *Pascack*, 388 F.3d at 400 (citing *Davila*, 542 U.S. at 210). Second, no other legal duty can support the claim. *Pascack*, 388 F.3d at 400.

i. Whether Plaintiffs can bring their claims under ERISA 502(a)

Under the first prong of the *Pascack* test, a plaintiff could have brought his claim under ERISA 502(a) if (1) plaintiff is the type of party that can bring a claim pursuant to Section 502(a); and if (2) the actual claim asserted "can be construed as a colorable claim for benefits pursuant to [Section] 502(a)." *Atlantic Shore Surgical Assocs. v. Loc. 464A United Food and Com. Workers Union Welfare Fund*, No. 17-12166, 2018 WL 3611074, at *3 (D.N.J. July 27, 2018).

First, a plaintiff is the type of party that can assert a claim under ERISA 502(a)(1)(B) if he is a "participant or beneficiary" seeking "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). ERISA provides that a "participant" is "any employee or former employee of an employer, or any member or former member of any employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan." 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). "Healthcare providers that are neither participants nor beneficiaries in their own right may obtain derivative standing by assignment from a plan participant or beneficiary." *N. Jersey Brain & Spine Ctr. v. Aetna, Inc.*, 801 F.3d 369, 372 (3d Cir. 2015) (citing *CardioNet, Inc. v. Cigna Health Corp.*, 751 F.3d 165, 176 n.10 (3d Cir. 2014)). To determine whether a healthcare provider is a proper assignee, courts will "look to the language of the assignment." *Ctr. for Orthopedics & Sports Med. v. Horizon*, No. 13-1963, 2015 WL 5770385, at *4 (D.N.J. Sept. 30, 2015). On the other hand, an anti-assignment clause "bars a healthcare provider from vicariously asserting the insured's ERISA claim for benefits." *Somerset Orthopedic Assocs., P.A. v. Aetna, Inc.*, No. 19-12544, 2019 WL 13535769, at *8 (D.N.J. Oct. 24, 2019) (quoting *Glastein v. CareFirst Blue Cross Blue Shield*, No. 18-9664, 2019 WL 1397488, at *6 (D.N.J. Mar. 28, 2019)). This is because the Third Circuit has held that "anti-assignment clauses in ERISA-governed health insurance plans as a general matter are enforceable." *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018); *see also* *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F. 3d 218, 228-29 (3d Cir. 2020).

Defendants have not established that this prong of the *Pascack* test is satisfied. First, five out of the six plans Defendants attached to their notice of removal contain anti-assignment provisions. Specifically, Exhibits 7 through 11 all contain anti-assignment clauses. For example, the Preferred Provider Organization Medical Plan Booklet-certificate prepared exclusively for the Bloomfield Board of Education contains a section titled "Assignment of benefits," which provides that "[u]nless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an out-of-network provider or facility under this group policy unless it is an emergency medical condition or treatment for an urgent condition." [D.E. 1-9 at 90; *see* D.E. 1-10 at 94; D.E. 1-11 at 114; and D.E. 1-12 at 106; *see also* D.E. 1-13 at 17 ("Coverage and your rights under this Plan may not be assigned.")].

***7** Because these plans contain anti-assignment clauses, they cannot satisfy the first prong of ERISA 502(a) pre-emption. In *Univ. Spine Ctr. v. Aetna, Inc.*, 774 Fed. App'x. 60, 63-64 (3d Cir. 2019), the Third Circuit held that a hospital lacked standing to sue an insurance company on the patient's behalf, reiterating the principle that unambiguous anti-assignment clauses in patients' insurance plans deprive hospitals and other providers of standing under ERISA 502(a), because of "the black-letter law that the terms of an unambiguous private contract must be enforced." Similarly, here, because these plans unambiguously state that the insurer "will not accept an assignment to an out-of-network provider or facility under this group policy," or that "[c]overage and your rights under this Plan may not be assigned," Defendants cannot demonstrate that, under these plans, Plaintiffs could be the type of party that can bring claims for benefits pursuant to Section 502(a). *See also* *Pascack*, 388 F.3d at 400-01 (holding a hospital's claims were not pre-empted under ERISA 502(a) because there was nothing in the record to establish the patients assigned any claims to the hospital); *Atlantic Shore Surgical Assocs. v. Loc. 464A United Food and Com. Workers Union Welfare Fund*, No. 17-12166, 2018 WL 3611074, at *3 (D.N.J. July 27, 2018) (holding no complete preemption under ERISA 502(a) in part because the removing defendants could not establish the existence of a valid assignment).[3]

In support of the first prong, Defendants point to the assignment Patient D.P. granted to Plaintiffs, along with the J&J plan, Exhibit 6 in Defendants' Notice of Removal, which does not prohibit assignment, to demonstrate that Plaintiffs "can be the 'type' of party that

can bring an ERISA claim." [D.E. 1 at 5, ¶¶ 13-14; *see* D.E. 1-7; D.E. 1-8]. Defendants also point to a form wherein Patient D.P. purportedly provided an assignment to Dr. McCracken; and a letter wherein Dr. Drzala requested documents as an assignee under D.P.'s J&J Plan. [D.E. 60 at 5-6; *see* D.E. 60-1 and 60-2]. Out of the six plans Defendants offered in support of removal, Patient D.P.'s is the only plan that could have possibly satisfied the first prong of ERISA 502(a) pre-emption because it was neither a government plan nor contained an anti-assignment provision. However, even if Defendants met their burden of demonstrating a valid assignment, after the District Court's dismissal with prejudice of the claims against J&J [D.E. 57], Defendants cannot show Plaintiffs are the type of party that can bring a claim pursuant to Section 502(a) under the first prong of the *Pascack* test.[4]

Second, Courts in this District have explained that, under the first prong of the *Pascack* test, a claim cannot be construed as a colorable claim for benefits under Section 502(a) "[w]here a plaintiff does not challenge the type, scope or provision of benefits under [an ERISA] healthcare plan" and instead "only asserts its right as a third-party provider to be reimbursed for pre-authorized medical services it rendered." *See E. Coast Advanced Plastic Surgery v. Blue Cross Blue Shield of Tex.*, No. 19-6175, 2019 WL 3208694, at *4 (D.N.J. June 11, 2019) (internal quotations omitted). Here, Defendants have not demonstrated that Plaintiffs' claims assert a right to recover under an ERISA plan or challenge the type, scope, or provision of benefits under the Patients' alleged ERISA plans. Instead, Plaintiffs assert claims based on alleged oral pre-authorization agreements with Defendants into which they entered as third-party, out-of-network providers. Therefore, Plaintiffs' claims cannot be construed as colorable claims for benefits under ERISA, and the first prong of the *Pascack* test is not satisfied.

ii. Whether any other legal duties can support Plaintiffs' claims

***8** The test for complete ERISA 502(a) pre-emption is conjunctive, so federal question jurisdiction fails here because the first prong is not satisfied. *See New Jersey Carpenters*, 760 F.3d at 303; *E. Coast Advanced Plastic Surgery v. Blue Cross Blue Shield of Tex.*, No. 19-6175, 2019 WL 3208694, at *4 (D.N.J. June 11, 2019) (remanding for lack for ERISA 502(a) pre-emption and explaining that after "[h]aving determined that defendant has not established ... the first prong of the *Pascack* test, the Court need not reach the second prong."). Still, even if Defendants could satisfy the first prong of the *Pascack* test, they cannot demonstrate that the second prong is met. Specifically, Defendants cannot demonstrate that no other legal duty supports Plaintiffs' claims, because such claims arose from alleged oral representations for reimbursement for out-of-network services and "would exist whether or not the ERISA plan existed."

Under the second prong of the *Pascack* test, claims are completely pre-empted under ERISA 502(a) if no other legal duty can support them. 388 F. 3d at 400. In other words, there cannot be an independent legal duty that could support a plaintiff's claim. "[A] legal duty is independent if it is not based on an obligation under an ERISA plan, or if it 'would exist whether or not an ERISA plan existed.' " *New Jersey Carpenters*, 760 F.3d at 303 (quoting *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 950 (9th Cir.2009)). This means that a legal duty is independent if it "is not 'derived from, or conditioned upon' the terms of an ERISA plan, and 'nobody needs to interpret the plan to determine whether that duty exists.' " *New Jersey Carpenters*, 760 F.3d at 303 (quoting *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 614 (6th Cir. 2013)).

Any legal duties that Defendants may owe to Plaintiffs related to alleged oral pre-authorization contracts are independent. Addressing the second prong, Defendants refer to the Patients' insurance plans, Exhibits 6-11 to Defendants' Notice of Removal, and argue Plaintiffs' services were out-of-network benefits that were not independent of the plans. [D.E. 1 at 5-6, ¶¶ 16-17; *see* D.E. 1-8, 1-9, 1-10, 1-11, 1-12, and 1-13]. However, Courts in this district have held that in the context of ERISA preemption, pre-authorization calls that result in agreements to reimburse out-of-network providers for services give rise to duties independent of ERISA plans. *See, e.g.*, *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F. 3d 218, 229 (3d Cir. 2020); *N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co.*, No. 16-1544, 2017 WL 659012, at *5 (D.N.J. Feb. 17, 2017), *report and recommendation adopted*, No. 16-1544, 2017 WL 1055957 (D.N.J. Mar. 20, 2017) (remanding to state court and explaining that because the plaintiff was out-of-network and its claims were "based on an alleged implied contract with Aetna arising out of a course of dealing between the parties," they were therefore "based on that independent duty [and] not preempted under § 502(a)."); *E. Coast Advanced Plastic Surgery v. Horizon Blue Cross Blue Shield of N.J.*, No. 18-7718, 2018 WL 6185544, at *6 n. 3 (D.N.J. Sept. 17, 2018), *report and*

recommendation adopted, No. 18-7718, 2018 WL 6178869 (D.N.J. Nov. 26, 2018); *Emergency Physicians of St. Clare's, LLC v. Horizon Blue Cross Blue Shield of N.J.*, No. 19-12112, 2020 WL 13841366, at *5 (D.N.J. Nov. 19, 2020), *report and recommendation adopted*, No. 19-12112, 2020 WL 13841349 (D.N.J. Dec. 4, 2020).

In *Plastic Surgery*, patients with ERISA plans received surgical procedures from an out-of-network provider who sued Aetna after Aetna allegedly breached oral agreements to reimburse the provider for its services at a "reasonable amount" and at "the highest in-network level" for "all component services" under the plans. 967 F. 3d at 231-32. The Third Circuit rejected Aetna's argument that the provider "agreed to be bound by all terms and conditions of the plan," and that therefore, the claims were not independent. *Id.* at 232. In doing so, the Court explained that, in the provider's breach of contract and promissory estoppel claims, "only the amount of payment and not the scope of services was to be determined in accordance with the terms of the plan." *Id.* As such, the Third Circuit explained that the provider's claims "arose precisely because there was no coverage under the plans for services performed by an out-of-network provider," and there was no obligation for the provider to supply "services to the plan participants, no obligation for Aetna to pay the [provider] for its services, and no agreement that compensation would be limited to benefits covered under the plan." *Id.* at 231. Consequently, the Court held the claims plausibly sought to enforce obligations independent of the plan. *Id.*

***9** Similarly, here, even if Defendants could establish valid assignments from the Patients, Defendants have not demonstrated that the alleged oral pre-authorizations from the Aetna Defendants were not independent of any ERISA plans. The Complaint avers that all Plaintiffs were "out-of-network, or non-participating, healthcare providers regarding Aetna and the other defendants." [D.E. 1-3 at 8, ¶ 23]. Plaintiffs' claims arose out of Defendants' alleged "oral pre-authorizations relating to the surgical services" [D.E. 1-3 at 14, ¶ 39], which occurred precisely because Plaintiffs were out-of-network providers, and which give rise to legal duties that are independent of any ERISA plans. Plaintiffs' claims are for the amount of payment and plead that the alleged pre-authorizations created "the expectation to be reasonably compensated at UCR-based rates consistent with the statements, representations, policies, industry custom and/or course of conduct of defendants." [D.E. 1-3 at 14-15, ¶ 39]. In sum, the second prong for complete ERISA pre-emption is not satisfied because none of the alleged oral pre-authorizations supporting Plaintiffs' claims are based on an obligation under an ERISA plan, and the claims could arise whether or not such a plan existed.[5] A court would not have to consider any ERISA plan to interpret the alleged agreements between Plaintiffs and Defendants. *See New Jersey Carpenters*, 760 F.3d at 303.[6]

B. Supplemental Jurisdiction

***10** The J&J plan held by Patient D.P. cannot provide supplemental jurisdiction. The Third Circuit has long held that "where the federal claims that formed the basis for original jurisdiction are dismissed, 'a district court may decline to decide the pendent state claims unless considerations of judicial economy, convenience, and fairness to the parties provide an affirmative justification for doing so.' " *Chey v. LaBruno*, 608 F. Supp. 3d 161, 188 (D.N.J. 2022) (citing *Hedges v. Musco*, 204 F. 3d 109, 123 (3d Cir. 2000)). In other words, "the presumptive rule is that the state claims shall be dismissed, unless reasons of economy and fairness dictate otherwise." *Chey*, 608 F. Supp. 3d at 188. The Third Circuit has exercised discretion to retain jurisdiction over pendent claims where the District Court had already completely resolved the dispute on the merits. *See, e.g., New Rock Asset Partners, L.P. v. Preferred Entity Advancements, Inc.*, 101 F.3d 1492, 1505-06 (3d Cir. 1996). Here, however, "where the case is nowhere close to trial, dismissal or remand is likely the proper course," because remand would not result in a waste of judicial resources or prejudice to the parties. *Chey*, 608 F. Supp. 3d at 188 (citing *Freund v. Florio*, 795 F. Supp. 702, 710 (D.N.J. 1992)). Even if Defendants met their burden in demonstrating Patient D.P.'s J&J Plan provided for complete ERISA 502(a) pre-emption, the claims against J&J were dismissed with prejudice, and Defendants have not demonstrated how judicial economy or fairness requires the exercise of pendent jurisdiction over the remaining claims. Defendants do not and cannot establish that ERISA pre-emption exists in this case, and this Court does not have subject matter jurisdiction over the claims in this action under federal question jurisdiction.

C. Diversity Jurisdiction

Defendants have not established that complete diversity exists between the parties in this action. A federal court is authorized to exercise diversity jurisdiction under 28 U.S.C. § 1332(a). Pursuant to that statute, federal district

courts "shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $75,000" and where the matter "is between citizens of different States." 28 U.S.C. § 1332(a)(1). There must be complete diversity among the parties, meaning the citizenship of each named plaintiff must be different from the citizenship of each named defendant. *Lincoln Prop. Co. v. Roche*, 546 U.S. 81, 89 (2005) (citing *Strawbridge v. Curtiss*, 3 Cranch 267, 2 L.Ed. 435 (1806) (establishing rule of complete diversity)); *see also Zambelli Fireworks Mfg. Co., Inc. v. Wood*, 592 F.3d 412, 419 (3d Cir. 2010) ("Complete diversity requires that, in cases with multiple plaintiffs or multiple defendants, no plaintiff be a citizen of the same state as any defendant."). The Supreme Court has held that "the presence in [an] action of a single plaintiff from the same State as a single defendant deprives the district court of original diversity jurisdiction over the entire action." *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 553 (2005). Courts must determine the existence of diversity jurisdiction by looking at the citizenship of the parties at the time the action was filed. *Grupo Dataflux v. Atlas Glob. Grp., L.P.*, 541 U.S. 567, 570 (2004).

For diversity jurisdiction purposes, "a corporation shall be deemed to be a citizen of every State and foreign state by which it has been incorporated and of the State or foreign state where it has its principal place of business." 28 U.S.C. § 1332(c)(1). The citizenship of non-incorporated entities is determined by looking at the citizenship of each of its members. *Carden v. Arkoma Assocs.*, 494 U.S. 185, 195-96 (1990).

i. Fraudulent Joinder

If parties lack complete diversity and if there is no federal question as a basis for jurisdiction, the doctrine of fraudulent joinder permits removal to federal court if the defendant "can establish that the non-diverse defendants were 'fraudulently' named or joined solely to defeat federal jurisdiction." *In re Briscoe*, 448 F.3d 201, 216 (3d Cir. 2006). "A fraudulently joined party will be disregarded for purposes of diversity." *Reuter v. Medtronics, Inc.*, No. 10-3019, 2010 WL 4628439, at *3 (D.N.J. Nov. 5, 2010), *report and recommendation adopted*, No. 10-3019, 2010 WL 4902662 (D.N.J. Nov. 23, 2010). Fraudulent joinder is, therefore, an exception to the requirement that removal be predicated solely upon complete diversity. *Briscoe*, 448 F.3d at 215-16.

***11** "Joinder is fraudulent where there is no reasonable basis in fact or colorable ground supporting the claim against the joined defendant, or no real intention in good faith to prosecute the action against the defendants or seek a joint judgment." *Briscoe*, 448 F.3d at 217. Joinder cannot be considered fraudulent "[u]nless the claims against the non-diverse defendant could be deemed 'wholly insubstantial and frivolous.' " *Id.* at 218. In other words, "a district court must rule out any possibility that a state court would entertain the cause before holding that joinder of a non-diverse defendant was fraudulent." *Id.* at 219 (citing *Batoff v. State Farm Ins. Co.*, 977 F.2d 848, 851 (3d Cir. 1992)). "[I]f there is even a possibility that a state court would find that the complaint states a cause of action against any one of the resident defendants, the federal court must find that joinder was proper and remand the case to state court." *Id.* at 217 (citing *Batoff*, 977 F.2d at 851-52).

Because "removal statutes are to be strictly construed against removal and all doubts should be resolved in favor of remand," and because the removing party has the burden of establishing subject matter jurisdiction, "the removing party carries a heavy burden of persuasion" to demonstrate that joinder was fraudulent. *Briscoe*, 448 F.3d at 217 (citing *Batoff*, 977 F.2d at 851-52). In evaluating whether fraudulent joinder exists, "the district court must focus on the plaintiff's complaint at the time the petition for removal was filed." *Briscoe*, 448 F.3d at 217. "[T]he district court must assume as true all factual allegations of the complaint." *Steel Valley Auth. v. Union Switch and Signal Div.*, 809 F.2d 1006, 1010 (3d Cir. 1987). The court must also "resolve all contested issues of substantive fact in favor of the plaintiff and must resolve any uncertainties as to the current state of controlling substantive law in favor of the plaintiff." *Boyer v. Snap-on Tools Corp.*, 913 F.2d 108, 111 (3d Cir. 1990).

In some cases, a court may look to more than just the pleading allegations to identify indicia of fraudulent joinder. *See, e.g., Abels v. State Farm Fire & Cas. Co.*, 770 F.2d 26, 32 (3d Cir. 1985). Courts have emphasized that this evaluation "must not step from the threshold jurisdictional issue into a decision on the merits," however. *Briscoe*, 448 F.3d at 219 (citing *Boyer*, 913 F.2d at 112). In *Abels*, the District Court looked beyond the complaint to determine whether the

plaintiff's conduct was consistent with actual intention to proceed on its claims against certain unnamed "John Doe" defendants. 770 F.2d at 32. The Third Circuit expressed skepticism about whether state law provided the plaintiff with the bases for its claimed causes of action. *Id.* Nonetheless, it held that "enough recent authority supporting such a cause of action exists to constrain us from holding that there is no 'colorable' legal basis' " for the claims, and that "[t]o inquire any further into the legal merits would be inappropriate in this preliminary jurisdictional determination." *Id.* at 32-33.

In *Briscoe*, the Third Circuit's evaluation of a fraudulent joinder argument turned on whether the claims against the non-diverse defendants were barred by the state law's statute of limitations. 448 F.3d at 217. While conducting a limited look beyond the pleadings, the court stressed that the statute of limitations defense was not merits-based and therefore would not run any "risk of usurping jurisdiction over cases that properly belong in state court." *Id.* at 220.

Finally, the Third Circuit has explained that inquiry into the pleadings in a fraudulent joinder analysis is less searching than under Rule 12(b)(6). *Batoff*, 977 F.2d at 852. Therefore, it is possible for a federal court to find no fraudulent joinder and for a state court to then, upon remand, dismiss the same case for failure to state a claim. *Id.*

***12** The parties do not dispute that AHI and the Payor Defendants, Insmed, SHIF, and J&J, would destroy diversity jurisdiction because these entities are all citizens of New Jersey. Instead, in their notice of removal, the Removing Defendants assert these non-diverse defendants were fraudulently joined. [D.E. 1 at 9, ¶¶ 21-23; D.E. 19 at 12, 16]. The Removing Defendants argue that Plaintiffs' alleged oral contracts were with the Removal Defendants without any involvement from AHI, Insmed, SHIF, or J&J, and therefore, the Complaint alleges no colorable ground to support claims against those non-diverse parties. [*See* D.E. 19 at 12, 16; D.E. 60 at 8, 12].

In response, Plaintiffs argue that the Complaint alleges colorable, direct causes of action against AHI and each Payor Defendant. [D.E. 59 at 8, 11]. Specifically, Plaintiffs argue none of the Payor Defendants were fraudulently joined because the Complaint alleges direct causes of action against them, and all three are liable as principals of the Aetna Defendants, their agents. [D.E. 59 at 8-9]. Plaintiffs assert AHI was properly joined, because "Aetna including AHI holds itself out to the public, and healthcare providers, as a cohesive, integrated family of companies that operate together to insure, administer insurance and process claims." [D.E. 59 at 12].

ii. Whether the Payor Defendants, Insmed, SHIF, and J&J, were fraudulently joined

Plaintiffs assert their Complaint "pleads NJ common law claims, sounding in contract, quasi contract and economic tort, directly against each of the Payor defendants," relying on paragraphs 10-14, 30-31, 34-39, 41-50, 61, 63, 66, 73-83, 103-17, and 123-27 in the Complaint. [D.E. 59 at 8]. Those allegations either involve the Aetna Defendants only; contend the Aetna Defendants are agents of the Payor Defendants; or reference the Payor Defendants' liability based on the alleged oral representations the Aetna Defendants made in communications with Plaintiffs. Therefore, the Court examines whether Plaintiffs' claims that the Aetna Defendants entered into those alleged agreements as agents of the Payor Defendants, their alleged principals, are wholly insubstantial and frivolous.

New Jersey common law provides that "[a]n agency relationship is created when one party consents to have another act on its behalf, with the principal controlling and directing the acts of the agent." *Sears Mortg. Corp. v. Rose*, 134 N.J. 326, 337 (1993). To determine if an agency relationship exists, courts "will look at [the parties'] conduct and not to their intent or their words as between themselves but to their factual relation," and so, the lack of an agreement between parties regarding an agency relationship is not determinative. *Id.* "[D]irect control of principal over agent is not absolutely necessary; a court must examine the totality of the circumstances to determine whether an agency relationship existed even though the principal did not have direct control over the agent." *Id.* at 338 (citing 2 C.J.S. Agency § 36, at 599-600 (1972)). If no actual agency relationship exists, apparent authority can still "impose[ ] liability on the principal ... because the principal's actions have misled a third-party into believing that a relationship of authority in fact exists." *Gayles by Gayles v. Sky Zone Trampoline Park*, 468 N.J. Super. 17, 24 (App. Div. 2021) (citing *Mercer v. Weyerhaeuser Co.*, 324 N.J. Super. 290 (App. Div. 1999)). The party asserting an agency relationship based on apparent authority must establish that (1) the appearance of authority was created by the conduct of the alleged principal, which cannot be shown solely by the conduct by the supposed agent; (2) a third

party relied on the agent's apparent authority to act for a principal; and (3) the reliance was reasonable under the circumstances. *See Gayles*, 468 N.J. Super. at 24.

***13** Here, Defendants argue, in part, that the Payor Defendants were fraudulently joined because the "Administrative Services Agreements between Aetna and the Plan Sponsors expressly disclaim[ed] such an agency relationship." [D.E. 60 at 13]. To support this, Defendants point to the Master Services Agreements between Aetna and Insmed, SHIF, and J&J (together, the "Master Services Agreements" or the "MSAs"). [*See* D.E. 19-2 at 19 (Master Services Agreement between Aetna and Insmed providing that "Network Providers are not agents or employees of Us nor are We an agent or employee of any Network Providers."); D.E. 19-3 at 8 (Master Services agreement between Aetna and SHIF providing that "[t]his Agreement is not intended and shall not be interpreted or construed to create an association, agency, joint venture or partnership between the parties or to impose any liability attributable to such a relationship."); and D.E. 19-4 at 18 (Master Services Agreement between Aetna Life Insurance Company and J&J providing that "the parties shall have no relationship other than that of independent contractors, except Aetna will be an agent for the Plan solely with respect to the issuance of claim payments under the Plan, and that neither party shall make any representation to the contrary.")].

However, to determine whether the basis for the claims against the Payor Defendants are wholly insubstantial and frivolous, the Court's inquiry is limited to an examination of the relevant allegations in the Complaint. *See Briscoe*, 448 F.3d at 217. While it is true that in some cases courts can "look to more than just the pleading allegations to identify indicia of fraudulent joinder," *Id.* at 219, it is well-established under New Jersey common law that the intent or words of parties between themselves is not determinative of the existence of an agency relationship. *See, e.g., Sears*, 134 N.J. at 337-38; *eTeam Inc. v. Hilton Worldwide Holdings, Inc.*, No. 15-5057, 2017 WL 2539395, at *3 (D.N.J. June 12, 2017) (rejecting a party's argument that a clause in a franchise agreement that expressly disclaimed an agency relationship meant that no such relationship existed, because "[t]he legal relationship between parties cannot depend on what the parties call it; it must be defined by what it actually is."). Thus, even if this Court were to consider the MSAs, clauses therein that expressly disclaim an agency relationship do not necessarily mean such a relationship did not exist. Unlike in *Briscoe* and *Abels*, where consideration of evidence outside of the pleadings did not encroach upon the merits of the case or pose danger of an analysis on the merits, using the MSAs to determine at this point in the case that the existence of an agency relationship is wholly insubstantial and frivolous because no state court could find causes of action against the Payor Defendants would impermissibly step from the threshold jurisdictional issue into a decision on the merits. Therefore, the MSAs cannot establish fraudulent joinder.

Again, the focus is on whether the facts alleged in the Complaint provided a colorable basis for Plaintiffs' claims, which assert liability against the Payor Defendants through an agency theory. On that point, the Removing Defendants assert that Plaintiffs alleged no facts to show the Payor Defendants gave Plaintiffs reason to believe Aetna had either actual or apparent authority to act outside of the Plans, and that Plaintiffs alleged no facts that "Aetna and the Plan Sponsors had a relationship other than Aetna's role as a third-party administrator." [D.E. 60 at 12-13]. The Court cannot conclude that Aetna's role as a third-party administrator means there is no colorable ground to support Plaintiffs' claims arising out of oral representations for out-of-network reimbursement based on an agency theory.

The Complaint alleges Aetna provided administrative services for Insmed's, SHIF's, and for J&J's self-insured health plans [D.E. 1-3 at 4, ¶ 7], and that "for a single patient encounter, different Aetna Defendants take part in claims administration, including pre-authorization...." [D.E. 1-3 at 5, ¶ 8]. The Complaint also alleges that when Plaintiffs Essex, Dr. Drzala, Dr. Reiter, and Dr. McCracken called regarding pre-authorization for services—regardless of which plan sponsor it was—they spoke with an Aetna representative. [D.E. 1-3 at 4-5, ¶ 8]. The Complaint additionally alleges that, when someone uses the pre-authorization phone number, "there is no indication which specific Aetna company or affiliate is processing the pre-authorization call." [D.E. 1-3 at 5, ¶ 8]. In reliance on the communications that allegedly took place during these pre-authorization phone calls with Aetna, Plaintiffs Essex, Dr. Drzala, Dr. Reiter, and Dr. McCracken provided surgical and medical services for the Patients. [*See* D.E. 1-3 at 9, ¶¶ 24, 26; D.E. 1-3 at 10, ¶ 28; D.E. 1-3 at 11, ¶ 30; D.E. 1-3, ¶¶ 32, 34; and D.E. 1-3 at ¶36]. On those facts and others alleged in the Complaint, this Court cannot conclude that Plaintiffs' assertions that Insmed, SHIF, and J&J created the appearance of authority in Aetna to act on their behalf to provide preauthorization of services are wholly insubstantial and frivolous. Nor can the Court conclude that Plaintiffs' allegations that they reasonably relied on this appearance of authority are wholly insubstantial and frivolous.

***14** A lack of fraudulent joinder is further supported by allegations in the Complaint which, if true and drawing all inferences in favor of Plaintiffs, suggest the principal Payor Defendants endorsed the outward appearance of authority they created in Aetna by sanctioning the reimbursement rates Aetna provided. "A principal's ratification confirms or validates an agent's right to have acted as the agent did." RESTATEMENT (THIRD) OF AGENCY § 4.01 (2006). A principal's act ratifies that of an agent's where the principal displays an "externally observable manifestation of assent to be bound by the prior act of another person," and this "often serves the function of clarifying situations of ambiguous or uncertain authority." *Id.* "If the principal ratifies the agent's act, it is thereafter not necessary to establish that the agent acted with apparent authority." *Id.*

Here, Plaintiffs Essex, Dr. Drzala, and Dr. Reiter argue that when they appealed after receiving payment "inconsistent with any UCR-based rate" from Insmed, it stated it had "no role" in determining "reimbursement rates to providers," and that "Aetna is the claim fiduciary and Insmed has no role in a claim appeal." [D.E. 1-3 at 11-12, ¶¶ 30-31]. Concerning SHIF, Plaintiff Essex argues that after it received payment inconsistent with the allegedly promised UCR-based rate for providing surgical and medical services to Patient N.S., SHIF stated Essex's claims "had been processed and paid based on its UCR fee schedule." [D.E. 1-3 at 12-13, ¶¶ 34-35]. Essex alleges that, in doing so, "SHIF merely rubberstamped Aetna's initial determination via a boilerplate letter without responding to the substance." [D.E. 1-3 at 13, ¶ 35]. As to J&J, the Complaint alleges "J&J declined to respond on the merits to [Plaintiffs Dr. McCracken's and Dr. Drzala's] appeal," stating "these matters have been addressed through Aetna." [D.E. 1-3 at 14, ¶ 38].

To be clear, the Court does not find, on the merits, that the Payor Defendants endorsed the Aetna Defendants' outward appearance of authority by ratifying their oral representations, only that the facts alleged in the Complaint asserting the Payor Defendants did so support the conclusion that Plaintiffs' claims against the Payor Defendants as principals of the Aetna Defendants are not insubstantial and frivolous for purposes of assessing the Removing Defendants' fraudulent joinder argument.

Finally, the Court cannot conclude that Plaintiffs' claims asserting liability against the Payor Defendants as principals of Aetna are wholly insubstantial and frivolous, especially in light of holdings by New Jersey courts finding alleged agency relationships between Aetna, as a plan administrator, and insurance plan sponsors survive a motion to dismiss. *See, e.g., Garrick Cox, MD LLC v. Aetna, Inc.*, No. ESX-L-3306-22, 2024 WL 1533677, at *13-14 (N.J. Super. Ct. L. Div. Apr. 2, 2024) (holding that the pleading adequately alleged the Aetna defendants, in their capacities as plan administrators, were agents of the plan sponsors); *Atl. Shore Surgical Assocs., P.C. v. Aetna Life Ins. Co.*, No. ESX-L-6558-20, 2022 WL 1236070, at *8 (N.J. Super. Ct. L. Div. Apr. 22, 2022) (denying a motion to dismiss because "[o]ne 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," and therefore, "the Complaint [ ] 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 ...").

Having established that Plaintiffs have alleged colorable claims against the Payor Defendants as principals of their alleged agents, the Aetna Defendants, the Court considers whether it was wholly insubstantial and frivolous for Plaintiffs to have alleged that the Payor Defendants breached an implied contract with Plaintiffs. In New Jersey, "[a] contract may be expressed, or implied, or it may be a mixture of the two." *Comprehensive Neurosurgical, P.C. v. Valley Hosp.*, 257 N.J. 33, 57 (N.J. 2024). "[E]xpressed contracts include those in which the parties have orally stated the terms to each other or have placed the terms in writing." *Id.* "An implied contract is one in which the parties show their agreement by conduct." *Id.* As an example, "if someone provides services to another under circumstances that do not support the idea that they were donated or free, the law implies an obligation to pay the reasonable value of services." *Id.* Thus, New Jersey courts have explained that an implied contract can arise from "the parties conduct or from the circumstances surrounding their relationship." *Id.*

***15** Here, the Complaint alleges that Defendants, including the Payor Defendants, "indicated, by a course of conduct, course of dealings, industry custom and/or the circumstances surrounding the relationship" that they would "properly pay for surgical and medical services provided;" that they would "timely pay Plaintiffs UCR amounts based upon what other healthcare providers of the same specialty in the same geographic area were paid;" and that the "services rendered were pre-authorized" and/or that "pre-authorization was not required in order to be reimbursed." [D.E. 1-3 at 23-24, ¶¶ 73-77]. Specifically, the Complaint alleges that Aetna representatives affirmed to Plaintiffs that the insurance plans would reimburse Plaintiffs for their services at certain percentages of the UCR. [*See* D.E. 1-3 at 9, ¶¶24,

26; D.E. 1-3 at 10, ¶ 28; D.E. 1-3 at 11, ¶ 30; D.E. 1-3 at 12, ¶¶ 32, 34; D.E. 1-3 at 13, ¶ 36; D.E. 1-3 at 14, ¶ 37]. The Complaint further alleges that Defendants did not properly or timely reimburse Plaintiffs for their UCR rates. [D.E. 1-3 at 24, ¶ 81; *see also* D.E. 1-3 at 9, ¶ 25; D.E. 1-3 at 10, ¶¶ 27, 29; D.E. 1-3 at 11, ¶ 31; D.E. 1-3 at 12, ¶ 33; D.E. 1-3 at 13, ¶ 35; and D.E. 1-3 at 14, ¶ 38].

Taking these facts as true, and drawing all inferences in favor of Plaintiffs, the Court concludes that the Complaint alleges conduct on the part of both Plaintiffs and the Payor Defendants to establish a colorable claim for implied contracts and to establish a colorable claim that the Payor Defendants, at least, breached such implied contracts. Therefore, joinder of the Payor Defendants Insmed, SHIF, and J&J was proper. The citizenships of these non-diverse Payor Defendants—necessary components of the diversity jurisdiction calculus—destroy complete diversity. Accordingly, in the absence of complete diversity, this action must be remanded to state court for lack of subject matter jurisdiction.[7]

D. Severance

Because the Court concludes that it does not have subject matter jurisdiction over this action, the Court does not reach the question of whether the Plaintiffs' claims should be severed. *See Freeland v. Liberty Mut. Ins. Co.*, No. 07-6160, 2008 WL 2625226, at *2 (D.N.J. June 27, 2008) (explaining the Supreme Court has held "subject matter jurisdiction should be resolved before any other matters are adjudicated," and, as such, "motions to remand and motions to sever may be considered together, but the motions to sever should not be considered before jurisdiction has been established").

III. CONCLUSION

This action was removed to this Court based on federal question jurisdiction, 28 U.S.C. § 1331, and based on diversity jurisdiction, 28 U.S.C. § 1332(a). However, Plaintiffs' claims are not pre-empted by ERISA, and complete diversity between Plaintiffs and Defendants does not exist. The removing parties have failed to meet their burden to demonstrate the claims are federally pre-empted and that the non-diverse parties were fraudulently joined. Therefore, subject matter jurisdiction does not exist. Accordingly, for the foregoing reasons, this Court resolves doubt concerning federal subject matter jurisdiction in this matter in favor of remand and respectfully recommends that the District Court remand this action to the Superior Court of New Jersey, Bergen County, pursuant to 28 U.S.C. § 1447(c).

***16** Pursuant to 28 U.S.C. § 636(b)(1), Fed. R. Civ. P. 72(b)(2), and L. Civ. R. 72.1(c)(2), the parties may file and serve objections to this Report and Recommendation within fourteen days of service of a copy thereof.

The Clerk of Court is directed to serve the parties with electronic notice upon the filing and entry of this Report and Recommendation, and to terminate the motion pending at Docket Entry Number 18 and activate this Report and Recommendation for the District Court's Review.

All Citations

Slip Copy, 2024 WL 5264892

Footnotes

1 Specifically, because "there is no indication which specific Aetna company or affiliate is processing the pre-authorization call," Essex alleges that it contacted "Aetna" on or around December 6, 2018, to obtain pre-authorization for the services it rendered Patient T.A. [D.E. 1-3 at 9, ¶ 24]. Essex contacted Aetna for pre-authorization for the services it rendered Patient D.A. on or around January 9, 2019. [D.E. 1-3 at 9, ¶ 26]. Essex contacted Aetna for pre-authorization for Patient T.M. on or around March 10, 2021. [D.E. 1-3 at 12, ¶ 32]. Essex contacted Aetna for pre-authorization for Patient N.S. on or around March 17, 2021. [D.E. 1-3 at 12, ¶ 34].

Both Essex and Dr. Drzala contacted Aetna to obtain pre-authorization for the surgical and medical services they rendered to Patient D.L. on or around May 29, 2019. [D.E. 1-3 at 10, ¶ 28]. Both Essex and Dr. Drzala contacted Aetna around November 27, 2018, to obtain pre-authorization for surgical and medical services they provided to

Patient K.S., and Dr. Reiter rendered services that constituted continuation of care for these services about a month later, on December 19, 2018. [D.E. 1-3 at 11, ¶ 30].

As for Patient D.P., Dr. McCracken contacted Aetna for pre-authorization on or around July 5, 2018. [D.E. 1-3 at 13, ¶ 36]. While performing surgery, Dr. McCracken required assistance from Dr. Drzala. [D.E. 1-3 at 14, ¶ 37]. After Dr. Drzala rendered such surgical services, he contacted Aetna about re-imbursement. [*Id.*]. The Complaint alleges Aetna confirmed "pre-authorization was not required, and represented that surgeons are to be reimbursed at 90% of UCR." [*Id.*].

[2] Specifically, Essex rendered surgical and medical services to Patient T.A. [D.E. 1-3 at 9, ¶ 24]; to Patient D.A. [D.E. 1-3 at 9-10, ¶ 26]; to Patient T.M. [D.E. 1-3 at 12, ¶ 32]; and to Patient N.S. [D.E. 1-3 at 12, ¶ 34]. Both Essex and Dr. Drzala rendered surgical and medical services to Patient D.L. [D.E. 1-3 at 10, ¶ 28]. Essex, Dr. Drzala, and Dr. Reiter rendered surgical and medical services to Patient K.S. [D.E. 1-3 at 11, ¶ 30]. Both Dr. Drzala and Dr. McCracken rendered surgical and medical services to Patient D.P. [D.E. 1-3 at 13-14, ¶¶ 36-37].

[3] Moreover, four of the five plans that contain anti-assignment provisions are also plans maintained by local governments. Specifically, Exhibits 7, 8, 9, and 11 are plans for the Bloomfield Board of Education, Newark Public Schools, Wayne Township Public Schools, and the School District of Chathams. [*See* D.E. 1-9, 1-10, 1-11, and 1-13, respectively]. ERISA provides exceptions to its applicability, specifying that its provisions "shall not apply to any employee benefit plan if such plan is a governmental plan." 29 U.S.C. § 1003(b)(1). ERISA defines "governmental plan" as "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing." 29 U.S.C. § 1002(32). Thus, even if these four plans did not contain anti-assignment clauses, they could not provide a basis for ERISA 502(a) pre-emption.

[4] At the June 5, 2024 status conference held to address the parties' disputes over limited jurisdictional discovery, Defendants also seemed to recognize that dismissal of the claims against J&J would mean there is no ERISA pre-emption, by stating that if Plaintiffs "dismissed [the claims against the J&J plan sponsor] with prejudice, now we have a fraudulent joinder argument," and answering in the affirmative after the Court asked if it was the Defendants' position that dismissal of J&J with prejudice would end the question of ERISA pre-emption. [*See* D.E. 58 at 28:21-22; 29:2-11].

[5] This is true notwithstanding any agreements Plaintiffs had with Multiplan. *See N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, No. 17-05967, 2018 WL 6592956, at *8 (D.N.J. Dec. 14, 2018). In *MultiPlan*, the plaintiff was a medical practice that asserted New Jersey statutory, regulatory, and common law claims against an insurance company, ERISA plan sponsors, and Multiplan after those defendants failed to reimburse the plaintiff for patient services under an agreement it had with Multiplan. *Id.* at *2. The defendants removed to federal court asserting complete ERISA 502(a) pre-emption, and the plaintiff moved for remand. *Id.* at *3. The Court held that the first prong of the *Pascack* test was satisfied, because the plaintiff received valid assignments from at least eleven patients in the matter. *Id.* at *6. This notwithstanding, the Court held that no complete ERISA 502(a) preemption existed because the second prong of the *Pascack* test was not satisfied. *Id.* at *8. The removing defendants argued in part that the Court would have to "make determinations of whether plaintiff's claims were for covered services ... under the ERISA plans" and that the plaintiff alleged no duty independent of the patients' ERISA plans. *Id.* at *3. The Court rejected those arguments, however, explaining that the agreement between the plaintiff and Multiplan that

gave rise to the plaintiff's claims was independent from agreements between the insurance company and Multiplan, as well as any ERISA benefits plans. *Id.* at *7-8.

[6] The cases Defendants cite to support their argument that "claims based upon pre-service phone calls are governed by ERISA where the plan provides for out-of-network benefits" are distinguishable. [*See* D.E. 60 at 6; D.E. 19 at 18 n.9; D.E. 1 at 5-6]. In *Princeton Neurological Surgery, P.C. v. Aetna, Inc.*, No. 22-01414, 2023 WL 2307425, at *6 (D.N.J. Feb. 28, 2023), the Court held the asserted claims were not independent of a patient's ERISA plan because the preauthorization in question was specifically pursuant to the terms of the patient's plan and the preauthorization letter referenced the ERISA plan throughout. Similarly, in *Peer Grp. for Plastic Surgery, PA v. United Healthcare Servs., Inc.*, No. 23-02073, 2024 WL 1328134, at *6 (D.N.J. Mar. 28, 2024), the Court held that the pre-authorization letter in question provided that the out-of-network providers would be reimbursed at the "in-network benefit level subject to the Plans," and therefore, it would be "impossible to determine the merits of plaintiffs' claims without examining the provisions of the ERISA-governed plans." In *Advanced Orthopedics & Sports Med. Inst., P.C. v. Oxford Health Ins., Inc.*, No. 21-17221, 2022 WL 1718052, at *5 (D.N.J. May 27, 2022), the Court held that the claims "related to" an ERISA plan in part because the written pre-authorization did not refer to usual and customary rates and instead expressly stated that "payment is based on ... the Member's health benefits plan." Therefore, eligibility for payment and the amount of payment rested "on a plan-based obligation." *Id.* In *Park Avenue Podiatric Care, PLLC v. Cigna Health & Life Ins. Co.*, No. 23-1134, 2024 WL 2813721, at *2 (2d Cir. June 3, 2024), the Second Circuit explained that the plaintiff's own allegations made clear that the insurance company's reimbursement obligations for the out-of-network coverage in question were pursuant to the patient's ERISA plan and therefore necessarily related to the ERISA plan. In *Bristol SL Holdings, Inc. v. Cigna Health and Life Ins. Co.*, 103 F. 4th 597, 602 (9th Cir. 2024), the Ninth Circuit held that a provider's claims were not independent of an ERISA plan and were therefore pre-empted where "there [was] no dispute that the patients and their treatment were covered under the [ERISA] plans but where payment was later rejected based on fee-forgiving, which the plans prohibited." In doing so, the Court specifically distinguished *Bristol* from *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F. 3d 218, 229 (3d Cir. 2020). *Id.* at 607.

[7] The conclusion that the Complaint establishes a colorable claim for breach of implied contract against non-diverse Defendants Insmed, SHIF, and J&J is sufficient to reject Defendants' fraudulent joinder argument and to remand this case back to state court. *See* *Briscoe*, 448 F.3d at 217 ("[I]f there is even a possibility that a state court would find that the complaint states a cause of action against any one of the resident defendants, the federal court must find that joinder was proper and remand the case to state court."); *see also* *A.S.*, 769 F.3d at 208 (explaining that all doubts concerning whether the Court has subject matter jurisdiction must be resolved in favor of remand); 28 U.S.C. § 1447(c) ("If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded."). For the same reasons, even if the Removing Defendants had met their heavy burden of persuasion to demonstrate that joinder of non-diverse Defendant AHI was fraudulent, this matter must still be remanded. *Zambelli Fireworks Mfg. Co., Inc.*, 592 F.3d at 419 ("Complete diversity requires that, in cases with multiple plaintiffs or multiple defendants, no plaintiff be a citizen of the same state as any defendant."). Thus, the Court need not analyze the remaining claims.

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