PREPARED AND FILED BY THE COURT

NORTH JERSEY SPINE GROUP,

Plaintiff,

v.

AETNA LIFE INSURANCE CO., et al.

Defendants.

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: ESSEX COUNTY
Civil Action
CBLP Action

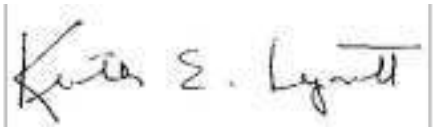
DOCKET NO. ESX-L-3992-19

ORDER

THIS MATTER having been brought before the Court by way of Motion of Defendants for an Order dismissing the Complaint with prejudice; and the Court having heard oral argument and considered the papers submitted in support of the Motion and in opposition thereto, and for good cause shown;

IT IS ON THIS 18 day of May, 2020, **ORDERED** that Defendants' Motion is **DENIED** for reasons stated in the accompanying Statement of Reasons;

IT IS FURTHER ORDERED that a copy of this Order shall be served upon all parties within 7 days of the date hereof.



HON. KEITH E. LYNOTT, J.S.C.

Opposed

Statement of Reasons

In this action alleging underpayment of claims for medical services, the Defendants Aetna Life Insurance Company ("Aetna"), Quest Diagnostics, Inc., North Jersey Municipal Employee Benefits Fund, IBM Corporation, UBS, Genesis Healthcare, Inc., BioReference Laboratories, Inc., Teamsters Western Region and New Jersey Health Care Fund (collectively, the "Defendants") move to dismiss the Complaint of the Plaintiff North Jersey Spine Group (the "Plaintiff" or "NJSG"). The motion seeks dismissal of the Complaint pursuant to R. 4:6-2(e). The Court holds that the Complaint passes muster under the applicable pleading standards.

I

A motion to dismiss for failure to state a claim is granted only in rare cases. In Printing Mart-Morristown v. Sharp Elec. Corp., 116 N.J. 739, 772 (1989), the Supreme Court stated that trial courts must accord such motions "meticulous and indulgent examination" and, accordingly, should grant them in only "the rarest of instances." See also Smith v. SBC Communications, Inc., 178 N.J. 265, 282 (2004) ("The motion to dismiss should be granted only in rare instances and ordinarily without prejudice.") (internal quotations omitted).

On a motion to dismiss a complaint pursuant to R. 4:6-2(e), the Court must determine whether "a cause of action is 'suggested' by the facts." Printing Mart-Morristown, 116 N.J. at 746 (quoting Velantzas v. Colgate-Palmolive Corp., 109 N.J. 189, 192 (1988)). The Court is required to examine the complaint "in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned from an obscure statement of claim." Ibid.

The Court must accept the facts alleged in the pleading as true. See Malik v. Ruttenberg, 398 N.J. Super. 489, 494 (App. Div. 2008) (the court must "accept as true the facts alleged in the complaint, and credit all reasonable inferences therefrom"). The pleading party is entitled to "every

reasonable inference of fact." Printing Mart-Morristown, 116 N.J. at 746. The Court is "not concerned with the ability of plaintiffs to prove the allegation contained in the complaint," but merely with "the legal sufficiency of the facts alleged on the face of the complaint." Ibid.

The examination of the complaint "should be one that is at once painstaking and undertaken with a generous and hospitable approach." Ibid; see also Piscitelli v. Classic Residence by Hyatt, 408 N.J. Super. 83, 103 (App. Div. 2009) (the court must review the complaint with "a generous and hospitable approach") (internal quotations omitted). The Court must "search the complaint in depth and with liberality" to identify the causes of action asserted. Lieberman v. Port Auth. of N.Y. & N.J., 132 N.J. 76, 79 (1993) (internal quotations omitted). In addition, "[a] complaint should not be dismissed under this rule where a cause of action is suggested by the facts and a theory of actionability may be articulated by way of amendment." Rieder v. State Dep't of Transp., 221 N.J. Super. 547, 552 (App. Div. 1987).

In examining a motion to dismiss, "the inquiry is confined to a consideration of the legal sufficiency of the alleged facts apparent on the face of the challenged claim," and therefore, "[t]he court may not consider anything other than whether the complaint states a cognizable cause of action." Ibid. (internal quotations omitted). Thus, the Court may not examine materials extrinsic to the complaint itself in adjudicating a motion to dismiss. An exception exists for exhibits attached to the complaint, matters of public record and materials that the plaintiff relies upon in the complaint or that are integral to the plaintiff's claims. See Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) ("In evaluating motions to dismiss, courts consider allegations in the complaint, exhibits attached to the complaint, matters of public record, and documents that form the basis of a claim") (internal quotations omitted).

The Rules of Court require only that a pleading contain "a statement of facts on which the claim is based, showing that the pleader is entitled to relief, and a demand for judgment for the relief to which the pleader claims entitlement." R. 4:5-2. The purpose of a pleading is not to provide a complete recitation of every possible fact or argument available, but to fairly apprise the adverse party of the claims and issues to be raised at trial. See Dewey v. R.J. Reynolds Tobacco Co., 121 N.J. 69, 75 (1980) ("Although more by way of facts regarding the design defect would have been enlightening, see Rule 4:5-2, we agree with the Appellate Division's finding that '[t]o the extent that plaintiff's complaint was deficient, the judge properly looked to the entire record, giving plaintiff every favorable inference,' 225 N.J. Super. at 382 n.5, and that the trial court had correctly concluded that the complaint was sufficient to support a claim of design defect").

II

The Court draws the pertinent facts from the Complaint. It accepts as true the averments of the Complaint solely for purposes of the pending motion. As required by the case law, the Court examines the Complaint in depth and in its entirety and with a generous and hospitable approach.

The Complaint contains 106 separate paragraphs and eight separate counts stating causes of action for relief. The Complaint sets forth a list of disputed patient accounts that are the subject of this action, identifying the patient's initials, ID numbers, the date of service, the amount billed and a brief reference to whether the services were emergency or pre-authorized.

NJSG is a medical practice specializing in spine surgery and treatment. Aetna is an insurance company licensed to do business in New Jersey. The other moving Defendants in this case are Quest Diagnostics, Inc., North Jersey Municipal Employee Benefits Fund, IBM Corporation, UBS, Genesis Healthcare, Inc., BioReference Laboratories, Inc., Teamsters Western Region and New Jersey

Health Care Fund. Each of the Defendants sponsored, funded, operated, controlled and/or administered healthcare plans of individuals who sought medical treatment from NJSG.

NJSG alleges that it is an "out-of-network, or non-participating, healthcare provider" in relation to Aetna and the other Defendants. It avers that it rendered "emergency and/or pre-approved medically necessary and related medical services" to individuals covered by "healthcare plans sponsored, funded, operated, controlled and/or administered by defendants." NJSG asserts that "when it came to pay the bills [for such services], defendants issued gross underpayments in excess of $1 million contrary to state common, statutory, and regulatory laws."

This is a direct action by the provider against the payers. NJSG is suing in its own capacity as a provider and not in a derivative capacity as a holder of assignments from the patients/subscribers to the Defendants' healthcare plans. Based on the Complaint as it presently stands, NJSG seeks relief for 11 open patient accounts or "Disputed Claims" as set forth therein.

NJSG asserts that it rendered emergency and non-emergency, pre-approved, medically necessary hospital and medical services, including inpatient, outpatient and same day services as reflected in a list of Disputed Claims. As noted, the list identifies (by initials) patients to whom NJSG provided emergency services for which it was underpaid or pre-authorized services for which the payment was less than represented. The Complaint alleges that the Defendants "indicated, by a course of conduct, dealings and the circumstances surrounding the relationship, to NJSG that it [sic] would honor, *inter alia* (a) its representations to NJSG that the services were authorized and/or pre-certified, and (b) its representations to NJSG that preauthorization was not required, *e.g.*, emergent care; and (c) the parties' MultiPlan Global Agreement."

The Plaintiff alleges that the Defendants in some instances "made promises to NJSG that proper coverage for surgical and medical services would be afforded the patients identified in the [list

of Disputed Claims], including by pre-authorizing and/or pre-certifying services, or paying for initial care, and then in each instance refusing proper payment when the bills were submitted by NJSG." It contends that, before it rendered services, it contacted the Defendants "in certain instances to confirm whether there was health insurance coverage for the services" and "confirmed, in those instances, that the services were covered by the patient's health insurance plans."

The Plaintiff avers that the Defendants expected, or reasonably should have expected, the Plaintiff to rely upon such pre-authorizations in rendering services to the patients at issue. The Complaint alleges that "statutory law" bars retroactive withdrawal of pre-authorization for services, "to the extent pre-authorization was sought for any of the patient claims identified [as Disputed Claims]," in the absence of material misrepresentations by the provider.

The Plaintiff asserts the Defendants knew, or should have known, that under New Jersey law, statutes and regulations, the Plaintiff was required to provide emergency care to all patients, regardless of ability to pay for the services. It alleges the Defendants were also aware that their subscribers/insureds must be held harmless and thus the Defendants must pay the Plaintiff 100% of their billed usual, customary and reasonable ("UCR") charges for emergency services. The UCR fee is the usual charge for a particular service rendered by comparable providers in the same geographic area.

The Complaint alleges that the Plaintiff has an established course of dealings with the respective Defendants regarding the timely payment for emergency services. The Plaintiff avers that, "[a]s a matter of routine business practice," it engaged in "regular communications and discussions with defendants and/or their agents regarding coverage, reimbursement and other issues."

The Plaintiff asserts that Aetna regularly advises the public, and thus the subscribers, that certain state laws do not allow providers to "balance bill" a patient for such services if the patient is

fully insured and issues Explanations of Benefits to the Plaintiff acknowledging that it may not "balance bill" the patient. The Complaint alleges that the Defendants "indicated, by a course of conduct, dealings and circumstances surrounding the relationship, to NJSG that defendants would pay for surgical and medical services provided, including the emergency services provided" by it to the Defendants' insureds.

The Plaintiff asseverates the Defendants "represent that their members and beneficiaries are covered for out-of-network emergency and/or pre-authorized care . . . and that they will only be responsible, at most, to pay the plan's copayments, coinsurance and deductibles at an in-network level when emergency services are rendered." It avers that the Defendants "were paid premiums by the patients for out-of-network emergency healthcare coverage, and the services of NJSG were necessary to satisfy the surgical and medical needs of the relevant patients."

The Plaintiff alleges that it timely submitted claims for payment with supporting documentation. However, when the Plaintiff submitted bills, the Defendants refused proper payment. Specifically, it alleges that "[e]ven though the services rendered by NJSG were emergency or pre-approved, medically necessary surgical care, and covered by defendants' health benefit plans (facts upon which plaintiff reasonably relied), defendants systematically failed to issue proper reimbursement for the services rendered by NJSG to defendants' insureds identified in the [Disputed Claims]." The Complaint avers that, despite this course of dealing and acknowledged obligation to pay the Plaintiff's UCR charges for emergency services, the Defendants "systematically downgraded emergency coverage, thereby improperly exposing defendants' insured identified in the [Disputed Claims] to balance bills that greatly exceed their applicable copay, coinsurance or deductible."

The Plaintiff asserts the Defendants "issued gross underpayment." It claims that "[i]n making improper payments, defendants' actions or inactions were unlawful and improper because defendants

failed to calculate the *amount* of the payment in accordance with state statutory, regulatory and /or common law." (Emphasis in original). The Plaintiff claims that it has prosecuted internal appeals of the alleged underpayments and that further pursuit of such appeals would be futile.

The Plaintiff alleges that the action "addresses defendants' failure to provide the appropriate *amount* of coverage" to the patients at issue and the Defendants' "failure to properly *reimburse* plaintiff" for its services to that patient. (Emphasis in original). The Plaintiff avers that "[t]here is no dispute that defendants' plan provides coverage for the patient claims contained in the [list of Disputed Claims], as defendants already issued partial payments."

The Plaintiff asserts that the Defendants "intentionally and deliberately administer their plans in a self-serving manner to lower reimbursement for out-of-network services" in order to increase profits or discourage insureds/patients from seeking service from out-of-network providers. It alleges this practice exists "even though the patients pay higher premiums in order to access the out-of-network provider of their choice, and are promised by defendants access to such providers as part of their insurance coverage."

The Complaint avers the Defendants were required by applicable "prompt pay" laws to pay the Plaintiff's claims for reimbursement in the correct amount within 30 or 40 days of submission (depending on the method of submission). It alleges the Defendants are now obligated under such laws to pay interest at a rate of 12%.

The Plaintiff alleges that its claims arise under state common, statutory and regulatory law. It avers that its claims and causes of action are grounded in "independent duties" owed by the Defendants and are "unfettered by any type of ERISA preemption," referring to the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA"). It alleges that such independent duties arise from New Jersey laws, statutes and regulations governing the reimbursement of out-of-network providers

rendering emergency services which laws provide "implied contractual duties and implied private rights of action" to the Plaintiff. It asserts the independent duties are also based on the "pre-authorizations and/or pre-certifications provided by defendants to plaintiff to induce plaintiff to render surgical and medical services with promise of coverage and payment," and prompt pay laws, statutes and regulations. It also avers such laws, statutes and regulations are "saved" from preemption as they regulate insurance.

The First Count of the Complaint purports to state a claim for breach of an implied contract between the Plaintiff and the Defendants. It asserts that the Defendants indicated by a course of conduct, dealings and circumstances surrounding the relationship to NJSG that they would pay for surgical or medical services, including emergency services, provided to the Defendants' insureds. The Plaintiff asserts the Defendants represent to their members and beneficiaries that they are covered for out-of-network treatment and/or emergency care; that they may go to any hospital emergency room when they need emergency care; and that they will only be responsible in such circumstances to pay for applicable co-payments, coinsurance and deductibles at an in-network level. The Plaintiff avers that the Defendants received premiums from those patients in return for affording access to out-of-network emergency and other healthcare services, such as provided by NJSG, and the services of NJSG were necessary to satisfy the needs of the patients.

The First Count further avers that the Defendants indicated through a course of conduct, dealings and circumstances surrounding the relationship that they would hold harmless their insureds and pay the Plaintiff its UCR amounts based upon what other healthcare providers of the same specialty services in the same geographic area charge for services rendered by them. It alleges that the Defendants indicated by dealings and circumstances surrounding the relationship that they would honor representations to the Plaintiff that the services rendered were pre-authorized or pre-certified or

that pre-authorization was not required due to the need for urgent or emergent care. The Plaintiff asserts it rendered medically necessary surgical and medical services to the patients whose Disputed Claims are the subject of the action and reasonably expected the Defendants to "properly compensate plaintiff."

The Second Count of the Complaint purports to state a claim for breach of the covenant of good faith and fair dealing contained in the alleged implied-in-fact contracts with the Defendants. It alleges that the Defendants acted with an improper motive and "injured" the Plaintiff's rights and benefits under such contracts.

The Third Count purports to state a claim for unjust enrichment and quantum meruit. It alleges that the Defendants refused to pay NJSG the correct amounts for the surgical and medical services provided to the patients identified in the Complaint, which patients were covered under plans sponsored, funded, insured and/or administered by the Defendants. The Plaintiff alleges such refusal was contrary to the insurance provided by the plans, and to common law, statutory and regulatory obligations of the Defendants. This Count avers that the Defendants needed NJSG to render hospital and medical services, including emergency services, to these patients in order to satisfy their contractual and legal obligations to them and that the Defendants benefited from the undertaking of the Plaintiff to perform such services.

The Third Count asserts that, as a result of the services the Plaintiff provided, the Defendants have received and retained a benefit, because the Plaintiff rendered hospital and medical services for which the Plaintiff expected remuneration, but it has instead been grossly underpaid. The Plaintiff alleges the Defendants were unjustly enriched by use of funds that they should have paid to the Plaintiff.

The Fourth Count purports to set forth a claim for a promissory estoppel. This Count asserts that the Defendants promised NJSG that they would afford proper coverage for hospital and medical services to members of their plans, including by pre-authorizing or pre-certifying services or paying for initial care. The Count alleges the Defendants subsequently refused to pay when the Plaintiff submitted its bills.

The Fourth Count asserts that, in some cases, the Plaintiff contacted the Defendants before performing services to confirm whether there was coverage for such services and received such confirmation. In other instances, the Plaintiff confirmed that it would be paid specific UCR percentages for the services to be provided. The Plaintiff avers that the Defendants expected or reasonably should have expected the Plaintiff to rely on such assurances and it did so to its "definite and substantial detriment."

The Fifth Count alleges a claim for negligent misrepresentation. It asserts that the Defendants negligently represented that they would provide proper coverage to the patients at issue and pay the Plaintiff's claims for reimbursement, including by way of pre-authorization or pre-certification or by paying for initial care. The Plaintiff avers that the Defendants materially misrepresented that the Defendants' plans entitled the patients to receive coverage for the hospital and medical services provided by the Plaintiff. The Plaintiff asserts that such representations were false.

This Count alleges that NJSG reasonably relied on representations as to pre-authorization and/or payment by the Defendants in connection with providing services. The Plaintiff alleges that, contrary to such representations, the Defendants subsequently refused proper payment for bills submitted by the Plaintiff.

The Sixth Count purports to state a claim for interference with economic advantage. The Plaintiff alleges a reasonable expectation of economic advantage arising from the patient/provider

relationship. This Count asserts that the Defendants knew or reasonably should have known of the Plaintiff's expectation of economic advantage and that the Defendants wrongfully interfered with such expected economic benefit in circumstances in which it is reasonably probable that the Plaintiff would have realized the benefit.

The Seventh and Eighth Counts purport to state causes of action under allegedly applicable New Jersey statutory and regulatory provisions. The Plaintiff asserts a right to a private cause of action under such statutory and regulatory framework.

In the Seventh Count, the Plaintiff sets forth a cause of action grounded in statutory and regulatory provisions requiring that providers, such as the Plaintiff, must render emergency services to all patients regardless of ability to pay or source of payment and mandating that payors "determine coverage and pay promptly" the charges of providers for such services. The Plaintiff alleges that applicable regulations obligate a payor to notify subscribers that they are entitled to have access to emergency services. This Count asserts that, pursuant to such regulations, when a patient seeks emergency services from an out-of-network provider, the payor must pay the provider a large enough amount to ensure that the patient is not "balance billed" or charged for the difference between the provider's actual charges and the amount reimbursed by the insurer. The Complaint avers that this regulatory mandate applies even if the payor "must pay the provider its actual billed charges minus the copayments, coinsurance and deductible that would have applied had the patient sought treatment from an in-network provider."

On the basis of such statutory and regulatory framework, the Complaint alleges that the Defendants are obligated to pay NJSG, as the case may be, 100 percent of the Plaintiff's UCR charges incurred for providing emergency care to the Defendants' subscribers, less the applicable copayment, coinsurance or deductible. The Plaintiff asserts that the Defendants have failed to comply with such

regulatory requirements by failing to pay the Plaintiff's UCR charges for emergency services rendered to the Defendants' insureds.

The Eighth Count purports to state a claim under the Healthcare Information Networks and Technologies Act, as amended by the Health Claims Authorization Processing and Payment Act. It contends that such laws and the regulations promulgated thereunder establish a time period (30 to 40 days) within which a payor must either pay or challenge a provider's bills. The Plaintiff asserts that, under such laws and regulations, it has a private right of action to prosecute claims for the Defendants' failures in complying with the same by refusing to pay the full amount of charges submitted by the Plaintiff.

The Plaintiff alleges that the Defendants as a matter of practice and policy delayed payments due under invoices for surgical and medical services it rendered to the Defendants' insureds, failed to pay the claims correctly and failed to pay interest on delayed payments. The Plaintiff asserts that, pursuant to such laws and regulations, the outstanding amounts bear simple interest at a rate of 12% per annum. The Eighth Count seeks to enforce such right to simple interest at the established rate.

III

The Defendants move against the Complaint on a variety of grounds. They assert that, because the Plaintiff's claims relate to health insurance plans that are subject to ERISA, the Court must dismiss such claims in their entirety on the basis of express preemption pursuant to ERISA Section 514(a). 29 U.S.C. § 1144(a). Examining each Count separately, the Defendants assert that the Plaintiff has failed to state a claim upon which relief can be granted.

The Defendants assert that all of the claims that form the subject matter of the Plaintiff's action "relate to" ERISA-subject healthcare benefits plans in a manner and to an extent as to require a determination that such claims are preempted. They argue that adjudication of the Plaintiff's claims

for underpayment of their invoices for medical services perforce requires the Court to review, apply and interpret the underlying benefits plans – an exercise that this Court is not permitted to undertake, but that must take place, if at all, in a federal court. They contend the Court would have to determine not only that the individual patients have coverage under such plans for the services rendered by the Plaintiff, but would have to review the plans to ascertain the applicable copayments, coinsurance and/or deductible in order to assess the amount (if any) of the underpayments. They assert that the Plaintiff explicitly acknowledges this circumstance in its Complaint, thus requiring the Court to conclude on this motion to dismiss that the claims are preempted.

The Plaintiff counters that the claims do not "relate to" any such ERISA-subject benefits plans. It asserts that, as to each of the disputed claims, the Plaintiff either performed emergency services – in respect of which applicable law required the Plaintiff to treat the patients and the Defendants to hold them harmless from balance billing – or received assurances of coverage through the Defendants prior to performing the services. In either case, according to the Plaintiff, there is no need for the Court to review the respective healthcare benefits plans to render a coverage determination.

The Plaintiff thus asserts that, in seeking reimbursement from the Defendants for underpayment of the Disputed Claims, it is only contesting the amount of reimbursement. It asseverates that there is no question as to the existence of coverage under any of the underlying plans and the Court is not, and will not be, asked or required to construe or interpret the terms and conditions of such plans in adjudicating this case.

The Plaintiff points out this case involves direct claims against the Defendants and not derivative claims based upon an assignment from the patients. It contends it does not stand in the shoes of beneficiaries of the Defendants' plans and is not asserting claims predicated on the terms and conditions of the plans themselves. Instead, it asserts the basis for its claims are independent duties

owed to it by the Defendants under the common law and New Jersey statutes and regulations. It also contends that such statutes and rules regulate insurance and, accordingly, are "saved" from preemption by the express terms of Section 514(a).

ERISA Section 514(a), 29 U.S.C. § 1144(a), provides in pertinent part as follows:

> The provisions of this subchapter and subchapter 1111 of this chapter shall supersede any and all State laws insofar as they may now or hereafter **relate to** any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.
>
> (Emphasis added).

ERISA Section 514 (b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), in turn, provides that "[e]xcept as provided in subparagraph (B) nothing in this subchapter shall be considered to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." The statute thus preempts state laws as they "relate to" any employee benefit plan, except insofar as such laws regulate insurance.

Courts have recognized that, despite the use of the phrase "relate to" to establish the reach of the provision, ERISA Section 514(a) does have limits. The Supreme Court in NYS Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 655 (1995), stated that it declined to apply "uncritical literalism" to that phrase, instructing courts to examine the objectives of the ERISA statute in determining what state laws would survive preemption analysis.

"If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.' But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality." Id. at 654-655 (internal quotations omitted). Thus, courts must "look to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.'" Nat'l Sec. Sys., Inc. v. Iola, 700

F.3d 65, 83-84 (3d Cir. 2012) (quoting California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc., 519 U.S. 316, 325 (1997) (internal quotations omitted)).

In In re Reglan Litigation, 226 N.J. 315, 329 (2016), the New Jersey Supreme Court stated that, when Congress legislates in a field where states have traditionally exercised their historic police powers, "the preemption inquiry begins with the assumption that Congress did not intend to supersede a State statute unless that was Congress's clear and manifest purpose." This presumption against preemption is especially pertinent here, given the traditional role of States in regulating matters of healthcare. See Freedman v. Redstone, 753 F. 3d 416, 429-430 (3d Cir. 2014). Moreover, as healthcare providers are generally not considered "beneficiaries" or "participants" under ERISA, a determination that the claims asserted here are preempted would very likely leave the Plaintiff without a remedy.

The Defendants assert that, in prior cases involving the same Plaintiff and counsel, the Plaintiff has misled the Court into concluding, in the context of a case like this involving alleged underpayment for services provided to a subscriber of an ERISA-subject health plan, the question of preemption is a "fact-sensitive endeavor." See R.F. v. Abbott Labs., 162 N.J. 596, 619 (2000). They assert this proposition applies only to the assessment of facts such as legislative history and regulatory statements, not at issue in the circumstance here.

Even granting the point that the Supreme Court's statement in Abbot Labs has such limited effect – and the Court does not find it was intentionally misled – the preemption analysis here nonetheless requires the Court to determine if the Plaintiff's claims are so closely connected to ERISA-subject plans as to require it to have to examine such plans in order to adjudicate the Plaintiff's claims for underpayment. That analysis is inherently fact-sensitive and requires a full record concerning the specific nature of and factual basis for the claims asserted.

Assuming that the patients to whom the Plaintiff provided services were insured under ERISA-subject plans, it is not clear at this juncture that the Plaintiff's causes of action are necessarily preempted. As noted, the Plaintiff is suing in a direct capacity. It is not suing as, or standing in the shoes of, a beneficiary. It alleges in its Complaint – and the Court must accept as true on this motion – that it performed emergency or pre-authorized surgical or medical services for the patients. It asserts that, in relation to the emergency services, the laws of the State and the Defendants' obligations under such laws – which the Complaint avers the Defendants have openly acknowledged – require the Defendants to bear the full cost of the Plaintiff's services (save for applicable coinsurance, copayments or deductibles). It alleges that, in relation to the pre-authorized services, it received advance assurances of coverage and payment.

If the record as subsequently developed bears out such factual contentions, the Plaintiff's right vel non to additional payment would likely not turn on an examination or interpretation of the relevant plans. In any event, the determination of such questions requires a factual record.

The Plaintiff relies upon Memorial Hospital System v. Northbrook Life Insurance Co., 904 F. 2d 236 (5th Cir. 1990), to support its claim that preemption is not warranted in the circumstances here. In that case, the plaintiff provider alleged that a health insurer misrepresented the existence of coverage for a patient seeking treatment from the provider. The court held that preemption under ERISA Section 514(a), on the basis that the claim "relate[d] to" an ERISA-subject benefit plan, would not serve the statutory purpose of protecting employees/beneficiaries. The court noted that application of preemption to bar a state law claim by the provider in the circumstances of that case would ignore commercial realities and could lead providers as a practical matter to insist on prepayment rather than accept the risk of nonpayment.

The court also concluded that the cause of action seeking payment in such circumstances – that is, a claim alleging misrepresentation as to the existence of coverage – would not "relate to" the terms and conditions of the underlying welfare plan as its adjudication would not affect or would only tangentially affect the actual administration of the plan. Id. at 248, 250. See also The Meadows v. Employers Health Insurance, 47 F. 3d 1006, 1008-1110 (9th Cir. 1995)(noting that "independent state law claims of [the plaintiff], a third-party provider, lie outside the bounds of the ERISA 'relates to' standard" and "courts have held that ERISA does not preempt third-party provider's independent state law claims against a plan sponsor precisely because those claims do not 'relate to' the administration of the plan"); McCall v. Metropolitan Life Ins. Co., 956 F. Supp. 1172, 1186 (D.N.J. 1996) (stating that the provider's negligent misrepresentation claims against the defendant insurers are "sufficiently removed" from the plan to avoid the scope of ERISA preemption).

In St. Peter's Univ. Hospital v. New Jersey Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div.), certif. denied, 216 N.J. 366 (2013), the Appellate Division cited Memorial Hospital System, 904 F. 2d 236, with approval and stated that, although ERISA preemption is "clearly expansive," to interpret the language to its furthest extent "would render the reach of the provision limitless." Accordingly, a court should not find state law claims preempted if such state law has only a "tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." Id. at 456 (internal quotations omitted). Instead, a determination of preemption is warranted when the existence of an ERISA plan is a "critical factor" in establishing the Defendants' liability and the Court's inquiry would necessarily be "direct[ed] to the plan." Id. at 455-456 (internal quotations omitted).

In St. Peter's Univ. Hospital, 431 N.J. Super. 446, the trial court and Appellate Division did conclude, albeit on a motion for summary judgment after discovery, that the claim brought by the

plaintiff hospital against a welfare fund seeking additional remuneration was preempted. The Appellate Division found that the claims dealt directly with payment of benefits under the plan and involved more than a peripheral reference to the plan. The court held that the hospital's claims were based on the plan's obligations under its subscriber agreement with a preferred provider organization; and that the plan itself was referenced and incorporated in that agreement.

The court determined that, in order to adjudicate the hospital's claims, the court would be required to examine and consult the terms of the ERISA plan. It found that, before the court could determine if a benefit was payable, it would be necessary to conduct an inquiry into the terms of the plan to determine such matters as whether the benefit was covered, the amount of the copayment, the amount of the deductible, whether the plan was primary or secondary, whether Medicaid coverage was available for purposes of the coordination of benefits and the cap on benefits. Accordingly, the court concluded that the claims were neither tenuous nor peripheral, but rather "clearly 'relate to' the ERISA plan within the intendment of the statute and are expressly preempted." Id. at 460.

In this case, the Court does not and cannot determine at this time whether the Plaintiff's claims are or are not preempted. The Plaintiff has specifically alleged, and the Court must accept as true, that it does not seek a determination as to the terms and conditions of any underlying ERISA-subject plans, but only a determination of the amount of reimbursement owed for claims involving either emergency or pre-authorized services. It asserts claims under various legal theories that, so it contends, arise from independent legal obligations on the Defendants' part to pay the Plaintiff's UCR charges for services provided to the Defendants' insureds. It alleges such obligations arise from an independent, implied-in-fact contract, or from quasi-contract based on a promise or obligation to pay for a benefit conferred. It also avers, as in Memorial Hospital System, 904 F. 2d 236, that its legal rights arise from negligent misrepresentations of the Defendants as to the coverage afforded to the plan subscribers. It claims the

Defendants' liability for payment arises under statutory or regulatory provisions to which the Defendants are allegedly subject.

The Plaintiff thus asserts its rights do not derive from the underlying plans and are peripheral to the terms and conditions of such plans. It contends that adjudication of the claims will therefore not require the Court to delve into the terms and conditions of such plans. In short, it alleges facts that, if proved, could cause the Court to conclude that the existence of an ERISA plan is not a "critical factor" in establishing the Defendants' liability and the Court's inquiry would not be "directed to the plan." St. Peter's Univ. Hospital, 431 N.J. Super. at 455-456 (internal quotations omitted).

The Defendants assert that this case differs from other cases in which this Court has taken up the ERISA preemption issue in relation to claims by medical providers of underpayment by a plan sponsor or administrator. They have placed in the motion record documentary evidence in the form of written requests by this Plaintiff to the plan sponsor/administrator for copies of the plan pertaining to a particular patient. They contend such requests amount to binding admissions by the Plaintiff that examination of the relevant plan(s) is required in order to determine the Plaintiff's right vel non to additional payment. They contend that, at least in this case, the Plaintiff's assertion that its claims do not "relate to" ERISA plans is undermined by its requests for copies of the relevant plan(s).

As noted above, on a motion to dismiss, the Court is limited to examination of the pleading and extrinsic materials to which the Plaintiff refers in the Complaint or that are integral to the Plaintiff's claims. Banco Popular, 184 N.J. at 183. Here, the documents cited by the Defendants are not integral to the Plaintiff's claims, as the Plaintiff alleges facts in its Complaint to the effect that its rights to additional payment are not based on the applicable plans but instead are grounded in alleged assurances of payment given by the Defendants via pre-certification of the Plaintiff's services and in acknowledgements of obligations under applicable statutes and regulations to bear the billed cost of

emergency services provided by the Plaintiff. Put another way, the proffered documents may be integral to a defense posited by the Defendants on preemption grounds, but they are not structural pillars of the Plaintiff's pleaded claims that may be considered at this juncture.

In any event, the Court cannot, on a motion to dismiss, draw the conclusion that the Defendants assert it must draw from these requests. At the pleading stage, one cannot know what, if any, use the Plaintiff made of the requested plan documents and/or whether and to what extent the relevant plans are connected to the Plaintiff's claims. It is entirely possible that the Plaintiff's requests for the relevant plans were formulaic and, upon receipt, the Plaintiff consigned the documents to a file drawer or otherwise ignored them. On the other hand, the record may disclose the Plaintiff requested the plan(s) because examination of the same was in fact the only way to establish the right to and amount of payment. In all events, until there is an adequate factual record, it is not possible to determine the effect (if any) of these requests and the responses on the pre-emption analysis.

The Defendants cite to more recent decisions in the District of New Jersey suggesting an emerging trend in that court of granting motions to dismiss on preemption grounds as to state law claims resembling those asserted here. However, the cases cited are not published, are not controlling and were decided under a different standard for adjudicating a motion to dismiss. Most of the cases relied upon appear to have been decided by the same United States District Judge and other Judges within the District have reached contrary conclusions.

Moreover, the cases cited also appear to involve circumstances different from the circumstances here, at least on the basis of the present limited record. Thus, in Advanced Orthopedics and Sports Medicine Institute v. Empire Blue Cross Blue Shield, 2018 U.S. Dist. LEXIS 96814 (D.N.J. June 7, 2018), the court noted the plaintiff provider merely alleged that, prior to performing surgery, it obtained authorization for admission of the patient from the emergency room department. Although

the plaintiff asserted a claim against the insurer for breach of an implied contract, among other theories, the court concluded the facts alleged did not indicate that the defendant insurer was even involved in the claimed agreement at all. Nor did the complaints allege an agreement to pay an amount other than that specified in the applicable plan.

In contrast, the Court reads the Complaint of the Plaintiff here – examined with liberality as required by Printing Mart-Morristown – to allege it received pre-authorization from the respective plans as to coverage for the services to be provided and for payment of the Plaintiff's UCR charges for the same or acknowledgments that the services were emergent in nature and must be provided and would be covered. Whether that will prove to be true and whether such circumstances, even if true, will permit the Plaintiff's claims to proceed under state law theories of action are matters that remain to be seen. However, given the Plaintiff's allegations in this case, there is not a sufficient basis to dismiss the Complaint at this early juncture.

The Defendants contend the Plaintiff admits in the Complaint that the Court will necessarily be directed to the plans to determine, at minimum, the applicable coinsurance, copayment or deductible pursuant to the terms of the respective plans. The Plaintiff asserts otherwise, arguing that the Defendants' course of dealing involved policies by which they did not apply copayments, coinsurance or deductibles in matters involving emergency services. But even granting the Defendants' position to be so, the Court must still determine whether the need to consult the applicable plans to ascertain the applicable coinsurance, copayment or deductible renders the plans a "critical factor" in determining the Defendants' liability. The Court can only arrive at such a determination on the basis of a more complete record.

In all the circumstances, the Court concludes it is necessary to have a full record before determining whether the Plaintiff's claims "relate to" ERISA-subject benefit plans within the

intendment of that phrase. Stated otherwise, it is necessary to explore in greater detail and on a more complete factual record than permitted on a motion to dismiss the nature and substance of the Plaintiff's claims – and the basis for the same – before it could determine that the claims are preempted on the grounds that the Court would necessarily have to examine, apply and interpret the underlying ERISA-subject benefits plans. Such record is necessary for the Court to examine whether adjudication of the Plaintiff's claims bears only a "tenuous, remote, or peripheral connection" to ERISA-covered plans or whether such plans, as in St. Peter's Univ. Hospital, 431 N.J. Super. 446, have a more direct connection to the claims asserted. Accordingly, for the present time, the Court denies the Motion to Dismiss on grounds of preemption for the reasons stated herein.

IV

As noted above, the Defendants also challenge each pleaded cause of action on the grounds that the pleading is insufficient to state a cause of action upon which relief can be granted. The Court now surveys each of the Counts in order to ascertain whether or not the Plaintiff has pleaded facts sufficient to sustain a viable cause of action.

The First Count claims a breach of an alleged contract. The Plaintiff alleges that, as to the underlying reimbursement claims, the Defendants engaged in a course of conduct giving rise to an implied-in-fact contractual obligation to pay the amounts subsequently billed by the Plaintiff based upon the Plaintiff's UCR charges.

As required by Printing Mart-Morristown, 116 N.J. 739, the Court examines the factual contentions of the Complaint in their entirety and with a generous and hospitable approach to the same. The Court finds that the Complaint alleges that, as to some of the disputed patient accounts, the Plaintiff contacted the Defendants and sought and obtained pre-authorization to render the services

provided to the subject patients. The Plaintiff alleges an implied-in-fact agreement by which it agreed to perform services in return for the pre-authorized payment of the UCR charges for such services.

As to other Disputed Claims, the Plaintiff alleges that it contacted the Defendants and were informed that, due to the nature of the circumstances – namely, the need for emergent care – it was not necessary to secure pre-authorization. The Plaintiff alleges an implied-in-fact agreement in which it had an obligation to perform and did perform emergency services in return for payment of all billed charges. The Complaint read as a whole avers as well that the Plaintiff was legally required under applicable New Jersey statutes and regulations to perform the emergency services and the Defendants were – and at all times knew they were and acknowledged – legally obligated to pay for the same in sufficient amount so that the patients/beneficiaries would not be balance billed. The Complaint also alleges the Defendants adopted a course of dealing by which they undertook to pay for emergency services in a manner that protected the patients/insureds from balance billing.

The Court concludes the factual allegations of the Complaint, read liberally and in their entirety, are sufficient to state claims for breach of an implied contract as to each of the underlying Disputed Claims. The Complaint establishes a course of dealing between the putative contracting parties, the resulting existence of an implied contract to perform surgical or medical services in return for payment, a flow of consideration, breach of the terms of the implied contract arising from the Defendants' failure to pay the amounts billed and resulting damages.

The mutual assent discernible from the Complaint arises from the factual allegations concerning the parties' conduct. The Complaint alleges communications seeking pre-authorization for hospital services to be rendered by the Plaintiff, followed by authorization by the Defendants or a notification that such authorization was not necessary in light of the emergent nature of the services and the legal requirements imposed on both parties. The Complaint alleges a course of dealing by

which the Defendants agreed to coverage for the services to be provided or acknowledged an obligation to pay in a manner that held the patients/insureds harmless from balance billing. The Complaint alleges performance of the services and demand for payment. The terms of the implied contract alleged involve performance of services in return for payment of the UCR applicable to the services.

The Court finds the Complaint alleges consideration flowing to the Defendants in connection with the implied contracts as to each Disputed Claim. The Complaint alleges that the Defendants accepted premiums from or on behalf of patients for plans affording them the right to secure out-of-network services in certain circumstances and that the Defendants were legally obligated under Federal and state laws to cover subscribers for emergency services and acknowledged such obligations. The Complaint avers that, by providing out-of-network emergency and/or pre-authorized services to the Defendants' insureds/beneficiaries, the Plaintiff enabled the Defendants to satisfy contractual or legal obligations to those individuals. The Court finds that the Complaint contains sufficient factual allegations as to consideration to state claims as to an implied contract.

Where a complaint alleges sufficient facts to establish the existence of a meeting of the minds as to the rendering of service in return for payment, it is not a quantum leap to conclude that a benefit of this nature is sufficient to establish consideration to support an express or as here an implied-in-fact contract. It is a hornbook principle of contract law that a court will not inquire into the amount or adequacy of consideration to support a determination that a contract exists. The Court finds here only that the Plaintiff's pleading alleges facts from which may be derived the elements of an implied contract, including consideration, and a claim for breach thereof.

The Court concludes that the Plaintiff has alleged sufficient facts to determine the terms of the alleged implied-in-fact contract – namely, a promise to provide out-of-network services, either

emergency or pre-authorized services, as the case may be, in return for a promise to pay the Plaintiff's billed charges, based on its UCR rates. The Complaint also alleges sufficient facts as to each underlying Disputed Claim by detailing the specific account, the patient and the general nature of the services.

The Defendants contend that the Plaintiff's allegations of an implied-in-fact contract fail because the statute on which the Plaintiff principally relies only applies to hospitals and not physician practices. N.J.S.A. 26:2H-18.64. They also assert the statute and implementing regulations do not require them to pay the Plaintiff's full billed charges, but instead deal only with how much a member of the plans can be required to pay and/or require the Defendants to reimburse for services in a manner provided by their respective plans. As to the claim pertaining to alleged pre-authorized services, the Defendants contend the alleged pre-authorization relates only to the existence of coverage and not the amount of payment. They assert there is no factual averment that the Defendants agreed to pay the Plaintiff's UCR charges for the pre-authorized services.

Although the Defendants' arguments may ultimately carry the day, they overlook the procedural posture of the pending motion and the Court's obligation to examine the pleading with a generous and hospitable approach. The Plaintiff relies, in part, on N.J.A.C. 11:24-5.3, which provides, as noted above, that "carriers" must reimburse "hospitals and physicians" and establish policies and procedures that afford "[c]overage for out-of-service area medical care when medically necessary for urgent or emergency conditions where the member cannot reasonably access in-network services." It also refers to a course of dealing by which, so it alleges, the Defendants agreed, in satisfaction of their obligations under such applicable laws and regulations, to afford coverage for emergency services and to bear the Plaintiff's UCR charges so as to hold harmless the patients/insureds from balance billing.

The Court also reads the Complaint to allege a course of dealing by which the Defendants agreed, upon accepting coverage and pre-authorizing services, to pay the Plaintiff's actual or UCR charges in accordance with that course of dealing. Thus, the Complaint avers that "[d]espite indicating to NJSG by a course of conduct, dealings and circumstances surrounding the relationship that defendants would properly and timely reimburse plaintiff for either its actual charges as an out-of-network provider or its UCR rates, defendants failed to do so." Particularly given the standards that apply to determine the legal sufficiency of a pleading, the Court finds the Plaintiff has alleged claims sounding in breach of an implied contract based on a course of dealing, and/or applicable statutes and regulations governing the respective conduct of both the Plaintiff and the Defendants.

The Court finds only that the allegations of the Complaint, viewed liberally, establish the "fundament" of a cause of action for breach of an implied contract, and do so with sufficient clarity and precision to fairly apprise the Defendants of what they allegedly did wrong to permit them to answer and defend. Printing Mart-Morristown, 116 N.J. at 746. Whether on a full factual record the facts will likewise establish a triable claim for breach of an implied contract remains a different matter.

The Second Count purports to state a claim for breach of the implied covenant of good faith and fair dealing. Having found that the pleading alleges an implied-in-fact contract, that contract under New Jersey law perforce contains as one of its implied terms a covenant of good faith and fair dealing.

The Plaintiff avers that the Defendants, imbued with improper motive, breached this covenant of the alleged implied-in-fact agreement. It alleges sufficient facts beyond the mere breach of the terms of the contract that could support a finding of breach of the covenant of good faith and fair dealing.

Specifically, the Complaint alleges that the Defendants systematically downgraded emergency coverage exposing the patients/insureds to balance billing. The Complaint alleges the Defendants have, and acted on the basis of, a financial incentive to lower reimbursement for out-of-network services in

order to receive additional compensation measured in part by out-of-network reimbursement rates. It alleges the Defendants acted in a manner as to discourage patients/insureds from seeking out-of-network services such as were provided by the Plaintiff.

The Complaint asserts a course of conduct that could support a finding of improper efforts to deprive the Plaintiff of the fruits of the implied-in-fact bargain. Once again, under the Printing Mart-Morristown standard, the Court finds it is possible, on a liberal reading of the Complaint, to glean the fundament of a cause of action for breach of the covenant of good faith and fair dealing from the facts alleged.

The Third Count of the Complaint also purports to state causes of action for unjust enrichment and quantum meruit. The elements of a claim for unjust enrichment are that "[the] defendant received a benefit and that retention of the benefit would be unjust." Castro v. NYT Television, 370 N.J. Super. 282, 299 (App. Div. 2004) (internal quotations omitted). Likewise, a claim for quantum meruit arises when a party confers a benefit on another with the reasonable expectation of payment for the same.

The Court concludes that the Complaint states causes of action for unjust enrichment and quantum meruit – once again, after examining the Complaint in its entirety under the Printing Mart-Morristown standard. Although claims in quasi-contract do not lie when the party relies on an express or implied contract, the Plaintiff, as it does here, is permitted under our rules to plead in the alternative, and even to plead inconsistent theories.

As noted, the causes of action for unjust enrichment or quantum meruit require the Plaintiff to allege that it conferred a benefit upon the Defendants and as to which it would be unjust to permit the Defendants to retain the benefit or circumstances in which it reasonably expected compensation. The Defendants dispute the existence of a benefit conferred by the Plaintiff on the Defendants. They assert

any benefit arising from the services provided by the Plaintiff accrued to the patients only and not the Defendants.

However, even assuming the Plaintiff must establish a benefit to sustain both theories, the Court finds that the pleading alleges sufficient facts concerning a benefit conferred on the Defendants. The Complaint asserts the Defendants represented to their insureds that their plans afforded them rights to out-of-network services and indeed charged higher premiums for such rights. They also acknowledged that insureds were entitled to seek and receive emergency services from out-of-network providers without risk of balance billing, consistent with statutory and regulatory obligations to which the Defendants were subject. The Complaint alleges the performance by the Plaintiff of out-of-network emergency or pre-authorized services for the Defendants' patients/insureds enabled the Defendants to discharge their contractual and/or legal obligations to those patients by permitting them to obtain such services. In light of these allegations, the Court finds that, under the Printing Mart-Morristown test, the facts pleaded are sufficient from which to glean the fundament of a cause of action for quasi-contractual relief.

The Defendants cite cases, none of which are controlling on this Court, in which the courts did determine that an insurer/payor received no benefit when a provider merely provided a service to an insured. The courts in those cases concluded that the only outcome for the payor in such circumstances was a demand for payment. Such courts noted that the payor is indifferent as to which out-of-network provider the patient/insured actually chooses.

But other courts, typically in cases involving claims grounded in quasi-contract and the performance of emergency services, have determined that the payor did receive a benefit from the provider's services – namely, the services enabled the payor to discharge a legal obligation owed to the patient/insured. One such case is El Paso Healthcare Services v. Molina Healthcare of New

Mexico, Inc., 683 F. Supp. 2d 454, 461 (W. D. Tex. 2010), where the court reasoned that "[w]hile it is true that the immediate beneficiaries of the medical services were the patients, and not Molina [the health maintenance organization], that company *did* receive a benefit of having its obligations to plan members and to the state in the interests of plan members, discharged." (Emphasis in original). The court noted that "Molina describes this discharging of obligations benefit as 'incidental,' but the Court finds this benefit 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 this core obligation fulfilled is hardly incidental." Ibid.

The court stated that "[i]f these obligations are not deemed material and central to the Medicaid managed care scheme, how is such a system supposed to function?" Id. at 462. It found that "[i]n sum, these discharges were furnished for the benefit of Molina, which enjoyed and accepted them, and Molina even acknowledged as much when it tendered payment for them at a rate it deemed to be proper." Ibid. Referring to the elements of a claim in quasi-contract, the court held that "prongs two and three [requiring a benefit to be conferred upon and accepted by the defendant] have been fulfilled as well as one and four, even though Molina disputes this characterization of the facts." Ibid.

It is true that El Paso Healthcare Services involved a managed care organization providing coverage to Medicaid-eligible patients. As such, that entity had obligations to ensure the delivery of certain services to enrolled patients.

But it is not a significant leap of logic to find that a similar benefit accrued to the Defendants here, at least under the facts as alleged by the Plaintiff. The services provided were either emergency services that applicable regulations required the Defendants to cover without the insureds being balance billed or out-of-network services that the Defendants had agreed their subscribers could receive and, accordingly, pre-authorized the Plaintiff to perform. The performance of such services

enabled the Defendants to satisfy contractual and legal obligations to obtain emergency services or permit the subscribers to seek, in appropriate cases, service from out-of-network providers – obligations that, as the Complaint alleges, were supported by the receipt of higher premiums.

In the Fourth Count, the Complaint also purports to state a cause of action for promissory estoppel. Such a claim for promissory estoppel requires a showing of a clear and definite promise made with the expectation of reliance, reasonable reliance, and substantial detriment. See Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499 (App. Div. 2003). Here again, the facts set forth in the Complaint, considered as a whole, establish a cause of action for promissory estoppel.

The Plaintiff alleges a promise to pay for out-of-network or emergency services delivered as to each disputed patient account. The Complaint alleges the Defendants either gave prior authorization for the services or advised that such authorization was unnecessary. In either event, the Complaint alleges the result of such communication was a promise to pay for the services on which the Plaintiff relied to its detriment.

The Complaint also lodges in the Fifth Count a claim for negligent misrepresentation. Karu v. Feldman, 119 N.J. 135, 146-147 (1990), sets forth the elements of such a claim. A plaintiff must establish the negligent provision of information; that the plaintiff was a reasonably foreseeable recipient of such information; reasonable reliance on the false representations; and that the false statements caused damages.

The Plaintiff's Complaint alleges that, as to the disputed patient accounts, the Defendants falsely advised the Plaintiff of the pre-certification of the treatment and/or the lack of need for the same, and of an agreement or intention to pay for the services to be provided to the patients/insureds. These factual averments are sufficient to establish a negligent misrepresentation. The Complaint also

adequately alleges that the Plaintiff reasonably relied on the allegedly false assurances by providing the services on the basis of the same.

The Court finds the Plaintiff has pleaded the circumstances of such misrepresentations as to the Disputed Claims with the requisite particularity. R. 4:5-8. The Complaint read as a whole sets forth the specific nature of the misrepresentations and the approximate time – the date of service – when it was given. The Complaint specifically alleges facts going to reliance on the alleged misrepresentations via allegations of performance of services for each patient/insured. The Plaintiff may, of course, be required in discovery to supply additional pertinent information as to each individual Disputed Claims.

The Complaint also purports to state claims in the Sixth Count for interference with prospective economic advantage. To state such a claim, a plaintiff must allege a protected interest, including a prospective economic relationship or contract; malice – defined as an intentional interference without justification – a reasonable likelihood that the interference caused the loss of the prospective gain; and damages. See Printing Mart-Morristown, 116 N.J. at 751.

The prospective economic advantage alleged here is the economic benefit derived from the provider/patient relationship allegedly existing between patients and the patient/insureds of the Defendants who sought treatment from the Plaintiff. The Complaint alleges facts from which one may glean a claim for interference with such relationships arising from the Defendants' alleged pre-certification of the services to be rendered or their acknowledgment that the same was not required for emergency services, followed by their failure or refusal to pay the full amount the Plaintiff claim is due.

The Complaint also sets forth facts supporting the assertion that the Defendants acted intentionally, without justification, and with improper purposes. As noted earlier, the Complaint alleges the Defendants systematically downgraded the emergency services, exposing the

patients/insureds to balance billing and resulting in gross underpayments to the Plaintiff. It alleges the Defendants intentionally withheld payment to realize incentives for reducing reimbursements for out-of-network services and to discourage patients/insureds from seeking out-of-network services from providers such as the Plaintiff.

The Seventh and Eighth Counts lodge claims – asserted as implied private rights of action – under New Jersey statutes and regulations. The Plaintiff purports to state private claims for relief under New Jersey statutes and regulations pertaining to the provision of emergency services to patients and "Prompt Pay" laws and promulgated rules.

In the Seventh Count, the Plaintiff alleges a private right of action under New Jersey rules requiring that an out-of-network provider ensure, in cases involving a patient seeking emergency services, that the provider is paid a sufficient amount such that the patient is not balance billed. The Plaintiff alleges that the Defendants are obligated to pay the Plaintiff's UCR charges for such emergency services, less applicable co-pay, coinsurance, or deductible, pursuant to N.J.A.C. 11:22-5.8, 11:24-5.3 and 11:24-9.1(d). N.J.AC. 11:24-5.3 specifically requires "carriers" to reimburse "hospitals and physicians" for all medically necessary emergency and urgent care covered under the health benefit plans in circumstances where the member cannot reasonably access in-network services.

As neither the cited regulations or authorizing statutes provide an express private right of action, the Court must consider whether the Plaintiff is among the intended beneficiaries of the statute or rule, whether there is indicia of legislative intent to establish a private right of action, and whether an implied private right of action advances the statutory and regulatory objectives. Here, the cited rule actually requires the insurer to pay hospitals or physicians for certain emergency services. This appears to establish not only that the Plaintiff is an intended beneficiary of the provisions or at least that the

rules seek to protect the interests of hospitals and physicians, but that the rules contemplate a right of action to obtain the required reimbursement.

In this regard, though the Legislature may have adopted these laws (and authorized regulations to implement them) for the primary benefit of patients, that does not necessarily mean that it did not also intend to protect the interest of physicians. This is particularly true here when the statutory/regulatory specifically obligates insurers to pay the providers' charges for emergency services.

The Court concludes at this juncture that the Complaint states a private right of action under the cited statutes and regulations for reimbursement of costs for providing emergency services to at least some of the Defendants' insureds. Parenthetically, the Court also notes that, at minimum, the Complaint alleges that the terms and conditions of the regulatory provisions governing provision of emergency services are part and parcel of the alleged implied-in-fact contract extant between the Plaintiff and the Defendants.

As this motion involves a comprehensive challenge to all of the Counts of the Complaint on a wide variety of grounds, the Court concludes that the parties have understandably not concentrated their briefing on the question of whether there is a private right of action under the statutes and rules governing emergency services. The Court determines here only that the Plaintiff has adequately pleaded a claim under such statutory regulatory framework and that that framework evinces sufficient indicia of an intention to permit an implied right of action to permit this Court to allow the Seventh Counts to stand at this time. The Court denies the Motion to Dismiss, but without prejudice to a subsequent application based upon a more complete record and/or more complete briefing by the parties.

The Eighth Count alleges an implied private cause of action under the Prompt Pay laws and regulations adopted in New Jersey. Specifically, the Plaintiff asseverates that, pursuant to the Health Information Networks and Technologies Act, N.J.S.A. 17B:30–23, 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2 and 26:2J-8.1 and implementing rules at N.J.A.C. 11:22-1 et seq., the Defendants were obligated to pay or contest the Plaintiff's invoices within a specified time period. It further alleges that overdue payments bear simple interest under such statutes and regulations of 12 percent per annum. Indeed, N.J.S.A. 17B:27-44.2(d)(9) specifically provides that an overdue payment shall bear simple interest at a 12 percent per annum rate. It further provides that "interest shall be paid to the healthcare provider at the time the overdue payment is made" and further provides that any such amount actually paid shall be credited to any civil penalty assessed for a violation.

The statutory text thus appears to contemplate a payment of interest directly to the provider and thus the right of the provider to charge and recover the same. The providers – the Plaintiff here – are certainly among the parties whom statute appears intended to protect or benefit, in addition to the protection of patients and the general public. It likewise appears that the manifest purpose of the statute – prompt payment of uncontested statements and/or prompt notice of billing disputes – would be advanced by finding an implied right of action.

The Court again finds that the Plaintiff has stated a claim for relief under the cited statutory and regulatory framework, and that the statute evinces an intention to permit a private right of action for interest at the established statutory and regulatory rate. For the reasons just noted, it denies the Motion to Dismiss without prejudice to the right of the Defendants to seek dismissal or summary judgment on the basis of a full record and/or more focused briefing.