PREPARED AND FILED BY THE COURT

FILED

10:52 am, Oct 01, 2019

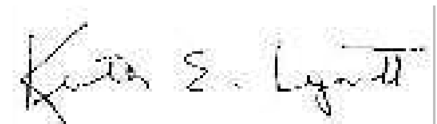
NORTH JERSEY BRAIN & SPINE CENTER, Plaintiff, vs. AETNA LIFE INSURANCE COMPANY; COSTCO WHOLESALE CORPORATION; COMPASS GROUP USA, INC.; PARTY RENTAL LTD; SPECTRUM FOR LIVING DEVELOPMENT INC.; AETNA BETTER HEALTH OF NEW JERSEY; PANASONIC CORPORATION OF NORTH AMERICA; and ABC CORPS. 1-100, Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIV., ESSEX COUNTY DKT. NO. L-5817-18 **CIVIL ACTION** **ORDER**

THIS MATTER having been opened to the court by motion of Elliott Greenleaf, P.C., attorneys for Defendants, upon notice to Plaintiff, for an order granting Defendants' Motion to Dismiss; and the Court having heard oral argument and considered the moving papers and the opposition papers; and for good cause shown;

IT IS on this **1** day of **October**, 2019:

ORDERED that Defendants' Motion to Dismiss is **DENIED** for reasons stated in the accompanying Statement of Reasons; and it if further

ORDERED that Defendants' counsel shall serve a copy of this Order and the accompanying Statement of Reasons on all parties within **7** day of electronic posting hereof.



Judge Keith Lynott

Statement of Reasons

In these two separate actions alleging underpayment of bills for medical services, the Defendants move to dismiss the Complaints of the Plaintiffs North Jersey Brain & Spine Center ("North Jersey") and Jeffrey Pan, MD, PC ("Pan") respectively. Each of the Complaints is similar in regard to the facts alleged and substantively identical in relation to the claims asserted. Each case involves Aetna Life Insurance Company ("Aetna") as a Defendant. And each motion seeks dismissal of Complaint pursuant to R. 4:6-2(e). Accordingly, the Court heard the motions contemporaneously (at the parties' request and with their consent) and now issues a single Statement of Reasons that pertains to both cases.

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., 179 N.J. 265, 282 (2004) ("A 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 at this stage with whether the plaintiff can prove the facts averred in the Complaint, but merely with the legal sufficiency of the pleading." 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 plaintiff is entitled to relief, showing that the pleader is entitled to relief, and a demand of 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 Complaints of North Jersey and Pan, respectively. It accepts as true the averments of each of these Complaints solely for purposes of the pending motions. As required by the case law, the Court examines the Complaints in depth and in their entirety and with a generous and hospitable approach.

The North Jersey Complaint contains 103 separate paragraphs and eight separate counts stating causes of action for relief. The Complaint sets forth a list of disputed patient accounts that is the subject of this action, identifying the patient's initials, the date of service, the amount billed and a brief reference to whether the services were emergency or preauthorized. The Pan Complaint consists of 97 separate paragraphs and eight separate Counts. It also sets forth a list of the individual disputed claims.

North Jersey, located in Oradell, is a "medical practice specializing in neurological procedures and treatment of the brain and spinal cord." Aetna is an insurance company licensed to

do business in New Jersey. The other Defendants in the North Jersey case are Costco Wholesale Corporation ("Costco"), Compass Group USA Inc., Party Rental Ltd., Spectrum for Living Development, Aetna Better Health of New Jersey and Panasonic Corporation of America. Each of the Defendants sponsored, funded, operated, controlled and/or administered healthcare plans of individuals who sought medical treatment from North Jersey.

North Jersey 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." North Jersey asserts that "when it came to pay the bills [for such services], defendants issued gross underpayments contrary to state common, statutory, and regulatory laws."

Jeff Pan, M.D. is a licensed physician. Pan is "a medical practice specializing in neurosurgical procedures and treatment of the brain and spinal cord" and has its principal offices in Perth Amboy. The Defendants in the action bought by Pan are Aetna, Costco, ADP, LLC, and Hazen and Sawyer, P.C. (the Plaintiff dismissed the latter from the action). Pan alleges that each of the Defendants sponsored, funded, operated, controlled and/or administered healthcare plans of individuals who sought medical treatment from Pan.

Pan alleges 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." Pan avers that "when it came to pay the bills [for such services], defendants issued gross underpayments contrary to state common, statutory, and regulatory laws."

The Court notes that this is a direct action by the providers against the respective payers. North Jersey and Pan are suing in their own capacities as providers and not in a derivative capacity as holders of assignments from the patients/subscribers to the Defendants' healthcare plans.

Based on the Complaint as it presently stands, North Jersey seeks relief for 25 open patient accounts or "Disputed Claims" as set forth therein. Pan seeks relief for eight such claims.

North Jersey and Pan assert that they rendered emergency and non-emergency, pre-approved, medically necessary hospital and medical services, including inpatient, outpatient and same day services as reflected in the open patient accounts. The lists of Disputed Claims identify (by initials) patients to whom North Jersey or Pan, as the case may be, provided emergency services for which they were underpaid or pre-authorized services for which the payment was less than represented. The Complaints allege that the Defendants "indicated, by a course of conduct, dealings and the circumstances surrounding the relationship, to [North Jersey or Pan, as the case may be] that it [sic] would honor, inter alia (a) its representations to [North Jersey or Pan] that the services were authorized and/or pre-certified, and (b) its representations to [North Jersey or Pan] that preauthorization was not required, *e.g.*, emergent care."

The Plaintiffs allege that the Defendants in some instances "made promises to [North Jersey or Pan, as the case may be] 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 [North Jersey or Pan]." They contend that, before they rendered services, they 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 Plaintiffs aver that the Defendants expected, or reasonably should have expected, the Plaintiffs to rely upon such pre-authorizations in rendering services to the patients at issue. The Complaints allege 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 Plaintiffs assert the Defendants knew, or should have known, that under New Jersey law, statutes and regulations, the Plaintiffs were required to provide emergent care to all patients, regardless of ability to pay for the services. They allege the Defendants were also aware that their subscribers/insureds must be held harmless and thus the Defendants must pay the Plaintiffs 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 Complaints allege that each of the Plaintiffs has an established course of dealings with the respective Defendants regarding the timely payment for emergency services. The Plaintiffs aver that, "[a]s a matter of routine business practice," they engaged in "regular communications and discussions with defendants and/or their agents regarding coverage, reimbursement and other issues."

The Plaintiffs assert that Aetna regularly advises the public 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 Plaintiffs advising each of them 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 [North Jersey or Pan, as the case may be] that defendants would pay for surgical and medical services provided, including the emergency services provided" by them to the Defendants' insureds.

The Plaintiffs contend the Defendants "represent that their members and beneficiaries ae covered for out-of-network emergency and/or pre-authorized care . . . and that that they will only be responsible to pay the plan's copayments, coinsurance and deductibles at an in-network level when emergency services are rendered." They aver that the Defendants "were paid premiums by the patients for out-of-network emergency healthcare coverage, and the services of [North Jersey or Pan, as the case may be] were necessary to satisfy the surgical and medical needs of the relevant patients."

The Plaintiffs allege that they timely submitted claims for payment with supporting documentation. However, when the Plaintiffs submitted bills, the Defendants refused proper payment. Specifically, they allege that "[e]ven though the services rendered by [North Jersey or Pan, as the case may be] 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 [North Jersey or Pan] to defendants' insureds identified in the [Disputed Claims]." The Complaints aver that, despite this course of dealing and acknowledged obligation to pay the Plaintiffs' 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 Plaintiffs assert the Defendants "issued gross underpayment." They claim 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." The Plaintiffs claim that they have prosecuted internal appeals of the alleged underpayments and that further pursuit of such appeals would be futile.

The Plaintiffs allege that this 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. The Plaintiffs aver that "[t]here is no dispute that defendants' plan provides coverage for the patient claims contained in the [list of Disputed Claims], as the defendants already issued partial payments."

The Plaintiffs assert 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. They allege 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 Complaints allege the Defendants were required by applicable "prompt pay" laws to pay the Plaintiffs' claims for reimbursement in the correct amount within 30 or 40 days of submission (depending on the method of submission). They allege the Defendants are obligated under such laws to pay interest at a rate of 12%.

The Plaintiffs allege that the claims arise under state common, statutory and regulatory law. They aver that their claims and causes of action arise from "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. Sec. 1001, et seq. ("ERISA"). They allege 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 Plaintiffs. They assert the independent duties also arise from 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. They also aver such laws, statutes and regulations are "saved" from preemption as they regulate insurance.

The First Count of each Complaint purports to state a claim for breach of an implied contract between each of the Plaintiffs and the respective Defendants. It asserts that the Defendants indicated by a course of conduct, dealings and circumstances surrounding the relationship to North Jersey or Pan that they would pay for surgical or medical services, including emergency services, provided to the Defendants' insureds. The Plaintiffs assert 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 Plaintiffs aver that the Defendants received premiums from those patients for out-of-network emergency healthcare coverage and the services of North Jersey or Pan, as the case may be, 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 Plaintiffs their UCR amounts based upon what other healthcare providers of the same specialty and 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 Plaintiffs that the services rendered were preauthorized or precertified or that preauthorization was not required due to the need for urgent or emergent care. The Plaintiffs assert they rendered medically necessary surgical and medical services to the patients whose open accounts

are the subject of the actions and reasonably expected the Defendants to "properly compensate plaintiff."

The Second Count of the Complaints 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" plaintiff's rights and benefits under such contract.

The Third Count purports to state a claim for unjust enrichment and quantum meruit. It alleges that the Defendants refused to pay North Jersey or Pan, as the case may be, the correct amounts for the surgical and medical services provided to the patients identified in the Complaints which patients were covered under plans sponsored, funded, insured and/or administered by the Defendants. The Plaintiffs allege such refusal was contrary to the insurance provided by the plans, and to common law, statutory and regulatory obligations of the Defendants. This Count alleges that the Defendants required North Jersey or Pan, as the case may be, to render hospital and medical services, including emergency services, to such patients in order to satisfy their contractual and legal obligations to them.

The Third Count asserts that, as a result of the services the Plaintiffs provided, the Defendants have received and retained a benefit because the Plaintiffs rendered hospital and medical services for which the Plaintiffs have been grossly underpaid. The Plaintiffs allege the Defendants were unjustly enriched by use of funds that they should have paid to the Plaintiffs.

The Fourth Count asserts a claim for a promissory estoppel. This Count asserts that the Defendants made promises to North Jersey or Pan, as the case may be, that they would afford proper coverage for hospital and medical to members of their plans, including by preauthorizing or pre-certifying services or paying for initial care. The Count asserts the Defendants subsequently refused to pay when the Plaintiffs submitted their bills.

The Fourth Count alleges that, in some cases, the Plaintiffs contacted the Defendants before performing services to confirm whether there was coverage for such services and received such confirmation. The Plaintiffs aver that the Defendants expected or reasonably should have expected the Plaintiffs to rely on such assurances and they did so to their "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 Plaintiffs' claims for reimbursement, including by way of preauthorization or precertification or by paying for initial care. The Plaintiffs aver that the Defendants materially misrepresented that the Defendants' plans entitled the patients to receive coverage for the hospital and medical services provided by the Plaintiffs. The Plaintiffs assert that such representations were false.

This Count alleges that North Jersey and Pan reasonably relied on representations as to preauthorization and/or payment by the Defendants in connection with providing services. The Plaintiffs allege that, contrary to such representations, the Defendants subsequently refused payments for bills submitted by the Plaintiffs.

The Sixth Count purports to state a claim for interference with economic advantage. The Plaintiffs allege a reasonable expectation of economic advantage arising from the patient/provider relationship. This Count alleges that the Defendants knew or reasonably should have known of the Plaintiffs' 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 Plaintiffs would have realized the benefit.

The Seventh and Eighth Counts purport to state causes of action under allegedly applicable New Jersey statutory regulatory provisions. In each case, the Plaintiffs assert a right to a private cause of action under such statutory and regulatory framework.

In the Seventh Count, the Plaintiffs allege a cause of action grounded in statutory and regulatory provisions requiring that providers, such as the Plaintiffs, 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 Plaintiffs allege that applicable regulations obligate a payor to notify subscribers that they are entitled to have access to emergency services. This Count alleges 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 Complaints aver 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 Complaints allege that the Defendants are obligated to pay North Jersey or Pan, as the case may be, 100 percent of the respective Plaintiff's UCR fees incurred for providing hospital and emergency care to the Defendants’ subscribers, less the applicable copayment, coinsurance or deductible. The Plaintiffs allege that the Defendants have failed to comply with such regulatory requirements by failing to pay the Plaintiffs’ 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 asserts 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 Plaintiffs assert that, under such laws and regulations, they have 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 Plaintiffs.

The Plaintiffs allege that the Defendants as a matter of practice and policy delayed payments due under invoices they tendered for surgical and medical services they rendered to the Defendants' insureds, failed to pay the claims correctly and failed to pay interest on delayed payments. The Plaintiffs allege 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 Complaints on a variety of grounds. They assert that, because the Plaintiffs' 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., Section 1144(a). Examining every Count separately, the Defendants assert that the Plaintiffs have failed in each instance to state a claim upon which relief can be granted.

The Defendants also assert that, as to any counts that survive, the Court should require a more definite statement of the factual averments supporting each such cause of action. They contend the facts as presently alleged are insufficient to place the Defendants on notice of what they are alleged to have done wrong and to permit them to plead in response and defend the action.

Turning first to the issue of preemption, the Defendants assert that all of the claims that form the subject matter of each Plaintiff's action "relate to" ERISA-subject healthcare benefits plans in a manner and to an extent require a determination that such claims are preempted. They argue that adjudication of the Plaintiffs' 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 Plaintiffs, 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 Plaintiffs explicitly acknowledge this circumstance in their Complaints, thus requiring the Court to conclude on this motion to dismiss that the claims are preempted.

The Plaintiffs counter that their claims do not "relate to" any such ERISA-subject benefits plans. They assert that, as to each of the disputed claims, the relevant Plaintiff either performed emergency services – in respect of which applicable law required the Plaintiffs 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 Plaintiffs, there is no need for the Court to review the respective healthcare benefits plans to render a coverage determination.

The Plaintiffs thus assert that, in seeking reimbursement from the Defendants for underpayment of submitted claims, they are only contesting the amount of reimbursement. They asseverate 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 Plaintiffs point out that both of these cases involve direct claims against the Defendants and not derivative claims based upon an assignment from the patients. They contend they do not stand in the shoes of beneficiaries of the Defendants' plans and are not asserting claims predicated on the

terms and conditions of the plans themselves. Instead, they assert the basis for their claims are independent duties owed to them by the Defendants under the common law and New Jersey statutes and regulations. They also contend 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 USC Section 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 USC Section 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.

The Court concludes in the circumstances here that it is premature at this early juncture to determine whether all or any aspect of Plaintiffs' claims are subject to express preemption under ERISA Section 514(a). Courts have recognized that, despite the use of the phrase "relate to" to establish the reach of the provision, ERISA 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 "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 (3rd Cir. 2012) (quoting California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc., 519 U.S. 316, 325 (1997)).

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 Plaintiffs without a remedy.

The New Jersey Supreme Court has also held that preemption is a "fact sensitive endeavor." R.F. v. Abbott Labs, 162 N. J. 596, 619 (2000). Here, even granting that the patients to whom the Plaintiffs provided services were insured under ERISA-subject plans, it is not clear at this juncture that the Plaintiffs' causes of action are necessarily preempted. As noted, the Plaintiffs are suing in a direct capacity. They are not suing as, or standing in the shoes of, a beneficiary. They allege in their Complaints – and the Court must accept as true on this motion – that they performed emergency or preauthorized surgical or medical services for the patients. They assert that, in relation to the emergency services, the laws of the State and the Defendants' obligations under such laws – which the Complaints aver the Defendants have openly acknowledged – require the Defendants to bear the

full cost of the Plaintiffs' services (save for applicable coinsurance, copayments or deductibles). They allege that, in relation to the preauthorized services, they received advance assurances of coverage and payment.

The Plaintiffs rely upon Memorial Hospital System v. Northbrook Life Insurance Co., 904 F. 2nd 236 (5th Cir. 1990), to support their 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 and 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. Metlife Insurance 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. 2nd 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.

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 concluded 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 Plaintiffs' claims are or are not preempted. The Plaintiffs have specifically alleged, and the Court must accept as true, that they do 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 preauthorized services. They assert claims under various legal theories that, so they contend, arise from independent legal obligations on the Defendants' part to pay the Plaintiffs' UCR charges for services provided to the Defendants' insureds. They allege 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. They also aver, as in Memorial Hospital System, 904 F. 2nd 236, that their legal rights arise from negligent misrepresentations of the Defendants as to the coverage afforded to the plan subscribers. They claim the Defendants' liability for payment arises under statutory or regulatory provisions to which the Defendants are allegedly subject.

In all events, the Plaintiffs assert their rights do not derive from the underlying plans and are peripheral to the terms and conditions of such plans. They contend that adjudication of their claims will therefore not require the Court to delve into the terms and conditions of such plans. In short, they allege 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).

In the circumstances, recognizing both the presumption against preemption and the fact sensitive nature of the issue presented, the Court concludes it is necessary to have a full record before determining whether the Plaintiffs' claims "relate to" ERISA-subject benefits plans within the intendment of that phrase. Put it in another way, 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 Plaintiffs' claims before it could determine that the claims are preempted on the basis that the Court would necessarily have to examine, apply and interpret the underlying ERISA-subject benefits plans.

A more complete record is necessary for the Court to examine whether adjudication of the Plaintiffs' 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. A full record is necessary to examine whether the Court would necessarily be directed to the plans in an adjudication, in which event the claims would be subject to preemption. Accordingly, for the present time, the Court denies the Motion to Dismiss on grounds of preemption for the reasons stated.

The Defendants assert that more recent decisions in the District of New Jersey represent a 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 complaint allege an agreement to pay an amount other than that specified in the applicable plan.

In contrast, the Court reads the Complaints of the Plaintiffs here – examined with liberality as required by Printing Mart-Morristown – to allege they received preauthorization from the respective plans as to coverage for the services to be provided and for payment of the Plaintiffs' 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 Plaintiffs' claims to proceed under State law theories of action are matters that remain to be seen. However, given the Plaintiffs' allegations in this case, there is not a sufficient basis to dismiss the Complaints at this early juncture.

The Defendants contend the Plaintiffs admit in their Complaints 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 Plaintiffs contend otherwise, asserting 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 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 concludes it can only arrive at such a determination on the basis of a more complete record.

As noted above, the Plaintiff also challenges 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 pleaded Counts for relief in order to ascertain whether or not the Plaintiffs have pleaded facts sufficient to sustain a viable cause of action.

The First Count claims a breach of an alleged contract. The Plaintiffs allege 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 Plaintiffs based upon the Plaintiffs UCR charges.

As required by Printing Mart-Morristown, 116 N.J. 739, the Court examines the factual contentions of the Complaints in their entirety and with a generous and hospitable approach to the same. The Court finds that the Complaints allege that, as to some of the disputed patient accounts, the Plaintiffs contacted the Defendants and sought and obtained preauthorization to render the services provided to the subject patients. The Plaintiffs allege an implied-in-fact agreement by which they agreed to perform services in return for the preauthorized payment of the UCR charges for such services.

As to other disputed patient accounts, the Plaintiffs allege that they 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 preauthorization. The Plaintiffs allege an implied in fact agreement in which they agreed to perform and did perform emergency services in return for payment of all billed charges. The Complaints read as a whole aver as well that the Plaintiffs were legally required under applicable New Jersey statutes and regulations to perform the emergency services and the Defendant were – and at all times knew they were - legally obligated to pay for the same in sufficient amount so that the patients/beneficiaries would not be balance billed. The Complaints also allege 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 Complaints, read liberally and in their entirety, are sufficient to state claims for breach of an implied contract as to each of the underlying

disputed accounts. The Complaints establish a course of dealing between the putative contracting parties, the 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 Complaints arises from the factual allegations of the parties' conduct. The Complaints allege communications seeking preauthorization for hospital services to be rendered by the Plaintiffs, 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 Complaints allege 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 Complaints allege 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 Complaints allege consideration flowing to the Defendants in connection with the implied contracts as to each disputed patient account. The Complaints allege that the Defendants accepted premiums from or on behalf of patients for plans affording such subscriber 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 Complaints allege that by providing out-of-network emergency and/or preauthorized services to the Defendants' insureds/beneficiaries, the Plaintiffs enabled the Defendants to satisfy contractual or legal obligations to those individuals. The Court finds that the Complaints contain 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 Plaintiffs' pleadings allege 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 Plaintiffs have 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 preauthorized or emergency services, as the case may be, in return for a promise to pay the UCR. The Complaints also allege sufficient facts as to each underlying disputed account by detailing the specific account, the patient and the general nature of the services.

The Defendants contend that the Plaintiffs' allegations of an implied-in-fact contract fail because the statute on which the Plaintiffs principally rely 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 Plaintiffs' 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 covered under their plans. As to the claim pertaining to alleged preauthorized services, the Defendants contend the alleged preauthorization relates only to the existence of coverage and not the amount. They assert there is no factual averment that the Defendants agreed to pay the Plaintiffs' UCR charges for the preauthorized services.

Although the Defendants' arguments may ultimately carry the day, they overlook the procedural posture of the pending motions and the Court's obligation to examine the pleading with a

generous and hospitable approach. The Plaintiffs rely, 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." They also refer to a course of dealing by which, so they allege, the Defendants agreed, in satisfaction of their obligations under such applicable laws and regulations, to afford coverage for emergency services and to bear the Plaintiffs' UCR charges so as to hold harmless the patients/insureds from balance billing.

The Court also reads their Complaints to allege a course of dealing by which the Defendants agreed, upon accepting coverage and preauthorizing services, to pay the Plaintiffs' actual or UCR charges in accordance with that course of dealing. Thus, they allege that "[d]espite indicating to [North Jersey or Pan, as the case may be] 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 Plaintiffs have alleged claims sounding in breach of an implied contract based on a course of dealing.

At the oral argument, the Defendants challenged the averments of a course of dealing by noting that the Plaintiffs alleged numerous occasions on which the Defendants allegedly grossly underpaid the Plaintiffs. How, they asserted, can there be a course of dealing if the Defendants so frequently failed to act in accordance with it? But the Plaintiffs countered that the patient accounts that are the subject of this action represent only a subset of the interactions between the Plaintiffs and the Defendants. They thus suggested there are other circumstances in which the Defendants paid the

Plaintiffs' UCR charges in accordance with the alleged understanding. These, of course, are matters for another day.

The Court finds only that the allegations of the Complaints, 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 claims for breach of the implied covenant of good faith and fair dealing. Having found that the pleadings allege 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 Plaintiffs allege that the Defendants, imbued with improper motive, breached this covenant of the agreement. They allege 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 Complaints allege that the Defendants systematically downgraded emergency coverage exposing the patients/insureds to balance billing. The Complaints allege 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. They allege the Defendants acted in a manner as to discourage patients/insureds from seeking out-of-network services such as were provided by the Plaintiffs.

The Complaints allege 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 Complaints, 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 Complaints 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 that benefit would be unjust. Castro v. NYT Television, 370 N.J. Super. 282, 299 (App. Div. 2004). 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 Complaints state causes of action for unjust enrichment and quantum meruit – once again, after examining the Complaints in tier 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 Plaintiffs, as they do here, are 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 Plaintiffs to allege that they conferred a benefit upon the respective Defendants and circumstances in which they reasonably expected compensation for the same or as to which it would be unjust to permit the Defendants to retain the benefit without remuneration. The Defendants dispute the existence of a benefit conferred by the Plaintiffs on the Defendants. They assert any benefit arising from the services provided by the Plaintiffs accrued to the patients and not the Defendants.

However, the Court finds that the pleadings allege sufficient facts concerning a benefit conferred on the Defendants. The Complaints allege 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 Complaints allege the performance by the Plaintiffs of out-of-network emergency or preauthorized 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 a party in the Defendants' position received no benefit when a party in the Plaintiffs' position merely provides a service to an insured of the Defendants. 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, that company *did* receive a benefit of having its obligations to plan members and to the state in the interest of plan members, discharged." 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 the 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 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 is one and four, even though Molina disputes this characterization of the facts." Ibid.

It is true that El Paso 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 Plaintiffs. 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, preauthorized the Plaintiffs 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, an obligation that, as the Complaints allege, was supported by the receipt of higher premiums.

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

The Plaintiffs alleges a promise to pay for out-of-network or emergency services delivered as to each disputed patient account. The Complaints allege 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 as to which the Plaintiffs relied to their detriment.

The Complaints also lodge in the Fifth Count that claims negligent misrepresentation. Karu v. Feldman, 119 N.J. 135, 146-147 (1990), sets forth the elements of a claim for negligent misrepresentation. A plaintiff pursuing such a claim 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 Plaintiffs' Complaints allege that, as to the disputed patient accounts, the Defendants falsely advised the Plaintiffs of the precertification of the treatment and/or the lack of need for the same, and of an agreement or intention to pay forth services to be provided to the patients/insureds. These factual averments are sufficient to establish a negligent misrepresentation. The Complaints also adequately allege that the Plaintiffs reasonably relied on the allegedly false assurances by providing the services on the basis of the same.

The Court finds the Plaintiffs have pleaded the circumstances of such misrepresentations as to the disputed patient accounts with the requisite particularity. The Complaints read as a whole set forth the specific nature of the misrepresentation and the approximate time – the date of service – when it was given. The Complaints specifically allege facts going to reliance on the alleged misrepresentation via allegations of performance of services for each patient/insured. The Plaintiffs may, of course, be required in discovery to supply additional pertinent information as to each individual disputed patient account.

The Complaints also purport to state claims in the Sixth Count for interference with prospective economic advantage. To state a claim for tortious interference with prospective economic advantage, 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. 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 Plaintiffs. The Complaints allege facts from which one may glean a claim for interference with such relationships arising from the Defendants' alleged precertification 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 Plaintiffs claim is due.

The Complaints also set forth facts supporting their assertion that the Defendants acted intentionally, without justification, and with improper purposes. As noted earlier, the Complaints allege the Defendants systematically downgraded the emergency services, exposing the patients/insureds to balance billing and resulting in gross underpayments to the Plaintiffs. They allege 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 Plaintiffs.

The Seventh and Eighth Counts lodge claims – asserted as implied private rights of action – under New Jersey statutes and regulations. The Plaintiffs purport 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 Plaintiffs allege 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 Plaintiffs' 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 11:24–9.1D. 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 Plaintiffs are 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 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 Plaintiffs are intended beneficiaries 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.

The Court concludes at this juncture that the Complaints state a private right of action under the cited statutes and regulations for reimbursement of unreimbursed costs for providing emergency services to at least some of the Defendants' insureds. Parenthetically, the Court also notes that, at minimum, the Complaints allege 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 Plaintiffs and the Defendants.

As this motion involves a comprehensive challenge to all of the Counts of the Complaints 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 Plaintiffs have 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 that 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 Plaintiffs allege 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 2 -- 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 Plaintiffs' statements within a specified time period. It further alleges that overdue payments bear simple interest under such statutes and regulations of 12 percent per annum pursuant. Indeed, N.J.S.A. 17B:27–44.2D9 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 Plaintiffs here, are certainly among the parties whom statute is intended to protect or benefit, in addition to the protection of the general public interest. It appears 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 Plaintiffs have stated a claim for relief under the cited statutory and regulatory framework, and that the statute appears to evince 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.