2018 WL 3579463 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Civil Part
Essex County

MHA, LLC, Plaintiff,
v.
EMPIRE HEALTHCHOICE HMO, INC., et al., Defendants.

No. ESX-L-5041-17.
June 23, 2018.

Transcript of Decision

Eric D. Katz, Esq., (Mazie, Slater, Katz & Freeman, LLC), for the plaintiff.

Matthew J. Aaronson, Esq. and Amanda L. Genovese, Esq. (Troutman Sanders, LLP), for the defendants.

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Keith E. Lynott, Judge.

***1** Place: Essex County Superior Court

Historic Courthouse

470 Dr. Martin Luther King, Jr. Blvd.

Newark, New Jersey 07102

Date: June 18, 2018

BEFORE:

THE HONORABLE KEITH E. LYNOTT, J.S.C.

TRANSCRIPT ORDERED BY:

INDEX

THE COURT: All right. Good morning, everyone. This matter is *MHA, L.L.C., d/b/a Meadowlands Hospital Medical Center versus Empire HealthChoice HMO, Inc., Empire HealthChoice Assurance, Inc*. It is L-5041-17.

Pending before the Court is a Motion to Dismiss the complaint brought by the defendants. The Court previously heard oral argument in this matter and will now render an oral decision.

Parties are present on the telephone. Can we go around the virtual room and have everyone identify themselves?

MR. KATZ: Yes. Good morning, Your Honor. Eric Katz, of the law firm of Mazie, Slater, Katz & Freeman on behalf of the plaintiff.

THE COURT: Very well. Good morning.

MS. GENOVESE: Good morning.

MR. AARONSON: Good morning, Your Honor. Matthew Aaron- -- Matthew Aaronson and Amanda Genovese, from Troutman Sanders, on behalf of the defendants.

THE COURT: All right. Good morning to both of you.

Sorry to have had to reschedule this a couple of times. It was my intention to give you a -- a decision as quickly as possible and due to scheduling issues, I did have to carry it a couple of times. I probably could have, I mean --

COURT STAFF: I think there is another attorney on the phone.

THE COURT: Is there another -- well, someone else on the phone? I'm sorry. I didn't -- didn't mean to -- there is no one else on the phone. Is that correct?

MR. KATZ: I think that's it, Judge.

THE COURT: Yes. That -- that's what I thought. Okay.

COURT STAFF: I'm sorry. I thought I heard somebody else.

THE COURT: All right. As -- as I said, I probably could have converted my handwritten notes here in that interceding period into a -- a written opinion, but I kept thinking that those dates would hold. So I apologize for any inconvenience.

Just so you're clear. I think I asked my secretary to alert you to this. This probably will take some time. So I hope you're all in a place where you can -- want to listen in and -- and do so -- do so comfortably. I -- if you can't hear me at any time, please don't hesitate to interrupt and let me know about that and I'll try to fix that.

All right. As I said, pending before the Court is a motion by the defendants, Empire HealthChoice HMO, Inc. and Empire HealthChoice Assurance, Inc., whom I will collectively refer to in this opinion as Empire, to dismiss the complaint of the plaintiff, MHA, L.L.C., which I -- I will refer to as either the plaintiff or MHA. The application seeks to dismiss the complaint in its entirety, pursuant to *Rule* 4:6-2e.

The plaintiff, MHA, is a limited liability company that at times relevant to the complaint owned and operated the Meadowlands Hospital Medical Center, a New Jersey based licensed general acute care hospital. In the complaint, MHA alleges that it is an out-of-network provider of hospital services in relation to Empire, which insures or administers health insurance plans for its subscribers.

***2** In essence, MHA asserts that as to some 2,935 Empire subscribers, it provided preauthorized, medically necessary services or emergency services. MHA asserts that it submitted statements to Empire for payment and that Empire systematically and consistently underpaid such statements.

MHA asserts that as of April 2017, it had submitted bills to Empire totaling $43,498,128.88, against which Empire paid $4,570,620.81.

MHA seeks the unpaid portion of its statements and other relief under a variety of contractual, quasi-contractual and tort theories, as well as under statutory and regulatory provisions of both New York and New Jersey law.

Empire moves against the complaint on a variety of grounds. It asserts that contrary to the averments of the complaint, MHA is in actuality an in-network provider as to Empire and subject to agreed upon rates and schedules for payment. It asserts that the plaintiffs, insofar -- the plaintiff's claims, insofar as they relate to health insurance plans that are subject to ERISA are in their entirety subject to express preemption, pursuant to ISRA [sic] -- ERISA Section 514A, 29 *U.S.C.*, Section 1144.

The defendant asserts, based on its examination of the patient claims as to which the plaintiff is seeking relief that the vast majority, in excess of 2,000 such claims, involve plans that are subject to ERISA.

The defendant asserts that the plaintiff has, for a variety of reasons pertinent to each count, failed to state a claim upon which relief can be granted as to each of the ten counts of the complaint. It assets that the plaintiff is barred in whole or in part from the relief it seeks under the applicable statute of limitations on grounds of laches and under the Economic Loss Doctrine.

It also asserts that -- that as to any counts that survive, the Court should require a more definite statement of the factual averment supporting each such cause of action as it contends the facts -- the factual averments as presently -- as they presently stand are insufficient to place the defendant on notice of what it is alleged to have done wrong and -- and -- and to permit it to plead in response and defend the action.

It should be noted at the outset that MHA has recently completed the sale of Meadowlands Hospital Medical Center. However, it asserts that in connection with the transaction, it retained the claim that is the subject of this action.

The complaint contains 113 paragraphs and, as noted, ten separate counts stating causes of action for relief. Attached to and incorporated in the complaint is a listing of each open patient account that is the subject of this action, identifying the Empire ID number, the patient's initials, the admit and discharge date, the amount billed and the amount outstanding and the policy number.

The plaintiff contends the complaint provides an ample factual basis for each of the causes of action asserted. The defendant contends that the length of the complaint and number of paragraphs notwithstanding none of the counts survives *Rule* 4:6-2e scrutiny.

The Court notes that this is a direct action by the provider against the payer. MHA is suing, in its own capacity as provider, and not in a derivative capacity as holder of an assignment or assignments from the Empire subscribers.

The plaintiff seeks relief for 200 -- 2,935 open patient accounts. It recites that 1,416 such accounts involved emergency room care in respect to which plaintiff asserts Empire was and is required to pay 100 percent of the billed charges.

***3** It asserts that 1,519 accounts involved inpatient/outpatient rehabilitation and same day surgery, in respect of which it asserts it obtained preauthorization approval and/or consent from Empire to render the services in return for a promise of payment of its usual, customary and reasonable charges for such services.

Briefly reviewing the complaint, the Court notes the following.

The complaint alleges that at all times the plaintiff was an out-of-network or nonparticipating healthcare provider regarding Empire. It con- -- it asserts that Meadowlands 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.

It asserts that after rendering the services reflected in the open patient accounts, that Meadowlands -- what the Court is referring to as MHA is referred to as Meadowlands in the complaint -- timely filed clean claims for reimbursement; that prior to rendering several of the services reflected in -- in the open patient accounts, Meadowlands contacted Empire to request and was provided by Empire with preauthorization or precertification to render the services; that it relied on such preauthorization and precertification as Empire intended in agreeing to render the services. However, when bills were submitted, Empire refused proper payment.

The complaint further alleges Empire advised Meadowlands in certain cases that prior to rendering services, that preauthorization was unnecessary as the services were emergent or urgent. However, when Meadowlands submitted its bills in these instances Empire also refused payment, contending the services were not emergent.

It goes on to allege that in other instances Empire indicated through word and deed that there was coverage for the initial treatment and, in fact, paid for such treatment, but without notice, refused to provide reimbursement for subsequent related treatment which should have been recovered and is the subject of the continuing care provisions of Empire's plans.

It further contends that upon receiving Meadowlands bill, Empire agreed to reimburse Meadowlands for services rendered in certain cases. However, it subsequently refused to honor its payment agreement.

The complaint avers that at all relevant times with respect to the open patient accounts, the defendants provided the patients with out-of-network coverage, emergency services coverage, and/or authorized the services rendered, permitting the patients to seek treat- -- treatment from Meadowlands and that pre-authorization or approval is not required when an out-of-network provider is provi- -- is rendering emergency or urgent or related services.

The complaint recites it under applicable provisions of Federal and New Jersey law. Meadowlands was, like other hospitals, required to render emergency treatment to any patient entering the hospital, regardless of their ability to pay and regardless of the kind of health insurance they may have, and that Empire purposely availed itself of plaintiff's obligation under applicable law to coordinate and implement a systematic scheme of underpaying Meadowlands for the hospital and medical services it rendered to thousands of members and dependents of the defendant's plans.

It asserts similar obligations exist under New Jersey and under New York law. The complaint avers that the defendants engaged in a systematic practice of downgrading coverage by a variety of methods, including down coding and bundling of claims submitted by plaintiff, as well as the issuance of coverage denials to plaintiffs after they were admitted to hospital emergency room or before emergency or urgent treatment was completed.

***4** It alleges that Empire conducted itself in this manner without the benefit of sufficient medical or clinical information from attending physicians. It contends that in other cases, while the patient was being treated in the hospital, Empire would send correspondence to the patient's home, to the attending physician, or to others, indicating that the patient may be safely transferred to another participating facility for continued care without consulting the attending physician. And

that in other cases patients were advised that they should be aware that when electing to receive treatment from a non-participating hospital, they were likely to incur substantially higher out-of-pocket financial liabilities and other costs.

The -- the complaint alleges that Empire engaged in these practices, knowing that emergency services when rendered in an emergency room or following admission to the hospital are not considered elective by the patient, but rather are services obtained because the patient seeks immediate med --medical attention for a problem perceived to be a serious threat to the patient, including the threat of severe pain.

And the complaint further avers that the invoices for statements were not paid in a timely manner, in accordance with the *Health Information Networks and Technologies Act and Health Claims Authorization Processing and Payment Act*, statutory requirements that prescribe certain deadlines for either contesting or paying the amounts of a statement.

The complaint avers that with respect to open patient accounts is a matter of regular business practice. Meadowland engaged in regular communications and discussions with Empire regarding coverage, reimbursement, negotiation of disputes and other issues, that it submitted claims directly to the defendants, that they were processed by the defendants, and the defendants, when issuing underpayments, there was accompanying an Explanation of Benefits submitted to -- directly to Meadowlands and that Meadowlands subsequently undertook and engaged in numerous appeals of the defendant's reimbursement and payment decisions.

The complaint alleges that the com- -- that the matters asserted in the lawsuit dispute the reimbursement amounts paid by the defendants and, thus, do not arise or implicate Federal subject matter jurisdiction under ERISA or any other Federal or statutory scheme.

The -- the pleading asserts that the plaintiff's complaints go to the amount of coverage owed to the patients and -- and the defendant's failure to properly reimburse the plaintiff for its services as to those patients. It asserts that the action presently pending does not in any way implicate the actual plans at issue or provide coverage. The plans at issue are the scope or nature of the coverage afforded by those plans and, thus, does not require the Court to examine such plans as part of its adjudication.

The First Count of the Complaint purports to state a claim for breach of an implied contract. It asserts that the Empire represents to its members and beneficiaries that they're covered for out-of-network treatment and/or emergency care, that they may go to any hospital or 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 a in-network level.

It avers that Empire was paid premiums by those subscribers for out-of-network healthcare coverage, including such emergency services coverage and the services of Meadowlands were necessary to satisfy the needs of Empire's subscribers.

It further avers that Empire indicated through a course of conduct, dealings and circumstances surrounding the relationship that the defendant would pay the plaintiff its usual, customary and reasonable amounts based upon what other healthcare providers of the same specialty and the same geographic area charge for services rendered by Mead-- Meadowlands.

***5** It alleges that Empire indicated by dealings and circumstances surrounding the relationship that it would honor representations to Meadowlands if the services rendered were preauthorized or precertified or representations that preauthorization was not required due to the need for urgent or emergent care, and the pay -- the payment agreement to correctly pay for services that are medically necessary.

The Second Count of the Complaint purports to state a claim for breach of the covenant of good faith and fair dealing, alleging that the defendants, in breaching their contractual -- implied and, in fact, contractual obligations to the plaintiff acted with an improper motive and injured plaintiff's rights and benefits under such implied, in fact, contract.

The Third Count purports to state a claim for unjust enrichment and quantum meruit, alleging that Empire required the services of Med- -- of Meadowlands to render hospital and medical services, including emergency services, in order to satisfy its legal and contractual obligations to its subscribers. It asserts that the defendants have, as a result of the services the plaintiff provided, received and retained a benefit because the plaintiff rendering hospital and medical services for which the defendants have underpaid.

The Fourth Count asserts a claim for a promissory estoppel, asserting that Empire made promises to Meadowlands that proper coverage for hospital and medical services would be afforded to members of its plans, including by preauthorizing or precertifying services or paying for initial care and then subsequently refusing to pay when bills were submitted.

The Fifth Count alleges a claim for negligent misrepresentation, asserting that Empire negligently represented that it would provide proper coverage to the patients and thus correctly pay the claims, including by way of preauthorization or by paying for initial care and then subsequently refusing payments for bills submitted by Meadowlands.

It asserts that Meadowlands reasonably relied on representations as to preauthorization and/or payment by -- by Meadowlands in connection with those services. It asserts that such representations were false and that Empire materially made -- materially misrepresented that the defendant's plans entitled the patients to receive coverage for the hospital and medical services provided by the plaintiff.

The Sixth Count purports to state a claim for interference with economic advantage, alleging a reasonable expectation of economic advantage to the plaintiff arising from the patient/provider relationship. It alleges that Empire knew or reasonably should have known of that expectancy of economic advantage in that the defendants wrongfully interfered with that expectancy of economic benefit in circumstances in which it is reasonably probable that the plaintiff would realize such benefit.

The Seventh, Eighth, Ninth and Tenth Counts state -- purport to state causes of action under either applicable New Jersey statutory and -- and regulatory provisions, or New York statutory and regulatory provisions. In each case, the plaintiff purports to assert a private -- to have and to assert a private cause of action under such statutory and regulatory framework.

In Count Seven, the plaintiff alleges a cause of action grounded in statutory and regulatory provisions obligating -- obligating a payor to notify subscribers that they're entitled to have access to emergency services and that pursuant to such regulations when a privately insured patient seeks emergency services an out-of-network providers must be paid a large enough amount to ensure that the patient is not balance billed and, as noted, asserts a right to enforce such provisions on a private -- in connection with a private cause of action.

***6** On -- on the basis of such regulatory --statutory and regulatory framework, the complaint alleges that Empire is obligated to pay Meadowlands 100 percent of plaintiff's UCR fees incurred for providing hospital and emergency room care to Empire subscribers.

The Eighth Count states or purports to state a claim under the *Healthcare Information Networks and Technologies Act*, as amended by the *Health Claims Authorization Processing and Payment Act*, asserting that such laws promulgated regulations thereunder, establish a time period within which a -- a provider's bills must be either paid or challenged. The plaintiff asserts that under such laws and regulations it has a private right of action to prosecute its claims. That the payments due under the invoices are now overdue and according to the application of such laws and regulations now

bear simple interest at a rate of 12 percent per annum, pursuant to applicable law. And each -- the -- the -- the Eighth Count seeks to enforce such right to simple interest at the statutory --statutorily established rate.

The Ninth and Tenth Counts seek or purport to seek relief under similar provisions of the New York healthcare statutory and regulatory schemes, both in connection with the provision of out-of-network emergency services to the defendant subscribers and under New York version of Prompt Pay laws.

As this is a Motion to Dismiss the complaint, the applicable legal standard governing the Court's consideration of such motion is set forth in *Printing Mart-Morristown versus Sharp Electronics Corp*. which is at 116 N.J. 739, 746 (1989). There, at page 746, the Court specifically stated as follows, and I quote, "We approach --" -- I -- I quote with omission of citations and/or internal quotation marks.

"We approach our review of the judgment below mindful of the test for determining the adequacy of a pleading, whether a cause of action is suggested by the facts. In reviewing a complaint dismissed under *Rule* 462e, our inquiry is limited to examining the legal sufficiency of the facts alleged on the face of the complaint. However, a reviewing court searches the complaint in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned even from an obscure statement of claim, opportunity being given to amend, if necessary. As --at this preliminary stage of litigation, the Court is not concerned with the ability of plaintiffs to prove the allegation contained in the complaint. For purposes of analysis plaintiffs are entitled to every reasonable inference of fact. The examination of a complaint's allegations of facts required by the aforesaid principle should be at -- one that is one painstaking and undertaken with a generous and hospitable approach.

In *Smith versus SBC Communications, Inc*., 178 *N.J*. 265, 268, 269 (2004) the Court also stated that in examining a Motion to Dismiss the trial court is required to accept as true all allegations of the complaint.

The first ground for dismissal lodged by the defendant Empire is that MHA is, in fact, an in network provider of medical services as to Empire. As noted, this is an essential allegation of the plaintiff's complaint, namely, that it is an out -- that it is an essential allegation of the plaintiff's complaint that it is an out-of-network provider as to Empire.

***7** The defendant asserts that the opposite is true. It contends that the plaintiff is, in fact, an in network provider and its status as an in network provider undermines the entire basis of the complaint. For example, because Empire contends MHA is an in network provider. It asserts that MHA is subject to negotiated contractual rates and schedules for payment. As such, it asserts that -- that the plaintiff cannot pursue claims in im- -- in implied and quasi-contract stating contractual principles in terms that are different from those embodied in the express contract that governs an in network provider.

Distilled to its essentials, Empire's contention is at -- is as follows. MHA is undeniably an in network provider of Horizon Blue Cross Blue Shield of New Jersey. It -- the -- the -- Empire further contends that Horizon, although a nonparty to this case, is a licensee of the Blue Cross and Blue Shield Association and participant in the Blue Card Network pursuant to the Blue Card Program.

According to Empire, under this program out-of-state Blue Cross Blue Shield licensees, such as Empire, have access to Horizon's provider network in New Jersey at the rates negotiated by Horizon when paying claims with participating providers. Thus, according to Empire, when MHA provided emergency or other hospital services to Empire subscribers it did so on an in network basis as Empire, through its affiliation with Horizon is the Blue Cross Blue Shield Association has access to Horizon's in network providers and the concomitant rights and schedules that apply as between Horizon and its in network providers, including in this case, MHA.

Empire contends that the foundational allegation of the plaintiff's complaint is its out-of-network status. As it asserts this allegation is factually untrue, it contends the complaint falls of its own weight in its entirety.

Empire relies upon material extrinsic to the four corners of the complaint to establish the truth of its claim that MHA is, contrary to allegations of the complaint, an in network provider. It refers the Court to an acknowledgment by MHA in regulatory filings relating to its sale of the hospital, stating that it had recently renegotiated its in network contracts with Horizon.

It refers to content on Horizon's webpage indicating that Meadowlands Hospital Medical Center is in network. It refers to content on Empire's webpage also referring to the hospital as in network. It refers to other extrinsic materials that it contends demonstrate the manner in which the Blue Cross Blue Shield reciprocity arrangements function.

As Empire does not possess the actual contracts it alleges established plaintiff's in network status it actually attempted, prior to answering the complaint, to subpoena the same from Horizon. The Court quashed the subpoena as premature under the circumstances.

Empire asserts the Court can and should look beyond the complaint to these extrinsic materials it has adduced. It contends that plaintiff has intentionally omitted any reference to its status as an in network provider for Horizon in order to enable it to proceed with a complaint that Empire asserts rests on a demonstrably false factual premise.

The plaintiff contends the Court may not look beyond the factual averment in the complaint -- that is an out-of-network provider as to Empire. Instead it contends it is well-established in our law that the Court must at this early procedural juncture accept as true the averment that MHA is an out-of-network provider and must grant MHA all reasonable, favorable inferences that may be drawn from the complaint.

***8** MHA points to Empire's effort to subpoena the Horizon MHA contractor contracts as evidence that the question of MHA status (inaudible) as in network as to Empire is per force a disputed fact that can only be resolved after discovery.

Empire's position requires the Court to examine the body of case law that has developed over time, establishing certain limited circumstances in which a Court confronted with a Motion to Dismiss can examine extrinsic materials and grant a Motion to Dismiss if it determines that such extrinsic documents are materially at odds with factual allegations lodged in the complaint, rendering the complaint and the causes of action advanced there and unsustainable as a matter of law.

The most obvious circumstances, material actually attached to the complaint itself and to which the pleading party refers in the body of the complaint. But courts have, in certain cases, examined materials not attached to the complaint as well. See *Banco Poplar North America versus Gandhi*, 184 *New Jersey* 165 (2005). In that case, the claim asserted against a lawyer by a bank, alleging that the lawyer issued a false opinion letter to the bank on behalf of a client and a -- a borrower or guarantor of a loan.

The Court reversed the Appellate Division and reinstated a complaint previously dismissed for --alleging negligent misrepresentation. The Court in that case stated that a trial court may examine extrinsic materials that "form the basis for the claim, quoting *Lum v. Bank of America*, 361 *F. 3rd*, 217. Cert. denied, F. -- or -- *Third Circuit*, Cert. denied, 543 *U.S.* 918 (2004).

Here the materials at issue are manifestly not the basis for the plaintiff's claim as it contends it is an out-of-network provider. Instead, the materials to which the plaintiff points appear to the Court to be the basis for a demurrer -- a demurrer or a defense. In *Lum versus Bank of America*, *Super*. 361 *F. 3rd* 217, the Court examined a mortgage and credit card agreements of the named plaintiffs in a class action and determined that, contrary to allegations of the complaint, these agreements on which the plaintiffs were clearly relying to establish the entitlement to relief did not expressly define the prime rate as a rate given by the lender to its most creditworthy customers.

In that -- in that case each of the plaintiffs had entered into either a mortgage agreement or a credit card agreement with the lender and were contending that each of those agreements provided for a prime rate plus of -- of -- of interest charges and alleged that those agreements established that the prime rate was the rate given by the lender to its most creditworthy customers.

As the plaintiffs were relying explicitly for -- as a basis for their cause of action on the unattached mortgage agreement and/or credit card agreements, the Court examined those agreements in the course of disposing of a Motion to Dismiss and determined that, in fact, those agreements were at odds with the allegations of the complaint.

In so holding, the Court noted as follows at pages 221, 222. The amended complaint then identifies three financial transactions, pursuant to which the named plaintiffs obtained financing at a prime plus interest rate. The plaintiffs did not attach the agreements documenting these three transactions, but the defendants provided copies of the agreements in support of their Motion to Dismiss.

***9** In a footnote, the Court went on to state as follows. When plaintiffs do not -- while plaintiffs did not attach this credit agreement to the complaint, they do not dispute that the District Court properly considered the agreement. In deciding Motions to Dismiss pursuant to *Rule* 12B6, which is the equivalent of the New Jersey rule, I add parenthetically (462E) courts generally consider only the allegations of the complaint, exhibits attached to the complaint, matters of public record, and documents that form the basis of the claim, citing to *In re Burlington Coat Factory Securities Litigation* 114 *F. 3rd* 1410, 1426, (Third Circuit 1997), *Pension Benefit Guaranty Corp. versus White Consolidated Industries, Inc.*, 998 *F. 2nd* 1192, 1196 (Third Circuit 1993). A document forms the basis of the claim if the document is integral to or explicitly relied upon in the complaint, citing *Burlington Coat Factory Securities Litigation* 114 *F. 3rd* at 1426.

The purpose of this rule is to avoid the situation where a plaintiff with a legally deficient claim that is based on a particular document can avoid dismissal of that claim by failing to attach the relied upon document. Citation omitted. Further, considering such a document is not unfair to the plaintiff because by relying on the document the plaintiff is on notice that the document will be considered.

In the present case there is no dispute that the credit agreements are integral to and relied upon in the complaint and for the reasons noted the Court felt it appropriate to examine those documents as the plaintiffs were relying upon them to establish their right to relief and determined based upon his review of those documents that they were fundamentally at odds with the factual averments of the complaint.

Empire relies upon a series of Second Circuit cases, including *Chambers versus Time Warner, Inc.*, 282 *F. 3rd* 147 (Second Circuit 2002) for the proposition that the Court may also consider extrinsic matter if the pleader "knows about it and intentionally chooses to disregard it". It states then a moving defendant may also rely on that extrinsic matter in moving to dismiss.

In *Chambers*, the Court actually concluded that the District Court had improperly relied on extrinsic materials. The Court determined in the case involving alleged copyright violations as to a recording rights contract by various artists, alleging that the process of digitizing and distributing digitized versions of the plaintiff's work violated --was -- violated the contract and violated statutory rights of the plaintiff. The Court examined not only the recording contract but also examined certain other materials referred to as AFTRA codes, which essentially as describing by the Court were certain -- and in this case they were unsigned, but certain Union based codes establishing certain basic terms for a recording contract.

But in that context, the Court noted that the standard, that is, the standard by which a Court may examine extrinsic materials has been misinterpreted on occasion. We reiterate here that a plaintiff's reliance -- and that is underscored in

the opinion --on the terms and effect of the document in drafting the complaint is a necessary prerequisite to the Court's consideration of the document on a dismissal motion. Mere notice or possession is not enough.

In a footnote the Court goes on to cite a variety of Federal Circuit cases. I -- I -- I don't cite them here, except to note that in the footnote the Court distills from each such opinion references by the respective Court to referring to extrinsic materials that are essential to the claim on which the plaintiff's complaint necessarily relies, that are integral to or explicitly relied upon in the complaint, where the complaint is based on the document.

***10** In this case the Court noted that the -- at page (pauses) -- excuse me one moment -- (pauses) page 154, 155 of its opinion that although the text of the code suggests that they might have been incorporated into the contracts the record does not indicate whether this actually occurred. Consequently, the codes are not -- were not part of the amended complaint. Further, the parties disagree as to whether and how the codes relate to or affect the contractual relationships at issue. One possibility is that they were irrelevant. Another is that they were intended to modify the recording contracts.

Here, as in the *Chambers* case, the plaintiff did not rely on the extrinsic materials noted. Moreover, given the liberal standard the Court is required to apply in examining the complaint, the parties may be taken to disagree fundamentally over whether MHA is in network as to Empire by virtue of the operation of the Blue Card system.

Moreover, on the basis of the record be- --presently before the Court the parties as -- as in *Chambers* disagree over whether and how the interconnected contractual arrangements as between Horizon and its -- its Blue Cross Blue Shield licensees relate to or affect the contractual relationships at issue.

It simply is not possible to determine on the circumstances of this record, nor could -- should the Court examine these extrinsic materials, given the fact that they do not form, in the Court's assessment, the reading of the plaintiff's claim, matters that are central to the plaintiff's claim, that are necessarily relied upon by the plaintiff, that are integral to or explicitly relied upon in the complaint. *Cortec Industries, Inc. versus Sum Holding, LLP*, 949 *F. 2nd* 42 (1991), on which the defendants also rely is -- is -- is not -- is not apposite here. There a plaintiff in a matter involving alleged securities fraud sought relief against Westinghouse as a seller of the shares of stock that were at issue in the case.

The Court -- the plaintiff clearly relying upon the underlying stock purchase agreement, the Court determined that it was possible to examine the terms and conditions of the stock purchase agreement on which the plaintiff explicitly relied as the fundamental basis for its right of action alleging misrepresentations in that stock purchase agreement.

In examining that agreement the Court determined that in connection therewith Westinghouse, in fact, was not a direct seller to the plaintiff of its shares. Instead, it held a warrant for the purchase of shares and in the context under the stock purchase agreement and in the context of the transaction it actually tendered those warrants back to the, the, the companies whose shares were sold in return for consideration and thus was not paid for either the warrants or any shares directly by the plaintiff and thus was, for purposes of the statutory causes of action alleged, not a seller of stock.

The Court derived that principal at odds with the allegations of the complaint permits examination of the stock purchase agreement on which the plaintiff in that case explicitly relied.

Here the plaintiff alleges it is an out-of-network provider. It plainly has not referred to, incorporated by reference, or otherwise relied upon the contractual arrangements with Horizon and/or the interconnected agreements among Horizon and the other Blue Cross Blue Shield licensees, including Empire, as the basis for its complaint. Indeed, as noted, the opposite is true.

On the basis of the complaint, the allegations of which the Court must accept as true, the plaintiff manifestly disputes the claim that it is an in network provider as to Empire. In the circumstances the Court is not permitted to rely upon

such agreements and it is not permitted at this early juncture to resolve the factual dispute or to test the plaintiff's ability to prove its out-of-network status.

***11** Here, as well, the circumstances are considerably different from the cited cases in that the Horizon agreement, and the agreements that establish the alleged reciprocity among Blue Cross Blue Shield licensees are not even in the motion record. Instead, the defendants ask the Court to infer the in network fact from the fact that the plaintiff appears to be an in network provider as to Horizon and Horizon and Empire are part of the Blue Cross Blue Shield umbrella organization. But the Court certainly cannot make this leap, particularly on a Motion to Dismiss. There is no way of knowing on this record the precise manner in which the Blue Card Program works and whether and how its reciprocity provisions, whatever they are, do or do not apply to the -- the circumstances here.

The Court does recognize the question of MHA status as an in or out-of-network provider is a threshold matter, insofar as the plaintiff's theories of liability are concerned, and accordingly, although it declines to dismiss this complaint on the basis of the defendant's contention that the plaintiff is, in fact, an in network provider, following the disposition of this motion and the filing of an answer it will promptly convene a Case Management Conference to determine if it is appropriate to conduct discovery in a phased manner such that -- such that the question of an in versus out-of-network status is examined first.

The plain- -- the defendant also contends that the allegations and the claims lodged in the complaint are subject to ERISA express preemption. Pursuant to section 514 of ERISA with respect to those plans -- among the plans on which the plaintiff pre- -- predicates its complaint that are subject to ERISA. Empire asserts that all of the claims that form the subject matter of the plaintiff's action "relate to" such ERISA covered plans in a manner and to an extent it requires a determination that such claims are preempted. Indeed, Empire asserts that its investigation to date establishes that 2080 of 2900 claims "relate to" ERISA-governed health benefit plans.

The plaintiff counters that its claims do not relate to any such ERISA covered benefits plans. It asserts in its complaint that in seeking reimbursement from Empire for underpayment of submitted claims plaintiff 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, including the ERISA subject plans, or any ERISA subject 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 notes that this is a direct claim against Empire and not a derivative claim based upon an assignment from the patients that asserts that it is not therefore suing in a capacity as beneficiary under any ERISA subject plans.

Section 514A 29 *USC*, section 1114, provides in pertinent part, that the provisions of this subchapter and subchapter 1111 of this chapter shall supersede any and all State laws insofar as they relate to any employee benefit plan described in section 1003A of this title and not exempt under section 1003B of this title. Except 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.

The Court concludes that it is premature at this early juncture to determine whether all or any aspect of plaintiff's claim is subject to five --section 514A, express preemption. Courts have recognized that ERISA section 514A, preemption, does have limits. The Supreme Court in *NYS Conference of Blue Cross and Blue Shield plans versus Travelers Insurance Co*., 514 *U.S.* 645, 655 (1995) has stated that it declines to apply quote "uncritical literal --literalism" to the statutory phrase "relates to" instructing courts to examine the objectives of the ERISA statute in determining what State law would survive preemption analysis.

***12** In In re Rag- -- *In re Reglan Litigation*, 226 *New Jersey* 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. The New Jersey Supreme Court has also held that preemption is a "fact sensitive endeavor." *R.F. versus Abbott Labs*, 162 *New Jersey* 596, 619 (2000).

Here the defendant alleges that it has investigated the underlying patient claims and determined that more than 2,000 of 2,900 claims involve ERISA subject health benefit plans. However, the Court finds that it can not accept the assertion on a Motion to Dismiss. Even assuming a large number of the underlying claims do involve such ERISA subject plans, it is not at all clear at this juncture that as to such claims the plaintiff's causes of action are necessarily preempted.

As noted, the plaintiffs are suing in a direct capacity. It is not suing as or in the shoes of a beneficiary. In its capacity as provider its claims may not even be cognizable under ERISA.

The plaintiff points to a body of case law, including *Memorial Hospital System versus Northbrook Life Insurance Co*., 902 [sic] *F. 2nd* 236, (Fifth Circuit 1990), holding in cases involving alleged misrepresentation by a health insurer to a provider of the existence of coverage for a patient seeking treatment from the provider. That the -- that preemption would not serve the statutory purpose of protecting employees.

In that case the Court noted that application of preemption to bar a State law claim by the provider would or could lead providers as a practical matter, to insist on prepayment or other inconveniences, rather than accept the risk of nonpayment. The Court also noted 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. *Memorial Hospital*, 904 *F. 2nd* 236, 244, 246 24 -- to 248, 250.

See also *The Meadows versus Employers Health Insurance*, 47 *F. 3rd* 1006, 1008-1110, (Ninth Circuit 1995) noting the courts have held that ERISA does not preempt a third-party independent State law claims against a plan precisely because those claims do not relate to the administration of the plan.

McCall v. Metlife Insurance Co., 956 *F. Sup*. 1172, 1186, (District of New Jersey 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 Hospital versus NJ* Builders [sic] *Building Labor Statewide Welfare Fund*, 4031 *N.J. Super*. 446, 45 -- 5-58, Appellate Division, Cert. denied, 216 *New Jersey* 366, 213, the Appellate Division cited *Memorial Hospital* with approval and stated that preemption does not occur if the State law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.

***13** In *St. Peter's* the Court did conclude that a claim brought by a plaintiff against a Welfare Fund seeking additional remune- -- remuneration, contending that the defendants had violated a contractual undertaking with a third-party to which the Welfare Fund had subscribed, affording a certain discount for timely payments, was not complied with, the Court noted that although -- and this is at page 455, going on to 456. Although ERISA preemption is clearly expansive, to interpret the language to its further extent would render the reach of the provision limitless. Therefore -- citations and internal quotations omitted. Therefore, preemption does not occur if the State law has only a tenuous, remote or peripheral connection with covered plans, as is the case with many laws of general applicability, as noted.

A State law, the -- the Court in that case, although noting the limitations on ERISA preemption analysis, determined that in that particular case, the plan, the -- the claim was preempted. Having concluded that in order to adjudicate the hospital's claims the Court would be required to examine and consult the terms of the ERISA plan to determine whether the Fund was liable under either State law cause of action --those causes of action. I note parenthetically being -- stating -- sounding in breach of contract and unjust enrichment.

If the court were to determine that the hospital was entitled to an additional payment it would mean that a benefit must be paid from the plan. This is all at page 460 going on to 461. And before a benefit could be paid an inquiry into the plan would be required to determine such ter- -- such items as whether the benefit was covered, the amount of the copayment, the amount of the deductible, whether the plan was primary and secondary, whether Medicaid coverage is available for purposes of the coordination of benefits and the cap on benefits to calculate the benefit due to the hospital.

Accordingly, the Court said we are convinced that the -- the claims are neither tenuous nor peripheral, but rather clearly relate to the ERISA plan within the intendment of the statute and are expressly preempted, but the Court reached those conclusions on a Motion for Summary Judgment after discovery.

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 of the terms and conditions of end -- any underlying ERISA subject plans, but only a determination of the amount of reimbursement to which it is owed. It claims under various legal theories that its dealing with Empire resulted in an independent obligation on Empire's part to pay for services provided to Empire subscribers. It alleges this obligation arose from an independent contract, implied in fact, from quasi-contract based on a promise to pay for a benefit conferred. Or as in the cases -- in cases like *Memorial Hospital*, based upon negligent misrepresentation as to the coverage afforded to the plan subscribers or under statutory or regulatory provisions to which Empire is allegedly subject.

In all events MHA asserts its rights do not derive from the underlying plan but are peripheral to the terms and conditions of such plans and adjudication of its claims will therefore not require the Court to delve into the terms and conditions of such plans.

The Court concludes a more complete record must exist before it can take up the issue of IS- --ERISA preemption. It must first understand whether and to what extent the underlying claims to which the plaintiff is seeking relief actually involve ERISA subject health benefit plans. It then -- must then explore on a more complete record the question of whether adjudication of the plaintiff's claims bear only a tenuous, remote, or peripheral connection to ERISA-covered plans or whether such plans as in the St. Joseph's case bear a more direct connection to the claims asserted, such that the Court would necessarily be directed to the plan in its adjudication, in which event the claims of the cases such as St. Peter's would be subject to preemption.

***14** So for the present time the Court denies the Motion to Dismiss on grounds of preemption for the reasons stated.

As noted, the plaintiff also challenges each pleaded cause of action on the grounds that the pleading is insufficient to state a cause of action for relief upon which -- for relief up- -- 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 plaintiff has has pleaded facts sufficient to sustain a viable cause of action.

The First Count is a -- alleges a breach of alleged contract. The plaintiff alleges that as of the underlying reimbursement claims the defendant engaged in a course of conduct giving rise to a contractual obligation, implied in fact, to pay the amount subsequently billed by the plaintiff.

Examining the factual connection, --contentions of the complaint in their totality and applying the principle of a liberal reading of the same, the Court finds that as -- that the complaint alleges that as to some open patient accounts the plaintiff contacted Empire and sought and obtain preauthorization approval to render the services. The plaintiff alleges an implied, in fact, agreement by which it agreed to perform services in return for the preauthorized services -- in return for payment of his usual, customary and reasonable charges for some -- for such services.

As to other open patient accounts, the plaintiff alleges that it contacted Empire and was informed that due to the nature of the circumstances, namely, the need for emergent care, it was not necessary to secure preauthorization. The plaintiff alleges an implied in fact agreement in which it agreed to perform and did perform emergency services in return for payment of all billed charges.

The complaint read as a whole provides as well that the plaintiff was legally required under applicable New Jersey statutes and regulations to perform the emergency services and the defendant was legally obligated to pay for the same in sufficient amount so that the plaintiff would not be balance --so that the plaintiff subscribers would not be -- the defendant subscribers would not be balance billed. Plaintiff's complaint also recites facts to the effect that as to some open accounts the plaintiff tendered a bill which the plaintiff agreed to pay, but thereafter failed or refused to do so.

Empire claims that there are not sufficient facts alleged in the complaint to establish mutual assent or a meeting of the minds required to state a claim for breach of contract. That there are not sufficient facts to allege a flow of consideration to Empire from the alleged contractual undertaking. It contends it received no benefit from the services provided by MHA and the only parties, if any, who benefited from the provision of such services were the patient themselves. And further it contends there are insufficient facts alleged as to each of the patient accounts from which to discern the specific terms of the implied in fact contract.

The Court concludes the factual allegations of the complaint read liberally and in their entirety are sufficient to state a claim for breach of an implied contract as to each of the underlying open accounts. The complaint establishes through factual allegations of a course of dealing between the plaintiffs, the existence of a contract, a flow of consideration, breach of the terms of the implied contract arising from the defendant's failure to pay the amounts billed and resulting damages.

***15** The mutual assent discernible from the complaint arises from the factual allegations of the parties' conduct. That is, communications from MHA seeking preauthorization for hospital services to be rendered by MHA, followed by authorization by Empire --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, followed by a performance of the services and demand for payment. The terms of the implied contract alleged involve performance of services by MHA in return for payment of the UCR 100 percent of billed services.

The Court finds the complaint alleges consideration flowing to Empire in connection with the implied contracts as to each such open patient account. The complaint alleges that Empire accepted premiums for subscribers. As to plans of forwarding such subscriber's -- such -- such subscriber's out-of-network benefits and that Empire was legally obligated under Federal and State laws to cover subscribers for emergency services. The complaint alleges that by providing out-of-network services to Empire subscribers, including emergency services, MHA enabled the defendant to satisfy its contractual or legal obligations to those subscribers, affording them out-of-network coverage and a right to out-of-network emergency treatment.

The Court finds that the complaints --contains sufficient factual allegations as to consideration to state a claim as to an implied contract.

Empire cites cases, none of which are controlling on this Court, in which the courts did determine that a party in Empire's position receives no benefit -- when a party in MHA's position receives no benefit -- when -- receives no benefit

when a party in MHA's position provides services for subscribers. The Court in those cases did conclude that the only outcome for the payor in such circumstances was the demand for payment. Such Courts noted that the payor moreover is indifferent as to which out-of-network provider the subscriber actually chooses.

But MHA cites cases decided in other Courts, typically involving claims grounded in quasi-contract or involving -- and involving emer- -- emergency services in which the Court 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 subs- -- subscriber. An example of one such case is *El Paso Healthcare Services versus Molina Healthcare of New Mexico, Inc.* 683 *F. Sup.* 2nd 454, (Western District of Texas 2010), where the Court noted at pages 461, 462 and I quote, "While it is true that the immediate beneficiaries of the medical services were the patients and not Molina, that company did --" -- Molina being the -- the payor -- "--that company did receive and benefit of having its obligations to plan members and to the State in the interest of plan members discharged." Citation omitted.

"Molina describes this discharging of obligations benefit as incidental. But the Court finds this benefit material due to the aforementioned obligations." Citation omitted.

"Indeed, 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." Citation omitted.

"If these obligations are not deemed material and central to the Medicaid managed care scheme how is such a system supposed to function? In sum, these discharges were furnished for the benefit of the Molina which enjoyed and accepted them and Molina even acknowledge as much when it tendered payment for them at a rate it deemed to be proper. Thus prongs two and three have been fulfilled as well is one and four, even though Molina disputes this characterization of the facts."

***16** It is not a significant leap of logic to find that a similar benefit derived -- were the -- was derived where the services provided were not emergency services, but instead, enabled the insurer to satisfy a contractual obligation to permit the subscribers to seek in appropriate cases, out-of-network providers, an obligation that as the complaint alleges was supported by the receipt of premiums as noted in the complaint.

Not as -- as here where the complaint, the Court concludes alleges sufficient facts to state a claim for the existence of a contractual meeting of the minds as to the rendering of service in return for payment is it a quantum leap to conclude that a benefit of this nature is sufficient to establish consideration flowing to the pay or 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 it may --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 discern the terms of the alleged implied, in fact, contract, namely a promise to provide out-of-network/emergency services, as the case may be, in return for a promise to pay the UC or UCR or amount billed. The complaint also alleges specific --specific facts as to each underlying account by detailing the specific account and the patient, the amount billed and the amount outstanding.

The allegations of the complaint viewed liberally thus 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 defendant of what it allegedly did wrong to permit it to answer and defend.

Whether on a full factual record the facts will likewise established a triable claim for breach of an implied contract remains a far different matter.

Count Two purports to state a claim for breach of the covenant of good faith and fair dealing. Having found that the pleading alleges an implied in fact contract, that contract under New Jersey law per force contains in -- as one of its implied terms a covenant of good faith and fair dealing. The plaintiff alleges that the defendant imbued with improper motive has breached the complaint, has breached the covenant of the complaint, 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 as to certain accounts the defendant agreed initially to pay for emergency services, but then refuse to pay for follow-up procedures or treatment without consulting the phy- -- the attending physician. It alleges that as to certain accounts the defendant notified the plaintiff or patient that the patient was well enough to be removed from MHA, also without consulting as alleged the -- the physician, and thereafter refused to pay for subsequent services. The complaint alleges a systematic course of -- of down coding after accepting an obligation to pay in full that support a finding of -- that could support a finding of improper efforts to deprive the plaintiff of the fruits of the implied in fact bargain.

***17** Once again under the P*rinting Mart* standard the Court finds it is possible on a liberal reading of the -- 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 in the complaint.

The complaint also purports to -- to state a cause of action for unjust enrichment and quantum meruit. The elements of a claim for unjust enrichment are that the defendant received a benefit and retention of that benefit would be unjust. *Castro versus NJT* [sic] *Television*, 370 *N.J. Super*. 282, 299 (Appellate Division 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 complaint does state a cause of action for unjust enrichment, quantum meruit -- once again, under the *Printing Mart* standard. Although claims in quasi-contract do not -- do not lie when the party relies on an express or implied contract the plaintiff, as it does here, a plaintiff is permitted under our rules to plead in the alternative, and even to plead inconsistent theories.

As noted, the cause of action requires the plain- -- the cause of action for unjust enrichment or quantum meruit requires the plaintiff to allege that it conferred a benefit upon the defendant and circumstances in which it reasonably expected to be paid for the same or as to which it would be unjust to permit the defendant to retain that benefit.

Although the defendant disputes the existence of a benefit, as noted earlier the Court finds that the pleading alleges sufficient facts concerning the same, namely the performance by the plaintiff of out-of-network and/or emergency services for Empire subscribers that they thereby -- that thereby entitled the latter -- enabled the latter to discharge its contractual and/or legal obligations to those subscribers by permitting the subscribers to obtain such out-of-network or and/or emergency services.

At least at this early juncture, and under the *Printing Mart* test, the Court concludes that the facts pleaded are sufficient from which to glean the fundament of a cause of action for quasi-contractual relief.

The complaint also purports 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 versus O'Callaghan*, 357 *N.J. Super*. 488, 499 (Appellate Division 2003). Here again, the facts of 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 given as to each open patient account when MHA sought preauthorization from Empire for its services. The complaint alleges the defendant either gave the authorization 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 plaintiff relied to its detriment.

The complaint also lodges a claim for negligent misrepresentation, *Karu v. Feldman*, 119 *N.J.* 135, 146–147 (1990) sets forth the element of a claim for negligent misrepresentation. A plaintiff pursuing such a claim must establish the negligent providing of information, that the plaintiff was re- -- a reasonably foreseeable recipient of such information, reasonable reliance on the false representations, and that the false statements caused damages.

***18** The plaintiff's complaint alleges that as to the open 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 its agreement or intention to pay for the services to be provided to the subscribers.

This factual averment is sufficient to establish a negligent misrepresentation.

The complaint also adequately alleges that the plaintiff reasonably relied on the false statements by providing the services after being provided with the allegedly false information.

The Court finds the plaintiff has pleaded the circumstances of such misrepresentations as to the open patient accounts with the requisite particularity. The complaint read as a whole sets forth the specific nature of the misrepresentation and the apparent -- the approximate time, the date of admission when it was given. The complaint specifically alleges facts going to reliance by MHA on the misrepresentation, allegations of performance by MHA of its services for each patient subscriber.

The plaintiff may, of course, be called upon in discovery to supply additional pertinent information as to each individual open patient account.

The complaint also purports to state a claim for interference with prospective economic advantage. To state a claim for tortious interference with prospective economic advantage the 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 inter- -- the interference caused the loss of the prospective gain and damages. *Printing Mart* 116 *N.J.* 739, 751.

The economic -- the prospective economic advantage alleged here is the economic benefit to be derived from the provider/patient relationship allegedly existing between patients and subscribers of Empire who sought treatment in hospital services with MHA. The complaint alleges facts from which one may glean a claim for interference with such relationships arising from Empire's alleged precertification of the services to be rendered or its acknowledgment of the same was not required for emergency services, followed by its failure or refusal to pay the full amount of --the plaintiff claims is due.

The complaint also sets forth facts supporting a claim that Empire acted intentionally, without justification, and without improper [sic] purpose, at least to some open patient accounts. As noted earlier, the complaint alleges practices of down coding, improper refusal to pay for necessary follow-up treatment after agreeing to pay for initial services and after the hospital accepted the patient, or improper claims that the patient was fit for transfer.

Counts seven to -- seven, eight, nine and ten, allege -- lodge claims asserted as private rights of action under New Jer- -- Jersey and New York statutes and regulations. In Count Seven and Eight, the plaintiffs purports to state private claims for relief under New Jersey statutes and regulations pertaining to the provision of emergency services to patients and so-

called Prompt Pay laws and promulgated rules. In Count Seven MHA alleges a private right of action under New Jersey rules requiring than an out-of-network provider to ensure in cases involving patients seeking emergency services that the provider is paid a sufficient amount such that the patient is not balance billed.

***19** Plaintiff alleges that Empire is obligated to pay for 100 percent of patients UCR fees 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. It has asserted claims for 1,416 open patient accounts involving such alleged emergency services. *N.J.S.A.* 11:24–5.3C specifically requires "carriers" to reimburse "hospitals and physicians" for all medically necessary emergency and urgent care, health and urgent care health care services covered under the health benefit plans in circumstances where the member cannot reasonably access and network services.

It is not asserted that the cited regulations or authorizing statute provides an express right, private right of action. In order to find an implied private right of action, the Court must consider whether the plaintiff is within 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 hospital physician for certain emergency services. This appears to establish not only that plaintiff is an intended beneficiary of the provision or at least that the rule seeks to protect the influen--- the interests of the hospital, but that the rule contemplates the right of action to obtain the required reimbursement.

The Court concludes at this juncture that the complaint states a private -- a claim -- a private right of action under the cited statute and regulations for reimbursement of unreimbursed costs for providing emergency services to at least some Empire subscribers.

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 MHA and Empire.

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 been understandably not concentrated their briefing on the question of whether or not this is --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 for this -- to permit this Court to allow that count, Counts Seven, 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.

Count Eight alleges an implied private cause of action under the Prompt Pay laws and regulations adopted in New Jersey. Specifically, the plaintiff alleges 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 defendant was obligated to pay or contest MHA 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 to the -- to (inaudible), as amended by the *Health Claims* authorizing --*Authorization Processing and Payment Act*. *N.J.S.A.* 17B:27–44.2D9 specifically provides that an overview 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.

***20** 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 provider, MHA here, is certainly a specific party the statute is intended to protect or benefit, in addition to the protection of the general public interest and 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 plaintiff has 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, however, it denies the Motion to Dismiss without prejudice to the right of the defendant to seek dismissal or summary judgment on -- on the basis of a full record and/or a more focused briefing.

Counts Nine and Ten purport to state private claims under New York statutes and regulations, including the Prompt Pay laws, comparable in all material respects to the New Jersey statutory and regulatory framework.

The plaintiff alleges these laws and regulations apply here and afford a basis for relief, even though MHA provided the services at issue at a New Jersey hospital. The plaintiff contends this -- there is, at least as to -- at least -- the plaintiff contends this is so at least as to those open patient accounts involving New York residents who sought and obtained treatment in New Jersey.

The Court is not satisfied that these laws can or do have the asserted extraterritorial effect. Sus- -- to sustain Counts Nine and Ten the Court would have to find that the New York legislature and regulatory bodies not only intended to establish a private right of action, but they intended to vest such rights in a New Jersey-based hospital providing services in this State, albeit to New York residents.

The Court thus find -- the Court finds this is a bridge too far. Nothing has been cited to the Court that would provide a reasonable basis on which to conclude the New York legislature and regulatory bodies established their statutory and regulatory scheme with this purpose or objective.

Accordingly, the Court grants the Motion to Dismiss as to Counts 9 and 10 and those counts are dismissed.

The defendant also seeks dismissal of dismissal of portions of plaintiff's claims on the grounds that the claims are time-barred under the applicable six year statute of limitations and under the equitable doctrine of laches. The defender purports to have researched the underlying open patient accounts and to have determined that a portion of them were subject to final adjudication more than six years prior to the filing of the complaint. He contends that the Court can exercise -- can examine the results of this investigation as the plaintiff failed in its pleading purposefully so the argument goes, to recite the pertinent dates of adjudication of the statements rendered by MHA.

In order to dismiss the complaint at this juncture on statute of limitations grounds the failure to commence suit within limitations period must be apparent on the face of the complaint. The Court concludes there is nothing on the face of this complaint here that would warrant dismissal of any of the open patient accounts claims for which the plaintiff seeks reimbursement. Determination of whether some of the claims are time-barred requires an assessment of facts pertaining to the submission of the claim, the response of the payor, the process that following, and the nature and timing of the final denial of payment

***21** As New Jersey discovery rule may be just may be applicable to some or all of the plaintiff's causes of action it would be necessary to assess when the plaintiff knew, or in the exercise of diligence should have known that it had a factual basis for claim. The Court concludes it cannot address such matters at this stage of the proceeding.

The laches defense posits, in essence, that the plaintiff purposely waited for many years to assert its claims for millions of dollars in reimbursement, bundling together some 2,900 open patient accounts, many of which it alleges could have been the subject of a claim years earlier, all to the unfair disadvantage of the defendant.

Likewise, to the extent that the doctrine of laches can apply to shorten the term of the applicable statute of limitations on equitable grounds as Empire claims the Court could only do so on the basis of a full factual record addressing whether the plaintiff engaged in unreasonable delay pursuing -- in pursuing its claims, and whether the defendant has suffered resulting prejudice. A defense grounded in laches, even if available to the defendant is inherently dependent upon an assessment of all pertinent facts and circumstances relating to the manner in which the plaintiff proceeded.

The defendant contends that MHA's tort and quasi-contract theories are barred under the economic loss doctrine. In general, the economic loss doctrine bars claims sounding in tort for economic damages to which a party is only entitled by contract. In essence, Empire asserts that because the plaintiff seeks relief under an express or implied contract it cannot pursue claims in tort arising from the same circumstances.

However, where the existence of a contract implied or otherwise is disputed, the plaintiff is permitted to plead alternative theories of action, even inconsistent theories. Moreover, the claims grounded in quasi-contract would appear not to be not barred by the economic loss doctrine.

It is also an established principle that the economic loss doctrine is not applicable to tort claims alleging fraud and other tortious conduct in the inducement or establishment of a contractual relationship as opposed to claims in tort arising from the performance of the contract, and that tort claims arising from an independent duty owed by the defendant are not subject to the economic loss doctrine. See *Arcand v. Bro* [sic] *International Corp*., 673 *F. Sup*. 2nd 282, 307, 308 (District of New Jersey 2009). *Saltiel versus GSI Consultants, Inc*., 170 *New Jersey* 297 -- 2 (2002).

Here, the plaintiff's claims, grounded in negligent misrepresentation and tortious interference with prospective advantage, may be taken as alternative theories of relief to those sounding in contract.

Under the *Printing Mart* standard the claim for negligent misrepresentation alleges facts sufficient at this early stage to conclude that the claim asserts the tortious conduct occurred at the time the patient presented for services and had the effect of inducing the plaintiff to perform the same. That is, such conduct allegedly induced the plaintiff to undertake the hospital services for the Empire subscriber.

Moreover, the Court finds, again at this early stage, that both the negligent misrepresentation, and tortious interference claims as pleaded arise from an independent or could arise from an independent duty owed to the plaintiff separate from any contractual undertaking such that the application of economic loss doctrine to borrow the same as a matter of law at this time is unwarranted.

***22** The Court denies the motion asserted on this ground, once again, without prejudice to the right to raise the issue at a later time on a more complete factual record.

So for all those reasons, the Court will grant the motion in part, dismissing Counts Nine and Ten of the complaint and will deny the remainder of the motion for the reasons stated.

I once again thank the parties, as I believe I already did for their excellent submissions and arguments and will ask the plaintiff to submit an appropriate form of order.

That will conclude the Court's reading of its opinion.

MR. KATZ: Judge?

THE COURT: All right?

MR. KATZ: Your Honor -- Your Honor, this is Eric Katz. One housekeeping matter, if I may?

THE COURT: Yes, sir. Go ahead. Go ahead. (Off the record. On the record.)

MR. KATZ: -- opinion, can we get a date certain by which Empire will file an answer to the complaint? And I would -- would like to point out that the Clerk generated a computer generated physical notice for July 17th. So I want to make sure from a logistical standpoint we don't run afoul of (inaudible).

THE COURT: All right. Well, as to the later, I'll see if I can -- I can put a stop to the --the pro- -- the processing of -- of that computer-generated notice, but rest assured, if the complaint is for some reason dismissed for a [sic] administrative --on an administrative through the operation of -- of a the computer, I -- I would address it at that point and -- and vacate it, but nonetheless I'll see what I can do.

In terms of a -- a date certain for the defendants to answer, I would -- I would ask that you -- and I would think that you would be able to agree with -- among counsel as to when that date will be and you can embody in the form of Order. I would also ask that you leave a -- a placeholder in the Order, once an answer is filed. As I said, I will convene a Case Management Conference to schedule out the -- the discovery in this matter, at least the first phase or two of it. And I will ask the parties in connection with that conference to be prepared to address the point that I made in the opinion that -- that I -- I may be looking to phase the discovery to address this in network out-of-network issue first.

I recognize the parties may wish to be heard on that and I will hear you, but I'll at least expect that we -- the parties be prepared to discuss that issue at the conference. But in all events, if you could, in the Order leave a placeholder and I'll set this down for a -- a -- a Case Management Conference sometime contemporaneous with the scheduled date for filing of an answer and I'll ask that the parties just put in the Order what -- what the parties have agreed upon in terms of the date. If for some reason you're unable to agree on a date for the -- the tender of the filing and service of an answer then let me know and we'll -- we'll a brief telephone conference to resolve that. But I'm -- I'm presuming that the excellent attorneys on the phone will be able to agree upon that. All right?

MR. KATZ: Thank you, Your Honor.

THE COURT: All right. Anything else?

COUNSEL: (Inaudible).

THE COURT: All right. Very well. Thank you all. Have a good week.

(Proceedings Concluded)

***23** June 23, 2018

<<signature>>

Rebecca Y. Natal AD/T 557

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