NOT FOR PUBLICATION WITHOUT THE APPROVAL OF THE COMMITTEE ON OPINIONS

ATLANTIC NEUROSURGICAL SPECIALISTS, et al.,	SUPERIOR COURT OF NEW JERSEY LAW DIVISION : MORRIS COUNTY
Plaintiffs,	DOCKET NO. MRS-L-2172-21
vs.	CIVIL ACTION - CBLP
ANTHEM, INC. d/b/a ANTHEM BLUE CROSS BLUE SHIELD f/k/a WELLPOINT, INC., et al.,	**OPINION**
Defendants.	

Argued: May 23, 2023

Decided: June 19, 2023

David M. Estes, Esq. of Mazie Slater Katz & Freeman, LLC, attorneys for the Plaintiffs.

Valerie Sirota, Esq. of Troutman Pepper Hamilton Sanders LLP, attorneys for the Anthem Defendants.

Steven D. Gorelick, Esq. of Garfunkel Wild, P.C., attorneys for the Prime Defendants.

Francis A. Raso, Esq. of Littler Mendelson, P.C., attorneys for the Skanska Defendants.

I. BACKGROUND INFORMATION

This matter comes before the Court by way of a motion to dismiss pursuant to Rule 4:6-2, or alternatively a motion to sever the claims pursuant to Rule 4:38-2(a). The underlying dispute arises over amounts owed for medical services rendered.

Plaintiffs Atlantic Neurosurgical Specialists and Atlantic Shore Surgical Associates, PC ("Plaintiffs") are New-Jersey based medical providers, who are out-of-network for Defendants. Defendants include administrators of health plans and employers funding the respective group plans. The administrators are Anthem Inc. ("Anthem"), Anthem Insurance Companies, Inc., Anthem Life Insurance, Anthem Blue Cross Life & Health Insurance Company, Blue Cross of California, Community Insurance Company, Anthem Health Plans of Virginia, Inc., Anthem UM Services, Inc. (collectively, the "Anthem Defendants"). Defendant Highmark Blue Cross Blue Shield Delaware, also doing business as Highmark Health Insurance Company does underwriting for administrators, in particular, Patient R.M.[1] The employers are Skanska USA Building Inc., Skanska USA Inc. (together, the "Skanska Defendants"), the Prime Defendants (the "Prime Defendants" include Prime Healthcare Services-St. Michael's LLC or Saint Michael's Medical Center ("St. Michaels") and Prime Healthcare Services-St. Clare's, LLC), Securitas Security Services USA, Inc., Verizon Communications, Inc., Version Benefits Administration, Inc., Signet Financial Management, LLC, Camp Six, Inc., Siemens Industry Inc., and Bayer Corp. (collectively, the "Plan Sponsors"). Defendants cooperatively provide medical insurance (the "Plans") to the Patients. The Patients are employees of the Plan Sponsors, who received emergency medical treatment (the "Services") through Plaintiffs.

[1] To comply with HIPAA confidentiality, the Parties refer to relevant patients by their initials.

Plaintiffs contend that they submitted claims seeking reimbursement for the Services (the "Claims"), but that Defendants grossly underpaid Plaintiffs by nearly $2,000,000.00. The Disputed Claims List ("DCL") in the Verified Complaint ("VC" or "Verified Complaint") lists thirty-eight Claims for health benefits for sixteen Patients. Defendants assert, however, that not all Patients listed in the DCL are members of Plans administered or funded by each of the Defendants. The Skanska Defendants assert that the only claims that pertain to them are plans administered to V.S. (Claim No. 11) and H.P. (Claim Nos. 27, 28). The Prime Defendants assert that the only claims that pertain to them are plans administered to G.F. (Claim Nos. 3, 4, 17, 18, 19, 24) and N.G. (Claim unspecified; VC, ¶ 23). Anthem Defendants claim that only twenty-five Claims of alleged underpayment across eleven Patients pertain to Plans administered or funded by Defendants, which include L.O. (Claim Nos. 6–8, 10), S.S. (Claim No. 9), C.H. (Claim Nos. 12–14), K.L. (Claim No. 15), P.H. (Claim No. 16), T.W. (Claim No. 20), S.O. (Claim No. 21), R.S. (Claim Nos. 22, 23, 35), W.VN. (Claim Nos. 25, 26), W.L. (Claim No. 29), and J.S. (Claim Nos. 30–34, 36, 37). Certification of Sirota, Exhibit B; VC, ¶ 33. The submissions do not mention R.M. (Claim No. 1), S.A. (Claim No. 2), A. MG. (Claim No. 5), and M.M. (Claim No. 38).

Defendants argue that Plaintiffs' application is lacking in several respects, most particularly that the Claims are preempted by ERISA, and thus files the instant motion to dismiss the Verified Complaint in its entirety.

II. STANDARD OF REVIEW

A motion to dismiss for failure to state a claim upon which relief can be granted is governed by R. 4:6-2(e) of the New Jersey Court Rules. The rule "permits litigants, prior to the filing of a responsive pleading, to file a motion to dismiss an opponent's complaint, counterclaim, cross-claim, or third-party complaint" Malik v. Ruttenberg, 398 N.J. Super. 489, 493 (App. Div. 2008).

The proper analytical approach to such motions requires the motion judge to 1) accept as true all factual assertions in the complaint, 2) accord to the nonmoving party every reasonable inference from those facts, and 3) examine 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.'" Id. at 494 (*quoting* Printing Mart-Morristown v. Sharp Electronics Corp., 116 N.J. 739, 746 (1989).

The motion to dismiss should be approached with great caution and should only be granted in the rarest of instances. Sickles v. Cabot Corp., 379 N.J. Super. 100, 106 (App. Div. 2005). The allegations are to be viewed "with great liberality and without concern for the plaintiff's ability to prove the facts alleged in the complaint." Ibid. The plaintiff's obligation on a motion to dismiss is "not to prove the case but only to make allegations, which, if proven, would constitute a valid cause of action." Ibid. (quoting Leon v. Rite Aid Corp., 340 N.J. Super. 462, 472, (App.Div.2001)).

To set forth a cause of action for a breach of contract, a plaintiff must plead "it suffices if the pleading allege the making of the contract, the obligation thereby assumed, and the breach." Bauer v. Newark, 7 N.J. 426, 432 (1951). Where one party clearly announces that he will not or cannot fulfill a contract, the other party may bring a suit without waiting for the day set for performance. See Gaglia v. Kirchner, 317 N.J. Super. 292 (App. Div. 1999) (citing Ross Sys. v. Linden Dari-Delite, Inc., 35 N.J. 329, 340-41 (1961); Miller & Sons Bakery Co. v. Selikowitz, 4 N.J.Super. 97, 101 (App. Div.1949)).

III. ANALYSIS

Defendants insist that the Verified Complaint must be dismissed because Plaintiffs' claims are preempted by ERISA. Defendants submit that Congress enacted ERISA to create "a uniform regulatory regime over employee benefit plans." Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004)[2]; St. Peter's Univ. Hosp. v. N.J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 454 (App. Div. 2013) (quoting Bd. of Trs. of Operating Eng'rs Local 825 Fund Serv. Facilities v. L.B.S. Constr. Co., 148 N.J. 561, 565 (1997)) (further explaining that Congress created ERISA to "'protect participants of employee benefit plans and their beneficiaries'" by setting "'uniform standards'"); Finderne Mgmt. Co., Inc. v. Barrett, 355 N.J. Super. 170, 185 (App. Div. 2002)

[2] The Court acknowledges that it is only bound by New Jersey State case law. However, because ERISA is a Federal statute, the Court must address the Federal statutory and case law that offer insight into the interpretation and application of ERISA. This footnote encompasses all Federal legal authority contained in this Statement of Reasons.

("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans . . . [by setting] various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans") (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90-91 (1983)); see also Nat'l Sec. Sys. v. Iola, 700 F.3d 65, 82 (3d Cir. 2012) ("ERISA . . . aims 'to provide a uniform regulatory regime over employee benefit plans' in order to ease administrative burdens and reduce employers' costs.") (quoting Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004)).

Within ERISA, Congress included a preemption provision, codified at § 514(a). 29 U.S.C. § 1144(a). Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the Statute. 29 U.S.C. § 1144(a); see also Finderne Mgmt. Co., Inc. v. Barrett, 355 N.J. Super. 170, 188 (App. Div. 2002). "A state law claim relates to an employee benefit plan if 'the existence of an ERISA plan [is] a critical factor in establishing liability' and 'the trial court's inquiry would be directed to the plan[.]'" St. Peters Univ. Hosp. v. N.J. Bldg. Laboreres Statewide Welfare Fund, 431 N.J. Super. 446, 456 (App. Div. 2013) (alterations in original) (quoting 1975 Salaried Ret. Plan for Eligible Emps. of Crucible, Inc. v. Nobers, 968 F.2d 401, 406 (3d Cir. 1992)), certif. denied, 506 U.S. 1086 (1993); O'Brien v. Two W. Hanover Co., 350 N.J. Super. 441, 446 (App. Div. 2002) (clarifying that where a state law relates to an employee benefit plan that is governed by ERISA, and further that the "United States Supreme Court has noted that ERISA's preemption clause is 'conspicuous for its

breadth.'"). Defendants submit that, for the purposes of preemption under Section 514(a) of ERISA, state law includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any state." 29 U.S.C. § 1144(c)(1); Kollman v. Hewitt Assocs., LLC, 487 F.3d 139, 148 (3d Cir. 2007); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138-39 (1990); Finderne Mgmt. Co., Inc., 355 N.J. Super. at 185 (holding that ERISA preemption applies to state common law claims); St. Peter's Univ. Hosp., 431 N.J. Super. at 461 ("'Contracts however, express, cannot fetter the constitutional authority of Congress. . . [W]hen contracts deal specifically with a subject matter which lies within the control of Congress, they have a congenital infirmity. Parties cannot remove their transactions from the reach of dominant constitutional power by making contracts about them.'") (quoting Connolly v. Pension Benefit Guar. Corp., 475 U.S. 211, 223-24 (1986)).

Defendants contend that Plaintiffs' claims require an impermissible "reference to" the Patients' ERISA-governed plans, because of ERISA § 514 preemption. Defendants submit that Plaintiffs allege that Defendants issued pre-authorizations for the Services, that Plaintiffs then submitted claims to the Defendants for the subject Services, and that Defendants failed to sufficiently reimburse Plaintiffs for the Services provided. Defendants contend, however, that Plaintiffs would have never received pre-authorizations, submitted claims to Defendants, nor received any reimbursement from the Defendants if it were not for the Plans. Defendants assert that it is therefore indisputable that Plaintiffs' rights and Defendants' obligations regarding the Claims "relate to" and require reference to the ERISA-Plans' terms. Defendants argue that,

accordingly, the Claims are preempted. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 48 (1987). As such, Defendants argue that ERISA preempts claims S.S. (Claim No. 9), P.H. (Claim No. 16), T.W. (Claim No. 20), S.O. (Claim No. 21), R.S. (Claim Nos. 22, 23, 35), W.VN. (Claim Nos. 25, 26), W.L. (Claim No. 29), and J.S. (Claim Nos. 30–34, 36, 37). Certification of O'Brien, ¶ 5; Certification of Sirota, Exhibit B.

Defendants contend that Plaintiffs' reliance on the subject pre-authorization letters further support Defendants' arguments in favor of preemption. Defendants assert that, of the four pre-authorization letters that the Anthem Defendants have located that correspond to the pre-authorization numbers referenced in the DCL, the letters expressly contradict Plaintiffs' assertion that Defendants agreed to pay "100% of the usual, customary and reasonable charges" for the pre-authorized services performed by the Plaintiffs. Defendants insist, to the contrary, that the pre-authorization letters explicitly provide that the pre-authorization is not an approval or guarantee of payment and is subject to the applicable plan terms. O'Brien Cert., Ex. L-O ("this authorization is not a guarantee of payment; coverage is subject to all of the terms and conditions of the member's contract."). As such, Defendants argue that Plaintiffs' state law claims relating to Patients T.W., P.H., and S.O. are preempted by § 514 as they "'relate' to an ERISA plan, because the pre-authorization letter indicates that the insurer looks to the ERISA plan to determine both the scope of any services eligible for reimbursement, and the amount of any subsequent payment. See Plaintiff's Verified Complaint, ¶ 38, n. 11 (acknowledging that t if the health benefits plan does

not provide for usual, customary, and reasonable rates ("UCR"), which is the reimbursements Plaintiffs seek in this action, an out-of-network provider may be permitted in certain circumstances, and often required to avoid 'fee forgiveness' litigation, to bill the patient the outstanding balance (a practice commonly referred to as "balance billing"). Additionally, Defendants contend that the claims relating to Patient C.H. are belied by the agreement Plaintiffs rely upon. Defendants assert that this further shows that claims relating to Patients T.W., P.H., S.O., and C.H. should be dismissed.

Skanska Defendants separately reinforce that Plaintiff's entire Verified Complaint should be dismissed, as all six of the common law claims are expressly preempted under Section 514(a) of ERISA. Skanska Defendants submit that Plaintiffs allege that the Skanska Defendants administered a plan relating to patients V.S. and H.P for unspecified emergency services, for which Plaintiffs insist that they were grossly underpaid in the amount of $170,074.98. Plaintiff's Verified Complaint, ¶¶ 4, 6, 18, 33. Skanska Defendants assert that Plaintiffs came to this figure by claiming that the Skanska Defendants are responsible for paying one hundred percent of the UCR charges for their services, less each patient's co-pay, co-insurance, or deductible. Id., at ¶ 37. Skanska Defendants assert that, even assuming Plaintiff's allegations are true, the existence of Skanska Defendant's ERISA Plan is the critical factor to establish liability. Skanska Defendants maintain that their Plans cannot be construed as being merely peripheral to an ERISA plan, as Plaintiffs claims would require the Court to examine each Plan in detail to determine which

healthcare providers are in-network as opposed to out-of-network; to determine the amount of each Patient's co-pay; to determine the amount of each Patient's deductible; and to determine the amount of each Patient's "correct patient responsibility." See id., at ¶¶ 37, 41. Skanska Defendants insist, instead, that their plans are inextricably linked to ERISA, thereby preempting all of Plaintiffs' claims. Skanska Defendants further contend that they were only named as Defendants in this lawsuit because of their ERISA plan. Id., at ¶ 18 ("At all relevant times, Skanska sponsored, funded and/or administered a plan relating to Patients H.P. and V.S."); see also 1975 Salaried Ret. Plan for Eligible Emps. of Crucible, Inc., 968 F.2d at 406 (stating that a claim is expressly preempted under Section 514(a) of ERISA when "[i]n short, if there were no plan, there would have been no cause of action").

The Prime Defendants also write separately to assert that the Verified Complaint does not make any factual allegations that there was any independent agreement upon which Plaintiffs could rely to escape the preemptive effect of ERISA. See Plastic Surgery Center, P.A. v. Aetna Life Insur. Co., 967 F.3d 218, 231 (3rd Cir. 2020) (sustaining state law claims based on separate, single claim agreement). Prime Defendants contend that the derivative claims against by Plaintiffs against the Prime Defendants arise directly from the Prime Defendants' obligations to pay Plaintiffs for services rendered to Plan Members, which arise from the Plans, which are governed by ERISA. Similar to the argument by the Skanska Defendants, the Prime Defendants argue that Plaintiffs' claims would require the Court to interpret each of the respective Plans, which

inextricably links the claims to ERISA. See Ingersoll-Rand Co., 498 U.S. at 140 (finding claim "related to" ERISA if court's inquiry is directed to ERISA plan and noting that state law is preempted even if it only indirectly affects ERISA plan). As such, Prime Defendants argue that the state common law claims clearly "relate to" ERISA-governed employee benefit plans, they are preempted by Section 514(a) of ERISA and should be dismissed.

Plaintiffs counter that their claims are beyond the reach of ERISA. Plaintiffs assert that Defendants failed to disclose that the New Jersey Supreme Court rejected the literal reading of ERISA ¶ 514(a) preemption, holding,

> The [U.S. Supreme] Court [in Travelers] stated that although ERISA preemption is "clearly expansive," to interpret the language to its furthest extent would render the reach of the provision limitless.
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> Justice Scalia [in Dillingham] suggested that the time had come to acknowledge that the criteria used in earlier cases for preemption had been abandoned, and that "our first take on this statute was wrong; that the 'relate to' clause of the [ERISA] pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary [principles of] preemption [apply]…. Any other understanding of the "related to" language is "doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else."

Bd. of Trs. of Oprt'g Engrs. Loc. 825 Fund Serv. Facilities v. L.B.S. Constr. Co., 148 N.J. 561, 568-70, 575 (1997) (quoting N.Y.S. Conf. of Blue Cross & Blue Sh. Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) ("Travelers"), and Cali. Div. of Labor Sts. Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 336 (1997) (Scalia, J., concurring)). Plaintiffs submits that New Jersey Courts have cautioned an expansive use of ERISA preemption, stating,

> [P]re-emption 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. The Travelers Court found nothing in the language of the ERISA statute or the context of its passage which indicated Congress chose to displace laws relating to matters "historically" of local concern. The New Jersey Supreme Court has also recognized the trend in recent federal precedent which has limited ERISA preemption of general applicable state laws.

Finderne Mgmt. Co. v. Barrett, 355 N.J. Super. 170, 189-90 (App. Div. 2002).

Plaintiffs also submit that Federal precedent agrees with the New Jersey Supreme Court holding, stating,

> [R]ecogniz[ing] that, given its broadest reading, the phrase "relate to" would encompass virtually all state law…. The Court has, therefore, declined to apply an "uncritical literalism" to the phrase, and observed that "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."

Access Mediquip LLC v. UnitedHealthcare Ins. Co., 662 F.3d 376, 382 (5th Cir. 2011) (quoting Travelers, 514 U.S. at 655); McCulloch Orthopedic Surgical Servs., PLLC v. Aetna Inc., 857 F.3d 141, 149-50 (2d Cir. 2017) ("McCulloch's claim rests on whether Aetna promised to reimburse him for seventy percent of the UCR rate, whether he reasonably and foreseeably relied on that promise, and whether he suffered a resulting injury. The claim does not implicate the actual coverage terms of the health care plan or require a determination as to whether those terms were properly applied by Aetna"); Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 235 (3d Cir. 2020) ("[T]he fact [that] an ERISA plan is an initial step in the causation chain, without more, is too remote of a relationship with the covered plan to support a finding of preemption.").

Moreover, Plaintiffs contend that the standard in New Jersey for applying ERISA § 514(a) preemption has been articulated by the Appellate Division, which states,

> 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.'" A state law claim relates to an employee benefit plan if "the existence of an ERISA plan [is] a critical factor in establishing liability" and "the trial court's inquiry would be directed to the plan[.]

St. Peter's, 431 N.J. Super. at 455-56 (quoting L.B.S. Constr., 148 N.J. at 569); Feit v. Horizon Blue Cross & Blue Sh. of N.J., 385 N.J. Super. 470, 483-84 (App. Div. 2006) (quoting Blue Cross of Cali. v. Anesthesia Care Assocs. Med. Grp., Inc., 187 F.3d 1045, 1051 (9th Cir. 1999)) ("the bare fact that [an ERISA plan] may be consulted in the course of litigating a state-law claim does not require that the claim be extinguished by ERISA's enforcement provision"); Farina v. Nokia Inc., 625 F.3d 97, 115-16 (3d Cir. 2010) (holding that there is a "presumption against preemption"). Plaintiffs further contend that New Jersey has adopted the Memorial Hospital Rule of the Fifth Circuit, which holds that healthcare defendants are bound by representations during the pre-approval process, or said another way, that ERISA § 514(a) does not preempt a healthcare provider's state law misrepresentation and related claims that arise from a health administrator or payor's pre-authorization for a medical service. See generally, Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990); St. Peter's, 431 N.J. Super. at 455-58 (App. Div.), certif. denied, 216 N.J. 366 (2013) (approving Memorial Hosp. rule).

Plaintiffs submit, moreover, that it is black letter law that contractual duties between a healthcare provider and insurer or administrator give rise to duties and liabilities beyond ERISA preemption. Plaintiffs insists that, because Defendants' claims are based on independent duties, the claims are therefore not preempted by ERISA. Pascack Valley Hosp. v. Loc. 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 402 (3d Cir. 2004) ("[R]esolution of this lawsuit requires interpretation of the…Agreement, not the Plan. [Plaintiff] Hospital's right to recovery, if it exists, depends entirely on the operation of third-party contracts executed by the Plan that are independent of the Plan itself."). Plaintiffs contends that, "the bare fact that [a plan] may be consulted in the course of litigating a state-law claim does not require that the claim be extinguished by ERISA's enforcement provision." Feit v. Horizon Blue Cross & Blue Sh. of N.J., 385 N.J. Super. 470, 483-84 (App. Div. 2006).

Here, Plaintiffs submit that Defendants attempt to claim that the Plan Sponsors can knowingly make false statements to induce healthcare providers to render services, but then Plan Sponsors are not required to follow through on their promises, which Plaintiffs assert is wrong, legally, factually, and morally. Plaintiffs insist that liability will turn, not on the alleged ERISA Plans, but rather, on the representations to and conduct between the Plaintiffs and the Plan Sponsors, as well as the industry standard. Additionally, Plaintiffs argue that the interpretation of the facts, legal conclusions, and introduction of documents all go beyond the four corners of the Verified Complaint, making the affirmative defense of ERISA preemption premature. Plaintiffs

maintain that defense counsel and staff may not certify without proof or verification that the Plan descriptions are governed by ERISA. See O'Brien Cert., at ¶ 5; and see Sirota Cert., Ex. B, 6th Column. Plaintiffs assert that the matter of ERISA preemption is fact-sensitive and cannot be determined by the Court at this juncture.

Defendants respond by reiterating that Plaintiffs' state law claims are preempted by the expansive and extraordinary preemption provision of ERISA § 514. St. Peter's Univ. Hosp. v. N.J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455-56 (App. Div. 2013); see also Nat'l Sec. Sys. v. Iola, 700 F.3d 65, 82 (3d Cir. 2012) ("ERISA . . . aims 'to provide a uniform regulatory regime over employee benefit plans' in order to ease administrative burdens and reduce employers' costs.") (quoting Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004)). Defendants assert that Plaintiffs arguments against preemption fail for three reasons: (1) the Memorial Hospital Rule does not apply to this case. (2) the pre-authorizations at issue implicate ERISA, and (3) Defendants' actions have not created extra-contractual duties outside the scope of ERISA.

Concerning the Memorial Hospital Rule, Defendants assert that, despite Plaintiffs' contention that numerous New Jersey courts have adopted the Rule, only St. Peter's, an Appellate Division decision, rather than a Supreme Court decision, has in fact adopted the Rule. See St. Peter's Univ. Hosp., 431 N.J. Super. at 455-56. Defendants do concur, however, that St. Peter's does govern the standard for determining whether state law claims are preempted by ERISA and

should be followed by this Court. Id., at 460-61 (holding that, where an out-of-network hospital's state law claims concerning alleged underpayment for medical services clearly relates to the ERISA plan within statute's intent, the claim is thus expressly preempted under Section 514(a)). Defendants submit that St. Peter's explains that an out-of-network provider's state law claims for additional reimbursement for medical services rendered "are inextricably linked to the existence of the [] ERISA plan" and that "[b]ecause the [provider] cannot assert a direct contractual relationship between itself and the [defendant], its claims are based on the [defendant's] obligations under [the plan]." St. Peter's, 431 N.J. Super. at 454-55, 460 (holding that the "claims 'would not exist but for the presence of an ERISA plan that provided coverage to the patient'"). Here, Defendants maintain that Plaintiffs have not explained how the additional payment for health care benefits is not directly tied to the terms and conditions of each Patients' individual Plan, or how the determination of the same would not direct the Court's inquiry to the Plans, thereby inextricably placing the Plans behind the shield of ERISA preemption. See id., (explaining that "in order to adjudicate [Plaintiffs'] claims, the court would be required to examine and consult the terms of the ERISA plan to determine whether the [the Defendants were] liable"); see also Levine v. United Healthcare Corp., 402 F.3d 156, 163 (3d Cir. 2005) (holding that "reimbursement[s] of previously paid health benefits" are preempted by ERISA); see also Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 278 (3d Cir. 2001) (stating that "suits against . . . insurance companies for denial of benefits, even when the claim is couched in terms of common law

negligence or breach of contract, have been held to be preempted by § 514(a)"). Defendants insist that a determination that Plaintiffs are entitled to additional payments for the services rendered to the Plan Members would require that a benefit be paid from the Plans, and, in turn, the Court would be required to examine and consult the terms of the ERISA Plans to determine, among other things, 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 is available for purposes of coordination of benefits, and any cap on benefits, to calculate benefits due to the Plaintiffs. Defendants argue the Plans therefore relate to ERISA, and are thus preempted.

As for Plaintiffs' argument against pre-authorization implicating ERISA, Defendants counter that the mere existence of the pre-authorization letters referenced in the Verified Complaint inextricably links these claims to the ERISA health benefits plans that govern them, thus preempting Plaintiffs' state law claims. Defendants distinguish the cases upon which Plaintiffs rely in raising this argument. Defendants contend that Plastic Surgery explicitly limited its application to the specific facts within the case, providing,

> Nor do we suggest that out-of-network providers are categorically exempt from section 514(a), with carte blanche to file suit for services rendered to plan participants. . . Whether any agreement was reached with a provider, and the extent to which the terms of that agreement are so intertwined with the plan as to "relate to" an ERISA plan, are questions that depend on the facts and circumstances of the given case.

Plastic Surgery Center., P.A. v. Aetna Life Ins. Co., 967 F.3d 218, 231, n.16 (3d Cir. 2020) (internal citations omitted). Defendants distinguish this case by explaining that certain allegations which were critical in Plastic Surgery Center are not present in the instant matter, including that the members' plans did not provide for out-of-network benefits; that the members needed medical procedures that no in-network providers could perform; and that as a result, the out-of-network provider specifically negotiated and entered into an independent contract with the health insurer for an "in-network" exception, pursuant to which the health insurer agreed that the services provided would be paid at a "reasonable amount" and at the "highest in-network level." Id., at 223-24. Defendants contend that the Plastic Surgery Center Court held that, as the purported contractual agreement arose in spite of the ERISA-governed plans, rather than because of them, the out-of-network provider's state law claims did not relate to the patients' plans. Defendants submit that the present case is different, as the rendered services arose directly from the expressly covered services of out-of-network providers. Defendants similarly distinguish McCulloch. McCulloch Orthopaedic Surgical. Servs., PLLC v. Aetna Inc., 857 F.3d 141 (2d Cir. 2017). Defendants contend that the critical difference in McCulloch was that the parties in that case had had a telephone conversation during which the plan administrator had represented that the medical facility would be reimbursed at seventy percent of the UCR, whereas no such independent promise was made in the present case, and Plaintiffs do not allege that one occurred in the Verified Complaint. See id., at 144. Defendants further maintain that the pre-authorization letters explicitly

provide that a pre-authorization is not an approval or guarantee of payment and is subject to applicable Plan terms. See O'Brien Cert. Exs. L, M, N, & O.

Lastly, Defendants deny Plaintiffs' allegation that Defendants' conduct and dealings created an independent contractual duty. Defendants submit that the case Plaintiffs rely on for this argument, Pascack Valley Hospital, is distinguishable, because in Pascack Valley Hospital, the Plan was entered into by an independent consultant who was not a party to the action and the plaintiff asserted claims as a third-party beneficiary of the agreement; whereas, here, Defendants maintain that no independent contract exists between Defendants and Plaintiffs. See Pascack Valley Hospital v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 396-97 (3d Cir. 2004). Defendants argue that Plaintiffs have not stated what the purported course of conduct was that could give rise to such independent contract. Defendants clarify that every claim at issue in this action was addressed independently and only through consultation of the Plans of the respective patient.

The Skanska Defendants write separately to address the Plaintiffs' presumption that the matter of ERISA preemption is premature. The Skanska Defendants submit that it is well-settled that dismissal under R. 4:6-2(e) is appropriate when the applicability of an affirmative defense is apparent from the contents of the Verified Complaint itself. See Mac Prop Grp. LLC v. Selective Fire & Cas. Ins. Co., 473 N.J. Super. 1, 38 (App. Div. 2022) ("If, however, an affirmative defense's

applicability 'appears on the face of the complaint,' dismissal under Rule 4:6-2(e) may be proper."); Prickett v. Allard, 126 N.J. Super. 438, 440 (App. Div. 1974) (stating that a defendant may assert an affirmative defense in the context of a motion to dismiss when the applicability of the defense "appears on the face of the complaint"); see also Pressler & Verniero, *Current N.J. Court Rules*, cmt. 1.2.2 on R. 4:5-4 (2022) (stating that an affirmative defense need not be "specially pleaded" when the defense "appears on the face of the complaint" and "clearly goes to the maintainability of the action"). The Skanska Defendants submit that ERISA defines "employee welfare benefit plan" as,

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment[.]

29 U.S.C. § 1002(1); McCann v. Unum Provident, 907 F.3d 130, 142 (3d Cir. 2018) (holding that ERISA applies to "insurance policies obtained through (1) a plan, fund, or program (2) that is established or maintained (3) by an employer (4) for the purpose of providing benefits (5) to its participants or beneficiaries"); Debell v. Bd. of Trs., Pub. Employees' Ret. Sys. (PERS), 357 N.J. Super. 461, 467 n.3 (App. Div. 2003) ("ERISA applies to any employee benefit plan established and maintained by a private employer") (citing 29 U.S.C. § 1003). Because the Plans are referenced to and integral to the Verified Complaint, the Skanska Defendants and the Prime Defendants argue that the Court may consider them on a motion to dismiss.

In the instant matter, the Skanska Defendants submit that the elements of an employee welfare benefit plan under ERISA have been established within Plaintiffs' Verified Complaint. Defendants contend that the Verified Complaint sets forth that "Plaintiffs rendered emergency and pre-authorized, medically necessary surgical and other related medical services in New Jersey to patients who were members or dependents of members of healthcare plans sponsored, funded, insured and/or administered by Defendants" (VC, ¶ 1); that Plaintiffs are "out-of-network" or "non-participating" healthcare providers who rendered services to all of the Patients who were "entitled to health benefits" under their respective Plans (VC, ¶¶ 4, 6); that Defendants either "contract[ed] to provide health plans to individuals" whom they knew were New Jersey citizens, or "contract[ed] to provide or administer health benefit plans" that permitted individuals to "obtain medical care in New Jersey" (VC, ¶ 28); and that there is "no dispute" that the "defendants' plans provide benefits for emergency medical services" (VC, ¶ 70). The Skanska Defendants insist that the Verified Complaint therefor sets forth all elements essential to a finding that the Plans are employee welfare benefit plans. See 29 U.S.C. § 1002(1); 29 U.S.C. § 1003(a). Because Defendants' arguments for ERISA preemption do not rely on anything outside of the four corners of the Verified Complaint, the Skanska Defendants maintain that the affirmative defense of ERISA preemption may be brought forth before the Court.

The Prime Defendants also seek to distinguish other cases relied upon by Plaintiffs. The Prime Defendants submit that, in Bd. of Trs. of Oprt'g Engrs. Loc. 825 Fund Serv. Facilities v.

L.B.S. Constr. Co., 148 N.J. 561 (1997), the court held that ERISA preemption is applicable unless the preemption issue relates to "a state law that may have the potential to interfere with ERISA [that] is designed to address a unique local program." Id., at 567. The Prime Defendants contend that the instant matter is not a "unique local program," and thus the facts and analysis are not alike. The Prime Defendants also submit that Plaintiffs have relied on cases that arose from complete ERISA preemption under Section 502(a) which is a distinct and narrower analysis. See e.g., Feit v. Horizon Blue Cross & Blue Sh. of N.J., 385 N.J. Super. 470, 483-84 (App. Div. 2006). Finally, the Prime Defendants contend that Plaintiffs relied on cases in which the Plans were wholly unrelated to ERISA. Finderne Mgmt. Co., Inc. v. Barrett, 355 N.J. Super. 170, 193-94 (App. Div. 2002) (finding that the claims were not preempted because they "will not impact the structure or administration of the ERISA plans; they do not relate to any state laws that regulate the type of benefits or terms of the ERISA plan; they are unrelated to laws creating reporting, disclosure, funding or vesting requirements for the plans; and they do not affect the calculation of plan benefits."). The Prime Defendants argue that the instant matter is entirely distinct from Plaintiffs' cases, and thus cannot be applied to this case.

For all of the above reasons, Defendants maintain that Plaintiffs' state claims are preempted by ERISA, and that Plaintiffs' arguments trying to remove the shield of Section 514 ERISA preemption are unfounded and unsupported.

Counsel for the Prime Defendants and the Skanska Defendants advised the Court that there appeared to be a discrepancy between the Court's holding and dismissed claims. Plaintiffs' counsel submitted correspondence denying that there was any discrepancy and relying on its prior arguments should the Court review the issues raised by counsel. Pursuant to R. 4:42-2, a trial court has the discretion to revise an interlocutory order at any time before entry of final judgment. See also, Johnson v. Cyklop Strapping Corp., 220 N.J. Super. 250, 257 (App. Div. 1987), certif. denied, 110 N.J. 196 (1988)(holding that "the trial court has the inherent power to be exercised in its sound discretion, to review, revise, reconsider and modify its interlocutory orders at any time prior to the entry of final judgment.") and Lombardi v. Masso, 207 N.J. 517, 537 (2011)(finding that if a "judge later sees or hears something that convinces him that a prior ruling is not consonant with the interest of justice, he is not required to sit idly by and permit injustice to prevail"). Here, after reviewing the submissions by counsel, the Court *sua sponte* amends its prior ruling to be consistent with the Court's holding regarding the applicability of ERISA preemption to certain of plaintiffs' claims. The Court notes that the Patients can quickly be divided into two categories: those Patients whose Plans are ERISA Plans, and those Patients with non-ERISA plans (the "non-ERISA Patients"). The non-ERISA plans are Anthem Defendants' Patients L.O., C.H., and K.L.; and other Patients R.M., S.A., A.MG., and M.M.

ERISA has expansive preemption clauses. ERISA preemption may arise under Section 514(a), 29 U.S.C. § 1144(a), or under Section 502, 29 U.S.C. § 1132(a). Section 502 provides

complete preemption, preempting any state law cause of action, even if those claims are pleaded in terms of state law. Feit v. Horizon Blue Cross Blue Shield of New Jersey, 385 N.J. Super. 470, 484 (App. Div. 2006). Preemption under Section 514(a) states that "the provisions of this title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C.S. § 1144(a); 29 U.S.C. § 1144(c)(1) (including as state law "all laws, decisions, rules, regulations, or other State action having the effect of law, of any state"); Pascack Valley Hosp. v. Loc. 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393, 398 n.4 (3d Cir. 2004) ("Unlike the scope of § 502, which is jurisdictional and creates a basis for removal, § 514(a) merely governs the law that will apply to state law claims, regardless of whether the case is brought in state or federal court."). The Court acknowledges that recent State and Federal Court cases have narrowed ERISA preemption, noting that the "relate to" clause could expand to virtually any cause of action. See, e.g., Access Mediquip LLC, 662 F.3d at 382; see, e.g., Plastic Surgery Center, 967 F.3d at 229, n. 13; see, e.g., L.B.S. Constr. Co., 148 N.J. at 568-70, 575; see, e.g., Finderne Mgmt., 355 N.J. Super. at 189-90; see, e.g., St. Peter's, 431 N.J. Super. at 455-56.

The Court must determine if the claims brought by the Patients with ERISA Plans are preempted under Section 514(a). An ERISA plan is defined statutorily as follows:

> The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such

> plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1). In the present matter, counsel to the Defendants have certified that the Claims concerning certain Patients are governed by ERISA plans. Concerning the Anthem Patients, those Patients are Patients S.S., P.H., T.W., S.O., R.S. W.VN., W.L., and J.S. See Sirota Cert., Ex. B. As to the Prime Patients, those Patients are Patients G.F. and N.G. See Armstrong Cert., ¶ 6, Ex. 2, pg. 1; id., at Ex. 3, pg. 1. The Skanska Defendants assert that Plaintiff's Complaint admits that the Skanska Defendants received an ERISA plan by statutory definition, thus preempting all six claims therein. See Complaint, ¶ 18; and see Skanska Defendants' Moving Papers, at pg. 1, 6, 12. The Skanska Defendants' ERISA Patients are V.S. and H.P. While Plaintiffs argue that the Claims of the Skanska Defendants should not be preempted, Plaintiffs' arguments are devoid of any objection to the contention that the Skanska Defendants' Plans are ERISA Plans, nor that the Skanska Defendants insufficiently pleaded the elements of an ERISA Plan, including that the Skanska is a business sponsoring the employee health benefits plans. Plaintiffs have thus waived their right to argue that the Skanska Defendants Plans are not subject to a Section 514(a) evaluation.

The critical factor to consider in an evaluation of preemption under Section 514(a) is existence of an ERISA plan and the question of whether the Court's inquiry in evaluating the common law claims would require the Court to analyze the plan. St. Peter's, 431 N.J. Super. at 456. "Preemption does not occur 'if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with general laws of applicability.'" L.B.S. Constr. Co., 148 N.J. at 569 (quoting Travelers, 514 U.S. at 661); Plastic Surgery Center, 967 F.3d at 233-24 (holding that a cursory examination of the plan would not preempt the plan).

In the present matter, the causes of action are all New Jersey common law claims which arise from the purported underpayment by Defendants of emergency medical services rendered to Patients by out-of-network health care providers Plaintiffs. Plaintiffs have argued that the analysis of the issues will not turn on the contents of the Plans, but rather the Defendants' actions as compared to the industry standards by relying on the preauthorization letters. Generally, the Court would not be able to turn to the pre-authorization letters, as they are outside the four corners of the Complaint. An exception arises where the claim explicitly relies on a document to form its basis. Printing Mart-Morristown, 116 N.J. at 746; (citing Burlington Coat Factory Securities Litigation, 114 F.3d 1410, 1426 (1997); Rieder v. Department of Transp., 221 N.J. Super. 547, 552 (App. Div. 1987). This is to avoid a situation whereby a plaintiff may avoid dismissal of a legally deficient claim simply by failing to attach the document. Allowing the Court to consider such a document is not considered unfair to the plaintiff, because, by relying on the document in its

pleadings, the plaintiff is on notice that the document will be considered. As such, the Court may rely on the pre-authorization letters referenced in the Complaint.

Here, the four proffered preauthorization letters explicitly state that there is no guarantee of the payments authorized therein:

- O'Brien Cert., Ex. L: preauthorization letter issued to Patient C.H.[3], stating: "This is not an approval for claim payment. This approval is a confirmation of medical necessity only. We have not yet reviewed your health care plan. Depending on the limitations of the health care plan, we may pay all, part or none of the claim."
- Id., Ex. M: preauthorization letter issued to Patient P.H., stating: "Using evidence-based criteria, the item described above is considered to be medically necessary. However, this authorization is not a guarantee of payment; coverage is subject to all of the terms and conditions of the member's contract. Payment for the service(s) described above will be denied if any of the following are established: [listing excluding criteria]. The requested services pre-authorized might exceed the limits of the member's contract and would therefore not be covered."

[3] The Court notes that Patient C.H. is not one of the non-ERISA Patients, but includes the pre-authorization letter, because Plaintiff includes this letter in its opposition papers for the matters herein.

- Id., Ex. N: preauthorization letter issued to Patient T.W., stating: "Using evidence-based criteria, the procedure(s) described above is considered to be medically necessary. However, this authorization is not a guarantee of payment; coverage is subject to all of the terms and conditions of the member's contract. Payment for the service(s) described above will be denied if any of the following are established: [listing excluding criteria]."
- Id., Ex. O: preauthorization letter issued to Patient S.O., stating amongst other precautions that the amount covered may vary: "If you have selected a provider outside of the network, a lower benefit level may apply; resulting in higher deductibles, co-payments and/or coinsurance. Additionally, utilizing a provider outside of the network may result in significant additional financial responsibility for you, because your health benefit plan cannot prohibit non-network providers from billing you for the difference between the provider's charge and the benefit we provide."

The Court does not find that the pre-authorization letters establish a guarantee that payment to the out-of-network medical providers for the full UCR.

For this Court to determine whether Plaintiffs were underpaid, the Court would need to look to the services rendered to each individual Patient, whether that Patient's Plan covered that individual service, what the copays and deductibles were for each Plan, and any other nuance that may arise. The Court will necessarily be driven to precisely evaluate each ERISA Plan. St. Peter's,

431 N.J. Super. at 456; L.B.S. Constr. Co., 148 N.J. at 569; Plastic Surgery Center, 967 F.3d at 233-24. The Court thus finds that the claims "relate to" ERISA and are therefore preempted by Section 514(a). Accordingly, Anthem Defendants' Patients S.S., P.H., T.W., S.O., R.S. W.VN., W.L., and J.S. are hereby dismissed. Further, the claims against the Skanska Defendants and Prime Defendants, ERISA Patient plans, are dismissed.

The evaluation of the causes of action in the Complaint that arise from the Claims for the non-ERISA Patients are examined in depth below.

Defendants argue that Plaintiffs do not have standing to bring forth these matters. Defendants submit that R. 4:26-1 governs standing in New Jersey, providing "[e]very action may be prosecuted in the name of the real party in interest[.]" See also Triffin v. Somerset Valley Bank, 343 N.J. Super. 73, 80 (App. Div. 2001) (discussing that standing is a threshold inquiry that determines whether a party may "initiate and maintain an action before the court."); EnviroFinance Grp., L.L.C. v. Envtl. Barrier Co., LLC, 440 N.J. Super. 325, 339 (App. Div. 2015) ("A lack of standing by a plaintiff precludes a court from entertaining any of the substantive issues for determination.") (quoting In re Adoption of Baby T, 160 N.J. 332, 341 (1999). A party in interest must have "sufficient stake in the outcome of the litigation," a "real adverseness with respect to the subject matter," and a "substantial likelihood that [it] will suffer harm in the event of an unfavorable decision." In re Camden Cnty., 170 N.J. 439, 449 (2002); N.J. Citizen Action v.

Riviera Motel Corp., 296 N.J. Super. 402, 409-10 (App. Div. 1997); EnviroFinance Grp., 440 N.J. Super. at 340 (explaining that, in general, a party does not have standing to assert the rights of a third party).

Here, Defendants assert that several of the Patients' Plans contain a valid and enforceable anti-assignment provision rendering Plaintiffs without standing. Sirota Cert., Ex. B.; O'Brien Cert, Ex. A, p. 109; Id., Ex. C, p. 17, Id., Ex. D, p. M-81; Id., Ex. E, pg. 52; Id., Ex. J, p. 44; Id., Ex. K, p. 113. Because the claims cannot be assigned, leaving Plaintiffs without standing, Defendants assert that the Court must dismiss claims L.O. (Claim Nos. 6–8, 10), C.H. (Claim Nos. 12–14), K.L. (Claim No. 15), P.H. (Claim No. 16), W.L. (Claim No. 29), and J.S. (Claim Nos. 30–34, 36, 37). Defendants therefore maintain that Plaintiffs do not have standing to bring forth the claims in the Verified Complaint.

Plaintiffs counter that they do have standing to bring forth the present matter pertaining to all Patients listed in the Verified Complaint. As an initial matter, Plaintiffs assert that this argument goes beyond the pleadings, as it relies on unauthenticated documents completely unconnected to the Verified Complaint. Plaintiffs submit that in New Jersey, "[e]ntitlement to sue requires a sufficient stake and real adverseness with respect to the subject matter of the litigation. A substantial likelihood of some harm visited upon the plaintiff in the event of an unfavorable decision is needed for the purposes of standing." In re Baby T., 160 N.J. 332, 340 (1999).

Here, Plaintiffs submit that the Verified Complaint explicitly states that Plaintiffs have not pled nor are they asserting any third-party claims, submitting,

> All the claims in this action arise from state common, statutory, and regulatory law, and none are predicated on any purported federal law, right or statute (including for example, ERISA and FEHBA). Each plaintiff has asserted its own direct claims and causes of action, rather than derivative claims predicated on an Assignment of Benefits from a patient…. In addition, Blue Cross plans, e.g., Anthem, Highmark, routinely contain anti-assignment clauses, precluding federal standing and removal jurisdiction.
>
> Furthermore, all claims and causes of action herein arise from and/or under one or more "independent duties," unfettered by any type of federal preemption….
>
> In this action, plaintiffs do not assert any claim or recovery with respect to an assignment or right relating to a federal employee benefit plan…

Verified Complaint, ¶¶ 31, 67, 68. Plaintiffs contend, however, that they have standing regardless, because Plaintiffs have demonstrated a sufficient stake in the action as "Defendants grossly underpaid for these emergency services, i.e., just 5¢ on the dollar, and at this point, accumulated an outstanding balance exceeding $1.9 million, exclusive of interest" (VC, ¶ 33); because Plaintiffs have shown adverseness between the parties by way of the tone and substance of the motions; and because there is a substantial likelihood of some harm if Plaintiffs are denied standing, as they will have no other forum or remedy to address the wrongful conduct alleged in the Verified Complaint. Furthermore, Plaintiffs submit that, unlike Defendants' contention, the anti-assignment provisions could at most only bar standing of a third-party to sue Anthem for violating a plan term or right.

Defendants reiterate that the Plaintiffs' request for pre-authorizations and payments from Defendants for the pre-authorized services were submitted under the governing respective Plan

terms, and thus, the anti-assignment provisions in the Plans governing claims for Patients L.O., C.H., K.L., P.H., W.L., and J.S are applicable and enforceable, thus rendering Plaintiffs without standing to pursue these claims. See O'Brien Cert. Exs. A, C, D, E, J, & K.

For those claims not preempted by ERISA, the Court finds that Plaintiffs have standing to bring forth the causes of action within the Verified Complaint. The harm being asserted is the alleged underpayment by Defendants to Plaintiffs. Plaintiffs are the party that face a likelihood of substantial harm in the event of an adverse outcome to the litigation. See In re Baby T, 160 N.J. at 340.

Defendants submit that Anthem is not a proper party to the action, because Anthem does not administer or fund any of the Parties' Plans. Defendants submit that Anthem cannot be held responsible as a parent company for the acts of its subsidiaries, the Anthem Defendants. Defendants contend that only a Plan or Plan Administrator are proper defendants in a suit to recover ERISA benefits, because ERISA § 502(d)(2) provides that "[a]ny money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter." 29 U.S.C. § 1132(d). Defendants further submit that, where a plan administrator has not been designated within the plan, the plan sponsor that maintains the plan for the benefit of the employees becomes the plan administrator.

29 U.S.C. § 1002(16)(A)-(B). Defendants submit that Anthem is not liable under ERISA, because Anthem is not designated in the Plans as the plan administrator, and because Anthem is not the Patients' employer and therefore also not the Plan sponsor. Therefore, Defendants assert that the Verified Complaint should be dismissed as against Anthem in its entirety with prejudice.

Plaintiffs respond that Anthem is a proper party to this Verified Complaint. Plaintiffs deny that Anthem is a holding company that does not administer claims. Plaintiffs maintain that the Anthem Defendants are alter egos of each other and that the corporate veil can be pieced under the facts of this case. VC, ¶¶ 11, 12, 26, 44-49. Plaintiffs contend that, minimally, discovery must be conducted to discern the roles of the various Anthem entities before dismissing the Anthem Defendants from the lawsuit.

Defendants reply that, while it is undisputed that the other Anthem Defendants are administrators, Anthem is merely the parent holding company and is thus improperly named in this matter. Defendants maintain that there is no evidence or allegations to support that Anthem engaged in any claims administration or communications with Plaintiffs concerning the claims at issue, nor that Anthem funded, insured, or underwrote any of the Plans. Defendants further submit that Plaintiffs may not simply reprint portions of their Verified Complaint as a valid opposition, in hopes that it may be considered an argument. Accordingly, without a proper opposition,

Defendants assert that Plaintiffs cannot now argue that Anthem is anything more than a holding company, and the Verified Complaint must be dismissed against Anthem with prejudice.

The Court cannot make a determination at this juncture whether Anthem should be a party to this action. There is a factual dispute as to whether Anthem is a holding company to the other Anthem Defendants, whether Anthem could be considered a Plan Sponsor or a Plan Administrator in its own capacity, or whether Anthem is an alter ego whose corporate veil may be pierced for purposes of this litigation. The Court finds that discovery would need to be completed to fully determine Anthem's role in these matters, and thus dismissing Anthem as a Defendant at this point in the litigation is premature.

Defendants also assert that Plaintiffs have failed to sufficiently plead the necessary elements of each state law cause of action asserted in the Verified Complaint.

Defendants assert that Plaintiffs have not sufficiently plead a cause of action for breach of implied contract as stated in the First Count of the Verified Complaint. New Jersey law states that the "basic elements of a contract [are] offer, acceptance, and consideration." Smith v. SBC Commc'ns Inc., 178 N.J. 265, 283 (2004); EnviroFinance Group, LLC v. Envtl. Barrier Co., LLC, 440 N.J. Super. 325, 345 (App. Div. 2015) ("To prevail on a breach of contract claim, a party must prove a valid contract between the parties, the opposing party's failure to perform a defined obligation under the contract, and the breach caused the claimant to sustain damages.").

Defendants submit that a contract can only be enforced where the terms of the contract are specific enough to be understood and realistically enforced. Satellite Entm't Ctr., Inc. v. Keaton, 347 N.J. Super. 268, 277 (App. Div. 2002); Weichert Co, Realtors v. Ryan, 128 N.J. 417, 435 (1992) (quoting West Caldwell v. Caldwell, 26 N.J. 9, 24-25 (1958)) (internal quotations omitted) ("A contract arises from offer and acceptance, and must be sufficiently definite that the performance to be rendered by each party can be ascertained with reasonable certainty.").

Defendants insist that Plaintiffs do not and cannot plead mutually flowing bargained for consideration to support the formation of contract. Defendants contend that the Verified Complaint does not allege how Defendants, the insurers, benefitted and/or received consideration from Plaintiffs' performance of medical services on the Patients. Defendants maintain that there is nothing in the Verified Complaint that alleges that Plaintiffs intended to be bound to Defendants to perform medical services on the Patients. Defendants insist that this does not show the requisite meeting of the minds. And finally, Defendants contend that Plaintiffs' implied contract claim fails to allege specific terms of the alleged contract, but rather offers conclusory allegations that a contract existed. Defendants assert that, because Plaintiffs have failed to properly plead a cause of action for a breach of an implied contract, the First Count of the Verified Complaint should be dismissed.

Plaintiffs argue that is has properly plead a prima facie claim of breach of implied contract. Plaintiffs submit that, in New Jersey, "there are only two essential elements of a contract implied in law: (1) that the defendant has received a benefit from the plaintiff, and (2) that the retention of the benefit by the defendant is inequitable." Wanaque Borough Sewerage Auth. v. Twp. of W. Milford, 144 N.J. 564, 575 (1996) (rejecting "rigidity of Anglo–American pleadings [which] required some tangible basis for the enforcement of an implied-in-law contract."). Plaintiffs contends that, while Defendants rely on an absence of express terms, where the claim is for an implied contract, the terms thereto may also be implied, explaining,

> An implied contract is one in which the parties show their agreement by conduct. For example, if someone provides services to another under circumstances that do not support the idea that they were donated or free, the law implies an obligation to pay the reasonable value of services.
>
> Thus, an implied contract is an agreement inferred from the parties' conduct or from the circumstances surrounding their relationship. In other words, a defendant may be obligated to pay for services rendered for defendant by plaintiff if the circumstances are such that plaintiff reasonably expected defendant to compensate plaintiff and if a reasonable person in defendant's position would know that plaintiff was performing the services expecting that defendant would pay for them.

N.J. Model Jury Charge § 4.10E (approved May 1998) (citing Wanaque Borough Sewerage Auth. v. Twp. of W. Milford, 281 N.J. Super. 22, 30 (App. Div. 1995)). For purposes of an implied contract, Plaintiffs also argue that silence is evidence of intent to be bound. Weichert Co. Realtors v. Ryan, 128 N.J. 427, 436 (1992) ("the relationships between the parties or other circumstances may justify the offeror's expecting a reply and, therefore, assuming that silence indicates assent to the proposal"); Berman v. Gurwicz, 189 N.J. Super. 89, 93 (Ch. Div. 1981), aff'd, 189 N.J. Super.

49 (App. Div. 1983) ("Silence, in the face of a duty to disclose, may be a fraudulent concealment. The relationship of the parties may create that duty").

Here, Plaintiffs argue that Plaintiffs reasonably expected Anthem to compensate Plaintiffs at the emergency or UCR rate, which demonstrates the implied terms. Separate Statement of Facts, ¶¶ 1-2, 7-9, 14-50. Plaintiffs assert that consideration is apparent, as Plaintiffs' services were necessary for Defendants to fulfill their legal obligations, including to provide their members access to emergency medical care, as well as their regulatory obligation as to network adequacy. VC, ¶¶ 77, 79, 97-100. As for intent, Plaintiffs submit that the industry custom and regulatory context show intent by Defendants, even in light of their silence on the matter. Separate Statement of Facts, ¶¶ 1-2, 7-9, 14-50. Plaintiffs argue, therefore, in looking to the totality of the circumstances, an implied contract was formed between the Parties, as is sufficiently pled in the Verified Complaint, and thus, the First Count must not be dismissed.

Defendants respond that Plaintiffs' arguments in the opposition are not persuasive. Defendants contend that in order to assert a viable breach of an implied-in-fact contract under New Jersey law, Plaintiffs must allege (1) a valid contract between the parties, (2) the opposing party's failure to perform a defined obligation under the contract, and (3) damages flowing from that breach. EnviroFinance Group, LLC v. Envtl. Barrier Co., LLC, 440 N.J. Super. 325, 345 (App. Div. 2015). Defendants submit that Plaintiffs' basis for the claim of a breach of contract arises

from an alleged pattern of conduct from which contract terms can be inferred. Defendants maintain however, that the supposed pattern is too vague to amount to even an implied contract. See Satellite Entm't Ctr., Inc. v. Keaton, 347 N.J. Super. 268, 277 (App. Div. 2002) ("the [alleged] contract [is] so vague [and] indefinite that it [can]not realistically be enforced"); Weichert Co. Realtors v. Ryan, 128 N.J. 427, 435 (1992) (holding that an absence of a meeting of the minds and failure to include essential terms prevents recognition of parties' obligations). Defendants argue that alleging that a "reasonable person in Anthem's position would know that Atlantic was performing the medical services expecting that Anthem would pay plaintiffs" does not constitute a meeting of the minds; offer and acceptance; consideration; or reasonably definite terms. Defendants insist that Plaintiffs' allegations are conclusory and devoid of any allegations as to the alleged "course of conduct," or that Plaintiffs entered into any type of agreement with or promise from Defendants, or the details of their assent to be bound, or the terms of such purported agreement (including any payment/reimbursement term), or any specific provisions that were allegedly breached. As such, Defendants assert that the First Count fails as a matter of law and should be dismissed.

The Court finds that Plaintiffs have sufficiently pled an implied contract claim to the Defendants overseeing the claims of the non-ERISA Patients. The relationship between an insurer and a health service provider is not direct, and thus Defendants are correct in arguing that there are no defined parameters of an express contract upon which to rely. However, as pled, it is a

reasonable expectation by Plaintiffs that Defendants would have compensated Plaintiffs in light of the emergency medical services rendered to Patients, based on the industry standard and the regular course of conduct between an insurer and a health care provider. N.J. Model Jury Charge § 4.10E (approved May 1998).

Defendants assert that the Second Count of the Verified Complaint fails to state a claim for breach of the covenant of good faith and fair dealing. Defendants assert that there can be no breach of an implied covenant to the alleged contract, because Plaintiffs have failed to sufficiently plead each of the elements to establish a contract, including an implied contract. See Noye v. Hoffman-La Roche Inc., 238 N.J. Super. 430, 434 (App. Div. 1990) ("In the absence of a contract, there can be no breach of an implied covenant of good faith and fair dealing."). Defendants contend that even if the Court finds that there does exist an implied contract between Plaintiffs and Defendants, New Jersey law limits the application of the implied covenant of good faith and fair dealing to three distinct types of situations: (1) when the contract in question does not provide a term necessary to fulfill the parties' expectations; (2) when bad faith serves as a pretext for the exercise of a contractual right to terminate; and (3) when the contract expressly provides a party with discretion regarding its performance. See Seidenberg v. Summit Bank, 348 N.J. Super. 243, 260 (App. Div. 2002).

Defendants submit that Plaintiffs' Verified Complaint does not allege facts pertaining to any of these three situations. Defendants maintain that Plaintiffs have provided mere conclusory allegations based on a non-existent implied contract. Accordingly, Defendants assert that the Second Count of the Verified Complaint should be dismissed with prejudice.

Plaintiffs counter that it has adequately pled a claim for the breach of the implied covenant of good faith and fair dealing. Plaintiffs submit that "every contract in New Jersey contains an implied covenant of good faith and fair dealing." Sons of Thunder, Inc. v. Borden, Inc., 148 N.J. 396, 420 (1997). Plaintiffs contend that the implied covenant of good faith and fair dealing is breached when a "party exercises its discretionary authority arbitrarily, unreasonably, or capriciously, with the objective of preventing the other party from receiving its reasonably expected fruits under the contract." Wilson v. Amerada Hess Corp., 168 N.J. 236, 251 (2001). Plaintiffs also submit that a breach of the implied covenant of good faith and fair dealing may arise where the breaching party induces the other party to perform under the contract while the breaching party has no intent to do the same. Bak-A-Lum Corp. v. Alcoa Bldg. Prods., Inc., 69 N.J. 123, 131 (1976) (finding a breach of the implied covenant of good faith and fair dealing where defendant induced plaintiff to continue perform under contract, while "defendant's selfish withholding from plaintiff of its intention…to impair" their contractual relationship to further an ulterior plan); Brunswick Hills Racquet Club, Inc. v. Route 18, 182 N.J. 210, 231 (2005) (finding that the defendant had unjustly enriched itself in disregard to the harm caused to plaintiff through

defendant's "course of conduct, a series of evasions and delays, that lulled plaintiff into believing it had exercised the lease option properly"). Plaintiffs assert that the Verified Complaint sets forth distinct allegations and claims which arise to the standards required at the pleading stage, including that Defendants acted in bad faith in its conduct. See VC, ¶¶ 43, 62, 89, 95, 115. As such, Plaintiffs maintain that the Second Count cannot be dismissed.

Defendants reply that Plaintiffs' failure to adequately plead a contract renders the claim for a breach of the implied covenant of good faith and fair dealing unsustainable as a matter of law. Cumberland Farms, Inc. v. N.J. Dep't of Enviro. Protection, 447 N.J. Super. 423, 443 (App. Div. 2016) (finding that trial judge should have dismissed breach of covenant claim as there was no enforceable agreement between parties); Noye v. Hoffmann-La Roche, Inc., 238 N.J. Super. 430, 434 (App Div. 1990) (same). Defendants counter that Plaintiffs are incorrect in their assertion that a claim for a breach of the implied covenant of fair dealing may be advanced upon a theory that the allegedly breaching party tricked a party into performing. Wilson v. Amerada Hess Corp., 168 N.J. 236, 251 (2001) ("an allegation of bad faith or unfair dealing should not be permitted to be advanced in the abstract and absent improper motive"). Defendants further argue that the cases upon which Plaintiffs rely are inapposite to the present matter. See Bak-A-Lum Corp., 69 N.J. at 131 (a case involving the termination of a clause of an existing contract, and not evaluating a cause of action concerning the implied covenant of good faith and fair dealing); see Brunswick Hills Racquet Club, 182 N.J. at 231 (a case concerning intentional malicious conduct by a landlord who

would not allow a tenant to exercise a lease option by ignoring the tenant's phone calls and letters for two years). Here, Defendants maintain that Plaintiffs' Verified Complaint amounts to nothing more than conclusory statements and a list of grievances without sufficiently pleading the existence of a contract or a breach of the same. Defendants therefore insist that the Second Count must be dismissed.

The Court reiterates the reasoning in the evaluation of the First Count that Plaintiffs sufficiently pled the existence of an implied contract. The Court does not find that the Verified Complaint sets forth the ways in which Defendants allegedly acted in bad faith, but rather argues conclusory statements. Plaintiffs have not sufficiently pled that the purported underpayments was an action that was done arbitrarily, unreasonably, or capriciously. See Amerada Hess Corp., 168 N.J. at 251. Accordingly, the Second Count of the Verified Complaint is dismissed without prejudice.

Defendants assert that Plaintiffs have failed to state a claim for *quantum meruit* in the Third Count. Defendants submit that the quasi-contract claim fails because Plaintiffs must establish "(1) the performance of services in good faith, (2) the acceptance of the services by the person to whom they are rendered, (3) an expectation of compensation therefor, and (4) the reasonable value of the services." EnviroFinance Group, LLC, 440 N.J. Super. at 349-50; Pollack v. Quick Quality Rests., Inc., 452 N.J. Super. 174, 194 (App. Div. 2017) (finding that "plaintiffs[] did not perform services

for defendant's benefit" because the "benefit received by defendant . . . was obtained through defendant's own negotiations" and plaintiffs "had no involvement" in the agreement); see also Woodlands Cmty. Ass'n, Inc. v. Mitchell, 450 N.J. Super. 310, 318 (App. Div. 2017) ("[r]ecovery under the[] doctrine[] [of quantum meruit] requires a determination that defendant has benefited from plaintiff's performance.").

Defendants contend that Plaintiffs' claims are for *quantum meruit* are premised on Plaintiffs' rendering of medical services to the Patients pursuant to the various contracts entered between Plaintiffs and their Patients, who themselves are parties to contracts with Defendants as enrolled members of health benefits plans. Defendants argue that, while Plaintiffs' claim is premised on the allegation that the Defendants "received and retained a benefit because of Plaintiffs' rendering surgical and medical services," for which "Defendants failed to compensate Plaintiffs" (VC, ¶¶ 91-102), the Defendants, as the insurers, cannot be said to derive a benefit from those services, but rather an obligation to pay money to the insured. Defendants submit that the Verified Complaint is devoid of any allegation that Defendants received a benefit sufficient to establish a cognizable *quantum meruit* claim. Accordingly, Defendants assert that the Third Count of the Verified Complaint should be dismissed.

Plaintiffs respond that Defendants are mistaken in contending that a claim of *quantum meruit* requires that there be a benefit conferred. See Plastic Surgery Center, 967 F.3d at 24o, n.26

(3d Cir. 2020) (rejecting the benefit conferred requirement, holding that this "reasoning [based on Travelers] is at odds with the decisions of the New Jersey state courts that have allowed these types of unjust enrichment claims to proceed"); VRG v. GKN Realty, 135 N.J. 539, 554 (1994) (plaintiff can prove unjust enrichment by "expected remuneration from the defendant at the time it performed or conferred a benefit"); County of Essex v. First Union, 373 N.J. Super. 543, 550 (App. Div. 2004) ("most common circumstance for application of unjust enrichment is when a [party] has not been paid despite having had a reasonable expectation of payment for services performed or a benefit conferred"), aff'd, 186 N.J. 46 (2006). Plaintiffs submit that a cause of action for *quantum meruit* requires,

> (1) the performance of services in good faith, (2) the acceptance of the services by the person to whom they are rendered, (3) an expectation of compensation therefor, and (4) the reasonable value of the services.

Starkey, Kelly, Blaney & White v. Estate of Nicolaysen, 172 N.J. 60, 68 (2002). Here, Plaintiffs maintain that there was a reasonable expectation of payment by Defendants for the emergency surgical services Plaintiffs performed. Plaintiffs contend that this is sufficient on a claim for *quantum meruit*.

Defendants reply that the Third Count for a claim of *quantum meruit* fails as a matter of law. Defendants distinguish caselaw upon which Plaintiffs rely, contending that Estate of Nicolaysen, 172 N.J. 60 (2002) states that "Courts generally allow recovery in quasi-contract when one party has conferred a benefit on another," which Defendants contend includes the provision

and acceptance of services. Id., at 68; see also Plastic Surgery, 967 F.3d at 237 (listing causes of action in the complaint, but declining to include *quantum meruit*). Here, Defendants argue that Plaintiffs cannot claim a benefit, as Plaintiffs merely rendered medical services to Patients, and any expectation for compensation exceeding the amounts set forth in the health benefits Plans is unreasonable. Additionally, Defendants maintain that Plaintiff's argument that a supposed pattern of conduct should entitle Plaintiffs to the UCR or the as-billed charges is insufficient as a matter of law.

The Court does not find that Plaintiffs sufficiently pled a claim for *quantum meruit*. In a claim for *quantum meruit* the compensation or benefit conferred is sought from the person to whom the services were rendered. In looking for guidance as to how to evaluate the present matter, the Court turns to an order entered in Mercer County. That Court found that the plaintiff did not have a claim for *quantum meruit*, because the defendant was not the party that accepted services. The Court explained:

> Plaintiff claims that it conferred a benefit on Defendant when it rendered services to D.K. and D.A. based on its "detrimental reliance" on the statements made by the Defendant customer service representatives. The Court does not find that Defendant received any benefit in the Plaintiff performing services to D.K. and D.A. See Plastic Surgery Ctr., LLC v. Oxford Health Ins. Inc., 2019 WL 4750010, at *4 (D.N.J. Sep. 30, 2019) ("'[A]n insurance company derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money to the insured – which can hardly be called a benefit.'"). [sic]

Anthem Defendants' Reply Brief, Sirota Cert., ¶ 3, Ex. A, pg. 108-11 (Princeton Neurological Surgery, P.C. v. Horizon Blue Cross Blue Shield of New Jersey, Docket No. MER-L-796-19); id,

at 117-26 (distinguishing a case that did not provide any out-of-network coverage, as "the only way the out-of-network provider in Plastic Surgery Center could receive payment from the health insurer for services rendered is if it entered into an agreement with the health insurer that excited outside of the terms of the ERISA-governed plans because those plans did not otherwise provide coverage"); see also, Aetna Health, Inc. v. Srinivasan, 2016 N.J. Super. Unpub. LEXIS 1515, *15 (June 29, 2016) (finding that past conduct between the same health care provider and insurer demonstrated the insurer had consistently paid the full value of the services following the issuance of a pre-authorization letter). While the Court acknowledges that unpublished opinions are not binding on this Court, the Court may look to those opinions to gain understanding as to how to evaluate similar matters. Here, emergency services were similarly rendered to the Patients, not to Defendants. Thus, the Court does not find that Defendants conferred a benefit from the emergency medical services. Accordingly, the Third Count of the Verified Complaint is dismissed without prejudice.

Defendants assert that Plaintiffs have failed to state a claim for promissory estoppel in the Fourth Count. Defendants submit that, to plead a claim for promissory estoppel, a plaintiff must allege "(1) a clear and definite promise; (2) made with the expectation that the promisee will rely on it; (3) reasonable reliance; and (4) definite and substantial detriment." Toll Bros., Inc. v. Bd. Of Chose Freeholders of Burlington, 194 N.J. 223, 253 (2008) (citations omitted); E. Orange Bd. Of Educ. v. N.J. Sch. Constr. Corp., 405 N.J. Super. 132, 148 (App. Div. 2009), certif. denied, 199

N.J. 540 (2009) (quoting Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499 (App. Div.), cert. denied, 177 N.J. 224 (2003)).

Defendants first argue that the accusation that Defendants "undertook conduct" does not meet the requisite specificity required to meet the burden for the first element. VC, ¶ 104. Defendants further submit that Plaintiffs' claim that Defendants "indicated and conveyed that reasonable payment would be made" through "the parties' course of dealings [and] industry custom" is not a sufficient and clear promise. Id. at ¶ 106; see also E. Orange Bd. Of Educ. v. N.J. Sch. Constr. Corp., 405 N.J. Super. 132, 147 (App. Div. 2009) (dismissing claim where plaintiff articulated nothing more than general expectation of payment); and see Malaker Corp. Stockholders Protective Comm. First Jersey Nat'l Bank, 163 N.J. Super. 463 (App. Div. 1978) (dismissing promissory estoppel claim because the alleged promise for a bank loan, where neither the amount of the loan nor the collateral was specified, was not sufficiently clear or definite). Next, Defendants assert that Plaintiffs have failed to sufficiently plead reliance, as evidence by the admission that Plaintiffs "were and are required to provide emergent care to all patients, regardless of their ability to pay, or the source of payment." VC, ¶¶ 36, 107-08. Defendants argue that Plaintiffs have not pled a promise or even a statement upon which Plaintiffs relied in coming to the conclusions that Defendants owed Plaintiffs any obligation. Finally, Defendants submit that Plaintiffs have not sufficiently pled damages, because the Patients, not Defendants, are obligated

to pay outstanding balances to Plaintiffs. For all of these reasons, Defendants assert that the Fourth Count of the Verified Complaint should be dismissed.

Plaintiffs counter that the Fourth Count for promissory estoppel should stand. Plaintiffs argue that Defendants have improperly applied cases that evaluate causes of action for promissory estoppel on a higher standard than is required at the pleading stage. Plaintiffs insist that the "clear and definite" requirement of Malaker has been relaxed in more recent decisions. Pop's Cones, Inc. v. Resorts Int'l Hotel, Inc., 307 N.J. Super. 461, 469–70 (App. Div. 1998) ("[M]ore recent decisions have tended to relax the strict adherence to the Malaker formula for determining whether a prima facie case of promissory estoppel exists. This is particularly true where, as here, a plaintiff does not seek to enforce a contract not fully negotiated, but instead seeks damages resulting from its detrimental reliance upon promises made during contract negotiations despite the ultimate failure of those negotiations."); accord *N.J. Model Civil Charge* § 4.10K (05/98), at pg. 1, n.1 (explaining that courts increasingly relax the strict adherence to a heightened standard of proof for the 'clear and definite' promise element of a promissory estoppel claim). Moreover, Plaintiffs argue that Malaker applies after the completion of discovery, rather than before. Malaker, 163 N.J. Super. at 468. Here, Plaintiffs contend that the Verified Complaint adequately provides the elements of promissory estoppel, as required by Printing Mart-Morristown v. Sharp Electronics Corp., 116 N.J. 739, 746 (1989). See VC, ¶¶ 104, 113. As such, Plaintiffs maintain that there is no need to dismiss the Fourth Count.

Defendants reply that Plaintiffs have failed to state a claim for promissory estoppel. Defendants distinguish the case upon which Plaintiffs rely to assert that the "clear and definite" standard has been relaxed, contending that Pop's Cones, Inc. stands for those circumstances in which a party "seeks damages resulting from its detrimental reliance upon promises made during contract negotiations." Pop's Cones, Inc., 307 N.J. Super. 461, 469–70 (App. Div. 1998); see also Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499-500 (App. Div. 2003) (explaining that the holding of Pop's Cones, Inc. was only to be applied to that narrow fact patter, and did not overturn the "clear and definite" showing of a promise requirement from Malaker in all cases). Because Plaintiffs have not proffered allegations of contract negotiations, Defendants insist that promissory estoppel arising therefrom cannot be evaluated under the Pop's Cones, Inc. standard. Defendants maintain that, even if the lower standard did apply, Plaintiffs have fallen short of demonstrating promissory estoppel, as the Verified Complaint merely asserts that Defendants "undertook conduct" and "indicated and conveyed that reasonable payment would be made," which Plaintiffs understood to mean that their full-billed charges would be paid. VC, ¶¶ 104, 106. Although not in the Verified Complaint, Defendants submit that Plaintiffs' argument falls short that the pre-authorization letters are evidence of the type of conduct required to demonstrate a promise, as the pre-authorization letters state that payments are subject to the terms of the respective health benefits Plans, and were not guarantees of payment. Accordingly, Defendants maintain that the Fourth Count should be dismissed.

The Court does not find that Plaintiffs sufficiently pled a claim of promissory estoppel. The industry standard and course of conduct rely primarily on the pre-authorization letters, which explicitly state that the receipt thereof does not guarantee payment at all. On the other hand, Plaintiffs are required to provide emergency medical services to those patients who require them, with or without any guarantee or promise of payment. Accordingly, the Fourth Count of the Verified Complaint is dismissed without prejudice.

Defendants assert that Plaintiffs have failed to state a claim for negligent misrepresentation in the Fifth Count. New Jersey R. 4:5-8 requires that a plaintiff plead the "particulars of the wrong, with dates and items if necessary" for allegations of misrepresentation. Defendants submit that negligent misrepresentation requires proof that an "incorrect statement was negligently made and justifiably relied upon and that injury was sustained as a consequence of that reliance." Sarlo v. Wells Fargo Bank, N.A., 174 F. Supp. 3d 412, 425 (D.N.J. 2015) (citing Mason v. Coca-Cola Co., 774 F. Supp. 2d 699, 704 (D.N.J. 2011); ADS Assocs. Grp., Inc. v. Oritani Sav. Bank, 219 N.J. 496, 521 (2014) (negligent misrepresentation claims "must be pled with particularity in accordance with Rule 4:5-8."); Kuhnel v. CNA Ins. Cos., 322 N.J. Super. 568, 581 (App. Div. 1999) (affirming trial court's dismissal of negligent misrepresentation because plaintiff failed to show detrimental reliance); see also Union Ink Co., Inc. v. AT&T Corp., 352 N.J. Super. 617, 646 (App. Div. 2002) (explaining that negligent misrepresentation requires a showing of justifiable reliance).

Here, Defendants contend that the record is devoid of details explaining what the alleged misrepresentations are or when they may have occurred. Defendants contend that Plaintiff's claim of negligent misrepresentation is conclusory and insufficient for only alleging that false representations were made and that those supposed representations damaged Plaintiffs. Moreover, Defendants assert that New Jersey law specifically holds that "[n]o hospital shall deny any admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payment." N.J.S.A. § 26:2H-18.64. Defendants contend that Plaintiffs therefore cannot claim that there was any reliance on payment for the emergency treatment rendered. As Plaintiff's pleadings do not meet the requisite particularity as required by R. 4:5-8, Defendants assert that the Fifth Count of the Verified Complaint must be dismissed.

Plaintiffs counter that Defendants have applied the wrong standard in arguing that the Verified Complaint is devoid of details. Plaintiffs submit that R. 4:5-8(a) only requires that pleadings set forth the "particulars of the wrong . . . insofar as practicable." R. 4:5-8(a); Dreier Co., Inc. v. Unitronix Corp., 218 N.J. Super. 260, 273-74 (App. Div. 1986) (holding that plaintiffs need not plead in details those matters that are held for discovery and "reject[ing] defendants' contention that plaintiff's claim of common-law fraud should be dismissed because plaintiff failed to plead the cause of action with particularity"); State, Dep't of Treasury v. Qwest Comms. Inter'l, Inc., 387 N.J. Super. 469, 485-86 (App. Div. 2006) ("reject[ing] Andersen's contention that NJT's claim of common-law fraud should be dismissed because NJT failed to plead the cause of action

with particularity. R. 4:5-8(a). An indulgent reading of the allegations in the amended complaint satisfies us that NJT has stated the necessary elements."); Talalai v. Cooper Tire & Rubber Co., 360 N.J. Super. 547, 565 (Law. Div. 2001) (holding "defendant's motion to dismiss is hereby DENIED . . . Defendant's argument that plaintiffs' complaint fails to plead fraud with the requisite particularity required by R. 4:5-8 falls short. The information cited by the defendant as lacking—the date plaintiffs' tires were purchased, the type of tire, the size, and the price of the tires—are matters of discovery."). Plaintiffs further argue that the rule of particularity is relaxed where movants are alleging acts against parties acting in concert, explain,

> [Plaintiff]'s complaint alleges that the defendants knowingly and falsely represented that they would provide him with customer leads . . . Those allegations satisfy the requirement of R. 4:5–8 . . . *[T]he failure of the complaint to specify which defendant did what, with respect to both claims, appears justifiable since, read indulgently, the thrust of the complaint is that the defendants were acting in concert.*

Kavky v. Herbalife, 359 N.J. Super. 497, 509 (App. Div. 2003) (emphasis added by Plaintiffs). Here, Plaintiffs maintain that the Verified Complaint sets forth a course of dealing with the Defendants upon which Plaintiffs reasonably relied, in addition to the pre-authorization forms, to establish negligent misrepresentation by the multiple Defendants.

Defendants reply in maintaining that Plaintiffs have not set forth proper pleadings for a cause of action for negligent misrepresentation. Defendants concede that Plaintiffs have set forth specific facts including the individual Defendants' reference numbers, the Patients' identification

numbers, the dates of the subject services, and the amounts billed, paid and outstanding for each service. Defendants insist, however, that Plaintiffs have not proffered information that would show the amount that Defendants supposedly promised to be paid for each service. Moreover, Defendants submit that Plaintiffs' argument is inapplicable here that the Verified Complaint need not set forth the specificities of the alleged negligent misrepresentation where multiple Defendants are acting in concert. Defendants deny acting in concert at any point prior to the initiation of this lawsuit, but rather maintain that the claims are for medical services performed on different patients, on different dates, and processed and paid pursuant to different health benefits Plans. Defendants maintain that the Verified Complaint is nothing more than broad, conclusory statements. Rego Indus., Inc. Am. Modern Metals Corp., 91 N.J. Super. 447, 456 (App. Div. 1966) (holding that mere conclusory statements do not satisfy the particularity requirement). Lastly, Defendants submit that the pre-authorization letters cannot be relied on, as the letters explicitly states that the letters are not a guarantee of payment. Accordingly, Defendants argue that the Fifth Count must be dismissed.

The Court finds that Plaintiffs have sufficiently pled a misrepresentation claim as against the Defendants that are overseeing the claims of the non-ERISA Patients. Accordingly, the motion to dismiss the Fifth Count of the Verified Complaint is denied.

Defendants assert that Plaintiffs have failed to state a claim for tortious interference with economic advantage in the Sixth Count. Under New Jersey law, to state a claim for tortious interference with prospective economic advantage, a plaintiff must show: "(1) a protected interest, which need not amount to an enforceable contract; (2) intentional interference with that protected interest without justification; (3) the reasonable likelihood that the anticipated benefit from the protected interest would have been realized but for the interference; and (4) economic damage as a result." C&J Colonial Realty, Inc. v. Poughkeepsie Sav. Bank, FSB, 355 N.J. Super. 444, 478 (App. Div. 2002). Defendants submit that the allegations must be against defendants who are not party to the contractual relationship. Van Natta Mech. Corp. v. Di Staulo, 277 N.J. Super. 175, 182 (App. Div. 1994). Additionally, the complaint must allege that the "defendant's actions were intentional and malicious" where malice is defined to mean "that the harm was inflicted intentionally and without justification or excuse." Id. (citation omitted).

Here, Defendants argue that Plaintiffs merely rely on vague and conclusory allegations. Defendants submit that the Verified Complaint does not allege any direct or implied protected interest with which the Defendants purportedly interfered. Accordingly, Defendants assert that the Sixth Count of the Verified Complaint must be dismissed.

Plaintiffs argue that the Sixth Count should not be dismissed, as Plaintiffs can demonstrate interference with a contract. Plaintiffs rely on the following to explain intentional interference of a contract without justification:

> Malice is not used here in its literal sense to mean "ill will"; rather, it means that harm was inflicted intentionally and without justification or excuse. It is determined on an individualized basis, and the standard is flexible, viewing the defendant's actions in the context of the facts presented. Often it is stated that the relevant inquiry is whether the conduct was sanctioned by the "rules of the game," for where a plaintiff's loss of business is merely the incident of healthy competition, there is no compensable tort injury . . . The line clearly is drawn at conduct that is fraudulent, dishonest, or illegal and thereby interferes with a competitor's economic advantage . . . [D]efendant claiming a business-related excuse must justify not only its motive and purpose, but also the means used. . . [N]ot all sanctioned conduct or customs of a specific industry will be immune from claims for tortious interference . . . "even if the defendant had established that the custom in the trade was to pirate salesmen from competitors, this court would not permit such a custom to justify and legitimatize what otherwise would be tortious conduct. The role of the court is to raise the standard of business morality and care, not judicially to sanction tortious activities. Higher standards benefit and protect both the innocent member of the industry and the general public.

Lamorte Burns & Co. v. Walters, 167 N.J. 285, 306-08 (2001). In the present case, Plaintiffs argue that the Verified Complaint, as supported by Lamorte Burns, sufficiently pleads the allegations to establish the elements of tortious interference, and thus, the Sixth Count should not be dismissed. VC, ¶¶ 1-2, 7-9, 14-50.

Defendants respond that Plaintiffs' reliance on Lamorte Burns is inapposite, as Lamorte Burns actually supports Defendant's argument that Plaintiffs needed to, but failed to, allege conduct that was malicious or even "fraudulent, dishonest, or illegal." Lamorte Burns, 167 N.J. 285, 307 (2001); Kopp, Inc. v. United Technologies, Inc., 223 N.J. Super. 548, 559 (App. Div.

1988) (holding that a complaint asserting tortious interference must allege that the interference was done with malice). Defendants maintain that Plaintiffs' reliance on pre-authorization letters that explicitly stated that payment was not guaranteed cannot be construed to be viewed as a tortious interference of contract or a tortious interference for prospective economic advantage. Moreover, Defendants insist that the Verified Complaint is devoid of facts that set forth the purported economic advantage with the supposed conduct interfered. Leslie Blau Co v. Alfieri, 157 N.J. Super. 173, 185-86 (App. Div. 1978) (explaining that a "plaintiff must show that "if there had been no interference, there was a reasonable probability that the victim of the interference would have received anticipated economic benefits."). Defendants maintain that the Sixth Count is nothing more than conclusory statements that are insufficient, even at the pleading stage. Accordingly, Defendants argue that the Sixth count must be dismissed.

The Court does not find that allegations in the Complaint have established a tortious interference with a contract. The Court reiterates that the use of the preauthorization letters alone to show detrimental reliance on a contract is insufficient here, as the letters state that payment is not guaranteed. Accordingly, the Sixth Count of the Verified Complaint is dismissed without prejudice.

Defendants assert that the New Jersey State statutes and regulations referred to in the Verified Complaint are inapplicable to this case. Defendants submit that Plaintiffs have claimed

that Defendants must pay Plaintiffs 100% of the UCR pursuant to N.J.A.C. 11:22-5.8, 11:24-5.1, 11:24-5.3, and 11:24-9.1(d), and that Defendants must promptly pay claims pursuant to N.J.S.A. 17B:30-23, 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2 and 26:2J-8.1. First, Defendants maintain that, to the extent that any of the claims relate to ERISA-governed plans, the claims are preempted. Second, Defendants insist that a statute must provide a plaintiff with a private cause of action where the damages sought arise from an alleged violated of state law. R.J. Gaydos Ins. Agency, Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 271–76, 279–81 (2001). New Jersey courts consider whether: (1) plaintiff is a member of the class for whose special benefit the statute was enacted; (2) there is any evidence that the Legislature intended to create a private right of action under the statute; and (3) it is consistent with the underlying purposes of the legislative scheme to infer the existence of such a remedy. Id. at 272; see generally Jalowiecki v. Leuc, 182 N.J. Super. 22 (App. Div. 1981) (same).

Here, Defendants contend that the statutes cited do not give rise to a private right of action, because the statutes were enacted to protect consumers and concern the rights of patients who subscribe to health care plans, and do not protect providers like Plaintiffs. See e.g., N.J.S.A. § 26:2H-18.64 ("No hospital shall deny any admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payments.") (VC, ¶ 36); and see e.g., N.J.A.C. § 11:24-5.1(a) ("The [health maintenance organization ("HMO")] shall, at a minimum, provide or arrange for the provision to its members all basic comprehensive health care services and all other services

enumerated in this subchapter in N.J.S.A. § 26:2J-1 et seq., as it may be amended from time to time.") (VC, ¶ 37); and see e.g., N.J.A.C. § 11:24-5.3(a) ("The HMO shall establish written policies and procedures governing the provision of emergency and urgent care which shall be distributed to each subscriber at the time of initial enrollment.") (VC, ¶ 75); and see e.g., N.J.A.C. § 11:24-5.8(a) ("[Point of service] contracts issued by health maintenance organizations and health service corporations, and [selective contracting arrangement] policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider[.]") (VC, ¶ 75); and see e.g., N.J.A.C. § 11:24-9.1(d)(1)-(13) (listing the requirements for inclusion in a "statement of the member's rights") (VC, ¶ 75); and see e.g., N.J.A.C. § 11:24A-2.5(b)(2) (stating insurance carriers' policies and procedures "shall address" the right of "covered persons to have access to services, and payment of appropriate benefits therefor, when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions, if covered") (VC, ¶ 75). As these provisions all relate to the rights of third-party subscribers, Defendants assert that, even if these claims were not all preempted by ERISA, Plaintiffs would not have standing to bring these claims and therefore the Verified Complaint should be dismissed.

Plaintiffs respond that Defendants' argument is moot, as it seeks to dismiss claims that are not asserted, because the Verified Complaint has not asserted independent causes of action under any statute or regulation. Plaintiffs submit that the Verified Complaint merely explains that New

Jersey statutes and regulations require that health insurers and insurance administrators are required to timely issue payments to providers and guarantee that the payment is large enough to ensure that a patient is covered when seeking emergency medical services. See VC, ¶¶ 36-37, 75, 78; see N.J.S.A. § 17B:30-33; see N.J.A.C. § 11:22–1.1(a); see N.J.A.C. § 11:22-5.8; see N.J.A.C. § 11:24-5.3; see N.J.A.C. § 11:24-5.1; see N.J.A.C. § 11:24-9.1(d). Plaintiffs contend that addressing these regulations provide context to the parties' course of dealings, industry custom, as well as potential standards of care. Accordingly, Plaintiffs suggest that Defendants' arguments merely seeking improper advisory opinions and need not be addressed.

Defendants concede that there are no causes of action within the Verified Complaint that arise solely from one of the listed statutes and regulations cited therein, however, Defendants insist that Plaintiffs have manipulated the statutes and regulations to improperly suggest that they demonstrate course of conduct in the industry. Defendants first argue that the listed provisions do not apply to employer-funded health plans. See N.J.S.A. §26:2H-18.64 (applying to hospitals); see N.J.A.C. § 11:22-5.8 (applying to "health maintenance organizations," "health service corporations," and "insurance companies"); see N.J.A.C. § 11:24-5.1 (applying to health maintenance organizations); see N.J.A.C. § 11:24-5.3 (applying to health maintenance organizations); see N.J.A.C. § 11:24-9.1 (applying to health maintenance organizations). Defendants secondly submit that Plaintiffs have misconstrued the law in omitting that it is well-established that "the breach of administrative regulations does not of itself give rise to a private

right of action." Ferraro v. City of Long Branch, 314 N.J. Super. 268, 287 (App. Div. 1998); see N.J.S.A. §26:2H-18.64; see N.J.A.C. § 11:22-5.8; see N.J.A.C. § 11:24-5.1; see N.J.A.C. § 11:24-5.3; see N.J.A.C. § 11:24-9.1. To determine whether a statute or regulation confers an implied right of action, Defendants insist that the Court must consider, whether a plaintiff is a "member of the class for whose special benefit the statute was enacted[;]" (2) whether there is "any evidence that the Legislature intended to create a private right of action[;]" and (3) whether it is "consistent with the underlying purposes of the legislative scheme to infer the existence of such a remedy." R.J. Gaydos Ins. Agency, Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 272 (2001). Defendants therefore maintain that the provisions confer neither an express nor an implied right of action. Accordingly, Defendants argue that the Court cannot rely upon the listed statutes and regulations within the Verified Complaint.

The Court concurs with Plaintiffs that Defendants' argument is inapposite that the New Jersey statutes and regulations referenced in the Verified Complaint must be dismissed. There are no claims that arise under any of the listed statutes and regulations and there are no private rights of actions asserted therefrom. The Court finds that Defendants' argument is moot.

Defendants assert that Plaintiffs' demand for compensatory damages, jury trial, and attorneys' fees must be stricken. Defendants submit that ERISA does not permit recovery of extra-contractual or punitive damages. See Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)

(stating that lack of express inclusion in ERISA Section 502(a) of a remedy of extra-contractual damages precluded recovery of such damages). Defendants similarly argue that there is no right to a jury trial under ERISA. Finally, Defendants submit that New Jersey favors parties bearing their own attorneys' fees, absent express authorization by statute, court rule, or contract. See State, Dept. of Environmental Protection v. Ventron Corp., 94 N.J. 473, 504 (1983) (relying on R. 4:42-9). Defendants argue that, because these exceptions do not exist in the instant matter, Plaintiffs have not established a right to attorneys' fees. For the foregoing reasons, Defendants insist that the Court deny the request for compensatory damages, jury trial, and attorneys' fees.

Plaintiffs respond that ERISA limitations on damages and juries do not apply. Because the Verified Complaint pleads six counts of New Jersey common law causes of action, Plaintiffs argue that the federally governed ERISA limitations do not apply to the instant matter. Plaintiffs thus assert that the Verified Complaint's *ad damnum* clauses and jury demand should not be stricken.

Defendants counter that ERISA explicitly prohibits compensatory damages, and that there is no right to a jury trial under ERISA. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). Defendants maintain that the claims within Plaintiffs' Verified Complaint are governed by ERISA, and thus the demand for both compensatory damages and a jury trial must be stricken.

Defendants request, in the alternative and in the interests of judicial economy, that Plaintiffs' claims be severed. New Jersey Court Rule 4:38-2(a) provides that "[t]he court, for the

convenience of the parties or to avoid prejudice, may order a separate trial of any claim . . . or separate issue, or any number of claims . . . or issues." Defendants submit that decisions about whether to sever under Rule 4:38-2(a) are "within the sound exercise of a trial court's discretion." Wolosky v. Fredon T'ship, 472 N.J. Super. 315, 332 (App. Div. 2022) (citation omitted); Cogdell by Cogdell v. Hosp. Ctr. at Orange, 116 N.J. 7, 27-28 (1989), citing Crisipin v. Volkswagenwerk, A.G., 96 N.J. 336, 354-55 (1984) ("Any possible unfairness to litigants, confusion in the presentation of issues, administrative unmanageability, or distortion in the truth-determining process that may result from compulsory joinder of parties-or claims-can be eliminated or at least minimized by a trial court possessed of the discretion to excuse joinder or to order severance.").

Defendants submit that the lawsuit should be severed into sixteen separate lawsuits, representing the individual Patients, who each have unique claims, with different facts, governed by different employee benefit plans and administered by different entities. Defendants argue that each claim is feasible standing alone. Defendants also submit that it would be highly unlikely that there would be any overlap in defense witnesses for each of the Patients. Defendants insist that, while Plaintiffs will not be prejudiced by a severance, Defendants would be, because of the continuous requirement to simultaneously analyze each of the Patients at each stage of the litigation, particularly as each Patient was administered a separate Plan by one of several different Plan Sponsors. Because there is no efficiency gained in bringing all of the claims in the Verified Complaint in one lawsuit, because there is no valid justification to keep the Patients together,

because severance would prevent jury confusions, and because judicial efficiency warrants severance, Defendants request that the Court sever the claims.

Alternatively, the Prime Defendants request that St. Michael's be dismissed individually, because Plaintiffs have not alleged that they provided any services to Patient N.G., who is the only Patient that Plaintiffs claim St. Michael's funded.

Plaintiffs argue that Defendants improperly seek to have the claims severed into sixteen separate lawsuits. Plaintiffs contend that this request is unsupported by legal authority or controlling facts. Plaintiffs distinguish Defendants' use of R. 4:38-2(a), which permits a Court to "order a separate trial of any claim" to prevent the confusion of a jury only once a matter reaches trial. Plaintiffs insist that applying this rule is premature and speculative, as the instant lawsuit has not even begun discovery. Plaintiffs also distinguish the caselaw provided by Defendants, contending that the cases were misapplied and inapplicable to the instant matter. See Cogdell v. Hosp. Ctr. at Orange, 116 N.J. 7, 26-29 (1989) (discussing entire controversy & joinder of new parties, but not discussing severance); Mystic Isle Dev. Corp. v. Perskie & Nehmad, 142 N.J. 310, 324 (1995) (same); Hobart Bros. Co. v. Nat'l Union Fire Ins. Co., 354 N.J. Super. 229, 244–45 (App. Div. 2002) (same). Plaintiffs suggest that Defendants' request is driven by a perceived litigation advantage, rather than legal need. Plaintiffs maintain that, although there are sixteen separate Patients at issue, the core set of facts pertains to all Patients and their Administrators. VC,

¶¶ 1-2, 7-9, 14-50. Plaintiffs insist that Defendants are mistaken in contending that this action requires separate and in-depth inquires into the sixteen respective Plans, but rather submit that the Court need only look to the patterns of behavior of Defendants in comparison to industry standards. Plaintiffs assert that these matters involve interrelated and overlapping experts and discovery, and therefore, judicial economy does not favor their separation. Moreover, Plaintiffs submit that this request violates the entire controversy doctrine, which requires that these matters be litigated together. To explain the entire controversy doctrine, Plaintiffs quote,

> The entire controversy doctrine as traditionally invoked is not without some disadvantages . . . What must be stressed are the comparative benefits in disposing of an entire controversy in a single, comprehensive, though complex, litigation, as opposed to piecemeal disposition of one controversy in successive actions . . . [C]ounsel's fragmentation of the controversy and tactical maneuvers have traduced the doctrine's goals of judicial conservation, fairness to litigants, avoidance of confusion and uncertainty, and assurance of just results. His actions cannot be reconciled with the strong policy of single litigation encompassed by the entire controversy doctrine . . . A party should not be permitted to maintain such independent action when a directly related suit is pending. The aims served by a rule mandating the joinder of parties in circumstances such as these are so central to a responsive and principled system of judicial administration that it is unacceptable to leave the decision of joinder to the parties themselves. Procedural maneuvering by attorneys that spread-eagles litigation and squanders judicial resources ostensibly to achieve the best result for a client will only rarely and fortuitously produce the just and fair result that is the goal of the justice system.

Crispin v. Volkswagenwerk, A.G., 96 N.J. 336, 354–55 (1984) (concurrence, Handler, J.). For all of these reasons, Plaintiffs maintain that separate the claims would be duplicative and costly, and thus the Court should not entertain Defendants' request.

In response to the Prime Defendants' assertion that no allegations have been raised in connection with St. Michael's only Patient within the Verified Complaint, Patient N.G., Plaintiffs deny this argument, and refer to the following in the Verified Complaint,

> Defendant Prime Healthcare Services–St. Michael's LLC, doing business as Saint Michael's Medical Center, ("St. Michael's") maintains its office at 111 Central Avenue, Newark, New Jersey 07102. St. Michael's is, on information and belief, a citizen of New Jersey. It registered to do business in the State of New Jersey, see N.J. Entity ID # 0400584178, and so consented to its jurisdiction and regulation. At all relevant times, St. Michael's sponsored, funded and/or administered a plan relating to Patient N.G.

VC, ¶ 23. As such, Plaintiffs insist that the Prime Defendants should not be severed or dismissed from the lawsuit.

Defendants reply that Plaintiffs' arguments are unavailing that the claims of the sixteen Patients are related. Defendants insist that the alleged patterns of behavior do not rise to the burden of a group plea that is required by the New Jersey judicial system. Defendants reiterate that the Verified Complaint sets forth thirty-six claims for sixteen Patients, each of whom received different medical services, and each of whom have their own respective Plan, each of which is bound by its own separate terms and conditions. Defendants submit that precedence indicates that R. 4:38-2(a) was intended for broad application to provide trial courts an avenue for case management. Lech v. State Farm Ins. Co., 335 N.J. Super. 254, 260 (App. Div. 2000) ("As with all complex litigation, whether it involves multiple claims or multiple parties, the trial judge has broad case management discretion") (citing R. 4:38-2(a)); Malik v. Ruttenberg, 398 N.J. Super.

489, 498 (App. Div. 2008) ("A judge has the authority to determine the order in which witnesses shall be called, the order in which issues will be presented, and whether separate actions may be consolidated in a single proceeding . . . [which] . . . authority extends to the basic management of the proceeding, and the trial judge possesses wide discretion to control the trial") (citing, *inter alia*, R. 4:38-2)). Defendants also clarify the holding in Codgell, explaining that the limits of the entire controversy doctrine,

> are reached when the joinder would result in significant unfairness or jeopardy to a clear presentation of the issues and just result. Implicit in the development of the entire controversy doctrine is the recognition that economies and the efficient administration of justice should not be achieved at the expense of these paramount concerns. The entire controversy doctrine does not demand monolithic adjudications. Any possible unfairness to litigants, confusion in the presentation of issues, administrative unmanageability, or distortion in the truth-determining process that may result from compulsory joinder of parties—or claims—can be eliminated or at least minimized by a trial court possessed of the discretion to excuse joinder or to order severance.

Cogdell v. Hosp. Ctr. at Orange, 116 N.J. 7, 27-28 (1989), quoting Crispin v. Volkswagenwek, A.G., 96 N.J. 336, 354-55 (1984). Accordingly, Defendants therefore maintain that the Court has discretion to require the Plaintiffs to show the individual merits of each claim and then determine which claims may be heard together.

As the Court has found that the claims against the ERISA Plan Defendants are preempted by ERISA, there is no basis to sever the remaining non-ERISA Patients. The matter will be actively case-managed to avoid any prejudice to the parties. The Court does not find that the overlap of witnesses and evidence would be great, or that the potential confusion amongst the

many Claims would be extensive. In addition, as the non-ERISA claims are based on the common law, there is no basis to strike the demand for compensatory damages and a jury trial. Accordingly, the motion to sever the claims is denied.

IV. CONCLUSION

By way of summation, Defendants' motions are granted in part. The Court has dismissed the claims against Anthem Patients S.S., P.H., T.W., S.O., R.S. W.VN., W.L., and J.S., Prime Defendants G.F. and N.G., and Skanska Defendants V.S. and H.P. as being preempted by ERISA; Plaintiffs have standing to bring the Verified Complaint against the Defendants overseeing the claims of the non-ERISA Patients; there are no New Jersey statutes and regulations under which a claims arises in the Verified Complaint for the Court to dismiss; discovery is needed to determine if Anthem is a proper party to this action; the Second, Third, Fourth, and Sixth Counts of the Verified Complaint are dismissed without prejudice; the motion to sever is denied. Plaintiffs may file an amended pleading within 30 days to address any Counts dismissed without prejudice.