Prepared by the Court

ATLANTIC ER PHYSICIANS, PA, *et al*	:	Superior Court of New Jersey
Plaintiff	:	Law Division- Gloucester County
v.	:	
	:	CIVIL ACTION
UNITEDHEALTH GROUP, INC.,	:	Docket No. GLO-L-1196-20 (CBLP)
UNITEDHEALTHCARE INS. CO., *et al*	:	
And MULTIPLAN, INC.	:	**Memorandum of Decision**
Defendants	:	

These motions to dismiss under R. 4:6-2(e), arise from an action filed by plaintiffs, "NJ Team Health", who are emergency room physicians groups from all over the State who generally complain about out-of-network reimbursement rates from the defendants, who are health insurers and third-party administrators of employee health benefit plans.

More specifically, Team Health is a large emergency room staffing, billing and collections company that operates throughout the United States. They provide outsourced emergency medicine services on a national scale, and operate as many as 3,400 emergency medical facilities, employing approximately 19,000 people. Defendants are health insurers and third-party administrators who operate the largest health insurance carrier in the United States. These are primarily employee health benefit plans. Most healthcare providers enter into agreements ("network agreements")

with health insurers and third-party administrators which specify how much the health plan will reimburse the provider for medical services rendered to their covered insureds. Healthcare services provided without any contractual agreement specifying a providers' reimbursement rates are "out-of-network", and the benefit amount is governed by the applicable heath benefit plan of which the patient is enrolled.

With regard to the instant action, until May 2020, Team Health plaintiffs allege their relationship with the defendant was controlled by a written contract in which they agreed to accept a certain negotiated amount for the health care services they provided to the defendants' insureds. It is alleged that around 2018, the United defendants unilaterally decided to substantially reduce reimbursement rates for plaintiffs' out-of-network services. In May 2020, United began implementing that plan against plaintiffs by terminating the express written agreements between the parties and thereafter began paying substantially less than what was previously agreed and substantially less than the reasonable value of the services plaintiffs provide. After May 2020, defendants contracted with defendant, Multiplan, Inc. to determine this out-of-network payment. Multiplan promotes itself as an unregulated cost management company that offers "cost control" through a program known as Data iSight. Multiplan claims the Data iSight program determines a reasonable reimbursement rate for health care services by applying a proprietary formula to the submitted claims. It is alleged that Multiplan receives a share of the fees an insurance company earns from adjudicating a health care provider's claim for less than the amount the provider charged.

This case involves 27,000 disputed claims for emergency services provided by plaintiffs to United members during the period from May 15, 2020, to December 31,

2021. As emergency medicine providers, the plaintiffs are required by law to treat and stabilize patients who present to the emergency room regardless of insurance coverage. The plaintiffs rely upon commercial insurance companies to pay a reasonable rate for the critical health care services provided. Plaintiffs allege that United and Multiplan conspired together to deny plaintiffs their billed amounts for medical services relying upon Multiplan's payment methodology. Plaintiffs contend that Multiplan's publicly stated claims process is based upon rational and accepted data is a fraud. Plaintiffs insist that United dictates the rates to be paid and uses Multiplan as a cover for this fraud. Plaintiffs contend that United and Multiplan reap huge profits at the expense of the plaintiffs. Plaintiff are suing to recover the reasonable value of their services over what was paid on these 27,000 claims. The plaintiffs' Second Amended Complaint sues the defendants alleging five separate causes of action- Count One- Breach of Implied-in Fact Contract; Count Two- Quantum Meruit; Count Three- Violation of New Jersey Health Claims Authorization, Processing and Payment Act ("HCPPA") (the first three counts are directed to defendants United, only); Counts Four and Five allege RICO violations and conspiracies as to both defendants. This similar litigation has been advanced in 6 or 7 other states to date.

STANDARD OF REVIEW

Under R. 4:6-2(e), a motion to dismiss for failure to state a claim must be denied if, giving plaintiff the benefit of all the allegations asserted in the pleadings and all favorable inferences, a claim has been established. Grillo v. State, 469 N.J. Super. 267 (App. Div. 2021). The test for determining the adequacy of the pleading is whether a

cause of action is suggested by the facts. Motions to dismiss should be granted in only the rarest of instances. *See,* Printing Mart v. Sharp Elec. Corp., 116 N.J. 739 (1989).

ERISA PREEMPTION

This matter was originally filed on November 2, 2020, and defendants removed to the United States District Court, District of New Jersey. On February 17, 2021, plaintiffs filed a motion to remand this lawsuit from the District Court. On March 30, 2022, United States District Court Judge Renee Marie Bumb entered an Order that states in pertinent part, "unless and until there is clearly established precedent, if United Defendants argue for federal subject matter jurisdiction in the future based upon ERISA preemption, they must disclose to the court the caselaw that cuts against their legal arguments. United Defendants should lay out that federal district courts in New Jersey, Pennsylvania, Nevada, Arizona, Florida and perhaps elsewhere have denied their arguments for ERISA preemption." When pressed at oral argument, plaintiffs' counsel conceded that no court has found ERISA preemption in this matter.

ERISA was passed by Congress in 1974 to address "mismanagement of funds accumulated to finance employee benefits. ERISA does not guarantee benefits. The statute seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures. Gobeille v. Liberty Mut. Ins. Co., 136 S.Ct. 936, 946 (2016). ERISA was created to ensure employee benefit plans would be subject to a uniform nationwide regulatory scheme, and not a patchwork of inconsistent state regulations. To that end, ERISA includes "expansive pre-emption

provisions" to ensure that the regulation of employee benefit plans remain "exclusively a federal concern". Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). There are two preemption types. Complete preemption under Section 1132(a), which is jurisdictional in nature. This preemption was rejected by Judge Bumb. The other form of preemption is conflict preemption under Section 514(a). this section expressly preempts state action and state law claims that "relate to" an ERISA plan. United Defendants argue that plaintiffs' claims relate to ERISA-governed health benefit plans and therefore must be dismissed with prejudice as conflict preempted.

A common law claim "relates to" an employee benefit plan governed by ERISA "if it has a connection with or reference to such a plan". Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004). At this stage of the proceeding, the court finds that plaintiffs' state law claims relate solely to the rate of reimbursement, not the right of reimbursement. Each of the 27,000 claims at issue here have been paid by the defendants. Plaintiffs are not disputing the right to coverage under the plan rather they plead that the United defendants did not pay the reasonable value of the emergency services or they were underpaid for these services. Plaintiffs cite the U.S. Supreme Court case of Rutledge v. Pharm. Care Mgmt. Ass'n, 141 S.Ct. 474 (2020) as support for their position. As stated therein, "[C]rucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." Id. at 480. Continuing, the Court says "ERISA does not preempt state rate regulations that merely increase costs..". At this stage, the court finds plaintiffs' arguments persuasive. As plaintiffs' state in their brief, they seek to hold United to its

obligation to pay a reasonable value for the benefits United has already agreed to pay out. Plaintiff allegations do not implicate coverage determinations or plan administration requirements. Plaintiffs allege that they are entitled to the "reasonable value" of their services under applicable state law- not an ERISA plan. ERISA's goals of protecting participants and beneficiaries of employee benefits plans are not altered by plaintiffs claims.

Defendants request to dismiss for 514(a) preemption is denied.

DEFENDANTS CLAIM THAT PLAINTIFF CASE SHOULD BE DISMISSED BY THE ARBITRATION PROCESS ENACTED IN N.J.S. 26:2SS-1

In 2018, the New Jersey Legislature passed the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "Act"). Defendants claim that plaintiffs must arbitrate any claims decision at issue in this case under the process outlined in Sections 9,10 and 11 of the Act. This argument is without merit. The Act's definitions under Section 3 specifically exclude self-funded plans unless the self-funded plan elects to be subject to the provisions of the Act. United defendants claim they are self-funded plans in their argument regarding preemption and have not provided any proof that they have opted-in to this statutory scheme. This basis alone precludes dismissal of plaintiffs' complaint.

COUNT ONE- BREACH OF IMPLIED-IN-FACT CONTRACT

United defendants seek dismissal of Count One of the Second Amended Complaint that alleges breach of an implied-in-fact contract. Plaintiffs' complaint alleges that prior to May 2020, the parties had a written contract for the reimbursement rates to be paid for out-of-network emergency health care services. They allege in paragraph 3 that in 2017 to 2018, "United concluded it could make more money by paying Plaintiffs and other emergency room doctors less, so United embarked on a scheme to do just that." In paragraph 28 through 31, it is alleged that United terminated the express written agreement in place to pursue greater profits by substantially reducing reimbursement rates it provided plaintiffs. The complaint says that United cut reimbursement rates to less than half what United had paid in the past pursuant to its previous contract. The plaintiffs now sue for recovery of the difference between what they bill versus what they were paid.

The essential feature of an implied-in-fact contract cause of action is that the asserted contractual obligation must have arisen from mutual agreement and intent to promise but where no written agreement is in place. However, the facts as pleaded decisively refute the existence of such agreement. To prevail on a breach of contract action, whether written or implied, a plaintiff must be able to prove all of the necessary terms of the contract. Here, the Second Amended Complaint could not be clearer that the parties were not in agreement as benefit amount the defendants would pay for the plaintiffs' services. Plaintiffs want the amount billed, as they contend it is a reasonable amount as to the value of their services. Defendants, however, paid a different amount- an amount they say is appropriate according to the Data iSight methodology. This

essential term- price is in no way an agreed upon term in this implied contract. Certainly, the court agrees that many of the other factors are in place, i.e. the agreement to provide out-of-network emergency services to the plan members and the expectation that the providers would be paid. But price is the element that does not exist in this arrangement. Plaintiffs specifically plead defendants terminated the contract in place prior to May 2020 because defendants did not want to pay the agreed upon rates. This undermines this cause of action.

Count One of plaintiffs' complaint is dismissed for failing to state a cause of action as plead.

COUNT TWO- QUANTUM MERUIT

In order to recover on a claim for the quasi-contractual theory of quantum meruit, a plaintiff must establish four elements: (1) the performance of services in good faith; (2) the acceptance of services by the person to whom they are rendered; (3) an expectation of compensation therefore; and (4) the reasonable value of the services. Sean Wood LLC v. Hegarty Group, 422 N.J. Super. 500, 513 (App. Div. 2011). "Quasi-contractual recovery on the basis of quantum meruit rests on the equitable principle that a person shall not be allowed to enrich himself unjustly at the expense of another" Id. at 512.

In order for plaintiffs to sufficiently plead this cause of action, it must demonstrate that the services they performed in good faith conferred a benefit not only on the patients they served (who are not defendants) but rather on the insurers of the patients. The complaint alleges in paragraph 59 that "[B]oth United and United's Members benefited from the services Plaintiff provided. For example, United used and enjoyed the benefit of Plaintiff's services because Plaintiffs help United discharge its

legal and contractual obligation to its insureds to provide them with emergency care". At this stage of the proceedings, this argument is persuasive. The insurer defendants received a benefit by paying the plaintiffs a rate of reimbursement significantly less than a reasonable rate. They were able to pocket the difference in profits while simultaneously discharging its contractual obligation to pay for out-of-network emergency care for its members. Though the benefit conferred is not direct, there is arguably a benefit conferred to the defendants.

COUNT THREE- VIOLATION OF NEW JERSEY HEALTH CLAIMS AUTORIZATION, PROCESSING AND PAYMENT ACT ("HCAPPA")

Team Health plaintiffs allege in Count Three that the defendants failed "to timely pay the full amounts due to plaintiffs for their out-of-network emergency claims", in violation of HCAPPA, N.J.S. 17B:26-9.1. This statute permits the provider from recovering 12% interest on any unpaid claims. The parties go back and forth on whether the statute confers a private right of action by a medical provider against an insured. At this point, the court does not have to reach this answer. This statutory penalty for failing to pay a valid insurance claim promptly is only applicable if plaintiff is successful in this litigation compelling payment from the defendants. The court will revisit this issue upon a successful recovery by plaintiff.

COUNTS FOUR AND FIVE- VIOLATIONS OF NJ-RICO (as to both sets of defendants)

In Counts Four and Five of the Second Amended Complaint, plaintiffs allege that the defendants committed acts of theft under N.J.S. 2C:20-3(a) and (b), 2C:20-4(a)-(c) and 2C:20-8(a) by a pattern of racketeering activity in violation of N.J.S. 2C:41-1.

Basically, the plaintiffs state that United and Multiplan engaged in a conspiracy to divert millions of dollars away from the plaintiffs by falsely and fraudulently hiding behind Data iSight methodology, which in fact was a deceitful ploy to pay reimbursement rates set by United rather than reasonable value.

To state a claim for violation of New Jersey's RICO law (N.J.S. 2C:41-1, et seq.), a plaintiff must allege (1) the existence of an enterprise; (2) that the enterprise engaged in activities that affected trade or commerce; (3) that the defendants were employed by or associated with the enterprise; (4) that the defendants participated in the conduct of the affairs of the enterprise; (5) that the defendants participated through a pattern of racketeering activity; and (6) that the plaintiff was injured as a result of the activity. Marina Dist. Dev. Co. v. Ivey, 216 F. Supp. 3d 426, 436 (N.J. Dist. Ct. 2016). A defendant in a racketeering conspiracy need not itself commit or agree to commit predicate acts. Smith v. Berg, 247 F.3d 532, 537 (3d Cir. 2001). Rather, "all that is necessary for such a conspiracy is that the conspirators share a common purpose." Id. Thus, if defendants agree to a plan wherein some conspirators will commit crimes and others will provide support, "the supporters are as guilty as the perpetrators." Salinas v. United States, 522 U.S. 52, 64, 118 S. Ct. 469, 139 L. Ed. 2d 352 (1997). Each defendant must "agree to commission of two or more racketeering acts," United States v. Phillips, 874 F.2d 123, 127 n.4 (3d Cir. 1989), and each defendant must "adopt the goal of furthering or facilitating the criminal endeavor," Smith, 247 F.3d at 537.

Defendants first argue that plaintiff's pleading is deficient in that it does not comply with the heightened pleading standard required by R. 4:5-8. This rule requires "[I]n all allegations of misrepresentation, fraud, …. Particulars of the wrong, with dates and items *if necessary*, shall be stated *insofar as practicable.* (emphasis supplied). Here, the complaint satisfies the Rule by placing defendants on notice of the alleged wrongs. Specifically, the complaint states that between May 2020 and December 2021, United Healthcare defendants conspired with Multiplan defendant to unilaterally set the rate of reimbursement for the plaintiffs. This rate was set by United but asserts fraudulently that the reimbursement rate was determined by Data iSight at a geographically competitive rate. The fraud/conspiracy began just before the May 2020 change. The plaintiff alleges damages calculated at the amount billed by plaintiff minus the amount paid by defendants. This pleading is sufficient as to R. 4:5-8.

The more interesting argument raised by both defendants is that plaintiffs fail to allege that the defendants' racketeering conduct was the proximate cause of their damages. See, Maio v. Aetna Inc., 221 F.3d 472, 483 holding that plaintiff must "make two related but analytically distinct threshold showings…(1) that the plaintiff suffered an injury to business or property; and (2) that the plaintiff's injury was proximately caused by the defendants' [RICO] violation. The defendants argue that plaintiffs are required to treat all patients who arrive at hospitals for emergency care, and even if the defendants shared their payment methodology, nothing would change, i.e. the plaintiffs would receive the same amount. This court finds this unpersuasive as the argument ignores the alleged fraud as alleged. Plaintiffs say that the Data iSight rate is merely a cover for

United's reimbursement rate that it unilaterally set. The plaintiffs allege that United and Multiplan conspired to set an artificially low rate to reap huge profits disguising its conspiracy by pretending the rate was set by Data iSight. Their damages would be the difference between they amount they billed and the amount they received. As alleged, the plaintiff's damages are the proximate cause of the RICO conspiracy. They may has performed the same services as required by law, but they would have received significantly more money for doing so, if not defrauded by the defendants.

The court requests the defendants prepare an Order consistent with this opinion.

DATED: August 23, 2022

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JAMES R. SWIFT, JSC