SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-3484-20

BRAINBUILDERS, LLC,

Plaintiff-Appellant,

v.

IBEW LOCAL UNION 456 WELFARE FUND, TRUSTEES OF THE IBEW LOCAL UNION 456 WELFARE FUND, I. E. SHAFFER & CO., and PRINCETON HEALTHCARE SYSTEM, a New Jersey nonprofit corporation, d/b/a PENN MEDICINE PRINCETON HEALTH PRINCETON EMPLOYEE ASSISTANCE PROGRAM,

Defendants-Respondents.

Submitted April 25, 2022 – Decided May 24, 2022

Before Judges Sabatino, Rothstadt, and Mayer.

On appeal from the Superior Court of New Jersey, Law Division, Ocean County, Docket No. L-0027-21.

Yaakov Pollak, attorney for appellant.

Lindabury, McCormick, Estabrook & Cooper, PC, attorneys for respondents IBEW Local Union 456 Welfare Fund, Trustees of the IBEW Local Union 456 Welfare Fund, and I. E. Shaffer & Co. (Elizabeth E. Manzo, on the brief).

Faegre Drinker Biddle & Reath, LLP, and Kimberly A. Jones (Faegre Drinker Biddle & Reath, LLP) of the Illinois bar, admitted pro hac vice, attorneys for respondent Princeton Healthcare System, a New Jersey nonprofit corporation, d/b/a Penn Medicine Princeton Health Princeton Employee Assistance Program (Jennifer G. Chawla and Kimberly A. Jones, on the brief).

PER CURIAM

Plaintiff Brainbuilders LLC appeals from the Law Division's May 14, 2021 order, as amended on July 14, 2021, dismissing plaintiff's complaint, under Rule 4:6-2(e), against defendants IBEW Local Union 456 Welfare Fund (the Plan), Trustees of the IBEW Local Union 456 Welfare Fund (Trustees or Plan Sponsor), I E Shaffer & Co., and Penn Medicine Princeton Health Princeton Employee Assistance Program (Penn Medicine). Plaintiff also appeals from the Law Division's July 23, 2021 order denying reconsideration, issued by the same motion judge.

Judge Craig L. Wellerson dismissed the complaint after he concluded that the parties' dispute over payment for medical services that plaintiff, an out-of-

network provider, provided to a patient was preempted by federal law because its resolution required consideration of the subject Plan's terms, which had to be resolved in accordance with the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 to 1461. On appeal, plaintiff contends the judge erred because its claim arose from a "single case agreement [(SCA)]" and reference to the Plan's terms was not required in order to resolve plaintiff's breach of contract based claims under state law.

Having considered plaintiff's contentions in light of the record and the governing principles of law, we affirm, substantially for the reasons stated by Judge Wellerson in his oral decisions placed on the record immediately prior to his entry of the challenged orders.

The salient facts developed from the motions' record are summarized as follows. The Plan is a health benefits plan sponsored by the Trustees and governed by ERISA. I E Shaffer is the third-party administrator of the Plan. It arranged with Penn Medicine to manage the mental health benefits provided under the Plan. The Plan provides benefits to participants and their qualified dependents for services rendered by in-network and out-of-network providers as detailed in the Plan's terms.

As already noted, plaintiff is an out-of-network provider. It provides services to children with autism spectrum disorders, including applied behavioral analysis (ABA) services.

As described in more detail herein, the parties' dispute in this matter centered on whether an authorization for payment of benefits to plaintiff contained a clerical error in the approved period of time that the services were to be performed. Pertinent to this appeal, the Plan's terms contain a provision entitled "Clerical Error," which states as follows:

> No clerical error on the part of the Plan Sponsor or claims processor shall operate . . . create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.
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> [(Emphasis omitted).]

A participant (the Participant) in the Plan sought services from plaintiff for his son (the Patient), who was also covered by the Plan. On March 6, 2020, plaintiff completed Penn Medicine's request for authorization form, requesting authorization to evaluate the Patient. The form stated, "AUTHORIZATIONS ARE BASED ON MEMBER'S BENEFIT PLAN, AGREEMENTS WITH

MEDICAL CARRIERS, FEDERAL/STATE REGULATIONS, AND PHCS EAP PSYCHOLOGICAL TESTING GUIDELINES." (Emphasis added). Plaintiff submitted the form to Penn Medicine and included its fee schedule.

On April 30, 2020, Penn Medicine emailed to Gitty Herzl, plaintiff's Authorizations Manager, that plaintiff's request was reviewed and was authorized. After evaluating the Patient, on May 13, 2020, pursuant to the authorization, plaintiff completed another request for authorization, this time requesting authorization for services outlined in its accompanying initial treatment plan which listed goals for the Patient, most of which had target dates between May 2020 and November 2020.

On May 27, 2020, Penn Medicine emailed Herzl that "the following ABA services were approved for [the Patient]: ABA Therapy – approved for 5/27/20 through 11/27/20. 97153 10 hours / week[,] 97155 2 hours/week[, and] 97156 1 hour/week. 97151 was not approved, as this was just approved in April 2020." (Emphasis added). According to Penn Medicine, this was the original SCA between it and plaintiff. Pursuant to this approval, plaintiff provided services to the Patient and was reimbursed by the Plan.

In September 2020, plaintiff's Director of Finances, Simon Nussbaum, requested Penn Medicine to pay increased rates retroactively for plaintiff's

treatment of the Patient. Penn Medicine coordinated with I E Shaffer to authorize payments at increased rates retroactively from April 30, 2020, through November 10, 2020, when the Trustees would next meet and could review the increased rate request and make a final determination.

Accordingly, on September 29, 2020, Penn Medicine issued a "revised authorization" effective April 30, 2020, however with a November 10, 2021 lapse date, not a November 10, 2020 expiration. That authorization, which plaintiff referred to as the initial SCA, included the following disclaimer:

> Insurance coverage has been verified with I E Shaffer and the patient is currently eligible for benefits. Please be aware that all payments are based on the patient's insurance eligibility and the [P]lan's provisions at the time the service is rendered and final claim submission is received at I E Shaffer.
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> [(Emphasis added).]

On November 10, 2020, the Trustees met and denied plaintiff's rate increase request. On November 16, Penn Medicine sent a letter to plaintiff and the Participant, notifying them that the rate increase was approved only through December 31, 2020, after which the Participant would be responsible for charges exceeding the authorized rates. It also advised the Participant that Penn Medicine could assist him with transitioning the Patient to an in-network provider.

On November 25, 2020, plaintiff, for a third and final time, completed Penn Medicine's request for authorization, this time requesting approval for services from November 28, 2020, through May 28, 2021. On December 3, 2020, Penn Medicine emailed plaintiff to remind it of the rate decrease effective January 1, 2021. In response, on December 7, 2020, Herzl asked, "In the meantime, would it be possible to authorize services until 12/21/20?" Accordingly, the same day, Penn Medicine provided a revised authorization, "extend[ing]" the end date to December 31, 2020.

On December 9, 2020, Nussbaum emailed Penn Medicine, seeking to maintain payments at the higher rates beyond December 31, 2020, and claiming the authorization with a lapse date of November 10, 2021, was a binding contract. In response, on December 11, 2020, Penn Medicine stated it made an error in the lapse year of the earlier authorization which should have stated it lapsed on November 10, 2020, not 2021. Penn Medicine included the most recent authorization that extended the lapse date to December 31, 2020.

On January 5, 2021, plaintiff filed the complaint in this matter, asserting claims of breach of contract, estoppel, and declaratory judgment. It asserted that the Plan provided coverage for out-of-network providers, including plaintiff, and that defendants agreed to reimburse plaintiff pursuant to the rates set forth

in the SCA but later defendants asserted the SCA contained an error and would not honor it. Plaintiff claimed defendants "anticipatorily repudiated and breached their contract with" plaintiff.

In response, defendants filed timely answers, and on March 22, 2021, Penn Medicine filed a motion to dismiss pursuant to Rule 4:6-2(e), which the Plan, Trustees, and I E Shaffer later joined. Penn Medicine asserted that plaintiff's claims were preempted by ERISA and, alternatively, that plaintiff failed to state a claim upon which relief can be granted. Penn Medicine supported its motion with its attorney's certification and exhibits that included the Plan's terms, correspondence between the parties throughout 2020, the requests for authorizations completed by plaintiff, and the ensuing approvals, including the "[i]ncorrect SCA" and the revised authorization.

Plaintiff filed opposition, claiming that the SCA was a standalone agreement which did not relate to the Plan's terms and that the November 10, 2021 lapse date was not a known typographical error.

At oral argument, Judge Wellerson recognized the parties' dispute regarding the typographical error, stating he "underst[oo]d that the plaintiff [was] taking the position that there absolutely was not a typographical error; this was the agreement, the undisputed material facts intentionally dissolved at that

moment." After considering arguments, the judge issued an oral decision granting defendants' motion to dismiss on the grounds that plaintiff's claims were preempted by ERISA.

In granting the motion, the judge explained that because the parties disagreed as to whether the authorization that stated it lapsed in 2021 contained an alleged clerical error, in order to resolve it, reliance on the Plan's governing provision was required. Specifically, the judge concluded as follows:

> The [c]ourt can't analyze the obligation to pay unless it looks at the Plan and looks at the insured's status within the Plan and the ability to cover one of the insured's household members. When the plaintiff submits bills to the defendant and then they are refused, the issue is whether or not there was a breach of contract, and the breach of contract claims are state law claims in this case. And because of the existence of the ERISA [P]lan they are super[s]eded and the [c]ourt has no jurisdiction under such a circumstance.
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> The [c]ourt can't analyze the plaintiff's claims without referencing the Plan and, in fact, examining the plaintiff's claim individually to make clear that each of the implications of the Plan terms are and such relates to an ERISA [P]lan.
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> Accordingly, the plaintiff's dispute with the out of network reimbursement position set forth the term of the [P]lan and underlies the claim, and, thus, the [c]ourt cannot analyze the plaintiff's claim without referencing the Plan. The application before the [c]ourt is a [Rule 4:6-2] application. It is in the [c]ourt's mind correctly brought before this [c]ourt, as the [c]ourt must make an

> initial determination as to whether or not the ERISA [P]lan super[s]edes any state law claims, and the [c]ourt is well satisfied that this dispute that is before the [c]ourt, and especially in the light of the fact that the ERISA [P]lan itself has language that indicates if there is a clerical error it is null and void.
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> Here the dispute is whether or not that was a clerical error, but in the [c]ourt's mind if there is a contest as to whether or not it is a clerical error the [c]ourt is obligated to make an investigation into the language of the [P]lan itself and immediately upon doing so would divest this [c]ourt of any jurisdiction as this being an ERISA [P]lan.
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> The [c]ourt is satisfied that all of the language of the [P]lan is critical to the determination of whether or not the plaintiff has a right to be reimbursed, and the [c]ourt is well satisfied that the claims of reimbursement are so tied to the language of the [P]lan that it is inescapable for the [c]ourt to conclude other than that the dispute relates to the [P]lan itself. Accordingly, the [c]ourt grants defendant's motion to dismiss the plaintiff's [c]omplaint.

The same day, the judge entered an order dismissing plaintiff's complaint against Penn Medicine with prejudice, which he amended on July 14, 2021, to also dismiss plaintiff's complaint against the remaining defendants.

Plaintiff filed a motion for reconsideration of the judge's May 14 order, which Penn Medicine opposed. After considering oral arguments on July 23, 2021 the judge issued an oral decision denying reconsideration for the reasons set forth in its initial decision. This appeal followed.

At the outset, we observe that the parties do not dispute that the Plan is subject to ERISA. In earlier opinions, we have had occasion to explain ERISA and its express requirement that ERISA preempts state law. For example, in Finderne Mgmt. Co., Inc. v. Barrett, 355 N.J. Super. 170 (App. Div. 2002), we stated the following:

> "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." ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." Consequently, ERISA embraces state common law claims.
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> ERISA preemption "can have profound consequences because the remedies under ERISA are far more limited than under state common law causes of action." ERISA preemption is an affirmative defense.
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> [Id. at 185 (alteration in original) (citations omitted) (first quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90-91 (1983); then quoting 29 U.S.C. § 1144(a); then quoting § 1144(c)(1); and then quoting Barbara J. Williams, ERISA and State Common Law Causes of Action, 192 N.J. Law. 29 (1998)).]

"To ensure that [employee benefit] plan regulation resides exclusively in the federal domain, Congress inserted . . . [ERISA's] expansive preemption

provision . . . ." Nat'l Sec. Sys., Inc. v. Iola, 700 F.3d 65, 82 (3d Cir. 2012); see § 1144(a). Accordingly, any state law claims that "relate to" an ERISA plan are preempted. § 1144(a). A claim relates to a plan if it has a "connection with or reference[s]" an ERISA plan to the extent that the plan is a "critical factor in establishing liability" and a judge's "inquiry would be directed to the plan." St. Peter's Univ. Hosp. v. N.J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455-56 (App. Div. 2013). However, if the claim has "only a tenuous, remote, or peripheral connection with covered plans," then it does not "relate to" the plan. Ibid.

Whether a trial judge correctly determined that a claim is preempted under ERISA is a question of law that we review de novo. Id. at 454.

On appeal, plaintiff argues its claims are not preempted by ERISA because its agreement with defendants is independent from the Plan since it is an out-of-network provider and the parties' obligations to one another are limited to payment for services as agreed to in what it identifies as the parties' SCA. We are unpersuaded by plaintiff's contentions.

We conclude that plaintiff's argument lacks sufficient merit to warrant further discussion in a written opinion. R. 2:11-3(e)(1)(E). Suffice it to say that we agree with Judge Wellerson's determination that the dispute over whether a

clerical error occurred bears much more than a remote relationship to the Plan. We therefore affirm substantially for the reasons expressed by Judge Wellerson in his May 14 oral decision. We only add the following brief comment.

Contrary to plaintiff's assertion, its circumstances are unlike those in Plastic Surgery Center, P.A. v. Aetna Life Insurance Company, 967 F.3d 218, 236 (3d Cir. 2020). In that case, the Third Circuit reversed the District Court's granting of a motion to dismiss claims of breach of contract and promissory estoppel because the plan in that matter, unlike the present action, did not provide coverage for out-of-network providers for the services sought. Instead, the plan administrator was alleged to have agreed to make payments to the provider entirely through oral negotiations that allegedly led to an oral agreement. Therefore, the court's inquiry into the ERISA plan was simply to verify payment rates.

Here, any agreement by Penn Medicine to pay plaintiff was reached entirely in writing after plaintiff submitted several requests for authorization that referenced and were required by the Plan. The SCA also referenced the Plan, and plaintiff's complaint did so as well. Therefore, resolution of the parties' dispute would not be limited to merely looking up payment rates of corresponding procedure codes in the ERISA Plan. Rather, it would at the very

least require a court to refer to, interpret, and apply the clerical error provision of the Plan—clearly not a cursory task such as verifying payment rates in a chart.

Because we conclude that Judge Wellerson correctly dismissed plaintiff's complaint, we need not consider plaintiff's challenge to the July 23, 2021 order denying reconsideration.

Affirmed.