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Carol Tomaszewski, Plaintiff, v. Horizon Healthcare Services, Inc., et al, Defendant(s).	:	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY DOCKET NO.: BER-L-5302-20

Defendant's Motion to Dismiss Plaintiff's Complaint

Decided: January 19, 2021

Honorable Robert L. Polifroni, P.J.Cv.

Philip J. Cohen, Esq., attorney for plaintiff (Kamensky Cohen & Riechelson, attorneys).

Andrew I. Hamelsky, Esq., attorney for defendants (White & Williams, attorneys).

MOTIONS TO BE CONSIDERED

This matter comes to the court by way of defendant's motion to dismiss plaintiff's complaint with prejudice, based on lack of subject matter jurisdiction.

BACKGROUND

This is a dispute regarding the payment of insurance benefits under the NJ Direct Plan ("NJ Direct"), a state-funded health insurance plan. Plaintiff Carol Tomaszewski was the spouse/ dependent of Andrew Tomaszewski, an enrollee the New Jersey State Health Benefits Program ("SHBP"). Plaintiff's complaint alleges: (1) plaintiff underwent medical procedures with an out of network health care provider; (2) defendant subsequently sent plaintiff a check for the medical expenses; (3) plaintiff reimbursed the healthcare provider with said check; (4) defendant then claimed that it mistakenly overpaid plaintiff by several thousands of dollars; (5) defendant unlawfully tried to recoups the funds with the knowledge that plaintiff reimbursed the treating physician; (6) defendant then refused to pay plaintiff's other out of network claims. See Pl.'s Compl. ¶¶ 3-10. Plaintiff filed suit on September 9, 2020 alleging that defendant is in tortious

breach of the covenant of good faith and fair dealing. Id. ¶¶ 11-20. Defendant filed the instant motion to dismiss on December 9, 2020 and plaintiff filed opposition.

LEGAL ARGUMENTS

Defendant's Motion to Dismiss

Defendant seeks to dismiss plaintiff's complaint in its entirety with prejudice. The NJ Direct Plan Guidebook explains that in the event of an adverse benefit determination, the member is afforded rights of appeal through the appeal procedures. After all internal appeals have been exhausted, the member may then appeal to the State Health Benefits Commission (Commission"). The Commission, via the Office of Administrative Law, has exclusive authority to hear any disputes as to the amount Horizon paid under NJ Direct for a patient's medical services. Murray v. State Health Benefits Comm'n, 337 N.J. Super. 435, 439 (App. Div. 2001). Once a final decision is issued by the Commission, a member has the right of appeal to the Appellate Division. Id.

Plaintiff's healthcare provider, Heritage Surgical Group, does not participate in NJ Direct and is therefore out-of-network. Heritage submitted a claim to Horizon in the amount of $17,063 for the services rendered to Plaintiff on October 17, 2019. Of this amount, $9,519 was the allowed amount pursuant to plaintiff's NJ Direct Plan. This amount was paid directly to plaintiff, who was to then provide the reimbursement check to Heritage. Heritage's claims for the primary and assistant surgeon were adjusted multiple times. As a result, Horizon paid Heritage directly and overpaid Heritage through two additional payments in the amounts of $1,700.01 and $9,519.[1] Defendant then sent a serious of Explanation of Benefits wherein it stated that Heritage was out-of-network, the total amount submitted by Heritage exceeded the maximum amount provided by NJ Direct, and provided information on how to file an appeal.

Plaintiff did not submit an appeal, but rather initiated this lawsuit against Horizon on or about September 10, 2020, alleging a sole claim of tortious breach of the covenant of good faith and fair dealing. Plaintiff alleges that Horizon breached the covenant of good faith and fair dealing by denying benefits and "refusing to provide the plaintiff with coverage that she was entitled to under her insurance policy." Def.'s Opp'n Br. P. 4-5. Benefit disputes, such as this one, must be appealed to the Commission. The Commission retains final authority and jurisdiction over such benefit disputes. It is well-settled that this Court lacks jurisdiction over SHBP coverage disputes. The Appellate Division has "consistently recognized the statutory and regulatory scheme that requires disputes regarding eligibility and the payment of benefits under the Plan to be submitted first to the [Commission], and, only thereafter, to [the Appellate Division] for resolution." Advanced Rehab of Jersey City v. Horizon Healthcare of N.J., Inc., 2011 N.J. Super. Unpub. LEXIS 2251, at *8 (App. Div. Aug. 19, 2011).

Defendant further argues that the situation in Advanced Rehab is similar to the instant case because it involved an NJ Direct enrollee who received out of network care. Advanced Rehab of Jersey City v. Horizon Healthcare of New Jersey, Inc., 2011 N.J. Super. Unpub. LEXIS 2251, at *1 (App. Div. Aug. 19, 2011). In that case, after the provider failed to make repayments, Horizon began to recapture the funds from eight different patient accounts from which the provider was

[1] Defendant does not attribute this overpayment to any fault of the plaintiff.

seeking payment. Id., at *2. The provider appealed, but while the appeal was pending, commenced a lawsuit against Horizon in the Law Division, Special Civil Part. Id. The motion court dismissed the provider's lawsuit, and the Appellate Division upheld the dismissal on appeal, finding that, "the Legislature has enacted a comprehensive scheme for the payment of medical benefits on behalf of the employees of state and local governments" and that it was not for the Courts "to second-guess that legislative determination." Id. at *9.

Accordingly, this court lacks jurisdiction to hear this case. The complaint should be dismissed with prejudice. This is a dispute over Horizon's administration of SHBP benefits, and by law the forum for such a dispute is the Commission. Only thereafter may plaintiff appeal to the Appellate Division.

Plaintiff's Opposition

Plaintiff first argues that defendant mischaracterizes plaintiff's claim. Plaintiff filed a complaint asserting that defendant's action, unilaterally applying an offset against plaintiff for an overpayment of one medical provider against plaintiff's other medical providers, leaves plaintiff in debt to multiple medical providers. See Pl.'s Compl. ¶¶ 11-20. Plaintiff's grievance does not pertain solely to a dispute of benefits payments.

Plaintiff's claim asserted in the complaint is that defendant had no legal authority to seek an offset of overpayment against plaintiff's future medical bills. Id. ¶ 7. Instead of seeking reimbursement of alleged overpayment from Heritage, defendant sought to recoup the alleged overpayment against the plaintiff. Defendant's February 27, 2020 correspondence did not provide any notice of an obligation to appeal defendant's determination regarding the overpayment. Id. It only stated to send a check for $9,519.00 if said amount is acceptable. Pl.'s Opp'n Br. Ex. A. Plaintiff also argues that under the Health Claim Authorization, Processing and Payment Act (HCAPPA), defendant was limited to recouping the overpayment from Heritage. 17:48E-10.1(d)(11). Defendant did not seek repayment from Heritage, who has now been paid. Further, defendant "arbitrarily, and without any legal authority, applied credits to payment of Plaintiff's subsequent medical bills." Pl.'s Opp'n Br. p. 2. Defendant failed on twenty six occasions to properly compensate plaintiff's subsequent medical providers, even though it was aware of said claims. See Pl.'s Opp'n Br. Ex. B. This has led plaintiff to delay further medical treatment. See Pl.'s Compl. ¶ 9.

Plaintiff then argues that the NJ Direct plan does not create any right for defendant to recoup overpayments from plaintiff. Instead, the "Recovery Right" section of the plan states that defendant may only recover against plaintiff for benefits provided to auto-related or work-related treatment. See Def.'s Br. Ex. 1, p. 50. The subject treatment by Heritage does not fall into either of those categories. Additionally, the plan provides for an appeal procedure in two instances. The first is limited to matters involving medical judgments made by Horizon BCBSNJ in the form of denials, reduction from application of clinical or medical necessity, or failure to cover items or services due to Horizon's determination that they are experimental, cosmetic or non-medical. Id. p. 53. The second pertains to an adverse benefit determination for a substance disorder and for claims in which the member believes benefits were erroneously denied. Id. p. 58. Plaintiff then points to N.J.S.A. 17:48E-10,1(d)(11) to state that recoupment for overpayment can be offset

against the health care provider upon future submission for payment. In the instant matter, defendant failed to make twenty six timely payments to plaintiff's subsequent medical providers and failed to seek recoupment from the surgeon that had allegedly been overpaid. Both actions violate New Jersey law and the NJ Direct plan.

Defendant's Burden

Defendant has not met its burden in showing that plaintiff's complaint must be dismissed.[2] In this matter, the complaint alleged that defendant applied an offset of payments against plaintiff's other medical providers due to an overpayment made to plaintiff's out of network surgeon. This violates New Jersey law and the terms of the NJ Direct plan. Under New Jersey law, the overpayment becomes due from the healthcare provider, not the plan beneficiary. In enacting the N.J.S.A. 17:48E-10(d)(11), the legislature intended to prevent the harm that would result if health insurers sought to recover overpayments from beneficiaries.

Plaintiff then argues that defendant's reliance on Advanced Rehab is misguided because in that case payment was issued to the medical provider, and after payment was provided, Horizon determined that the procedure was not medically necessary. Advanced Rehab, 2011 N.J. Super. Unpub. LEXIS 2251, at *2-3. Horizon then deducted from future payments issued to the medical provider that received the overpayment. Id, at *3. Further, the issue in the instant case is not related to issues within the plan; therefore, plaintiff does not need to exhaust all administrative appeals.

Defendant's Reply

Defendant argues that characterizing this case as anything other than a dispute arising under a SHBP plan must be disregarded. All disputes arising under NJ Direct, including underpayment or overpayment, are subject to SHBP regulatory appeals process. Plaintiff is asking this court to ignore the statutory and regulatory scheme mandated for SHBP benefit disputes. The mere fact that plaintiff has characterized defendant's conduct as "bad faith" does not grant this court jurisdiction to hear this dispute. The administrative appeal produce in the NJ Direct Member Guidebook applies to "plan benefit decision such as whether a particular service is covered or paid appropriately." Def.'s Reply Br. p. 1 (citing Ex. 1 to Hamelsky Cert. p. 59). Plaintiff's claim concerns SHBP benefits, and any disputes regarding those benefits must follow SHBP's regulatory appeals process. Separate tort claims are still subject to the SHBP regulatory appeals process. See Beaver v. Magellan Health Servs., Inc., 433 N.J. Super. 430, 433 (App. Div. 2013). In Beaver, the Appellate Division refused to hear contract and tort claims brought by an SHBP member against Horizon, finding that the claims were nothing more than "a thinly disguised effort to fit within the Law Division's jurisdiction." Id., at 442. In so ruling, defendant argues that the Appellate Division upheld the well-established rule that a member must first pursue an administrative appeal before pursuing an action at law, even if the member has leveled tort claims. Id. Defendant also cites to case law, holding: "'exclusive jurisdiction does not turn on the theory of the challenging party's claim or the nature of the relief sought.'" Id., quoting Mutschler v. N.J. Dep't of Envtl. Prot., 337 N.J. Super. 1, 8 (App. Div. 2001).

[2] Plaintiff cites to the standard in Printing Mart. However, defendant's motion is to dismiss for lack of subject matter jurisdiction, pursuant to R. 4:6-2(a), not R. 4:6-2(e), failure to state a cause of action.

Defendant further argues that plaintiff's own allegations prove that this claim must follow the regulatory appeals process mandated for SHBP benefit disputes because plaintiff takes issue with Horizon's attempt to recoup benefits issued for out-of-network treatment, and alleges that Horizon has "refused to pay" additional claims for "other out-of-network doctors." See Pl.'s Compl. ¶¶ 5-9. To support the bad faith claim, plaintiff alleges that defendant "failed or otherwise refused to provide plaintiff with the coverage that she was entitled to under her insurance policy." Id. at ¶ 15.

Defendant also argues that plaintiff's position on the inapplicability of Advanced Rehab is misguided because it is irrelevant that Advanced Rehab involved an overpayment dispute between the healthcare provider and Horizon, rather than the member and defendant. First, this distinction is irrelevant because the healthcare provider in that case sued Horizon as subrogee of the member; therefore, the same analysis applies as if the suit were between the member and Horizon. Advanced Rehab, at *1. Second, the court held that "the statutory and regulatory scheme that requires disputes regarding eligibility and the payment of benefits under the [SHBP] be submitted first to the [Commission] and, only thereafter, to this court for resolution." Id., at *8. For this reasons, plaintiff's attempt to distinguish Advanced Rehab from the case at bar is unwarranted.

Defendant then contends that plaintiff's arguments are also directly refuted by the SHBP plan documents. Plaintiff's own opposition alleges that defendant's actions were in violation of the plan. See Pl. Opp., at p. 2. According to defendant, this allegation "proves" that the Commission has exclusive authority to hear this dispute because the NJ Direct Member Guidebook include various language that is pertinent to the instant dispute.

Finally, defendant argues that plaintiff's reliance on HCAPPA is misguided because HCAPPA is inapplicable to this dispute. HCAPPA only applies to overpayment disputes between health insurance companies and providers. See N.J.A.C. § 11:22-1.1. In the case at bar, defendant provided plaintiff with payment available under the NJ Direct Plan for the out of network services plaintiff received. After the overpayment was discovered, defendant properly sought reimbursement of the overpaid amount from plaintiff directly because the payment was originally made directly to plaintiff.

DECISION

Rule 4:6-2(a) permits a motion to dismiss for lack of subject matter jurisdiction. In relevant portion, the Rule provides that:

> Every defense, legal or equitable, in law or fact, to a claim for relief in any complaint, counterclaim, cross-claim, or third-party complaint shall be asserted in the answer thereto, except that the following defenses may at the option of the pleader be made by motion, with briefs: (a) lack of jurisdiction over the subject matter.... [I]f a motion is made raising any of these defenses, it shall be made before pleading if a further pleading is to be made....

Lack of subject matter jurisdiction is a non-waivable defense, and thus may be raised at any time, even on appeal. R. 4:6-7; Macysyn v. Hensler, 329 N.J. Super. 476, 481 (App. Div. 2000). It involves an initial determination as to whether a court is legally authorized to decide the question presented. Gilbert v. Gladden, 87 N.J. 275, 280-281 (1981). When a court lacks subject matter jurisdiction, its authority to consider a case is "wholly and immediately foreclosed." Id. at 281 (quoting Baker v. Carr, 369 U.S. 186 (1962)).

Plaintiff, in her opposition brief, cites to case law discussing the standards for judicial treatment of motions brought under R. 4:6-2(e), i.e. failure to state a claim upon which relief can be granted. Respectfully, the cases cited are inapplicable to this motion filed under R. 4:6-2(a). A similar procedural point was addressed by Judge Kennedy in Beaver v. Magellan Health Servs., Inc., 433 N.J. Super. at 437. For that reason, this court rejects plaintiff's procedural opposition based upon movant not meeting the standards under R. 4:6-2(e).

Plaintiff Carol Tomaszewski is the spouse/dependent of Andrew Tomaszewski, an enrollee of the New Jersey State Health Program. This is a dispute regarding the payment of insurance benefits. The complaint reflects the dispute regarding the payment of insurance benefits under the NJ Direct Plan (NJ Direct) which is state-funded and subject to the statutory and regulatory scheme set forth by the State Health Benefits Program (SHBP). The program and its governing body, the State Health Benefits Commission (SHBC), were established by the New Jersey Health Benefits Program Act (the Act), N.J.S.A. 52:14-17.24 to .45. The purpose of the Program is "to provide comprehensive health benefits for eligible public employees and their families.... It establishes a plan for state funding and private administration of a health benefits program." Beaver v. Magellan Health Servs., Inc., 433 N.J. Super. 430 (App. Div. 2013); Heaton v. State Health Benefits Comm'n., 264 N.J. Super. 141, 151 (App. Div. 1993). The SHBC contracts with health insurers to provide various benefit plans to program participants. Beaver, at 433; Green v. State Health Benefits Comm'n., 373 N.J. Super. 408, 413 (App. Div. 2004). The State Benefits Program is in effect the State of New Jersey acting as a self-insurer. Burley v. Prudential Ins. Co. of Am., 251 N.J. Super. 493, 495 (App. Div. 1991).

The New Jersey Direct plan is a state-funded health insurance plan and is subject to the statutory and regulatory scheme set forth by the SHBP. The SHBP has established a regulatory appeals process that requires disputes over SHBP benefits to first be submitted to the State Health Benefits Commission, whose decision can be then appealed to the Appellate Division of the New Jersey Superior Court. A beneficiary can pursue an appeal to the Appellate Division only after participating in an appeal to the Commission. The SHBP contracts with Horizon to utilize Horizon's network of providers and to handle the SHBP claims administration functions; including processing of health care claims, issuing explanation of benefits, and handling internal administrative appeals. In essence, the State pays the benefits and Horizon administers the claims. Although the State contracts with health insurers to administer various benefits plans for program participants, the SHBC alone has the authority and responsibility to make payments on claims and to limit or exclude benefits. Beaver at 433; N.J.S.A. 52:14-17.29(B). The SHBC has formal authority to adjudicate disputes between plan members and State contracted claims administrators and may refer such disputes to the Office of Administrative Law (AOL) for an evidentiary hearing. Beaver at 433, citing Green, 373 N.J. Super. at 414, Burley, 251 N.J. Super. at 500.

Plaintiff argues the dispute as articulated in the complaint does not fall within the articulated claims subject to the administrative appeal. The defendant's citation to Beaver, 433 N.J. Super. 430, is on point. Judge Kennedy appropriately held that a plaintiff's characterization of a claim is irrelevant to whether plaintiff must first exhaust administrative appeals. In Beaver, the appellate court was faced with answering the following question: "Under what circumstances may a litigant pursue common law and statutory causes of action in the Law Division, rather than appeal from State final agency determination, where the merits of the agency determination are at issue?" As in Beaver, this question must be addressed in this matter before the court.

In Beaver, plaintiff submitted a claim for coverage, which the SHBC granted in part and denied in part. Id., at 434. Plaintiff then appealed the matter to the OAL. Id., at 435. The Administrative Law Judge (ALJ) conducted an evidentiary hearing, issued a decision recommending denial of plaintiff's appeal, and the SHBC adopted the ALJ's findings and conclusions. Id., at 435-36. Subsequently, plaintiff filed a notice of appeal but withdrew said appeal and filed a complaint in the Law Division. Id., at 436. The complaint sought relief for denial of the claim, alleged breach of contract, breach of fiduciary duty, and violation of the New Jersey Consumer Fraud Act. Id. Defendant moved to dismiss for lack of subject matter jurisdiction and failure to state a claim. Id., at 437. The Law Division obliged defendants and dismissed the plaintiff's complaint for lack of subject matter jurisdiction. Id., at 437.

On appeal, plaintiff argued that the Law Division judge erred in ruling that it lacked subject matter jurisdiction. Similar to plaintiff in the instant action, the plaintiff in Beaver argued that it was alleging contract and tort claims, and that it is not challenging the SHBC determination. Id., at 439. The Appellate Division noted that the plaintiff brought the complaint to recover unpaid benefits under the program. Id., at 441. The Appellate Division then stated:

> In a thinly disguised effort to fit within the Law Division's jurisdiction and divest this court of ours, plaintiff framed his claims as those alleging breach of contract, breach of fiduciary duty, consumer fraud under the CFA, and unjust enrichment. Ordinarily, if properly pled and substantively based, these claims might be sufficient to vest the Law Division with jurisdiction. However, our "exclusive jurisdiction does not turn on the theory of the challenging party's claim or the nature of the relief sought." Mutschler v. N.J. Dep't of Entl. Prot., 337 N.J. Super. 1, 8 (App. Div. 2001).
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> Beaver, at 442.

The Appellate Division further stated that:

> [S]tripped to their barest essentials, plaintiff's claims, sounding in tort and contract, amount to no more than a collateral challenge to the November 14, 2011 SHBC final agency action upholding the limitation of coverage for plaintiff's health benefit claims. Indeed,

> absent an attack on that final agency action, plaintiff's tort and contract claims are patently without basis in fact or law.
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> Id.

In the instant case, plaintiff is in the position similar to the plaintiff in Beaver. It is apparent the tort claim asserted within the Tomaszewski complaint is a challenge to Horizon's decision to recoup overpayment of claims submitted by out-of-network medical provider Heritage by denying subsequent claims, resulting in a non-payment of claims submitted by other medical providers. Plaintiff's attempt to distinguish this complaint from a claim dispute to be processed through the administrative appeal is not supported by the applicable documents or the case law. In essence, plaintiff's tort claim is challenging decisions made by Horizon regarding claims paid and its decision to recoup overpayment directly from the member of the plan, and not the out-of-network medical provider. Stated differently, the allegations of the complaint involve the claim dispute between the parties. Plaintiff's argument that the issue does not fall within the stated categories in the plan documents articulating plaintiff's right to appeal is unpersuasive. This court is satisfied that plaintiff's claims fall within the category of denied benefits, which both parties admit requires adherence to the administrative appeal process. The portion of the plan entitled "NJ Direct Administrative Appeal Procedure" is immediately followed by the following:

> The member or the member's authorized representative may appeal and request that Horizon BCBSNJ reconsider any claim or any portion(s) of a claim for which they believe **benefits have been erroneously denied based on NJ DIRECT's limitations and/or exclusions**. This appeal may be on an administrative nature. Administrative appeals question plan benefit decisions such as **whether a particular service is covered or paid appropriately**. (Emphasis added.)

See Def.'s Br. Ex. 1, p 58; Def.'s Reply Br. p 1 (citing Ex. 1 to Hamelsky Cert. p 58). Subsequent to the aforementioned language, the Guidebook details the three levels of appeal a beneficiary must take. See Def.'s Br. Ex. 1, p 58; Def.'s Reply Br. p 1 (citing Ex. 1 to Hamelsky Cert. p 58). After a beneficiary exhausts the three level of administrative appeals, the Guidebook states," [w]hen the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division." See Def.'s Br. Ex. 1, p 60; Def.'s Reply Br. p 1 (citing Ex. 1 to Hamelsky Cert. p 60).

The complaint alleges defendant is liable for a tortious breach of the covenant of good faith and fair dealing by denying benefits and "refusing to provide the plaintiff with coverage she was entitled to under her insurance policy." As such, the complaint represents an SHBP benefit dispute and, therefore, must be appealed to the Commission.[3] The Commission retains final authority and

[3] Indeed, it strikes this court that compelling plaintiff to pay out-of-pocket for a claims mistake made by Horizon in admittingly overpaying the out-of-network provider Heritage is an overreach, and that principles of waiver and estoppel ought to apply. This is particularly true if Heritage would not be seeking to compel plaintiff Tomaszewski to make up the difference between the amount billed by Heritage and the amount paid by Horizon. If evidence reveals that scenario to be accurate, regardless of broad, self-serving reimbursement language as set forth in the applicable

jurisdiction over SHBP benefit disputes and, accordingly, this court lacks subject matter jurisdiction to adjudicate the allegations of the complaint. Plaintiff is obligated to follow the mandatory internal appeals process as mandated within the Plan.

CONCLUSION

The defense motion is granted. This court lacks subject matter jurisdiction to adjudicate the claims set forth within plaintiff's complaint. The merits of the claims in the complaint are to be addressed and adjudicated through the administrative claims process. This decision does not impact any decision as to the merits of the claims as set forth within the complaint.

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documents, it seems inherently unfair for Horizon to force plaintiff to pay for Horizon's claim/accounting mistakes for which plaintiff had no culpability. But this musing is for the Commission to consider, as the court lacks the jurisdiction to so find.