PREPARED AND FILED BY THE COURT

**FILED**
*6:46 pm, Oct 07, 2019*

KAYAL ORTHOPAEDIC CENTER, P.C.,

Plaintiff,

vs.

UNIDTED HEALTHCARE INSURANCE COMPANY; OXFORD HEALTH INSURANCE, INC.; THE PORT AUTHORITY OF NEW YORK & NEW JERSEY; UNITED HEALTHCARE SERVICES, LLC; LONZA AMERICA, INC.; and NYSNA BENEFITS FUND,

Defendants.

SUPERIOR COURT OF NEW JERSEY
LAW DIV., ESSEX COUNTY
DKT. NO. L-6164-18

**CIVIL ACTION**

**ORDER**

**THIS MATTER** having been opened to the Court by motion of Stradley Ronon Stevens & Young, LLP, attorneys for Defendants United Healthcare Insurance Company, Oxford Health Insurance, Inc., United Healthcare Services, LLC, Lonza America, Inc. and NYNSA Benefits Fund, upon notice to the Plaintiff, for an order granting the moving Defendants' Motion to Dismiss; and the Court having considered the moving papers and the opposition papers; and for good cause shown;

**IT IS** on this **7** day of **October**, 2019:

**ORDERED** that the moving Defendants' Motion to Dismiss is **DENIED** for reasons stated in the accompanying Statement of Reasons; and it is further

**ORDERED** that the Defendants' counsel shall serve a copy of this Order and the accompanying Statement of Reasons on all parties within **7** day of electronic posting hereof.

Keith E. Lynott, J.S.C.

**Statement of Reasons**

In this action alleging underpayment of bills for medical services, the Defendants United Healthcare Insurance Company, Oxford Health Insurance, Inc., United Healthcare Services, LLC, Lonza America, Inc. and NYNSA Benefits Fund move to dismiss the Complaint of the Plaintiff Kayal Orthopaedic Center, P.C. ("Kayal"). The parties waived oral argument. For the reasons set forth herein, the Court denies the motion.[1]

I

A motion to dismiss for failure to state a claim is granted only in rare cases. In Printing Mart-Morristown v. Sharp Elec. Corp., 116 N.J. 739, 772 (1989), the Supreme Court stated that trial courts must accord such motions "meticulous and indulgent examination" and, accordingly, should grant them in only "the rarest of instances." See also Smith v. SBC Communications, Inc., 179 N.J. 265, 282 (2004) ("A motion to dismiss should be granted only in rare instances and ordinarily without prejudice") (internal quotations omitted).

On a motion to dismiss a complaint pursuant to R. 4:6-2(e), the Court must determine whether "a cause of action is 'suggested' by the facts." Printing Mart-Morristown, 116 N.J. at 746 (quoting Velantzas v. Colgate-Palmolive Corp., 109 N.J. 189, 192 (1988)). The Court is required to examine the complaint "in depth and with liberality" to ascertain "whether the fundament of a cause of action may be gleaned from an obscure statement of claim." Ibid.

The Court must accept the facts alleged in the pleading as true. See Malik v. Ruttenberg, 398 N.J. Super. 489, 494 (App. Div. 2008) (the court must "accept as true the facts alleged in the complaint, and credit all reasonable inferences therefrom"). The pleading party is entitled to "every

[1] The Defendant Port Authority of New York & New Jersey did not join the motion. Indeed, it submitted an opposition brief contending that its cross-claim for indemnification against the co- Defendant United Healthcare Insurance Co. is not preempted. Given the Court's disposition of the motion, it is not necessary for the Court to address this issue at this time.

reasonable inference of fact." Printing Mart-Morristown, 116 N.J. at 746. The Court is "not concerned at this stage with whether the plaintiff can prove the facts averred in the Complaint, but merely with the legal sufficiency of the pleading." Ibid.

The examination of the complaint "should be one that is at once painstaking and undertaken with a generous and hospitable approach." Ibid; see also Piscitelli v. Classic Residence by Hyatt, 408 N.J. Super. 83, 103 (App. Div. 2009) (the court must review the complaint with "a generous and hospitable approach") (internal quotations omitted). The Court must "search the complaint in depth and with liberality" to identify the causes of action asserted. Lieberman v. Port Auth. of N.Y. & N.J., 132 N.J 76, 79 (1993) (internal quotations omitted). In addition, "[a] complaint should not be dismissed under this rule where a cause of action is suggested by the facts and a theory of actionability may be articulated by way of amendment." Rieder v. State Dep't of Transp., 221 N.J. Super. 547, 552 (App. Div. 1987).

In examining a motion to dismiss, "the inquiry is confined to a consideration of the legal sufficiency of the alleged facts apparent on the face of the challenged claim," and therefore, "[t]he court may not consider anything other than whether the complaint states a cognizable cause of action." Ibid (internal quotations omitted). Thus, the Court may not examine materials extrinsic to the complaint itself in adjudicating a motion to dismiss. An exception exists for exhibits attached to the complaint, matters of public record and materials that the plaintiff relies upon in the complaint or that are integral to the plaintiff's claims. See Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) ("In evaluating motions to dismiss, courts consider allegations in the complaint, exhibits attached to the complaint, matters of public record, and documents that form the basis of a claim.") (internal quotations omitted).

The Rules of Court require only that a pleading contain "a statement of facts on which the claim is based showing that the plaintiff is entitled to relief, showing that the pleader is entitled to relief, and a demand of judgment for the relief to which the pleader claims entitlement." R. 4:5-2. The purpose of a pleading is not to provide a complete recitation of every possible fact or argument available, but to fairly apprise the adverse party of the claims and issues to be raised at trial. See Dewey v. R.J. Reynolds Tobacco Co., 121 N.J. 69, 75 (1980) ("Although more by way of facts regarding the design defect would have been enlightening, see Rule 4:5-2, we agree with the Appellate Division's finding that '[t]o the extent that plaintiff's complaint was deficient, the judge properly looked to the entire record, giving plaintiff every favorable inference,' 225 N.J. Super. at 382 n.5, and that the trial court had correctly concluded that the complaint was sufficient to support a claim of design defect").

II

The Court draws the pertinent facts from the Complaint. It accepts as true the averments of the Complaint solely for purposes of the pending motion. As required by the case law, the Court examines the Complaint in depth and in its entirety and with a generous and hospitable approach.

Kayal, located principally in Franklin Lakes, is a "medical practice specializing in orthopedic surgery and treatment." The Defendants United Healthcare Insurance Company and Oxford Health Insurance, Inc. are insurance companies licensed to do business in New Jersey. The other Defendants are United HealthCare Services, LLC, Lonza America, Inc., NYSNA Benefits Fund and the Port Authority of New York & New Jersey. Each of the Defendants sponsored, funded, operated, controlled and/or administered healthcare plans of individuals who sought medical treatment from Kayal. In this opinion, the Court refers to the moving Defendants – all named Defendants save for the Port Authority of New York & New Jersey – as the Defendants.

Kayal alleges that it is an "out-of-network, or non-participating, healthcare provider" in relation to the Defendants. It asserts that it "rendered pre-approved, medically necessary surgical care to six patients identified in the Complaint by initials, an associated ID# and date(s) of service.

Kayal avers that, prior to rendering services to each of the patients at issue, it obtained "pre-authorization to render the subject services and insurance verifications from defendants." It avers that, "[i]n each instance, Kayal then relied on the pre-authorization and insurance verification provided by the defendants, as defendants reasonably expected – in the ordinary course of business in the healthcare industry – and [Kayal] reasonably expected payment for its services pursuant to the insurance verification as a result." Kayal asserts that "in each instance, defendants failed to pay in accordance with the pre-authorizations and insurance verifications provided to Kayal."

The Complaint alleges that Kayal exhausted internal appeals processes for the claims at issue or that such processes were futile. It contends that its claims arise from New Jersey common law and are not predicated on assignments of benefits from the respective patients. It thus avers that its claims challenge the amount of coverage afforded the patients, not the existence of coverage, and do not implicate the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. ("ERISA"), or any other federal statutory or regulatory scheme.

The First Count asserts a claim for a promissory estoppel. This Count asserts that "[i]n reasonable reliance upon the defendants' pre-authorization and insurance verifications, plaintiff agreed to render medically necessary surgical services to the patients." It alleges the Defendants at no time withdrew such pre-authorizations and that they are not permitted to do so under applicable New Jersey Regulations, citing to N.J.A.C. 11:24B-5.2(a)(5)(v). Kayal avers that "[d]espite defendants' pre-authorization and insurance verifications to plaintiff to render the services to the patients, defendants have not paid correctly for the medical services provided." The Complaint alleges that the Defendants'

actions have caused Kayal to "suffer a detriment of a definite and substantial nature in reliance upon defendants' promises and representations, thus constituting an actionable claim pursuant to the doctrine of promissory estoppel."

The Second Count alleges a claim for negligent misrepresentation. It asserts that, "[d]espite pre-authorizing Kayal to render surgical services to the patients, and verifying insurance payment terms, which were then reasonably relied upon by plaintiff in accordance with applicable New Jersey regulations and industry practice, defendants have refused to pay the subject claims correctly." This Count alleges that the "Defendants' negligent misrepresentation to Kayal, manifested by defendants' authorizations and insurance verifications, were unknown to plaintiff at the time it agreed to render surgical services to the patients." Kayal asserts that the Plaintiff reasonably expected and relied upon what "it believed to be defendants' honest promises and representations that plaintiff would be paid correctly for its surgical services." It asserts its reliance on "these representations" was to its "substantial detriment."

The Third Count purports to state a claim for unjust enrichment and quantum meruit. It alleges that the Defendants refused to pay Kayal correctly for the surgical services provided to the patients identified in the Complaint, "contrary to insurance verifications provided by defendants." This Count alleges that the Defendants "were paid premiums by the patients for out-of-network coverage and, pursuant to said premiums, defendants were legally obligated to provide such coverage to the patients at correct rates in accordance with the insurance verifications provided." Kayal avers that "[t]o satisfy their coverage and legal obligations, defendants required the services of Kayal to render medical services" and Kayal in fact did so. The Plaintiff alleges that the Defendants have received and retained a benefit as a result of the services rendered by the Plaintiff in respect of which the Kayal was and remains underpaid. As a result, "defendants have been unjustly enriched through the use of funds that

earned interest or otherwise added to their profits when said money should have been paid in a timely and appropriate manner to plaintiff."

The Fourth Count purports to state a claim for interference with economic advantage. The Plaintiff alleges a reasonable expectation of economic advantage belonging or accruing to it. This Count alleges that the Defendants knew or reasonably should have known of the Plaintiff's expectation of economic advantage and that the Defendants wrongfully interfered with such expected economic benefit from the services rendered to the patients.

III

The Defendants move against the Complaint on a variety of grounds. They assert that, because the Plaintiff's claims relate to health insurance plans that are subject to ERISA, the Court must dismiss such claims in their entirety on the basis of express preemption pursuant to ERISA Section 514(a). 29 U.S.C. Section 1144(a). Examining every Count separately, the Defendants assert that the Plaintiff has failed in each instance to state a claim upon which relief can be granted.

Turning first to the issue of preemption, the Defendants assert that all of the claims that form the subject matter of the Plaintiff's action "relate to" ERISA-subject healthcare benefits plans in a manner and to an extent as to require a determination that such claims are preempted. They argue that adjudication of the Plaintiff's claims for underpayment of their invoices for medical services perforce requires the Court to review, apply and interpret the underlying benefits plans – an exercise that this Court is not permitted to undertake, but that must take place, if at all, in a federal court.

The Defendants submit with their motion documents relating to certain of the patient claims by which the relevant insurer confirmed its authorization for certain services, but also stated that payment was not guaranteed and would be made according to the terms of the applicable plan. They

contend the Court would have to review the plans to ascertain their applicability to the services provided in order to assess the amount (if any) of the underpayments.

The Plaintiff counters that its claims do not "relate to" any such ERISA-subject benefits plans. It asserts that, as to each of the disputed claims, the Plaintiff received assurances of coverage from the Defendants prior to performing the services. As a result, according to the Plaintiff, there is no need for the Court to review the respective healthcare benefits plans to render a coverage determination.

The Plaintiff thus asserts that, in seeking reimbursement from the Defendants for underpayment of submitted claims, it is only contesting the amount of reimbursement. It asseverates that there is no question as to the existence of coverage under any of the underlying plans and the Court is not, and will not be, asked or required to construe or interpret the terms and conditions of such plans in adjudicating this case. It asserts the Defendants failed to pay an amount that correctly corresponds to the insurance verifications the Defendants provided.

The Plaintiff points out that the Complaint involves direct claims against the Defendants and not derivative claims based upon an assignment from the patients. The Plaintiff does not stand in the shoes of beneficiaries of the Defendants' plans and is not asserting claims predicated on the terms and conditions of the plans themselves. Instead, it asserts the bases for the claims are independent duties owed to them by the Defendants under the common law. The Plaintiff attaches to its Reply papers documents it contends establish that, when the Defendants issued pre-authorizations for services to be rendered by the Plaintiff, they agreed to pay based upon a represented percentage of the Plaintiff's usual, customary and reasonable ("UCR") rates for the services.

ERISA Section 514(a), 29 U.S.C. §1144(a), provides in pertinent part as follows:

> The provisions of this subchapter and subchapter 1111 of this chapter shall supersede any and all State laws insofar as they may now or hereafter **relate to** any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

[Emphasis added.]

ERISA Section 514 (b)(2)(A), 29 U.S.C. §1144(b)(2)(A), in turn, provides that "[e]xcept as provided in subparagraph (B) nothing in this subchapter shall be considered to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." The statute thus preempts state laws as they "relate to" any employee benefit plan, except insofar as such laws regulate insurance.

The Court concludes in the circumstances here that it is premature at this early juncture to determine whether all or any aspect of the Plaintiff's claims are subject to express preemption under ERISA Section 514(a). Courts have recognized that, despite the use of the phrase "relate to" to establish the reach of the provision, ERISA 514(a) does have limits. The Supreme Court in NYS Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 655 (1995), stated that it declined to apply "uncritical literalism" to that phrase, instructing courts to examine the objectives of the ERISA statute in determining what State laws would survive preemption analysis. "If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.' But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality." Id. at 654-655 (internal quotations omitted). Thus, courts "look to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.'" Nat'l Sec. Sys., Inc. v. Iola, 700 F.3d 65, 83-84 (3rd Cir. 2012) (quoting California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc., 519 U.S. 316, 325 (1997)).

In In re Reglan Litigation, 226 N.J. 315, 329 (2016), the New Jersey Supreme Court stated that, when Congress legislates in a field where states have traditionally exercised their historic police

powers, "the preemption inquiry begins with the assumption that Congress did not intend to supersede a State statute" unless that was Congress's clear and manifest purpose. This presumption against preemption is especially pertinent here, given the traditional role of States in regulating matters of healthcare. See Freedman v. Redstone, 753 F. 3d 416, 429-430 (3d Cir. 2014). Moreover, as healthcare providers are generally not considered "beneficiaries" or "participants" under ERISA, a determination that the claims asserted here are preempted would very likely leave the Plaintiff without a remedy.

The New Jersey Supreme Court has also held that preemption is a "fact-sensitive endeavor." R.F. v. Abbott Labs, 162 N. J. 596, 619 (2000). Here, even granting that the patients to whom the Plaintiff provided services were insured under ERISA-subject plans, it is not clear at this juncture that the Plaintiff's causes of action are necessarily preempted. As noted, the Plaintiff is suing in a direct capacity. It is not suing as, or standing in the shoes of, a beneficiary. It alleges in the Complaint – and the Court must accept as true on this motion – that it performed preauthorized surgical services for the patients. It alleges that it received advance assurances of coverage and payment according to the terms of the insurance verification.

The Plaintiff relies upon Memorial Hospital System v. Northbrook Life Insurance Co., 904 F. 2nd 236 (5th Cir. 1990), to support its claim that preemption is not warranted in the circumstances here. In that case, the plaintiff provider alleged that a health insurer misrepresented the existence of coverage for a patient seeking treatment from the provider. The court held that preemption under ERISA Section 514(a), on the basis that the claim "relate[d] to" an ERISA-subject benefit plan, would not serve the statutory purpose of protecting employees/beneficiaries. The court noted that application of preemption to bar a State law claim by the provider in the circumstances of that case would ignore commercial realities and could lead providers as a practical matter to insist on prepayment rather than accept the risk of nonpayment.

The court also concluded that the cause of action seeking payment in such circumstances – that is, a claim alleging misrepresentation as to the existence of coverage – would not "relate to" the terms and conditions of the underlying welfare plan and would not affect or would only tangentially affect the actual administration of the plan. Id. at 248, 250. See also The Meadows v. Employers Health Insurance, 47 F. 3d 1006, 1008-1110 (9th Cir. 1995)(noting that "independent state law claims of [the plaintiff], a third-party provider, lie outside the bounds of the ERISA 'relates to' standard" and "courts have held that ERISA does not preempt third-party provider's independent state law claims against a plan sponsor precisely because those claims do not 'relate to' the administration of the plan"); McCall v. Metlife Insurance Co., 956 F. Supp. 1172, 1186 (D.N. J. 1996) (stating that the provider's negligent misrepresentation claims against the defendant insurers are sufficiently removed from the plan to avoid the scope of ERISA preemption).

In St. Peter's Univ. Hospital v. New Jersey Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div.), certif. denied, 216 N.J. 366 (2013), the Appellate Division cited Memorial Hospital System, 904 F. 2nd 236, with approval and stated that, although ERISA preemption is "clearly expansive," to interpret the language to its furthest extent "would render the reach of the provision limitless." Accordingly, a court should not find state law claims preempted if such State law has only a "tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." Id. at 456.

In St. Peter's Univ. Hospital, 431 N.J. Super. 446, the trial court and Appellate Division did conclude, albeit on a motion for summary judgment after discovery, that the claim brought by the plaintiff hospital against a welfare fund seeking additional remuneration was preempted. The Appellate Division concluded that the claims dealt directly with payment of benefits under the plan and involved more than a peripheral reference to the plan. The court held that the hospital's claims

were based on the plan's obligations under its subscriber agreement with a preferred provider organization; and that the plan itself was referenced and incorporated in that agreement.

The court determined that, in order to adjudicate the hospital's claims, the court would be required to examine and consult the terms of the ERISA plan. It found that, before the court could determine if a benefit was payable, it would be necessary to conduct an inquiry into the terms of the plan to determine such matters as 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 was available for purposes of the coordination of benefits and the cap on benefits. Accordingly, the court concluded that the claims were neither tenuous nor peripheral, but rather "clearly 'relate to' the ERISA plan within the intendment of the statute and are expressly preempted." Id. at 460.

In this case, the Court does not and cannot determine at this time whether the Plaintiff's claims are or are not preempted. The Plaintiff has specifically alleged, and the Court must accept as true, that it does not seek a determination as to the terms and conditions of any underlying ERISA-subject plans, but only a determination of the amount of reimbursement owed for claims involving preauthorized services. It asserts claims under various legal theories that, so it contends, arise from independent legal obligations on the Defendants' part to pay the Plaintiff's charges for services provided to the Defendants' insureds according to the insurance verifications it received. It alleges such obligations arise from quasi-contract based on a promise or obligation to pay for a benefit conferred. It also avers, as in Memorial Hospital System, 904 F. 2nd 236, that its legal rights arise from negligent misrepresentations of the Defendants as to the coverage afforded to the plan subscribers and payment for services to be provided.

In all events, the Plaintiff asserts its rights do not derive from the underlying plans and are peripheral to the terms and conditions of such plans. It contends that adjudication of the claims will

therefore not require the Court to delve into the terms and conditions of such plans. In short, it alleges facts that, if proved, could cause the Court to conclude that the existence of an ERISA plan is not a "critical factor" in establishing the Defendants' liability and the Court's inquiry would not be "directed to the plan." St. Peter's Univ. Hospital, 431 N.J. Super. at 455-456 (internal quotations omitted).

In the circumstances, recognizing both the presumption against preemption and the fact-sensitive nature of the issue presented, the Court concludes it is necessary to have a full record before determining whether the Plaintiff's claims "relate to" ERISA-subject benefits plans within the intendment of that phrase. Put another way, it is necessary to explore in greater detail and on a more complete factual record than permitted on a motion to dismiss the nature and substance of the Plaintiff's claims before it could determine that the claims are preempted on the basis that the Court would necessarily have to examine, apply and interpret the underlying ERISA-subject benefits plans.

A more complete record is necessary for the Court to examine whether adjudication of the Plaintiff's claims bears only a "tenuous, remote, or peripheral connection" to ERISA-covered plans or whether such plans, as in St. Peter's Univ. Hospital, 431 N.J. Super. 446, have a more direct connection to the claims asserted. Such a record is necessary to examine whether the Court would be directed to the plans in an adjudication, in which event the claims would be subject to preemption. Accordingly, for the present time, the Court denies the Motion to Dismiss on grounds of preemption for the reasons stated.

The Defendants rely upon a number of decisions from the District of New Jersey granting motions to dismiss on preemption grounds as to state law claims resembling those asserted here. However, the cases cited are not published, are not controlling and were decided under a different standard for adjudicating a motion to dismiss. Most of the cases relied upon appear to have been

decided by the same United States District Judge and other Judges within the District have reached contrary conclusions.

Moreover, the cases cited also appear to involve circumstances different from the circumstances here, at least on the basis of the present limited record. Thus, in Advanced Orthopedics and Sports Medicine Institute v. Empire Blue Cross Blue Shield, 2018 U.S. Dist. LEXIS 96814 (D.N.J. June 7, 2018), the court noted the plaintiff provider merely alleged that, prior to performing surgery, it obtained authorization for admission of the patient from the emergency room department. Although the plaintiff asserted a claim against the insurer for breach of an implied contract, among other theories, the court concluded the facts alleged did not indicate that the Defendant insurer was even involved in the claimed agreement at all. Nor did the complaint allege an agreement to pay an amount other than that specified in the applicable plan.

In contrast, the Court reads the Complaint of the Plaintiff here – examined with liberality as required by Printing Mart – Morristown – to allege it received pre-authorizations from the respective plans as to coverage for the services to be provided and for payment of the Plaintiff's charges for the same in accordance with the insurance verifications. Whether that will prove to be true and whether such circumstances, even if true, will permit the Plaintiff's claims to proceed under State common law theories of action are matters that remain to be seen. However, given the Plaintiff's allegations in this case, there is not a sufficient basis to dismiss the Complaint at this early juncture.

The Defendants have submitted documents that they assert, at least as to the patients to which the documents refer, are the pre-authorizations given for the Plaintiff's services. As noted above, they contend these documents establish that the relevant Defendant provided no guarantee of payment and advised that the amount of payment would depend upon verification of the services actually provided and the terms of the relevant plan. They assert such documents establish that it is necessary to examine

the relevant plan to ascertain whether the payment to the Plaintiff was correct or proper and the Court will thus perforce be directed to the plans to adjudicate the Plaintiff's claims.

On a motion to dismiss, the Court should only examine documents that are the basis of or integral to the plaintiff's pleaded claim or on which the plaintiff relies as the basis for such claim– not documents that may be part and parcel of the defendant's defense to the claim. Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183; In Re Burlington Coat Factory Securities Litigation, 114 F. 3d 1410, 1426 (3rd Cir. 1997). Although the claims in this case are grounded in alleged pre-authorizations of surgical services, it is not apparent that the Plaintiff is relying solely on written pre-authorizations it may have received. The Complaint, liberally construed, could also allege telephonic pre-authorizations. The Court also reads the Complaint, under the Printing Mart-Morristown standard, to allege a failure of correct payment in accordance with the verifications allegedly given by the Defendants. Such allegations encompass not only acknowledgments as to coverage but also as to the amount to be paid for the pre-authorized services.

Moreover, it is not clear that the documents submitted by the Defendants represent the complete written record concerning the terms of authorization for the services provided to the patients identified in such records. Indeed, documents submitted by the Plaintiff suggest they are not. The submissions of the parties confirm that the Court should await the development of a complete record before determining whether some or all of the Plaintiff's claims are preempted.

As noted above, the Defendant also challenges each pleaded cause of action on the grounds that the pleading is insufficient to state a cause of action upon which relief can be granted. The Court now surveys each of the pleaded Counts for relief in order to ascertain whether or not the Plaintiff has pleaded facts sufficient to sustain a viable cause of action.

In the First Count, the Complaint purports to state a cause of action for promissory estoppel. The claim for promissory estoppel requires a showing of a clear and definite promise made with the expectation of reliance, reasonable reliance, and substantial detriment. Lobiondo v. O'Callaghan, 357 N.J. Super. 488, 499 (App. Div. 2003).

The facts set forth in the Complaint considered as a whole establish a cause of action for promissory estoppel. The Plaintiff alleges a promise to pay for out-of-network services delivered as to each disputed patient account. The Complaint alleges the Defendants gave prior authorizations for the services and promised payment for the same in amounts in accordance with the insurance verifications given by the Defendants. The Complaint then alleges the result of such communication was a promise to pay for the services as to which the Plaintiff relied to their detriment.

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

The Plaintiff's Complaint alleges that, as to the disputed patient accounts, the Defendants falsely advised the Plaintiff of the preauthorization of the treatment and of an agreement or intention to pay for the services to be provided to the patients/insureds. These factual averments are sufficient to establish a negligent misrepresentation. The Complaint also adequately alleges that the Plaintiff reasonably relied on the allegedly false assurances by providing the services on the basis of the same.

The Court finds the Plaintiff has pleaded the circumstances of such misrepresentations as to the disputed patient accounts with the requisite particularity. The Complaint read as a whole sets forth the specific nature of the misrepresentation and the approximate time – the date of service – when it

was given. As noted, the Complaint specifically alleges facts going to reliance on the alleged misrepresentation via allegations of performance of services for each patient/insured. The Plaintiff may, of course, be required in discovery to supply additional pertinent information as to each individual disputed patient account.

The Third Count of the Complaint purports to state a cause of action for unjust enrichment and quantum meruit. The elements of a claim for unjust enrichment are that the Defendant received a benefit and that retention of that benefit would be unjust. Castro v. NYT Television, 370 N.J. Super. 282, 299 (App. Div. 2004). Likewise, a claim for quantum meruit arises when a party confers a benefit on another with the reasonable expectation of payment for the same.

The Court concludes that the Complaint states a cause of action for unjust enrichment and quantum meruit – once again, after examining the Complaint in its entirety under the Printing Mart-Morristown standard. The cause of action for unjust enrichment or quantum meruit requires the Plaintiff to allege that it conferred a benefit upon the respective Defendants and circumstances as to which it would be unjust to permit the Defendants to retain the benefit without remuneration and/or in which the Plaintiff reasonably expected compensation. The Defendants dispute the existence of a benefit conferred by the Plaintiff on the Defendants. They assert any benefit arising from the services provided by the Plaintiff accrued only to the patients and not the Defendants.

However, the Court finds that the pleadings allege sufficient facts concerning a benefit conferred on the Defendants. The Complaint alleges that the Defendants charged premiums for plans that afforded patients/insureds rights to services from out-of-network providers. The Complaint alleges the performance by the Plaintiff of out-of-network preauthorized services for the Defendants' patients/insureds enabled the Defendants to discharge their contractual obligations to those patients by permitting them to obtain such services. In light of these allegations, the Court finds that, under the

Printing Mart-Morristown test, the facts pleaded are sufficient from which to glean the fundament of a cause of action for quasi-contractual relief.

The Defendants cite cases, none of which are controlling on this Court, in which the courts did determine that an insurer/payor received no benefit when a provider merely provides a service to an insured. The courts in those cases concluded that the only outcome for the payor in such circumstances was a demand for payment. Such courts noted that the payor is indifferent as to which out-of-network provider the patient/insured actually chooses.

But other courts, typically in cases involving claims grounded in quasi-contract and the performance of emergency services, have determined that the payor did receive a benefit from the provider's services – namely, the services enabled the payor to discharge a legal obligation owed to the patient/insured. One such case is El Paso Healthcare Services v. Molina Healthcare of New Mexico, Inc., 683 F. Supp. 2d 454, 461 (W. D. Tex. 2010), where the court reasoned that "[w]hile it is true that the immediate beneficiaries of the medical services were the patients, and not Molina, that company *did* receive a benefit of having its obligations to plan members and to the state in the interest of plan members, discharged." (Emphasis in original) The court noted that "Molina describes this discharging of obligations benefit as 'incidental,' but the Court finds this benefit material, due to the aforementioned obligations." Ibid. It further observed that "[i]ndeed, Molina's very reason for existence is to ensure that such services are provided to plan members; seeing this core obligation fulfilled is hardly incidental." Ibid.

The court stated that "[i]f these obligations are not deemed material and central to the Medicaid managed care scheme, how is such a system supposed to function?" Id. at 462. It found that "[i]n sum, these discharges were furnished for the benefit of Molina, which enjoyed and accepted them, and Molina even acknowledged as much when it tendered payment for them at a rate it deemed to be

proper." Ibid. Referring to the elements of claim in quasi-contract, the court held that "prongs two and three [requiring a benefit to be conferred upon and accepted by the defendant] have been fulfilled as well is one and four, even though Molina disputes this characterization of the facts." Ibid.

It is true that El Paso involved a managed care organization providing coverage to Medicaid-eligible patients. As such, that entity had obligations to ensure the delivery of certain services to enrolled patients.

But it is not a significant leap of logic to find that a similar benefit accrued to the Defendants here, at least under the facts as alleged by the Plaintiff. The services provided were out-of-network services that the Defendants had agreed their subscribers could receive and, accordingly, preauthorized the Plaintiff to perform. The performance of such services enabled the Defendants to satisfy contractual obligations to permit the subscribers to seek, in appropriate cases, service from out-of-network providers, an obligation that, as the Complaint alleges, was supported by the receipt of premiums.

The Complaint also purports to state a claim in the Fourth Count for interference with prospective economic advantage. To state a claim for tortious interference with prospective economic advantage, a plaintiff must allege a protected interest, including a prospective economic relationship or contract, malice – defined as an intentional interference without justification – a reasonable likelihood that the interference caused the loss of the prospective gain and damages. Printing Mart-Morristown, 116 N.J. at 751.

The prospective economic advantage alleged here is the economic benefit derived from the provider/patient relationship allegedly existing between the Plaintiff and the patient/insureds of the Defendants who sought treatment from the Plaintiff. The Complaint alleges facts from which one may glean a claim for interference with such relationships arising from the Defendants' alleged

preauthorization of the services to be rendered, followed by their failure or refusal to pay the full amount the Plaintiff claims was due according to the insurance verifications provided.

The Complaint also sets forth facts supporting the assertion that the Defendants acted wrongfully. The Plaintiff alleges the Defendants withheld payment to increase their own profits at the expense of the provider and did so at a time when the Plaintiff had already provided the services to the patients on the basis of a promise of payment from the Defendants. The Court thus discerns the "fundament" of a cause of action for tortious interference from the pleading examined under the Printing Mart- Morristown standard.

For the reasons set forth herein, the Court denies the Defendants' motion to dismiss the Complaint. It concludes that the Plaintiff has stated claims upon which relief could be granted and that it would be premature at this nascent stage of the case to address the issue of preemption.