Prepared by the Court

HEALING AT HIDDEN RIVER, LLC, Plaintiff, v. AETNA LIFE INS. CO., d/b/a Aetna, a/k/a Global Claims Services, et al. Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ESSEX COUNTY DOCKET NO.: ESX-L-2381-25 Civil Action **ORDER**

FILED
NOV 21 2025
Hon. Stephen L. Petrillo, J.S.C.

THIS MATTER having been opened to the Court by Robinson & Cole LLP, and Calcagni & Kanefsky, LLP, attorneys for Defendants, Aetna Life Insurance Company, Meritain Health, Inc., Aetna Health, Inc., Aetna Health Management, LLC, Global Claims Services, Aetna, Inc., Jordache Enterprises, Inc., NAPA Management Services Corporation (improperly identified as "North American Partners in Anesthesia Management Services Corp."), PNC Financial Services Group, Inc., A. Duie Pyle, Inc., MetLife, Princeton University, Atlantic Health System Inc., CitiGroup, TriNet Group, Inc., Saint Peter's Healthcare System, Tramec, LLC., Bristol-Myers Squibb Co., Johnson & Johnson, and University of New Haven, (collectively "defendants") for an Order dismissing the claims asserted against defendants in plaintiff Healing at Hidden River, LLC's Complaint, and the court having considered all the moving papers, and any opposition thereto, and good cause having been shown;

IT IS on this 21st day of November 2025;

ORDERED that the defendants' Motion to Dismiss is hereby GRANTED without prejudice in so far as it relates to claims based on a theory of agency, Count 5 in part (negligence), and it is further;

ORDERED that the motion is DENIED as it relates to claims based on a theory of direct liability, Counts 1-4, Count 5 (negligent misrepresentation), and Counts 7-8; and it is further

ORDERED that a copy of this Order shall be served in accordance with R. 1:5-1(a).

HON. STEPHEN L. PETRILLO

Opposed

See ATTACHED opinion

SUPERIOR COURT OF NEW JERSEY
ESSEX VICINAGE
LAW DIVISION, CIVIL PART
DOCKET NO.: ESX-L-2381-25

HEALING AT HIDDEN RIVER, LLC,
Plaintiff,
v.
AETNA LIFE INS. CO., et al.,
Defendants.

OPINION

Petrillo, J.S.C.

I. INTRODUCTION

This matter comes before the court by way of a pre-answer motion to dismiss for failure to state a claim filed by Aetna Life Insurance, Co., Aetna Life Insurance Company, Meritain Health, Inc., Aetna Health, Inc., Aetna Health Management, LLC, Global Claims Services, Aetna, Inc. (collectively "Aetna"), Jordache Enterprises, Inc., NAPA Management Services Corporation (also identified as "North American Partners in Anesthesia Management Services Corp."), PNC Financial Services Group, Inc. A. Duie Pyle, Inc., MetLife, Princeton University, Atlantic Health System Inc., CitiGroup, TriNet Group, Inc., Saint Peter's Healthcare System, and Tramec, LLC (all are collectively "defendants"). The Vanguard Group is also a defendant in this action but separately moved to dismiss. Their motion was decided on October 8, 2025.

After careful review of the parties' submissions and the controlling legal precedents in New Jersey, the defendants' motion is hereby **GRANTED** in part and **DENIED** in part.

II. FACTUAL BACKGROUND

At this stage of the litigation all factual statements are drawn from the complaint and assumed to be true.[1]

This matter arises from a complaint filed by Healing at Hidden River, LLC ("plaintiff", "Hidden River"), a New Jersey-based healthcare provider specializing in behavioral health and residential services for female adolescents and young women with severe eating disorders. Plaintiff operates a 22-bed residential facility in northern New Jersey, representing approximately 65% of residential eating disorder treatment beds in the state and the only such facility in the northern region.

The complaint alleges that from December 2020 through February 2025, plaintiff provided medically necessary, pre-approved residential and related healthcare services to 16 patients aged between 8 and 26, who suffered from severe eating disorders and co-occurring psychiatric conditions. These services included individual counseling, medical and nutritional assessments, recreational therapy, group therapy, on-site academics, and family involvement. The patients referenced in the complaint are identified by initials and limited patient identification numbers in accordance with privacy regulations.

At all relevant times, plaintiff was an out-of-network provider with respect to defendants, primarily the Aetna entities and several employer-based healthcare payors. The complaint asserts that Aetna and the payor defendants do not maintain an adequate network of in-network providers for eating disorder services in the region and that plaintiff was not a participant in Aetna's National Advantage Program ("NAP") nor in any MultiPlan complementary network arrangements.

Prior to admitting patients, plaintiff engaged in telephonic pre-affirmations with representatives of the defendants. According to the complaint, these representatives orally affirmed that payment for services would be at usual, customary, and reasonable ("UCR") rates or specific percentages thereof, with assurances that the claims would not be subject to repricing or to Medicare-based rate calculation. Plaintiff relied upon these affirmations when agreeing to treat the patients.

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[1] See e.g., Printing Mart-Morristown v. Sharp Elecs. Corp., 116 N.J. 739, 746 (1989) ("In reviewing a complaint dismissed under Rule 4:6-2(e) our inquiry is limited to examining the legal sufficiency of the facts alleged on the face of the complaint"); Donato v. Moldow, 374 N.J. Super. 475, 483 (App. Div. 2005).

After services were rendered, the complaint alleges that claims were diverted by the defendants to Aetna's affiliate, Global Claims Services ("GCS"), for "repricing." This process purportedly reduced reimbursement rates to approximately 27% of the expected UCR rate, resulting in a cumulative outstanding payment balance to plaintiff of roughly $1.5 million. The complaint describes a self-interested "bait-and-switch" scheme in which Aetna allegedly enriched itself through administration fees and commissions on the portion of funds not paid to the provider, all while shifting the burden of underpayment onto patients who are subsequently exposed to significant medical debt.

Further, the complaint describes an industry-wide shift following prior settlements with regulators regarding manipulation of reimbursement databases. The complaint asserts that defendants have since reverted to the use of internal and affiliate-based repricing schemes inconsistent with independent UCR calculation standards.

The complaint states that jurisdiction and venue are proper in New Jersey state court, no federal claims are asserted, and no ERISA or FEHBA rights are invoked. Plaintiff claims that its exhaustion of administrative remedies was either completed where required or futile due to the nature of the defendants' appeal responses.

III. LEGAL STANDARD

A complaint should only be dismissed pursuant to R. 4:6-2(e) for failure to state a claim if it fails "to articulate a legal basis entitling plaintiff to relief." Sickles v. Cabot Corp., 379 N.J. Super. 100, 106 (App. Div. 2005). On a motion to dismiss a complaint for failure to state a cause of action under R. 4:6-2(e), a court must consider whether a cause of action is "suggested" by the facts. Printing Mart-Morristown v. Sharp Elecs. Corp., 116 N.J. 739, 746 (1989) (citing Velantzas v. Colgate–Palmolive Co., 109 N.J. 189, 192 (1988)).

"[T]he motion should be granted if even a generous reading of the allegations does not reveal a legal basis for recovery." Edwards v. Prudential Prop. & Cas. Co., 357 N.J. Super. 196, 202 (App. Div. 2003) (internal citation omitted). "[T]he essential facts supporting plaintiffs' cause of action must be presented in order for the claim to survive; conclusory allegations are insufficient in that regard." Scheidt v. DRS Techs., Inc., 424 N.J. Super. 188, 193 (App. Div. 2012) (internal citation

omitted). Dismissals generally should be without prejudice when granted. Printing Mart, 116 N.J. at 772.

IV. ANALYSIS

A. Extra-pleading documents

As an initial matter the court must decide which, if any, documents it will consider at this stage of the litigation. Defendants want the court to review hundreds of pages of documents with its motion, while plaintiff wants to preclude the same. The documents at issue include, among other things, alleged transcripts of phone calls referenced in the complaint (see Compl. ¶ 64) and Summary Plan Documents ("SPDs").

1. Transcripts

When considering a motion to dismiss the complaint a trial court may examine "documents specifically referenced in the complaint without converting the motion into one for summary judgment." Myska v. N.J. Mfrs. Ins. Co., 440 N.J. Super. 458, 482 (App. Div. 2015) (internal citation and quotation omitted). "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.'" Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) (quoting Lum v. Bank of Am., 361 F.3d 217, 222 n. 3 (3d Cir. 2004) (collecting cases)). If the court is presented with documents outside of these limits, then the court can, with proper notice, treat the motion to dismiss as a motion for summary judgment.[2]

First, defendants submitted documents which they allege are transcripts of some of the phone calls that are central to the complaint. See generally Petitt Cert. Plaintiff disputes the authenticity, completeness, and relevance of these transcripts.

[2] "If, on a motion to dismiss [for failure to state a claim] matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided by R. 4:46, and all parties shall be given reasonable notice of the court's intention to treat the motion as one for summary judgment and a reasonable opportunity to present all material pertinent to such a motion." R. 4:6-2.

Opp. Br. at 12. The 10 alleged transcripts are for 7 of the 15 patients' claims at issue in this motion.[3]

For several reasons the Defendants' arguments for submission of the transcripts fail. In Banco the New Jersey Supreme Court cited a Third Circuit case that delineates the exception to the general rule of "not consider[ing] matters extraneous to the pleadings" on a motion to dismiss for failure to state a claim. In re Burlington Coat Fac'y Sec. Litig., 114 F.3d 1410, 1426 (3d Cir. 1997); see also Lum, 361 F.3d at 222 n.3 (cited by Banco Court and collecting cases). There, the Third Circuit explained the underlying reasoning for the "integral document" exception, which the defendants [4] rely upon:

> "The rationale underlying this exception is that the primary problem raised by looking to documents outside the complaint -- lack of notice to the plaintiff -- is dissipated where plaintiff has actual notice . . . and has relied upon these documents in framing the complaint... What the rule seeks to prevent is the situation in which a plaintiff is able to maintain a claim of fraud by extracting an isolated statement from a document and placing it in the complaint, even though if the statement were examined in the full context of the document, it would be clear that the statement was not fraudulent."
>
> Burlington, 114 F.3d at 1426 (internal citations and quotations omitted).

Here, such rationale is inapplicable. Initially, plaintiff did not rely on these transcripts in framing the complaint. Plaintiff states in their opposition brief they were not in possession of these documents when drafting the complaint. See Opp. Br. at 11-12. They lacked the actual notice required to trigger this exception. See Chambers v. Time Warner, Inc., 282 F.3d 147, 153 (2d Cir. 2002) (emphasizing lack of notice as primary reason for this exception). Furthermore, they have not "extract[ed] an isolated statement from a document and plac[ed] it in the complaint,"

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[3] Defendant Vanguard filed a separate motion to dismiss related to patient A.B. The 15 remaining patients' claims are represented in this motion.

[4] Here, Defendants primarily cite to Princeton Neurological Surgery, P.C. v. Aetna, Inc., 2023 U.S. Dist. LEXIS 33542, (D.N.J. Feb. 28, 2023) for the holding that transcripts of these types can be considered at this stage without converting the motion to one for summary judgment. See also Id. at 2022 U.S. Dist. Ct. Motions LEXIS 619033 (D.N.J. Feb. 28, 2023). In that case the District Court relied on the "integral document" exception to rule in defendants' favor.

but summarized alleged conversations between the patients and the defendants. What took place before or after these conversations remains unknown and may be needed to properly interpret them. Absent discovery this court lacks the "full context" needed to understand the meaning of the transcripts. See Burlington, 114 F.3d at 1426.

Another important factor weighing against the defendants is the type of document they are asking the court to consider at this stage. The decisions cited in Lum and Banco all applied the exception to documents that give rise to legal rights. See Pension Benefit Guar. Corp. v. White Consol. Indus., 998 F.2d 1192, 1196 (3d Cir. 1993) (purchase and sale agreement); Burlington, 114 F.3d at 1426 (annual report); Lum, 361 F.3d at 222 n.3 (credit agreements); see also Chambers, 282 F.3d at 153 (contracts). Unlike the documents in those cases, whether the transcripts, or more accurately, the conversations these documents reference give rise to legal rights remains in dispute.

Even if the court were to consider the transcripts in full, and accept the defendants' arguments about them, the court could still not dismiss the entire complaint because the transcripts only address 7 of 15 patients. That leaves eight patients' claims unaddressed by the defendants.

For those reasons, the transcripts and recordings submitted by defendants should be disregarded. Summary judgment is a more appropriate place to consider evidence of this nature.

2. Summary Plan Documents ("SPD")

In similar fashion to the transcripts, defendants ask the court to consider numerous SPDs at the motion to dismiss stage. Still, "a necessary prerequisite for [the integral document] exception is that the plaintiff relied on the terms and effect of the document in drafting the complaint… mere notice or possession is not enough." Global Network Comm'ns v. City of N.Y., 458 F.3d 150, 156 (2d Cir. 2006) (cleaned up). Nothing can be gleaned from the complaint that suggests that plaintiff relied upon these plan documents in drafting their complaint. The "terms and effect[s]" of the documents are simply not present within the four corners of the complaint.

Additionally, for documents found outside the complaint their authenticity and completeness must not be disputed. "'Undisputed' in this context means that the authenticity of the document is not challenged." Columbia Hosp. at Med. City Dall.

Subsidiary, L.P. v. Legend Asset Mgmt. Corp., 2004 U.S. Dist. LEXIS 14890, at *10 (N.D. Tex. Apr. 9, 2004) (quoting Horsley v. Feldt, 304 F.3d 1125, 1134 (11th Cir. 2002)). Here, plaintiff challenges the authenticity and completeness of the plan documents. See Opp. Br. at 12.

Therefore, as a matter of law the court cannot consider these documents at this time.

B. ERISA Pre-emption

Drawing only from the facts contained in the complaint, the defendants fail to meet their burden here. See Printing Mart-Morristown v. Sharp Electronics Corp., 116 N.J. 739, 746 (1989). In short, how the state law claims asserted by plaintiff are "related to" the administration of an ERISA plan cannot be gleaned from the four corners of the complaint. Their motion as it relates to ERISA preemption should be **DENIED**.

Congress enacted ERISA to guarantee a uniform and comprehensive regulatory framework for employee benefit plans. To achieve this goal the law contains a sweeping preemption provision that preempts any and all state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a); See Bd. of Trs. of Operating Eng'rs Local 825 Fund Serv. Facilities v. L.B.S. Constr. Co., 148 N.J. 561, 565-66 (1997); see also Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) (explaining breadth of ERISA preemption); District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992) (same)).

However, the United States Supreme Court and the courts of New Jersey have repeatedly found limits to the scope of ERISA, despite the broad language of the statute. See, e.g., N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995); Finderne Mgmt. Co., Inc. v. Barrett, 355 N.J. Super. 170 (App. Div. 2002); St. Peter's Univ. Hosp. v. N.J. Bldg. Laborers Statewide Welfare Fund, 431 N.J. Super. 446, 455 (App. Div. 2013) (the words "relate to" should be given their commonsense meaning). Against this background, a plan falls under ERISA if "from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing and the procedures for receiving benefits." Finderne, 355 N.J. Super. at 186 (citing Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982)).

Because preemption is not boundless it "does not occur if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case

with many laws of general applicability." St. Peter's, 431 N.J. at 455-56 (internal quotations omitted). "A state law claim relates to an employee benefit plan if the 'existence of an ERISA plan is a critical factor in establishing liability' and the 'trial court's inquiry would be directed to the plan.'" Id. (quoting 1975 Salaried Ret. Plan for Eligible Emps. of Crucible, Inc. v. Nobers, 968 F.2d 401, 406 (3d Cir.)).

The facts as stated in the complaint do not direct the trial court's inquiry to an ERISA plan. See St. Peter's, 431 N.J. at 456. The facts direct the court's inquiry to discussions between a party that may be a plan administrator and a healthcare provider, and how those parties reacted to those statements. That is the crux of the complaint, not the administration of an employee benefit plan. Perhaps more importantly, the complaint does not on its face establish the existence of an ERISA plan. Among the essential "surrounding circumstances" discussed by the Appellate Division in Finderne the only one arguably ascertainable is the "intended benefits," (health insurance) meanwhile the "class of beneficiaries, the source of financing and the procedures for receiving benefits" remains elusive. Finderne, 355 N.J. Super at 186-87. In other words, who is to benefit from the plan and, how those benefits would be delivered is unclear.

Furthermore, the facts of the case as pled are too "tenuous" or "remote" (see St. Peter's, 431 N.J. Super at 455) to overcome the "presumption against preemption." N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co., 2019 N.J. Super. Unpub. LEXIS 3516 at *26 (Law Div. 2019) (quoting In re Reglan Litigation, 226 N.J. 315, 329 (2016)). The facts of this case are strikingly similar to N. Jersey Brain, another CBLP case from Essex County. In that case, the defendant insurers were alleged to have pre-authorized payment for services and then reimbursed plaintiff providers at a much lower rate. There, in denying defendants' attempt to dismiss the case on preemption grounds the court relied principally upon Mem'l Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). In both N. Jersey Brain and Mem'l Hosp., and here, the complaint rested on alleged misrepresentations by the insurers. Both courts held that because the state law claims alleging misrepresentations would not interfere with the administration of a plan, the claims were not preempted by ERISA. N. Jersey Brain, 2019 N.J. Super. Unpub. LEXIS 3516 at *28-29.

Other New Jersey cases, notably Finderne, support this conclusion. The St. Peter's court, while finding preemption after summary judgment, distinguished that case from Finderne because there the court "was not dealing with an independent misrepresentation." St. Peter's, 431 N.J. Super at 458. The Appellate Division reasoned in Finderne that because "Plaintiffs' claims will not impact the structure or

administration of the ERISA plans" and the statements were "preplan misrepresentations," preempting these claims would not serve the goals of ERISA. Finderne, 355 N.J. Super at 192-95 (collecting cases). Alleged misrepresentations are the heart of this case, therefore Finderne controls and the court must **DENY** the defendants' motion to dismiss in this regard, especially in light of New Jersey's liberal pleading standards.

C. Agency Theory of Liability against the payor defendants

An "agency relationship is created when one party consents to have another act on its behalf," Sears Mortgage Corp. v. Rose, 134 N.J. 326, 337 (1993), and there is "the right of the principal to control the conduct of the agent." Arcell v. Ashland Chem. Co., 152 N.J. Super. 471, 494 (Law Div. 1977). "There need not be an agreement between parties specifying an agency relationship; rather, the law will look at their conduct and not to their intent or their words as between themselves but to their factual relation." Sears Mortgage Corp., 134 N.J. at 337 (internal quotation omitted).

Agency relationships can arise from the principal's actual or apparent authority to control the agent. Plaintiff argues that the Court can find either one in the complaint. Actual authority can be express or implied. Reynolds Offset v. Summer, 58 N.J. Super. 542, 557 (App. Div. 1959), cert. denied, 31 N.J. 554 (1960). Implied authority can be inferred from conduct and the general course of business dealings. Sears Mortgage Corp., 134 N.J. at 337-38. Meanwhile, apparent authority arises when "the principal's actions have misled a third-party into believing that a relationship of authority in fact exists." Gayles, 468 N.J. Super. at 24 (citing Mercer v. Weyerhaeuser Co., 324 N.J. Super. 290 (App. Div. 1999)). The third party's reliance on the principal's actions must be reasonable in order for a court to find apparent authority. Id.

Here, the complaint lacks sufficient factual detail to infer an agency relationship. Even operating under the liberal Printing Mart standard, the court cannot glean from the four corners of the complaint a principal-agent relationship with Aetna acting as an agent for the Employer-Sponsors. Paragraph 42 of the complaint states in conclusory fashion that this relationship exists but does not support that conclusion with factual material. The complaint cannot be read to show that Aetna "perform[ed] functions on behalf of" the Employer-Sponsors, nor that they "control[led]" Aetna, nor that Aetna "manifest[ed]…consent to" this relationship. See N.J. Lawyers' Fund for Client Prot. v. Stewart Title Guar. Co., 203 N.J. 20, 221 (2010) (dismissing agency claims and distinguishing Sears, supra).

For the above reasons the defendants' motion is **GRANTED** without prejudice and any agency based claims are dismissed without prejudice.

D. Contractual Claims: Implied Contract, Promissory Estoppel, and Implied Covenant of Good Faith and Fair Dealing

1. Implied Contract

A contract can be implied in fact or in law. Plaintiff argues in their opposition brief that the complaint states a claim for one or both. See Opp. Br. at 35, 38.

An implied in fact contract can be inferred from "the parties' actions, course of conduct, oral expressions, or a combination of the three." Comprehensive Neurosurgical, P.C. v. Valley Hosp., 257 N.J. 33, 71 (2024) (internal citation omitted). "A true contract implied in fact 'is in legal effect an express contract,' and varies from the latter only insofar as the parties' agreement and assent thereto have been manifested by conduct instead of words." Saint Barnabas Med. Ctr. v. Cty. of Essex, 111 N.J. 67, 77 (1988) (quoting Saint Paul Fire & Marine Ins. Co. v. Indemnity Ins. Co. of N. America, 32 N.J. 17, 23 (1960)). To prevail on a breach of contract claim a plaintiff must prove (1) the existence of a contract with certain terms; (2) plaintiffs did what was required of them under the contract; (3) defendants failed to discharge their duty; and (4) that defendants' breach caused a loss to plaintiffs. See Goldfarb v. Solimine, 245 N.J. 326, 338 (2021) (internal quotations omitted).

In short, plaintiffs allege that defendants promised them payment at a certain rate if they performed services, which plaintiffs then performed before receiving less compensation than promised. See, e.g., Compl. ¶¶ 128-138 (breach of contract count); ¶ 64 (alleged oral affirmations by defendant); ¶¶ 1, 4 (describing services rendered and alleged underpayment). These averments are sufficient to state a claim for breach of an implied in fact contract.

Taking the allegations as a whole they demonstrate that the "the performance to be rendered by each party can be ascertained with reasonable certainty," i.e., rendering healthcare services in exchange for a specified rate of compensation. See Goldfarb, 245 N.J. at 339 (quoting Weichert Co. Realtors v. Ryan, 128 N.J. 427, 435 (1992)). That an implied in fact contract can arise from conduct instead of words does not bar plaintiff's claims. See Saint Barnabas, 111 N.J. at 77. Here, the parties' repeated, similar interactions give rise to the inference of mutual assent. See

Wanaque, 144 N.J. at 574; Troy v. Rutgers, 168 N.J. 354, 365-67 (2001) (holding, inter alia, that the existence of an implied in fact contract is a question of fact that generally precludes even summary judgment).

For similar reasons, the complaint adequately alleges an implied in law contract. "There are only two essential elements of a contract implied in law: (1) that the defendant has received a benefit from the plaintiff, and (2) that the retention of the benefit by the defendant is inequitable." Wanaque, 144 N.J. at 575 (internal quotations omitted).

Here, the complaint alleges that the defendants were able to maintain the appearance of network adequacy while paying less than they promised. See Compl. ¶¶ 3-4, 62-69, 113-14, 128-39, 146. Under New Jersey law, when a third party discharges an obligation the defendant would otherwise have had to fulfill, a benefit is conferred even if the performance was not directly requested by the defendant. See, e.g., Saint Barnabas, 111 N.J. at 79–80 (finding a benefit was conferred to a county where a hospital provided benefits to county, discharging county's duty to provide health care to an indigent inmate).

The complaint's allegations of a bait-and-switch-style operation mirror the type of enrichment fact pattern New Jersey courts have repeatedly found sufficient to withstand a motion to dismiss. See, e.g., Saint Barnabas, 111 N.J. at 79 ("extent the County benefited from plaintiff's discharge of its duty, recovery may be had based on quasi-contract"); Kopin v. Orange Products, Inc., 297 N.J. Super. 353, 366–68 (quasi-contract claims rest on the equitable principle that one should not be able to enrich themselves at the expense of another).

The motion is **DENIED** as to this claim.

2. Promissory Estoppel

Under New Jersey law, promissory estoppel requires a plaintiff to allege: "(1) a clear and definite promise; (2) made with the expectation that the promisee will rely on it; (3) reasonable reliance; and (4) definite and substantial detriment." Goldfarb, 245 N.J. at 340; see also Pop's Cones, Inc. v. Resorts Int'l Hotel, Inc., 307 N.J. Super. 461, 468 (App. Div. 1998).

Plaintiff alleges that, prior to rendering extensive residential healthcare services to multiple adolescent and young adult patients with eating disorders, representatives of defendants "pre-affirmed" over the telephone that plaintiff "would

be paid at a percentile of the market rates (70th or 80th percentile of 'reasonable and customary' rate), and also represented to plaintiff that 14 of the 16 patients that reimbursement would not be repriced or involve a Medicare-based rate." See Compl. ¶¶ 62–65, 67–69, 160–164, 187(a), 207. Plaintiff further alleges that these representations were made with knowledge and intent that plaintiff would rely on them, and that plaintiff, in fact, relied on them in admitting and treating the patients without requiring substantial advance payment or other guarantees.

These allegations are sufficient to plead a claim for promissory estoppel and therefore the motion should is **DENIED** as to this claim.

At this juncture, plaintiff's specific allegations of "pre-affirmations" by named individuals, for example, confirming payment at the 70th or 80th percentile of the UCR rate and that "there would be no repricing" (Compl. ¶¶ 62–67) are sufficient to plead a "clear and definite promise." See Pop's Cones, 307 N.J. Super. at 469–70.

As alleged, such pre-service verification calls are part of the "commercial realities and industry custom" in healthcare, and providers like Plaintiff justifiably rely on such affirmations before rendering weeks of costly, essential care. Compl. ¶¶ 67–68. Whether such reliance is "reasonable" is, at minimum, a fact-driven inquiry generally inappropriate for adjudication on a motion to dismiss. Pop's Cones, 307 N.J. Super. at 473. Finally, plaintiff's alleged underpayment is clearly a definite and substantial detriment.

3. Breach of Implied Covenant of Good Faith and Fair Dealing

Defendants rest their argument to dismiss this count on the premise that there is no underlying contract for the implied covenant to attach. However, as explained above, the complaint alleges a contract, and every contract in New Jersey contains an implied covenant of good faith and fair dealing. See Kalogeras v. 239 Broad Ave., L.L.C., 202 N.J. 349, 366 (2010) (citing Sons of Thunder v. Borden, Inc., 148 N.J. 396, 420 (1997)).

Because defendants have failed to otherwise address this count, their argument is waived. It is well settled that issues not briefed are waived. See, e.g., Telebright Corp., Inc. v. Dir., N.J. Div. of Taxation, 424 N.J. Super. 384, 393 (App. Div. 2012); Liebling v. Garden State Indem., 337 N.J. Super. 447, 465-66 (App. Div. 2001); Kratovil v. Angelson, 473 N.J. Super. 484, 536 (Law Div. 2020). Therefore, the motion should is **DENIED** as to this claim.

E. Quantum Meruit Claims

The New Jersey Supreme Court held that the elements of a quantum meruit claim are: (1) the performance of services in good faith, (2) the acceptance of services by the person to whom they are rendered; (3) plaintiff reasonably expected compensation for performing services; and (4) reasonable value of the services. Starkey, Kelly, Blaney & White v. Estate of Nicolaysen, 172 N.J. 60, 68 (2002).

Defendants principally rely on Haghighi v. Horizon Blue Cross Blue Shield of N.J., 2020 U.S. Dist. LEXIS 157246 (D.N.J. Aug. 31, 2020), to attack the complaint's sufficiency. They rest their argument on the grounds that a benefit must be conferred for a plaintiff to prevail on this cause of action and that, per Haghighi, the benefits as stated in the complaint cannot support this claim as a matter of law. See Mot. Br. at 22-23 (citing Haghighi, 2020 U.S. Dist. LEXIS 157246 at *13-15). So, there is no dispute as to whether the complaint alleges a benefit conferred, only whether the law requires one, or recognizes what the plaintiff alleges.

While the four-part test laid out in Starkey does not include the requirement of a benefit conferred, subsequent judicial opinions have made it clear that this is required for a successful quantum meruit claim. See Woodlands Cmty. Ass'n v. Mitchell, 450 N.J. Super. 310, 318 (App. Div. 2017) ("Recovery under both of these doctrines requires a determination that defendant has benefitted from plaintiff's performance"). Plaintiff has pled a benefit conferred. For the same reason they properly alleged to have conferred a benefit in the context of an implied-in-law contract, they allege to have conferred a benefit here. See supra section IV, subsection A. For those reasons, the motion is **DENIED** on this count.

F. Tort Claims: Negligence, Tortious Interference with Economic Advantage, and Fraud

Defendants' arguments that the economic loss doctrine bars all of the plaintiff's tort claims fail. As an initial matter, the ELD only applies when there is a contract, and here defendants deny the existence of any contract. See generally Saltiel v. GSI Consultants, Inc., 170 N.J. 297 (2002). Nonetheless, the court in Farese ruled that the complaint alleges a contract, but inconsistent pleading is permitted under the law. Farese v. McGarry, 237 N.J. Super. 385, 389 (App. Div. 1989). In other words, plaintiff can allege contractual claims *and* tort claims, even if after summary judgment or trial the ELD would bar some recovery there. To dismiss the

contract based claims at this point under the ELD would be inappropriate for that reason.

1. Negligence

Here, the complaint states a claim for negligent misrepresentation, but not other forms of negligence.

To state a claim for negligent misrepresentation a plaintiff must allege that the defendant (1) negligently made an incorrect statement of fact; (2) the plaintiff justifiably relied on it; and (3) plaintiff suffered a loss. See e.g., Karu v. Feldman, 119 N.J. 135, 146-48 (1990) (damages element of the claim can be for economic loss); Singer v. Beach Trading Co., 379 N.J. Super. 63, 75-77 (App. Div. 2005) (same). Here, the plaintiff pleaded all three elements. They pleaded that Aetna stated they would pay a certain percentage of the UCR, that they relied on that representation from Aetna, and that they were paid less than they otherwise would have made, i.e., suffered a loss as a result. The motion is **DENIED** as it relates to negligent misrepresentation.

However, it is **GRANTED** without prejudice as it relates to any other form of negligence. The complaint states there is a duty flowing from defendants to plaintiff (Compl. ¶ 170) but does not state what that duty is or what facts trigger that duty. Of course, duty is a "fundamental element" of any negligence cause of action. See Shields v. Ramslee Motors, 240 N.J. 479, 487 (2020). Without it there can be no claim for negligence.

2. Tortious Interference with Economic Advantage

Here, the plaintiff must plead that "(1) they had some reasonable expectation of economic advantage; (2) the defendants' actions were malicious in the sense that the harm was inflicted intentionally and without justification or excuse; (3) the interference caused the loss of the prospective gain or there was a reasonable probability that the plaintiff would have obtained the anticipated economic benefit, and (4) the injury caused the plaintiff damage." Mandel v. UBS/PaineWebber, Inc., 373 N.J. Super. 55, 79-80 (App. Div. 2004) (citing Printing Mart, 116 N.J. at 751-52).

Here, plaintiff has successfully pled those elements. Plaintiff identifies a reasonable expectation of economic advantage: rendering costly medical care based

on upfront affirmations from defendants regarding payment at market rates—sufficiently specific to constitute a prospective economic advantage as protected under New Jersey law. See Printing Mart, 116 N.J. at 751; Compl. ¶¶64–68, 149-150, 160-162, 179. Next, plaintiff pleads that defendants knowingly and intentionally induced plaintiff to provide care by affirming payment at specified rates, then after performance, altered their obligations by applying repricing and self-serving rate reductions. These actions alleged are contrary to both law and industry standards and thus without justification. See Lamorte Burns & Co. v. Walters, 167 N.J. 285, 306-308 (2001); Compl. ¶¶1, 62-65, 77-82, 109–113, 182–183, 201–203.

Plaintiff alleges that but for defendants' conduct, i.e., affirming a market rate, then reneging and applying repricing, plaintiff either would have been paid as expected or would not have rendered services. The loss of millions in anticipated payments directly results from defendants' alleged conduct. Printing Mart, 116 N.J. at 751-52; Compl. ¶¶184–185, 204–205. Finally, plaintiff clearly alleges resulting loss: nonpayment of at least $1.5 million in services rendered. Compl. ¶¶64, 69, 138, 185, 204–205. Therefore, the motion is **DENIED** on this count.

3. Fraud

Fraud must be pled with particularity. A "complaint sounding in fraud must satisfy R. 4:5-8(a)." Aetna Health v. Biodiagnostic Lab. Servs., 2021 N.J. Super. Unpub. LEXIS 2417, at *14 (App. Div. Oct. 7, 2021) (quoting State, Dep't of Treasury, Div. of Inv. ex rel. McCormac v. Qwest Commc'ns Intern., Inc., 387 N.J. Super. 469, 484 (App. Div. 2006)). This heightened pleading standard exists to "accord respect to contracts that such claims are invoked to avoid, to shield potential defendants' reputations, and to deter baseless suits." Aetna Health, at *14.

"In order to prevail on a common law fraud claim, plaintiff must show that defendant: (1) made a representation or omission of a material fact; (2) with knowledge of its falsity; (3) intending that the representation or omission be relied upon; (4) which resulted in reasonable reliance; and that (5) plaintiff suffered damages." DepoLink Court Reporting & Litig. Support Servs. v. Rochman, 430 N.J. Super. 325, 336 (App. Div. 2013) (quoting Jewish Ctr. of Sussex Cnty. v. Whale, 86 N.J. 619, 624 (1981)).

The complaint states quite clearly at ¶ 187 that defendants knew they were making false statements that they intended plaintiff to rely upon. These are not mere conclusory allegations; read together with the rest of the complaint the substance and intent of the alleged communications becomes obvious, i.e., to tell plaintiff they would receive one price for their services while knowing they in fact would receive

a lower one. Here, unlike in DepoLink the Plaintiff pleads reliance. See Id., 430 N.J. Super at 337; Compl. ¶¶ 186-87; 49-73 (explaining in detail the alleged scheme Plaintiff fell victim to). Plaintiff pled all elements of common law fraud with sufficient factual material. Therefore, the motion to dismiss the fraud claim is **DENIED**.

G. Conspiracy Claims

The complaint states a claim for civil conspiracy, therefore the motion is **DENIED** as it relates to this claim.

"In New Jersey, a civil conspiracy is a combination of two or more persons acting in concert to commit an unlawful act, or to commit a lawful act by unlawful means, the principal element of which is an agreement between the parties to inflict a wrong against or injury upon another, and an overt act that results in damage." Banco Popular N. Am. v. Gandi, 184 N.J. 161, 177 (internal quotation omitted). A conspiracy exists if those involved understand its general objectives, "accept[] them, and make[] and an implicit or explicit agreement to further those objectives." Lewis v. Airco, Inc., 2011 N.J. Super. Unpub. LEXIS 1914 at *93 (App. Div. July 15, 2011).

Plaintiff's complaint makes this out in granular detail. Initially, among other things, the complaint alleges unlawful acts (e.g., civil fraud) committed by two or more parties. Defendants argue that the complaint fails to allege that they understood the objectives of the conspiracy, accepted them, and agreed to further them. Motion Br. at 12. However, the complaint explains how they direct claims to GCS to be "repriced." See Compl. at ¶¶ 193-205. The complaint alleges with considerate factual detail defendants' knowledge of the alleged repricing scheme, its agreement to participate in it, and their acceptance of its objectives.

CONCLUSION

For the foregoing reasons, it is recommended that Defendant's Motion to dismiss be **DENIED** in part and **GRANTED** in part.

A memorializing order will be filed simultaneously with this opinion.