2018 WL 2758221
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NOT FOR PUBLICATION
United States District Court, D. New Jersey.

ADVANCED ORTHOPEDICS AND SPORTS MEDICINE INSTITUTE, Plaintiff,
v.
EMPIRE BLUE CROSS BLUE SHIELD, JOHN AND JANE DOE 1-10, AND ABC CORPORATIONS 1-10, Defendants.

Civil Action No. 17-cv-08697 (FLW) (LHG)
|
Filed 06/07/2018

OPINION

Hon. Freda L. Wolfson United States District Judge

***1** Currently before the Court is a Motion to Dismiss filed by Empire Blue Cross Blue Shield ("Empire" or "Defendant"). Plaintiff Advanced Orthopedics and Sports Medicine Institute ("Advanced Orthopedics" or "Plaintiff"), a healthcare provider, brings this suit to recover certain payments incurred from a medical procedure that Plaintiff performed on patient "MM," an insured under an employee health insurance plan administered by Empire (the "Plan"). The Complaint, which was removed from state court, asserts the following state law claims: (Count 1) breach of contract; (Count 2) promissory estoppel; (Count 3) account stated; (Count 4) fraudulent inducement; and (Count 5) violations of N.J.A.C. 11:22-5.8, 11:24-5.3; 11:24-5.1, and 11:24-9.1(d). Defendant moves to dismiss Plaintiff's Complaint in its entirety, arguing that all of Plaintiff's state law claims are preempted under the Employee Retirement Income Security Act ("ERISA"), and that, even if they are not, Plaintiff fails to allege facts sufficient to support the claims.

For the reasons expressed herein, Defendant's Motion to Dismiss is granted because Plaintiff's claims are preempted by ERISA, and the Complaint is dismissed in its entirety.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

Plaintiff Advanced Orthopedics is a provider of healthcare services organized and operating under the laws of the state of New Jersey. Compl., at ¶ 1. Defendant Empire is a New York corporation that served as administrator of the Plan. [1] *Id.* at ¶ 2. There is no dispute that the terms of the Plan are governed by ERISA.

Plaintiff's claims stem from a dispute over the amount that Defendant reimbursed Plaintiff for a medical procedure performed on "MM." MM slipped on oil on January 30, 2015, and received a pre-operative workup from Plaintiff, which diagnosed MM with a right comminuted patella fracture with significant displacement. *Id.* at ¶ 13. A day later, on January 31, 2015, Plaintiff's physician performed surgery on MM, specifically right knee patella open reduction and internal fixation and right knee repair of medial and lateral retinaculum and vastus medialis obliquus quadriceps tendon. *Id.* at ¶ 14. The Complaint alleges that, at some point prior to the surgery, Plaintiff "as part of the normal business practice, obtained authorization for the admission of the patient, 'MM' through the emergency room department." [2] *Id.* at ¶ 19. MM, at all relevant times, received health insurance coverage from Plaintiff through her spouse, "WM." *Id.* at ¶ 12. Plaintiff is an out-of-network provider and was not a participant in the Plan. *Id.* at ¶ 11.

***2** Following the procedure, Plaintiff billed Defendant $27,053.55, which according to Plaintiff, "represents normal and reasonable charges for the complex procedure performed by a Board Certified Orthopedic Surgeon practicing in New Jersey." *Id.* at ¶ 20. Empire, however, refused to cover the full amount, only reimbursing Advanced Orthopedics a total of $1,764.45, leaving a balance due of more than $25,289.10. *Id.* at ¶ 21. Plaintiff alleges that this payment "represents a gross underpayment and does not comport in any way with usual, customary or reasonable payments for the type of service rendered." *Id.* at ¶ 22. Plaintiff further alleges that Empire knew that Advanced Orthopedics was an out-of-network provider, but never disclosed "that payments made for the procedures would be denied in full or paid far below the usual and customary rates for these services." *Id.* at ¶ 23.

On August 30, 2017, Advanced Orthopedics filed a Complaint in the Superior Court of New Jersey, Law Division, Monmouth County. In its Complaint, Plaintiff asserts four state common law causes of action and one for violations of New Jersey regulations. The common law causes of action are (1) breach of contract; (2) promissory estoppel; (3) account stated; and (4) fraudulent inducement. *Id.* at ¶¶ 24–47. Plaintiff also alleges that Defendant violated "New Jersey Surprise Bill regulations," N.J.A.C. 11:22-5.8, 11:24-5.3, 11:24-5.1, 11:249.1(d). *Id.* at ¶¶ 48–53. In essence, Plaintiff alleges that the "dispute arises out of the defendants' refusal to pay plaintiff the money to which plaintiff is entitled for providing necessary medical services to patient, 'MM.' " *Id.* at ¶ 10. Plaintiff further alleges that Empire "induced plaintiff to provide the medical services with the explicit knowledge that it never intended to pay the amounts it was obligated to pay." *Id.* at ¶ 23. Plaintiff specifically seeks damages in the amount of $25,289.10, along with $100,000 in punitive damages. *See Id.* at WHEREFORE ¶¶ 1–5.

On October 19, 2017, Empire filed a Notice of Removal to this Court claiming that Plaintiff's state law claims are completely preempted by ERISA and that diversity jurisdiction exists. [3] ECF No. 1 at ¶ 11. On November 27, 2017, Empire filed a Motion to Dismiss the Complaint for failure to state a claim, pursuant to Federal Rule of Civil Procedure 12(b)(6), ECF No. 7, and on January 15, 2018, Plaintiff submitted an opposition to the dismissal motion. ECF No. 10.

II. 12(B)(6) MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM

1. Standard of Review

In reviewing a motion to dismiss for failure to state a claim upon which relief can be granted, pursuant to Federal Rule of Civil Procedure 12(b)(6), "courts accept all factual allegations as true, construe the complaint in the light most favorable to the plaintiff, and determine whether, under any reasonable reading of the complaint, the plaintiff may be entitled to relief." *Fowler v. UPMC Shadyside*, 578 F.3d 203, 210 (3d Cir. 2009) (internal quotation marks and citation omitted). While Federal Rule of Civil Procedure 8(a) 6 does not require that a complaint contain detailed factual allegations, "a plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation omitted). Thus, to survive a Rule 12(b)(6) motion to dismiss, the Complaint must contain sufficient factual allegations to raise a plaintiff's right to relief above the speculative level, so that a claim "is plausible on its face." *Id.* at 570; *Phillips v. Cty. of Allegheny*, 515 F.3d 224, 231 (3d Cir. 2008). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). While the "plausibility standard is not akin to a 'probability requirement,' ... it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.*

***3** To determine whether a plaintiff has met the facial plausibility standard mandated by *Twombly* and *Iqbal*, courts within the Third Circuit engage in a three-step progression. *Santiago v. Warminster Twp.*, 629 F.3d 121, 130 (3d Cir. 2010). First, the reviewing court "outline[s] the elements a plaintiff must plead to a state a claim for relief." *Bistrian v. Levi*, 696 F.3d 352, 365 (3d Cir. 2012). Next, the court "peel[s] away those allegations that are no more than conclusions and thus not entitled to the assumption of truth." *Id.* Finally, where "there are well-pleaded factual allegations, [the] court should assume their veracity and then determine whether they plausibly give rise to an entitlement to relief." *Iqbal*, 556 U.S. at 679. This last step of the plausibility analysis is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679.

The Third Circuit has reiterated that "judging the sufficiency of a pleading is a context-dependent exercise" and "[s]ome claims require more factual explication than others to state a plausible claim for relief." *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 98 (3d Cir. 2010) *cert. denied*, 132 S.Ct. 98 (2011). Generally, when determining a motion under Rule 12(b)(6), the court may only consider the complaint and its attached exhibits. However, while "a district court may not consider matters extraneous to the pleadings, a document integral to or explicitly relied upon in the complaint may be considered without converting the motion to dismiss into one for summary judgment." *Angstadt v. Midd–West Sch. Dist.*, 377 F.3d 338, 342 (3d Cir. 2004) (quoting *U.S. Express Lines, Ltd. v. Higgins*, 281 F.3d 383, 388 (3d Cir. 2002)); *see also In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997).

2. Express Preemption of Plaintiff's State Law Claims

Defendant argues that the Complaint should be dismissed because ERISA preempts all of Plaintiff's claims. Congress enacted ERISA to create "a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); *see New Jersey Carpenters & the Trustees Thereof v. Tishman Const. Corp. of New Jersey*, 760 F.3d 297, 303 (3d Cir. 2014) ("Congress enacted ERISA to ensure that benefit plan administration was subject to a single set of regulations and to avoid subjecting regulated entities to conflicting sources of substantive law."). "To ensure that plan regulation resides exclusively in the federal domain, Congress inserted in the statute an expansive preemption provision, codified at § 514(a)." *Nat'l Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 82 (3d Cir. 2012); *Davila*, 542 U.S. at 208 ("ERISA includes expansive pre-emption provisions, ... which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.' ") (quoting *Alessi v. Raybestos–Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Indeed, the Supreme Court has emphasized that ERISA possesses "extraordinary pre-emptive power." *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987); *see FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (noting that ERISA's "pre-emption clause is conspicuous for its breadth.").

Section 514(a), the express preemption provision of ERISA, provides that ERISA preempts "any and all State laws insofar as they ... *relate to* any employee benefit plan" covered under the statute. 29 U.S.C. § 1444(a) (emphasis added). The Third Circuit has observed that the statutory phrase "relate to" "has always been given a broad, common-sense meaning, such that a state law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Menkes v. Prudential Ins. Co. of Am.*, 762 F.3d 285, 293–94 (3d Cir. 2014) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983)) (internal quotation marks omitted). The statute defines "State law" as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State," 29 U.S.C. § 1144, and the Supreme Court has "emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.' " *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47–48 (1987) (quoting *Shaw*, 463 U.S. at 98). "State common law claims fall within this definition and, therefore, are subject to ERISA preemption." *Iola*, 700 F.3d at 83. For example, as relevant here, the Third Circuit has explained that claims for "reimbursement of previously paid health benefits," are claims for "benefits due," and thus are preempted by ERISA. *Levine v. United Healthcare Corp.*, 402 F.3d 156, 163 (3d Cir. 2005); *see also Early v. U.S. Life Ins. Co. in City of New York*, 222 Fed. Appx. 149, 151–52 (3d Cir. 2007) ("State law claims of bad faith and breach of contract ... ordinarily fall within the scope of ERISA preemption ...."); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 278 (3d Cir. 2001) (observing that "suits against .... insurance companies for denial of benefits, even when the claim is couched in terms of common law negligence or breach of contract, have been held to be preempted by § 514(a)."); *see, e.g., Ford v. UNUM Life Ins. Co. of Am.*, 351 Fed. Appx. 703, 706 (3d Cir. 2009) (holding that the plaintiff's state law claims for breach of contract, negligence, and intentional infliction of emotional distress were preempted under ERISA).

***4** Nevertheless, the Supreme Court has cautioned that if the term " '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 ...." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). Thus, in *Shaw*, the Court explained that a "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." 463 U.S. at 96–97. In applying that test, 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.' " *Iola*, 700 F.3d at 83–84 (quoting *California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325 (1997)).

Here, Plaintiff asserts four state common law causes of action: (1) breach of contract; [4] 2) promissory estoppel; [5] 3) account stated; [6] and 4) fraudulent inducement. [7] In its breach of contract claim, Plaintiff alleges that Defendant created an implied-in-fact contract by preauthorizing the surgery, thus agreeing to pay Plaintiff "usual and customary rates" for the procedure, which Defendant breached when it failed to reimburse Plaintiff at the customary rate. Compl., at ¶¶ 24–30. The promissory estoppel claim similarly alleges that, by preauthorizing the surgery, Defendant made a promise to pay Plaintiff "at the usual, customary and reasonable rate," which Plaintiff relied upon "by spending valuable, time, resources and

energy" performing the surgery. *Id.* at ¶¶ 31–35. The account stated claim asserts that "[a]fter providing the medical services, which were authorized by defendants, plaintiff submitted bills and requests for payment to defendants in the sum total of $27,053.55," but "defendants, having acknowledged receipt of the bills, have paid a small portion, $1,764.45." *Id.* at ¶¶ 37–38. Finally, for the fraudulent inducement claim, Plaintiff pleads only that "defendants induced plaintiff to provide the medical services," but "never intended to pay the plaintiff usual, customary, reasonable, and fair value." *Id.*, at ¶¶ 42, 45.

***5** In addition to these state common law claims, Plaintiff also asserts one cause of action alleging violations of New Jersey administrative regulations governing "Health Benefit Plans" ("HBPs") and "Health Maintenance Organizations" ("HMOs"),[8] N.J.A.C.11:22-5.8,[9] 11:24-5.1,[10] 11:24-5.3,[11] and 11:24-9.l(d).[12] This set of regulations, according to Plaintiff, requires that when "a privately-insured patient seeks emergency services, an out-of-network provider must be paid an amount sufficient to ensure that the patient is not balance-billed," that is, "charged for the insurer reimbursed amount and the provider's billed charges." Compl., at ¶ 49. Further, Plaintiff argues that this "mandate" applies to emergency services "even if it means that the insurer must pay the provider its actual billed charges, less copayments, coinsurance, and deductibles that would have applied had the patient been be treated by an in network provider." *Id.* Plaintiff claims that the regulations provide for a private right of action, and that Defendants are obligated to pay Plaintiff the entirety of Plaintiff's usual, customary, reasonable fees, less the patient's applicable co-pay, coinsurance or deductible. *Id.* at ¶ 51.

All of these causes of action, Plaintiff contends, relate not to Empire's ERISA plan, but to an "independent" preauthorization agreement that the parties entered into prior to the surgery. However, by disputing reimbursement for a medical procedure performed on a patient insured by an ERISA plan, Plaintiff asserts quintessential ERISA claims. Indeed, Plaintiff takes issue with the reimbursement of $1,764.45 from Empire. In doing so, Plaintiff's claims "seek reimbursement of billed medical charges and relate to challenges to the administration of benefits rather than the quality of the medical treatment performed." *N. Jersey Brain & Spine Ctr. v. Connecticut Gen. Life Ins. Co.*, No. 10-CV-4260 SDW, 2011 WL 4737063, at *3 (D.N.J. Oct. 6, 2011) (internal quotation marks omitted). It is Plaintiff's dispute with this out-of-network reimbursement payment, which is set forth in the terms of the Plan, that underlies its claims. The Court thus cannot analyze Plaintiff's claims without referencing the Plan.

***6** In fact, examining Plaintiffs' claims individually makes clear that each one implicates the Plan's terms and thus "relates" to the ERISA Plan. Indeed, in its breach of contract, promissory estoppel, and fraudulent inducement claims, and its claims for statutory violations, Plaintiff asserts that, by pre-authorizing the surgery, Defendant was bound to reimburse Plaintiff at a "usual, customary, and reasonable" rate. Compl. at ¶¶ 28, 32, 43, 51. As discussed, however, the reimbursement rate that Advanced Orthopedics must pay is not dictated by reasonability or fairness, but rather by Empire's out-of-network reimbursement rate.[13] For the third count, "Account Stated," Plaintiff does not specifically refer to the "usual and customary" rate but asserts that Empire did not pay Advanced Orthopedics the amount due. However, to determine the amount actually due, the Court must reference the Plan's out-of-network reimbursement provision.

Plaintiff's claims under New Jersey administrative regulations are also preempted because they too require reference to the plan.[14] Courts have repeatedly held that ERISA preempts these types of regulations because they " 'act[ ] immediately and exclusively' upon an ERISA plan ... and the existence of an ERISA plan is 'essential to the law's operation.' " *Cohen v. Horizon Blue Cross Blue Shield of New Jersey*, No. 15CV4528, 2017 WL 1206005, at *3 (D.N.J. Mar. 31, 2017) (quoting *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016)); *see also Cohen v. Horizon Blue Cross Blue Shield of New Jersey*, No. CV 16-8840, 2017 WL 3623832, at *2 (D.N.J. June 29, 2017), *report and recommendation adopted*, No. CV 16-8840, 2017 WL 3623746 (D.N.J. Aug. 22, 2017); *N. Jersey Brain & Spine Ctr. v. CIGNA Healthcare of NJ, Inc.*, No. CV 09-2630, 2010 WL 11594901, at *5 (D.N.J. Jan. 12, 2010). Indeed, the New Jersey regulations at issue here explicitly require an evaluation of whether the services for which reimbursement are sought are covered under the HMO or HBP. Thus, "if there was no plan, there would be no cause of action." *1975 Salaried Ret. Plan for Eligible Employees*

of Crucible, Inc. v. Nobers, 968 F.2d 401, 406 (3d Cir. 1992).

Plaintiff cannot use the purported independent preauthorization for services to circumvent ERISA preemption. The seminal case in this context is *Pascack Valley Hospital, Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 (3d Cir. 2004). There, the Third Circuit found that the plaintiff in-network hospital could pursue state law claims against an ERISA welfare benefit plan administrator for failure to pay for claims based upon an "independent" contractual obligation. In that case, the in-network hospitals, organized by an independent consultant, Magnet, Inc., had entered into a "Subscriber Agreement" that provided discounted rates to the plan administrator since hospitals did not contract directly with it. *Id.* This Subscriber Agreement expressly stated that "if Subscriber fails to pay within the appropriate time frame, the Subscriber acknowledges that it will lose the benefit of the MagNet discounted reimbursement rate and that Network Hospital is then entitled to bill and collect from Subscriber and the Eligible Person *its customary rate for services rendered." Id.* (emphasis added). The administrator did not pay within the appropriate time frame, and the hospital sued for breach of contract, demanding payment at its customary rate, as provided in the Subscriber Agreement. The court in *Pascack* concluded that the medical provider was seeking to enforce this agreement, rather than the plan itself, and as such a "resolution of this lawsuit requires interpretation of the Subscriber Agreement, not the Plan." *Id.* at 402. The court continued, "[t]he Hospital's right to recovery, if it exists, depends entirely on the operation of third-party contracts executed by the Plan that are independent of the Plan itself." *Id.*

***7** Here, Plaintiff argues that the agreement to preauthorize the medical procedure created a quasi-contract that bound Empire to reimburse Plaintiff at a reasonable and customary rate, much like the Subscriber Agreement independently bound the plan administrator in *Pascack*. But Plaintiff includes no facts that support the existence of an independent contract. In fact, the Complaint merely asserts that Plaintiff, "as part of the normal business practice, obtained authorization for the admission of the patient, 'MM' through the emergency room department." Compl. at ¶ 19. Setting aside the ambiguity of whether Defendant promised Plaintiff anything at all, this purported preauthorization agreement contains no reimbursement rate or any other provision dictating payment terms, much less any indication that payment would be at a usual and customary rate. The Subscriber Agreement in *Pascack*, in contrast, expressly stated that the administrator owed the hospital the customary rate because it missed its payment deadline. Thus, unlike in *Pascack*, this third-party agreement, even assuming it to be a valid contract, has no bearing on the dispute before the Court. The resolution of Plaintiff's claims must involve interpreting the Plan, not any independent contract; indeed, Advanced Orthopedics' right to recovery, if it exists, depends entirely on the terms and provisions of the Plan.

The other precedents that Plaintiff cites for support are equally unavailing because they too involve clear arrangements independent of an ERISA plan. *See, e.g., Progressive Spine & Orthopedics, LLC v. Anthem Blue Cross*, No. 17–536, 2017 WL 4011203 at *3 (D.N.J. Sept. 11, 2017) (remanding case when plaintiff medical provider alleged that it had spoken to insurer "on three occasions," and the insurer's representative assured plaintiff that it would pay the "usual, customary, and reasonable" rate)*; Progressive Spine & Orthopedics. LLC v. Empire Blue Cross Blue Shield.*, No. 16-1649, 2017 WL 751851 at *9 (D.N.J. Feb. 27, 2017) (the plaintiff alleged that defendant had made a "verbal promise or agreement to pay the usual, customary, and reasonable rate of the procedures")*; Elite Orthopedic & Sports Med., PA v. Cigna Healthcare*, No. 16CV4775, 2017 WL 1905266, at *4 (D.N.J. Apr. 20, 2017), *report and recommendation adopted*, 2017 WL 1902162 (D.N.J. May 8, 2017) (involving instance in which plaintiff "alleged that it entered into separate contracts with [defendant], independent of any health care plans").

A more apt comparison than the cases cited by Plaintiff is *North Jersey Brain & Spine Center v. Connecticut General Life Insurance Co.*, No. 10-CV-4260, 2011 WL 4737063, at *3 (D.N.J. Oct. 6, 2011). There, the court denied the plaintiff out-of-network medical provider's motion to remand because its state common law claims were preempted by ERISA. The plaintiff brought claims for estoppel, unjust enrichment, and negligent and intentional misrepresentation against the defendant insurer alleging that it was underpaid for medical services it provided. The Plaintiff attempted to argue that its claims related to a pre-certification agreement in which the defendant contacted plaintiff and agreed to pay "the usual customary

and reasonable fee," instead of the reimbursement rate set forth in the plan *Id.* at *3. The court ruled that the plaintiff had "failed to show that its claims are not related to the terms of the ... plan" because its claims seek "reimbursement of billed medical charges and relate to challenges to the administration' of benefits" under the plan. *Id.* Here, Advanced Orthopedics has an even weaker argument than the plaintiff in *North Jersey* as to the existence of an independent agreement. Plaintiff's perfunctory allegation that it "obtained authorization for the admission of the patient," Compl. at ¶ 19, does not indicate that Defendant was involved in the agreement at all, let alone whether it agreed to reimburse Plaintiff at a rate other than what is set forth in the Plan.

Similarly, courts routinely preempt state common law claims like the ones raised here that involve denial of benefits under an ERISA-governed plan. *See, e.g., Menkes v. Prudential Ins. Co. of Am.*, 762 F.3d 285, 294 (3d Cir. 2014) (claims alleging breach of contract, bad faith, or negligence in connection with the denial of benefits under an ERISA-covered plan are preempted under ERISA, because those claims are "are premised on the existence of the plan"); *Estate of Jennings v. Delta Air Lines, Inc.*, 126 F. Supp. 3d 461, 468–69 (D.N.J. 2015) (finding that the plaintiffs' "claims for negligence and breach of contract 'relate[d] to' the Plan for purposes of ERISA preemption," because they were based on the denial of a claim for benefits under an ERISA-governed plan); *Majka v. Prudential Ins. Co. of Am.*, 171 F. Supp. 2d 410, 414 (D.N.J. 2001) (holding that ERISA preempted the plaintiff's claims that she "was entitled to long-term disability benefits under the terms of the Plan and that Prudential's failure to provide those benefits constituted breach of contract and of the duty of good faith and fair dealing."); *D'Alessandro v. Hartford Life & Acc. Ins. Co.*, No. 09–115, 2009 WL 1228452, at *2 (D.N.J. May 1, 2009) (finding that ERISA preempted the plaintiff's state law claims for breach of contract and bad faith denial of disability benefits, since "Plaintiff is essentially seeking to claim benefits under the long-term disability plan."); *Thomas v. Aetna Inc.*, No. CIV. A. 98-2552, 1999 WL 1425366, at *8 (D.N.J. June 8, 1999) (finding that ERISA preempted plaintiff's fraudulent inducement claims). This case stands on no different footing; Plaintiff's state law claims are preempted.

V. CONCLUSION

***8** For the foregoing reasons, Defendant's Motion to Dismiss the Complaint is granted.

All Citations

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Footnotes

1 Although the Complaint does not specifically set forth Empire's role with respect to the Plan, it appears that Empire administered the Plan, and further, Plaintiff does not dispute Defendant's description of Empire as the plan administrator. Def. Br. at 13.

2 The Complaint does not indicate who provided this authorization, but, in its briefs, Plaintiff appears to characterize this as Empire's pre-surgery authorization of the procedure. The Court will assume this to be what Plaintiff is alleging.

3 Plaintiff has conceded to diversity jurisdiction, noting that "the *only* reason Plaintiff has not sought remand in this matter is the fact that there is, apparently, diversity jurisdiction." P. Opp'n at 1 (emphasis in original).

4 Breach of contract requires (1) a contract between the parties; (2) a breach of that contract; (3) damages flowing therefrom; and (4) that the party stating the claim performed its own contractual obligations. *Frederico v. Home Depot*, 507 F.3d 188, 203 (3d Cir. 2007). "General contract law recognizes and enforces 'implied-in-fact' contracts," which "may be inferred wholly or partly from conduct." *Luden's Inc. v. Local Union No. 6 of Bakery, Confectionery & Tobacco Workers' Int'l Union of Am.*, 28 F.3d 347, 355 (3d Cir. 1994) (quoting Restatement (Second) of Contracts § 19(1) (1981)).

5 Promissory estoppel requires, "(1) a clear and definite promise; (2) made with the expectation that the promise will rely on it; (3) reasonable reliance; and (4) definite and substantial detriment." *Toll Bros., Inc., et al. v. Board of Chosen Freeholders of County of Burlington, et al.*, 194 N.J. 233 (2008).

6 Account stated requires allegations of (1) an express or implied agreement as to the amount due and (2) the account was in fact stated or agreed to. *See Razor Enter. Inc. v. Aexim USA Inc.*, Case No. 11-6788 (ES), 2015 WL 790558 at *3 (D.N.J. Feb. 24, 2015).

7 Fraudulent inducement, which must be pled with particularity, requires allegations of (1) a material representation of a presently exiting or past fact; (2) made with knowledge of its falsity; (3) with the intention that the other party rely thereon;

(4) resulting in reliance by the party; (5) to his detriment. *RNS Sys., Inc. v. Modern Tech. Grp., Inc.*, 861 F. Supp. 2d 436, 451 (D.N.J. 2012).

8 HMOs, HBDs, and are among the words and phrases that are specifically defined in N.J.A.C. 11:22 and 11:24. Neither party has addressed whether these definitions apply to Defendant in this matter, and if so, whether the particular definitions impact the Court's analysis.

9 11:22-5.8 governs "Network and out-of-network coverage" for HBPs. It is not clear under which subsection of the regulation Plaintiff is suing. For instance, the regulation provides that "POS contracts issued by health maintenance organizations and health service corporations, and SCA policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider." Plaintiff does not allege that a POS contract or SCA policy is at issue here. The regulation further stipulates coverage for "network" hospitals, but Plaintiff's claims rely on the fact that it is out-of-network.

10 11:24-5.1 governs "Provision of health care services" for HMOs and provides, in relevant part, "If the HMO refers a member out of network, the service or supply shall be covered as an in-network service or supply, such that the HMO is fully responsible for payment to the provider and the member is only responsible for any applicable in-network level copay, coinsurance or deductible for the service or supply."

11 11:24-5.3 governs "Emergency and urgent care services" for HMOs and provides, in relevant part, "[e]mergency and urgent care services shall include, but are not limited to ... [c]overage for out-of-service area medical care when medically necessary for urgent or emergency conditions where the member cannot reasonably access in-network services," and that "carriers shall reimburse hospitals and physicians for all medically necessary emergency and urgent health care services covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury, in accordance with the provider agreement when applicable."

12 11:24-9.1(d) states that members of HMOs have the right "[t]o be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract."

13 It makes no difference that Plaintiff alleges in its fraudulent inducement claim that Empire misrepresented the reimbursement rate in the preauthorization agreement in order to induce Plaintiff into agreeing to perform the procedure. To determine the appropriate reimbursement rate, reference to the terms of the plan is necessary.

14 Plaintiff argues that a private right of action "is inferred by the statute" because, without one, "no one would know that the regulation would be impossible to enforce because violations would go unnoticed." P. Opp'n Br. at 5. Although I need to reach the issue because the cause of action is preempted by ERISA, I have found no authority supporting Plaintiff's position. *See Cohen v. Horizon Blue Cross Blue Shield of New Jersey*, No. CV 15-4525, 2017 WL 685101, at *6 (D.N.J. Feb. 21, 2017) (noting that "Plaintiff has not proven that [N.J.A.C. 11:24-5] permits a private cause of action")