2009 WL 10696172 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Bergen County

NORTH JERSEY BRIAN & SPINE CENTER,
v.
HEALTH NET, INC.

No. BER-L-5421-08.
August 24, 2009.

Trial Order

Joseph S. Conte, Judge.

***1** Before the Court are: Defendant's motion to dismiss, pursuant to *R.* 4:6-2(e) and Plaintiff's cross motion for partial summary judgment, pursuant to *R.* 4.46-2(c).

Introduction

This instant matter arises from a contractual relationship between New Jersey Brain & Spine Center (hereinafter "Plaintiff") and Health Net, Inc. (hereinafter "Defendant"). Plaintiff provided health care services to Defendant's insureds, who received their health benefits through benefits plans issued by Defendant's corporate subsidiaries. Particularly, Plaintiff performed several brain and spine surgeries for Defendant's insureds. Thereafter, Plaintiff submitted bills (HCFA-1500 forms) for its services to Defendant to receive compensation. Pursuant to the New Jersey Healthcare Information Networks and Technologies Act, ("HINT"), Defendant was required to pay Plaintiff's submitted within 40-days. Plaintiff contends that Defendant did not adhere to HINT guidelines "and similarly did not pay Plaintiff for several surgeries, with an outstanding balance of $416,065.07.

Accordingly, Plaintiff filed a July 18, 2008 complaint alleging (1) unjust enrichment; (2) violations of New Jersey regulations governing payment for emergency services from out-of-network providers; (3) violations of the Health Information Network and Technologies (HINT) Act; and (4) misrepresentation. On September 4, 2008, the matter was removed to Federal" Court, The United States District Court remanded the case to the Superior Court of New Jersey by Order dated March 17, 2009. Thereafter, Defendant filed the motion in question to dismiss Plaintiff's Complaint, with prejudice. Plaintiff filed a cross-motion for partial summary judgment for Defendant's (1) violations of the HINT Act, (2) violations of the New Jersey Services Non-Participating Provider Reimbursement regulations, and (3) unjust enrichment claim.

Parties' Contentions

Motion to Dismiss

Defendants contend that the First, Third and Fourth Counts of Plaintiff's Complaint are preempted by the Employee Retirement Income Security Act, § 514(a). (ERISA)

With respect to the First Count, Defendant emphasizes that ERISA preempts state common law claims for unjust enrichment.

29 U.S.C. § 1144(a) (stating that "except as provided in subsection (b) of this section, the provisions of this title…shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan,"); *See* also *Barber v. UNUM Life Ins. Co. of Amer.*, 383 F.3d 134, 137 (3d Cir. 2004). Additionally, Defendant contends that even if the First Count is not preempted by ERISA, the pleading lacks the facts necessary for an unjust enrichment claim. Defendant sets forth that New Jersey law requires a party alleging unjust enrichment to show: (1) a direct relationship between the grantor of the benefit and the grantee of the benefit, or (2) that the party conferred the benefit in mistake. *See Callano v. Oakwood Park Homes Corp.*, 91 N.J. Super. 105, 109 (App. Div. 1966). Accordingly, Defendant emphasizes that Plaintiff certified that it did not have a direct contractual relationship with Health Net. Therefore, Defendant asserts that Plaintiff has a direct relationship with Defendant's insureds, rather than Defendant and thus the First Count of the Complaint should be dismissed. *Callano*, 91 N.J. Super. at 109.

***2** As for Count Three, Defendant asserts that ERISA supersedes Plaintiff's state law claim for an alleged violation of the HINT Act. 29 U.S.C; §1144(a); *See also Barber*, *supra*. Even if ERISA does not preempt the HINT Act, Defendant asserts that the HINT. Act does not require it to pay Plaintiff charges billed to Defendant's insureds. Defendant submits that *N.J.S.A.* 17B: 27-44.2 requires a health insurer that does not pay a portion of the claim to notify the health care provider that the insurer disputes the amount claim and identify the basis for such dispute. As Plaintiff does not plead that there was a failure to notify it of non-payment, Defendant submits that the Third Count of the Complaint should be dismissed.

Defendant also submits that ERISA preempts the Fourth Count of Plaintiff's Complaint which alleges misrepresentation. 29 U.S.C. 1144(a); *Thomas v. Aetna, Inc*., 1999 U.S. Dist. Lexis 23462 (D.N.J. Jun. 8, 1999); *Crumley v. Stonhard, Inc.*, 920 F.Supp. 589 (D.N.J.) *aff'd*, 106 F.3d 384 (3d Cir. 1996). Defendant also argues that, even is the Court does not conclude the ERISA preempts the Fourth Count, Plaintiff fails to plead facts necessary to support a cause of action for misrepresentation. Defendant asserts that Plaintiff's allegations reflect that Plaintiff truly disputes whether the Value Defendant paid to Plaintiff was appropriate and as such the misrepresentation claim should be dismissed. *See Daibo v. Kirsch*, 316 N.J. Super. 580, 589 (App. Div. 1998); *Granite State Ins. Co. v. UJEX, Inc*., 2005 U.S. Dist. Lexis 13692 (D.N.J. Jul. 11, 2005). Moreover Defendant asserts that Plaintiff failed to plead that Defendant had knowledge or belief of the alleged falsity of the misrepresentation or that it misrepresentated a material presently existing or past fact. Gennari v. Weichert Co. Realtors, 148 N.J. 582, 584 (1997). As Plaintiff failed to plead the particulars of the wrong with dates and items, Defendant submits that the Fourth Count of Plaintiff's Complaint. See e.g. Frederico v. Home Depot, 507 F.3d 188, 201 (3d Cir. 2007).

Defendant also asserts that the Second Count of Plaintiff's Complaint should be dismissed because the regulations cited by Plaintiff are inapposite to this ease, do not establish a private cause of action and are not intended to benefit Plaintiff. Plaintiff emphasizes that Plaintiff's complaint for alleged violations of Administrative Code Regulations governing payment are inapplicable because neither Defendant nor its subsidiaries referred Defendant's insureds to Plaintiff. *NJ.A.C.* 11:24-5.1(a); *N.J.A.C.* 11:24-9.1(d)(9). Moreover, Defendants assert that *N.J.A.C.* 11:22-5.6(b) does not apply because it pertains to reimbursements to the facility where the insured receives health services, not reimbursement to the provider of health care. Moreover, Defendant asserts that Plaintiff does not demonstrate that (a) the Health Net Insureds could not reasonably access in-networfc services; and (b) the Disputed Health Care Services were for urgent or emergency conditions.

Additionally, Defendant contends that the regulations do not establish a private cause of action, even if the regulations do apply. Defendant sets forth that in inferring an implied private right of action, the court must consider whether:

> (1)Plaintiff is a member of the class for whose special benefit the statute was enacted; (2) there is any evidence that the legislature intended to create a private right of action under the statute; and (3) it is consistent with the underlying purposes of the legislative scheme to infer the existence of such a remedy.

R.J. Gaydos Ins. Agency, Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 272 (2001). Accordingly, Defendant emphasizes that when a statue contains civil penalty provisions, "the courts will not infer a private cause of action." *Id*. at 275. Additionally, Defendant contends that Plaintiff is not a member of any special class covered under *N.J.A.C.* 11:24-5. Moreover, Defendant provides that there is no evidence of legislative intent for a private cause of action, citing the Department of Health's enforcement remedies as favoring public, rather than private, cause. *See* 28 *N.J.R.* 2456(a); *N.J.A.C.* 11:24-2.14(A)(1-6). Additionally, Defendant sets forth that allowing Plaintiff a private a cause of action under *N.J.A.C.* 11:24-5.3(b) would not be consistent with the statute's underlying purpose of "protecting the public welfare." *R.J. Gaydos*, 168 N.J. at 280.

***3** In opposition, Plaintiff submits that Defendants' Motion should be denied as its claims are saved from ERISA preemption. Plaintiffs asserts that Defendant misapplies ERISA. Plaintiff provides that the "savings clause," of ERISA states "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance." 29 *U.S.C.* 1144(b)(2)(b). Plaintiff sets forth that the United States Supreme Court has repeatedly ruled that a state law "specifically directed toward the insurance industry" and which "regulates insurance" is "saved from ERISA preemption." *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003). Particularly, Plaintiff provides that *Kentucky Ass'n* sets forth that for a state law to be deemed a "law…which regulates insurance" it must satisfy two requirements: (1) State law must be specifically directed toward entities engaged in insurance and (2) The state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Id*. at 341-342. Plaintiffs accordingly contend that New Jersey emergency services regulations and prompt pay laws satisfy the" first prong. *Id*. Particularly, Plaintiff asserts that Defendant concedes a private right of action under the HINT Act, requiring Defendant to process claims in accordance with the statute and its regulations. *Id*. In relation to the second prong, Plaintiff provides that the prompt pay laws obligate Health Net to pay claims timely, or with interest, subject to a waiver provision and the forfeiture to contest the claims if defendant violates the law. *Id*. Particularly, the New Jersey prompt pay "waiver" specifies that Defendant must cover any claim and if Defendant fails to timely deny the claim and cannot show that the claim was submitted fraudulently. *Id*. Therefore, Plaintiff contends that the statutes and regulations directly impact the "risk pooling arrangement." *Id*.

Moreover, Plaintiff asserts that state courts have held that laws regulating insurance are exempt from ERISA preemption. *See*, e.g.: *White Consol. Industries, Inc. v. Lin*, 372 N.J. Super. 480, 484. (App. Div. 2004)("A[n] insured employee benefit plan [such as Health Net] is subject to state regulation and 'saved from the general rule of preemption by virtue of ERISA's saving's clause."); *O'Brien v. Two West Hanover Co.*, 350 N.J. Super. 441, 447 (App. Div. 2001)("If a State law relates to an employee benefit plan governed by ERISA, it is preempted. However, the savings clause is the state's authority to enforce its law if it regulates insurance.); *In the Matter of the Estate of Lanken*, 290 N.J. Super. 556, 559 (Ch. Div. 1996)("State laws relating to any ERISA plan are preempted unless they fall into the "saving" clause which exemptions from preemption state laws which regulate insurance.").

Plaintiff additionally contends that the HINT Act requires Defendant to pay when a violation occurs. In particular, Plaintiff sets forth that the HINT Act requires payment of claims within 30 or 40 days of receipt, and the failure to pay the claim deems it overdue with 12% interest. *N.J.S.A.* 17B-27-44(d)(7) and (9). Moreover, Plaintiff reiterates the fact that regulations set forth that failure to "timely respond to a claim results in a forfeiture to contest said claim. *N.J.A.C.* 11:22-1.6(b). Plaintiff emphasizes that the regulations are given great deference because "agencies have the specialized expertise necessary to enact regulations dealing with technical matters." *Saint Peter's University Hosp. v. Lacy*, 185 N.J. 1, 13 (2005).

Moreover, Plaintiff emphasizes that the New Jersey state insurance statutes function as the independent statutory legal duty, separate from ERISA, thereby compelling reimbursement. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

In its reply brief in support of its motion to dismiss, Defendant contends that Plaintiff's cause of action for alleged violations fails under the HINT Act, Particularly, Defendant asserts that the HINT Act is not "saved" from ERISA preemption because the HINT Act does not regulate insurance or substantially affect the risk pooling arrangement between the insurer and the insured. Defendant argues that the HINT Act does not compel Defendant to cover any claims in a timely or untimely manner. Instead, Defendant emphasizes that the HINT Act provides two penalties for Defendant for untimely payment through the HINT Act: interest and inability to contest the claim.

Similarly, Defendant contends that Plaintiff's use of *Kentucky Ass'n* is misapplied. Defendant contends that the HINT Act is similar to a "bad faith" statute and not an "any-willing provider" statute. Defendant relies on *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 137 (3d Cir. 2004), which sets forth that insurers who denied claims in bad faith did not substantially affect the risk pooling agreement between the insurer and the insureds' because the statute provides that "whatever the bargain struck, if the insurer acts in bad faith, the insured may recover punitive damages." *Id*. "at 143. Therefore, Defendant provides that the HINT Act imposes a potential penalty for an insurance company's breach of contract and does not provide any relation to the risk pooled. *Id*.; *See*: *Coles v. Metropolitan Life Ins. Co.*, 837 F. Supp. 764, 768 (M.D. La. 1993).

***4** Additionally, Defendant contends that Plaintiff's claim for unjust enrichment is preempted by ERISA. Defendant provides that Plaintiff does not explain how its. cause of action for unjust enrichment is independent of the health benefit plans that Defendant issued to its insureds and similarly does not provide any relevant case law. Moreover, Defendant emphasizes that

Plaintiff "misapplies *Callano* which sets forth that plaintiff plead either (1) that it has a direct relationship with Defendant or (2) that it mistakenly conferred a benefit on Defendant. *Callano*, 91 N.J. at 109. Defendant asserts that Plaintiff does not provide any authority showing that it "provided services on behalf of Defendant as an insurance provider." Instead, Defendant contends that Plaintiff shows a direct relationship to Defendant's insureds. Defendant emphasizes that *Callano* sets forth that there is no direct relationship between Plaintiff and Defendant. *Id*. In *Callano*, the Appellate Division rejected Plaintiff's claim for unjust enrichment and found that the Plaintiff only had a relationship with the *third party*. *Id*. (emphasis added).

Defendant additionally asserts that Plaintiff did not respond to its contention that ERISA preempts Plaintiff's cause of action for misrepresentation. Defendant therefore requests dismissal of Plaintiff's cause of action for misrepresentation, with" prejudice.

Additionally, Defendant contends that Plaintiff misrepresents their argument that the four emergency service administrative code regulations do not apply to this instant matter. In addressing regulation *N.J.A.C.* 11:24:5.1(a), Defendant contends that on its face, the regulation only applies to those instances in which an HMO refers a member out-of-network. Defendant asserts that Plaintiff does not address said discrepancy in its opposition and similarly does not plead that that Defendant referred its insureds to Plaintiff. Therefore, Defendant requests that the Court dismiss the Second Count of Plaintiff's Complaint with prejudice.

In addressing regulation *NJ.A.C.* 11:24-9.1(d)(9), Defendant contends that said statute only applies to insureds with a traditional HMO benefit plan, which Defendant's insureds did not possess. In contrast to the traditional HMO. plan, Defendant's insureds' had a Point of Service (POS) benefit plan, in which insureds can receive services out-of-network "without being required to obtain a referral or prior authorization to go to an out-of-network health care professional from the HMO." *N.J.A.C.* 11:24-14.3(g). The insured who has a POS is additionally financially responsible for copay, coinsurance, and/or deductible as well as any balance of the bull that exceeds the usual, reasonable and customary (UCR) charge as determined by the HMO. *Id*. Defendant contends that Plaintiff's argument that it is responsible for the billed charges because it "covered" the healthcare services in question is misplaced. When a POS health benefit plan "covers" an out-of-network heath care service, the POS plan may pay less than the out-of-network provider's billed charges. Therefore, unlike a traditional HMO plan, Defendant's function as a POS plan for its insureds precludes responsibility to pay for all billed charges.

In relation to *N.J.A.C.* 11:22-5.6(b), Defendant provides that *all* administrative code regulation only applies to facilities. Moreover, Defendant emphasizes that Plaintiff conceded that the code applied "happens to apply to facilities" and therefore should dismiss the Second Count of Plaintiff's Complaint with prejudice.

Moreover, Plaintiff contends that *N.J.A.C.* 11:24-5.3(b) does not apply because Plaintiff fails to plead the two-prong requirements needed to satisfy the code. Particularly, Defendant contends that Plaintiff does not show that (1) Defendant's insureds could not reasonably access in-network services and (2) Defendant's insureds healthcare services were for an urgent or emergency condition. *Id*.

Additionally, Defendant contends the. three administrative codes *N.J.A.C.* 11:24-5.1(a), *N.J.A.C.* 11:24-5.3(b), and *N.J.A.C.* 11:24-9.1(d)(9) do not establish a private cause of action. Accordingly, the New Jersey Supreme Court has set forth a three-prong test to determine whether a regulation establishes a private cause of action: (1) Member is a member of a class for whose special benefit the statute was enacted; (2) there is evidence that DOBI intended to create a private cause of action; and (3) a private cause of action is consistent with the underlying purposes of the regulatory scheme. In addressing the three-prong test, Defendant first sets forth that Plaintiff is not a member of the class for whose special benefit of the regulation as created because Plaintiff does not provide any regulatory authority from the Department of Banking and Insurance (DOBI) which suggest that out-of-network providers should be paid by Defendant and the DOBI does not apply to POS health benefit plans. *See Certification of Eric D. Katz, Ex. C*. Moreover, Defendant sets forth that the Order was "entered to assist physicians." In addressing the second prong, Defendant contends that there is no cause of action under *N.J.A.C.* 11:24-5.1(a); *N.J.A.C.* 11:24-5.3(b), and *N.J.A.C.* 11:24-9.1(d)(9). Particularly, Defendant asserts that the DOBI never enacted the proposed regulation. Defendant further asserts that even if the regulation was enacted, it does not propose establishing an alternative dispute resolution protocol or any private cause of action for disputes arising in connection with emergency service code regulations. In addressing the third and final prong, Defendant refutes Plaintiff's assertion that a

private cause of action is consistent with the underlying purpose of the regulatory scheme. Particularly, Defendant asserts that Plaintiff does not provide case law or other authority that the DOBI intended to ensure that "doctors "get paid," and further does not support their contention that the purpose of the administrative code was created expressly for the insured. Defendant therefore requests that the Second Count of Plaintiff's Complaint be dismissed with prejudice.

Partial Summary Judgment

***5** Plaintiff filed a cross-motion for partial summary judgment contending that it is entitled to partial summary judgment for Defendant's violations of the HINT Act and New Jersey Regulations regarding reimbursement of emergency services for non-participating providers, on its unjust enrichment claim, and on its claim for a private right of action.

Defendant sets forth that under the HINT Act, *N.J.S.A.* 26:2J-8.1(d)1(a)-(e) and *N.J.A.C.* 11:22-1.5(a), Defendant is required to remit payment to Plaintiff no later than 40 days after receipt of a claim. *Id*. According to the act, "all overdue payments must bear simple interest of 10% per annum paid at the time payment is made and within fourteen (14) days thereafter." *N.J.A.C.* 11:22-1.6(c). Moreover, Defendant's denials or disputes regarding payment mandate submittal of "specific" reasons to Plaintiff. *Id*. In addition, Plaintiff submits that DOBI stated that "the appropriate consequence for failing to comply with these rules is forfeiture of the ability to contest the claim." 33 *N.J. Reg.* 105(a) (January 2, 2001). Accordingly, Plaintiff submits that Defendant did not timely pay the claim, request additional information if such information was needed to process the claim, set forth all the reasons why claims were denied, or communicate with Plaintiff regarding the claim.

Additionally, Plaihtiif submits that Defendant is liable for. emergency services rendered for one patient on the date of April 24, 2005. Defendant contends that under *N.J.A.C.* 11:24-5.3(b) and 11:24(d)(9), non-participating providers such as Plaintiff, are required to pay 100% of billed charges "less the member's network copayment, coinsurance or deductible." *See DOBI March 21, 2007 Order*. Plaintiff emphasizes that contrary to Defendant's argument, the regulations are not limited to only those situations where Defendant may have referred a patient to Plaintiff. Instead, Plaintiff sets forth that coverage extends to "necessary, services that were *authorized or covered* by the HMO." *N.J.A-C.* 11:24-9(d)(9) In addition, Plaintiff counters that "physicians and other providers," not just "facilities" are covered under DOBI's Order. *See*; *Pl. Ex, C*. Moreover, Plaintiff sets forth that contrary to Defendant's argument, the services in which Plaintiff seeks 100% reimbursement were "medically necessary and some were emergency procedures."

Moreover, Plaintiff contends that it is entitled to partial summary judgment on its unjust enrichment claim. Plaintiff establishes that an unjust enrichment claim "must show both that defendant received a benefit and that retention of that benefit without payment would be unjust." *VRG Corp. v. GKN Realty Corp.*, 135 N.J. 539, 554 (1994). Plaintiff relies on *Callano* which states that Defendant must have "expected remuneration from defendant, or if the true facts were known to plaintiff, it would have expected remuneration from, defendant, at the time that the benefit was conferred." *Callano*, 91 N.J. Super. at 108. Plaintiff sets forth that by providing surgical services for Defendant's subscribers, they provided a benefit to both Defendant and its subscribers. Particularly, Plaintiff provides that without its services, Defendant's insureds would have been deprived of the medical care and emergency services they paid to receive. *See River Park Hospital, Inc. v. Blue Cross Blue Shield of Tennessee*, 173 S.W.3d 43 (Tenn. Ct. App. 2002); *Temple University Hospital Inc. v. Healthcare Management Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. 2003).

***6** Plaintiff sets forth that *Callano* does not mention a "contractual" relationship, as Defendant's contend, but instead a *direct* relationship: "Quasi-contract cases involve either *some direct relationship* between the parties or a mistake on the part of the person conferring the benefit." *Id*. (emphasis added). Plaintiff further provides that it does not have a "direct contractual relationship" with the Defendant, and if it did, it would be liable to recover under breach of contract, instead of unjust enrichment. *See Moser v. Milner Hotels, Inc.*, 6 N.J. 287, 280 (1951). Plaintiff relies on *River Park Hospital, Inc. v. Blue Cross Blue Shield of Tennessee*, 173 S.W.3d 43 (Tenn. App. Ct. 2002), a case involving comparable state regulations governing emergency, services reimbursement to non-participating providers where the Tennessee Court of Appeals affirmed a trial judge's finding that an out-of-network hospital providing emergency services to Blue Cross's members substantiated its unjust enrichment claim. *Id*. As a result, the ease was remanded for a trial on damages, to "determine a reasonable [non-participating] rate of reimbursement" for emergency services rendered. *Id*. at 47. Additionally, Plaintiff relies on *Temple University v. Healthcare Management Alternatives, Inc*. 832 A.2d 501 (Pa. Super. 2003), where a Pennsylvania Appellate

Court found that a health insurance carrier who did not compensate its provider was liable for unjust enrichment because "the parties virtually were compelled to operate in this manner, equitable principles…apply." *Id.* at 507. Plaintiff sets forth that like *Temple*, Plaintiff here was compelled to treat Defendant's patients and is entitled to partial summary judgment.

Plaintiff further contends that there is a private right of action for emergency services under the HINT Act contrary to Defendant's position that no such action exists. First, Plaintiff sets forth that its physicians are important direct beneficiaries of the regulations.. Plaintiff relies on DOBI Order A07-59, which states, "a carrier must pay the non-participating provider a benefit large enough to insure that the non-participating provider does not balance bill… even if it means [paying the provider's billed charges…]" Second, Plaintiff sets forth that DOBI's enforcement authority is not the determining factor in determining whether the legislature intended a private right of action for physicians. Instead, Plaintiff contends that the "intent" of the regulations is to provide a permissive ADR mechanism to all an individual provider to "resolve" payment disputes. 39 N.J. Reg. 2455(a).

Plaintiff sets forth that in *Sutter, M.D. v. Horizon Blue Cross Blue Shield*, Docket No. ESX-L-3685-02, Judge Rothschild relied on a similar principle in finding private right of action under the HINT Act, stating "a common sense reading [of the regulation] precludes a reading that the legislature intended a right without a remedy." *Katz Cert. Exhibit A* at 10-11. Moreover, Defendant contends that civil remedies "further the purpose of the statute." *Parks v. Pep Boys*, 282 N.J. Super. 1, 15 (App. Div. 1995). Particularly, Plaintiff emphasizes that the purpose of emergency services regulations is to ensure that patients are not stuck with bills and that doctors are adequately compensated for their services. Plaintiff sets forth that because DOBI is not responsible for correcting payment violations, a private cause of action is essential to vindicate claims. See *Graziano v. Grant*, 326 N.J. Super. 328, 342 (App. Div. 1999) (stating "equity will not permit a wrong to be suffered without affording the appropriate remedy"); See also *Loigman v. Kings Landing Condominium Association, Inc.*, 324 N.J. Super. 108 (Ch. Div. 1999). Plaintiff therefore contends that although a remedy is not expressly set forth in the laws, there is no "legislative prohibition" to remedy the wrong suffered by the provider. Moreover, Plaintiff contends that Defendants use of *Gaydos* is misapplied because it is distinguishable from the case at bar as this instant matter requires a private cause of action in order to afford relief to Plaintiff's physicians.

In its opposition, Defendant asserts that Plaintiff's Cross-Motion should be debued. First, Defendant contends that Plaintiff did not submit a "claim" as defined" by the HINT Act. The HINT Act defines a "claim" as a request "by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to healthcare services…covered under a health benefits plan." *N.J.A.C.* 11:22-1.2(a). Plaintiff sets forth that it is not a covered person or a participating health care provider. Accordingly, Defendant emphasizes that Plaintiff does not produce any evidence showing an assignment of benefits from the patients to whom Plaintiff provided services and is therefore not covered under *N.J.A.C.* 11:22-1.2(a). Therefore, Defendant contends that Plaintiff does not fall under *N.J.A.C.* 11:22-1.2(a) and should be denied partial summary judgment as a matter of law.

***7** Additionally, Defendant contends that Plaintiff has not established a private cause of action. Particularly, Defendant provides, that Plaintiff omits relevant case law which establishes that the HINT Act does not establish a private cause of action: "The Act does not specifically authorize private parties to file enforcement actions." *Medical Soc. of New Jersey v. AmeriHealth HMO, Inc.*, 376 N.J. Super. 48, 59-60 (App. Div. 2005). Moreover, Defendant contends that Plaintiff's use of *Sutter* is misapplied because it is trumped by *Medical Society* and because its facts are incongruent to the case at bar. *Id.* Defendant sets forth that *Sutter* establishes that a private cause of action under the HINT Act would "do little more than mirror common law breach of contract suits that generally contain interest claims." *Sutter*, ESX-L-3685-02. Accordingly, Defendant emphasizes that the instant case does not include a contract with Defendant.

In addition, Defendant contends that several disputes of material fact preclude partial summary judgment. Defendant asserts that genuine issues of material fact exist as to whether requests for payment were timely made, whether payment had already been made for services provided, and whether deficiencies prevented the payment of certain requests. Additionally, Defendant argues that there exist disputes as to whether certain claim falls under the HINT Act, whether services rendered were of an emergent nature, whether certain benefits were provided by Defendant, and whether certain patients exhausted their administrative remedies. Moreover, with respect to one patient, Defendant explains that it is still investigating a claim Plaintiff submitted for services. Thus, Defendant submits that the aforementioned issues of material fact necessitate discovery and should thus be denied partial summary judgment.

In addition, Defendant sets forth that Plaintiff's cross-motion for partial summary judgment with respect to its unjust enrichment claim should be denied because the parties dispute whether Defendant retained a "benefit." In particular, Defendant sets forth that a July 24, 2008 decision from the District of New Jersey, involving *McCoy v. Health Net, Inc*, 03-1801, required Defendant to pay up to $215 million and agreed to institute millions of dollars worth of business practice initiatives Defendant contends that Some of the disputed services in this instant matter fall under the *McCoy* Settlement Agreement. Accordingly, Defendant contends that it relinquished the "benefit" Plaintiff alleges it conferred. Defendant contends" that this disagreement precludes summary judgment.

Finally, Defendant sets forth that. Plaintiff's cross-motion for partial summary judgment should be denied because it did not directly issue health benefit plans to any of the patients who received healthcare services from Plaintiff.

In reply, Plaintiff sets forth that Defendant misconstrues the assignment of benefits issue Particularly, Plaintiff contends that claims for violations are considered to be independent from the assignment of benefits. Further, Plaintiff provides that the Explanation of Benefits (EOBs) sets forth that Plaintiff was authorized by individual patients to submit claims to Defendant.

Additionally, Plaintiff contends that Defendant's argument for no private right "of action mentioned in its reply brief was not set forth in its moving papers and is therefore improper. Plaintiff further contends that Defendant misconstrues the Appellate Division's holding in *Medical Society*, which expressly found that the prompt pay statute was enacted to benefit physicians to allow them to recover money damages. 376 N.J. Super. at 59.

Moreover, Plaintiff sets forth that two. Essex County Law Division decisions state that an implied private right of action exists under the HINT Act, allowing individual physicians to enforce their statutory right to prompt payment. *See Sutter, M.D. v. Horizon Blue Cross Blue Shield*, Docket No. ESX-L-3685-02 at 9-15; *Kirsch, D.D.S. v. Horizon Blue Cross Blue Shield*, Docket No. ESX-L-4216-05, at 37-42 and 47-49. Moreover, Plaintiff asserts that the prompt payment requirements always apply equally to out-of-network and in-network providers. *See N.J. Reg.*, 2455(a) (2002).

***8** Additionally, Plaintiff emphasizes that Defendant's concession that it responded to "most requests for payment in. the time prescribed by the HINT Act" demonstrates its untimely conduct. Moreover, Plaintiff sets forth that with certain patients, Defendant does not provide that it complied with the HINT Act and therefore concedes a violation of the statute. Plaintiff reiterates entitlement to partial summary judgment and $192,327.89 plus statutory interest for the aforementioned claims.

Moreover, Plaintiff asserts that Defendant's failure to address certain claims results in a concession that communications were not made "expeditiously" as required by the HINT Act. According to the DOBI, insurers such as Defendant are required to communicate with providers by telephone, email, facsimile, or overnight mail when disputing or denying a claim in order to satisfy the "expeditiously" requirement. *N.J. Reg.* 105(a)(January 2, 2001). Plaintiff provides that Defendant's use of tegular mail waives their right to dispute of the claims and must pay the claims submitted by the practice. *N.J.A.C.* 11:22-1.6(b). Therefore, Plaintiff contends that they ate entitled to partial summary judgment on the aforementioned claims and a total sum of $168, 984.99. Plaintiff thereby requests a total sum of $361,312.88.

Plaintiff further contends that Defendant's argument that its insureds should have exhausted administrative remedies prior to seeking relief is misguided. Particularly, Plaintiff emphasizes that it asserts a violation of the HINT Act, not an ERISA enforcement action. Therefore, Plaintiff contends that Defendant's argument to follow ERISA is irrelevant.

Plaintiff further refutes Defendant's argument against its unjust enrichment claim. Particularly, Plaintiff contends that Defendant's application of *McCoy* is misguided because it pertains to individual patients, not a group of physicians, like Plaintiff. *McCoy v. Health Net, Inc*, 03-1801. Therefore, Plaintiff contends that Defendant's use of *McCoy* is incorrect.

Additionally, Plaintiff sets forth Defendant's argument stating that it is not the correct Defendant because it is a subsidiary of Health Net of New Jersey ("HNNJ") is superfluous and should be waived because it did not make such an argument in its moving papers. Plaintiff relies on *Williams v. Bell Telephone*, 132 N.J. 109 (1993), in which a defense was denied, despite being plead, in the defendant's answer because the Defendant never otherwise asserted it. *Id*. Moreover, Plaintiff contends that Defendant's concession that it received all of the claim information submitted and was involved in their processing demonstrates that Defendant, not HNNJ is the "proper" defendant in this instant case.

Applicable Law and Analysis

Motion to Dismiss

A court may dismiss a claim or complaint pursuant to *R.* 4:6-2(e) for failure to state a claim upon which relief is granted." The litmus test for determining the adequacy of a pleading is whether a cause of action is "suggested" by the facts. *Velantzas v. Colgate-Palmolive Co.*, 109 N.J. 189, 192 (1988). In ruling, courts must "assume the facts as asserted by plaintiff are true and give him the benefit of all inferences that may be drawn in his favor." *Id.* at 192. Upon a motion made pursuant to *R.* 4:6-2(e), the court's inquiry is limited to examining the legal sufficiency of the facts alleged on the face of the complaint. *Rieder v. Department of Transp.*, 221 N.J.Super. 547, 552 (App. Div. 1987). The examination of a complaint's allegations of fact required by the aforementioned principles should be one that is at once painstaking and undertaken with a generous and hospitable approach. *Printing Mart - Morristown v. Sharp' Elec. Corp.*, 116 N.J. 739, 746 (1989).

***9** Thus, *R.* 4:6-2(e) motions to dismiss should be granted in "only the rarest [of] instances." *Lieberman v. Port Auth. of N.Y. & N.J.*, 132 N.J. 76, 79 (1993) (quoting *Printing Mart-Morristown*, 116 N.J. at 772). However, dismissal of a complaint is appropriate when the complaint states no basis for relief on its face. Pressler, *Current N.J. Court Rules*, Comment 4.1 on R. 4:6-2 (2009). If dismissal is granted, it "should be without prejudice to a plaintiff's filing of an amended complaint." *Printing Mart — Morristown*, 116 N.J. at 772.

As for the First, Third and Fourth Counts of the Complaint, the Court finds, viewing all reasonable inferences in Plaintiff's favor and accepting the facts alleged as true, that ERISA does not preempt these claims. The Court finds that these claims are not preempted by ERISA because the applicable regulations are specifically directed toward the insurance industry and regulates insurance. *Kentucky Ass'n*, supra, 538 U.S. at 341-342; *White Consol. Industries, Inc., supra*, 372 N.J.Super. at 484. Particularly, Plaintiff provides that Kentucky Ass'n sets forth that for a state law to be deemed a "law…which regulates insurance" it must satisfy two requirements: (1) State law must be specifically directed toward entities engaged in insurance and (2) The state law must substantially affect the risk pooling arrangement between the insurer and the insured."

In light of this determination, the Court finds that the Fourth Count of Plaintiff's Complaint should be dismissed without prejudice; however, all other claims should remain. In *Printing-Mart Morrisown*, supra, the Supreme Court made clear that a dismissal "should be granted without prejudice to a plaintiff's filing of an amended complaint." *Id.* The Fourth Count of the Complaint must be dismissed as the elements of misrepresentation are not plead with specificity; however, Plaintiff must be afforded the opportunity to file an amended complaint pursuant to *Printing Mart — Morristown.*

The First Count of the Complaint survives, as a cause of action for Unjust Enrichment exists. In order to establish a valid unjust enrichment claim, plaintiffs must plead either "(1) a direct relationship between the grantor of the benefit and the grantee of the benefit, or (2) that the party conferred the benefit in mistake." *Callano, supra*, 91 N.J. Super. at 109. Applying all reasonable inferences, in Plaintiff's favor, the Court here finds that Plaintiff alleges sufficient facts to demonstrate that it conferred a benefit upon Defendant in that Defendant has retained funds that should have been paid to Plaintiff as a result of services rendered to Defendant's insureds arid thus a cause of action for unjust enrichment exists.

As for the Third Count of the Complaint, the Court finds that a colorable claim for violations of the HINT Act exists. Plaintiff clearly asserts that statutory provisions of the HINT. Act have been violated by Defendant based upon failure to provide prompt payment and otherwise comply with HINT. Though Defendant asserts that it merely has an obligation to notify the health care provider of a disputed claim, Plaintiff alleges in its Complaint that Defendants failed to notify Plaintiff of the specific reasons for non-payment as required by N.J.S.A. 17B:27-44.2(d)(2). Accordingly, Plaintiff has asserted a valid cause of action for such violation.

***10** Regarding the Second Count of Plaintiff's Complaint, the. Court finds that Plaintiff has established a plausible claim for violation of New Jersey Regulations governing payment for emergency services rendered by non-participating providers. While Defendant asserts that regulatory code sections are inapplicable and do no establish a private cause of action, the Court finds that a plausible cause of action exists based upon the standard for Motions to Dismiss pursuant to *R.* 4:6-2(e). In *Sutter*,

M.D. v. Horizon Blue Gross Blue Shield, Judge Rothschild concluded, after careful consideration, that a dismissal of a claim for a private cause of action under the Prompt Payment Act and the HINT Act was inappropriate. The Court finds that the reasons set forth by Judge Rothschild are equally applicable to the emergency services regulations here and therefore the Court finds that Defendant's Motion to Dismiss the Second Count of Plaintiff's Complaint must be denied.

Summary Judgment

R. 4:46 governs Motions for Summary Judgment. *R*. 4:46-1 provides that "a party seeking any affirmative relief may, at any time after the expiration of 35 days from the service of the pleading…, move for summary judgment…" It is well established that an order for summary judgment "shall be rendered if the pleadings…show that there is no genuine issue as to any material fact challenged and that the moving party is entitled to a judgment or order as a matter of law." *R*. 4:4.6-2(c). In *Brill v. Guardian Life Ins. Co of America*, 142 N.J. 520 (1995), the New Jersey Supreme Court held that:

> Whether there exists a "genuine issue" of material fact that precludes summary judgment requires the motion judge to consider whether the competent evidential materials presented, when viewed in the light most favorable to the non-moving party, are sufficient to permit a rational fact-finder to resolve the alleged disputed issue in favor of the non-moving party.

Id. at 540. An issue is considered to be "genuine" if "the evidence submitted by the parties on the motion, together with all legitimate inferences there from favoring the non-moving party, would require submission of the issues to the trier of fact." *R*. 4:46-2(c). Under that standard, "where the evidence 'is so one-sided that one party must prevail as a matter of law,' the trial court should not hesitate to grant summary judgment." *Ibid*., quoting *Anderson et al. v. Liberty Lobby, Inc., et al*, 477 U.S. 242 at 252 (1986). It is equally well established that New Jersey precedent weighs decidedly against granting summary judgment where discovery is not yet complete. *See J. Josephson v. Crum & Forester Ins. Co.*, 293 N.J. Super. 170, 203 (App. Div. 1996).

Having reviewed the submissions of the parties in light of the governing Summary Judgment standard, the Court finds that Plaintiff's Cross-Motion for Summary Judgment must be denied. As the outset, it appears that discovery is not yet complete in this case. While the matter was removed to Federal Court in September 2008 and thereafter remanded to Superior Court in March 2009, Defendant has not filed its responsive pleading with the Superior Court, a discovery deadline has not been established, and the parties have not been reffered to mediation. On this basis alone, it appears that Summary Judgment would be inappropriate pursuant to *J. Josephson*, *supra*.

Summary Judgment is also inappropriate at this time, based upon the existence of genuine issues of material fact regarding the submission of requests for payments and the alleged issuance of checks to satisfy payment among other things. While these issues may be resolved through the process of discovery, they are currently unresolved and as such, a reasonable juror could conclude that. Defendant has satisfied its obligations under the HINT Act and the applicable regulations. For these reasons, summary judgment must be **denied**.

Dated: August 24, 2009

<<signature>>

***11** Hon. Joseph S. Conte, J.S.C.

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