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Via CM/ECF
Honorable Brian R. Martinotti, U.S.D.J.
United States District Court, D.N.J.
Martin Luther King Building & U.S. Courthouse
50 Walnut Street. Room 4015
Newark, New Jersey 07101

RE: Rowe Plastic Surgery of NJ LLC v. Aetna Life Insurance Company
Civil Case No.: 2:25-cv-15053-BRM-MAH

Dear Judge Martinotti,

This firm represents Plaintiff Rowe Plastic Surgery of NJ LLC ("Plaintiff") in the above-captioned matter. Pursuant to Your Honor's Rules and Procedures, Plaintiff respectfully submits this letter in opposition to Defendant Aetna Life Insurance Company's ("Defendant") request for a pre-motion conference relative to its proposed Motion to Dismiss [Dkt. No. 19].

ERISA section 502(a)(1)(B) provides a plan participant or beneficiary a cause of action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). "This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). Further, the interpretation and construction of a plan's terms are not limited to the four corners of the plan itself. Indeed, ERISA provides that plan fiduciaries must interpret and apply plan terms consistent with ERISA's substantive provisions. 29 U.S.C. § 1104(a)(1)(D) (plan fiduciaries must apply the terms of the plan "insofar as such documents and instruments are consistent with the provisions of" Title I of ERISA); *see also Bauer v. Summit Bancorp*, 325 F.3d 155, 160 (3d Cir. 2003) ("We are required to enforce the Plan as written unless we find a provision of ERISA that contains a contrary directive.")

"It is well settled that a healthcare provider, though not a statutorily designated ERISA beneficiary, may obtain standing to sue derivatively to enforce an ERISA plan beneficiary's claim." *See North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182, 191 (5th Cir. 2015); *see also Vt. Agency of Natural Res. v. U.S. ex rel. Stevens*, 529 U.S. 765, 773 (2000) ("[T]he assignee of a claim has standing to assert the injury in fact suffered by the assignor."). "To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016). While "tangible injuries are perhaps easier to recognize . . . intangible injuries can nevertheless be concrete." *Id*. at 340.

The No Surprises Act ("NSA"), as codified in the Public Health Service Act ("PHSA") and ERISA, explicitly requires insurers to pay non-participating medical providers "the amount by which the out-of-network rate . . . for such services . . . exceeds the cost-sharing amount" owed by the participant. 42 U.S.C. § 300gg-112(a)(3)(B); 29 U.S.C. § 1185f(a)(3)(B). The statute further requires that the payment "shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made" by a certified Independent Dispute Resolution ("IDR") entity. *Id.* §§ 300gg-111(c)(6), 300gg-112(b)(6); 29 U.S.C. § 1185f(b)(6). These provisions thus impose "a global directive that regulates the substantive content" of group health plans, *Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 750 (2004), and "effectively creates a mandatory contract term" - *i.e.*, to pay benefits in accordance with IDR awards. *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 374 (1999). A plan's failure to do so thus violates the plan (as modified by ERISA) and gives rise to a wrongful denial of benefits claim under section 502(a)(1)(B). Any plan terms to the contrary would be "trumped by ERISA" and "unenforceable." *N.R. v. Raytheon Co.*, 24 F.4th 740, 752 (1st Cir. 2022).

Here, the beneficiary of the health plan issued by Defendant executed an Assignment of Benefits ("AOB") and assigned her rights under her health plan to Plaintiff. Therefore, Defendant's failure to pay benefits in accordance with IDR awards is a wrongful denial of plan benefits that gives Plaintiff standing to bring suit under ERISA. This contractual inquiry alone provides a basis for Article III standing to plan participants and any assignee acting in their stead, regardless of whether participants suffer any tangible harm. *North Cypress Med. Ctr.*, 781 F.3d at 193. Since an anti-assignment clause is a plan term that is contrary to the NSA's ERISA modifications, for the limited purposes of an insurer violating plan terms by refusing to pay NSA awards, the plan's anti-assignment clause is "trumped" by ERISA and "unenforceable." *N.R.*, 24 F.4th at 752.

Additionally, and alternatively, Plaintiff has suffered its own independent injury separate and apart from that which is derivative (via assignment) of the ERISA plan member's wrongful denial of benefits. Plaintiff itself has a legally cognizable interest in the IDR-based payment that Defendant is required by statute to make and yet has refused to pay. *See* 29 U.S.C. § 1185f(b)(6); *cf. Vt. Agency*, 529 U.S. at 773 ("Congress can[] define new legal rights, which in turn will confer standing to vindicate an injury caused to the claimant.") This direct injury independently supports Plaintiff's standing to sue under ERISA section 502(a)(1)(B) separate from any injury incurred by plan participants. *See Vt. Agency*, 529 U.S. at 772 (explaining that a legally protected interest for standing purposes is one that "consist[s] of obtaining compensation for, or preventing, the violation of a legally protected right") (citations omitted).

As to unjust enrichment, to establish a claim of unjust enrichment under New Jersey law, Plaintiff must demonstrate that Defendant "received a benefit and that retention of that benefit without payment would be unjust." *Thieme v. Aucoin-Thieme*, 227 N.J. 269 (N.J. 2016). By providing the underlying medical services to Defendant's member, Plaintiff conferred a benefit upon Defendant for which Plaintiff reasonably expected compensation. Thus, it would be unjust for Defendant to retain the benefit without remuneration.

Pursuant to statutory and regulatory obligations to which Defendant is subject, Defendant's member was entitled to seek and receive medical services from out-of-network providers in a participating network facility without risk of balance billing. By permitting its member to obtain

such services, Defendant received a benefit from Plaintiff's services – namely, the services enabled Defendant to discharge a legal obligation owed to its member. *See El Paso Healthcare Sys. v. Molina Healthcare of N.M., Inc.*, 683 F.Supp. 2d 454, 461 (W. D. Tex. 2010) ("While it is true that the immediate beneficiaries of the medical services were the patients, and not Molina, that company *did* receive a benefit of having its obligations to plan members . . . discharged.") There, the Court found discharging of obligations to be a material benefit and further observed that "[i]ndeed, Molina's very reason for existence is to ensure that such services are provided to plan members." *Id*.; *see also Forest Ambulatory Surgical Assocs., LP v. United Healthcare Ins. Co.*, CV 12-2916, 2013 U.S. Dist. LEXIS 190703, at * 29 (C.D. Cal. Mar. 12, 2013) ("allegations in the SAC establish that Defendants received the benefit of having their obligations to the Health Plan members discharged.").

Lastly, Plaintiff's unjust enrichment claim is not preempted by ERISA. ERISA section 514(a), 29 U.S.C. § 1144(a), provides in pertinent part that the "provisions of this subchapter and subchapter 1111 of this chapter shall supersede any and all State laws insofar as they may now or hereafter **relate to** any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title (emphasis added)."

Courts have recognized that, despite the use of the phrase "relate to" to establish the reach of the provision, ERISA 514(a) does have limits. *See New York State Conf. of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (the court declined to apply "uncritical literalism" to that phrase, instructing courts to examine the objectives of the ERISA statute in determining what State laws would survive preemption analysis). Additionally, Courts have held that "independent state law claims of [the plaintiff], a third-party provider, lie outside the bounds of the ERISA 'relates to' standard" and "courts have held that ERISA does not preempt a third-party provider's independent state law claims against a plan sponsor precisely because those claims do not 'relate to' the administration of an ERISA plan." *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008-1110 (9th Cir. 1995); *see also McCall v. Metropolitan Life Ins. Co.*, 956 F.Supp. 1172, 1186 (D.N.J. 1996) (stating that the provider's negligent misrepresentation claims against the defendant insurers are sufficiently removed from the plan to avoid the scope of ERISA preemption).

Here, Plaintiff's unjust enrichment claim does not seek determination as to the terms and conditions of any underlying ERISA-subject plans, but rather judgment in the amount owed to Plaintiff from an independent legal obligation[1] to pay for a benefit conferred that Defendant owes to its member. Defendant's liability for payment arises under statutory and regulatory provisions to which Defendant is subject, not ERISA-subject benefit plans.

For the foregoing reasons, Plaintiff respectfully requests that this Court deny Defendant's request for a pre-motion conference and allow this matter to proceed to the next stage of litigation.

[1] If ERISA section 502(a)(1)(B) is not deemed a valid cause of action to remedy an unpaid IDR award, it cannot preempt an unjust enrichment claim. In that regard, by Defendant's own admission, unjust enrichment is not preempted unless this Court sanctions ERISA as a valid cause of action.

Respectfully submitted,

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cc: All Counsel of Record (*via ECF*)