Buffalo Emergency Assoc., LLP v Aetna Health, Inc.
2017 NY Slip Op 32462(U)
November 1, 2017
Supreme Court, New York County
Docket Number: 651937/2017
Judge: O. Peter Sherwood
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: COMMERCIAL DIVISION PART 49

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BUFFALO EMERGENCY ASSOCIATES, LLP, EMERGENCY CARE SERVICES OF NY, PC, EMERGENCY PHYSICIAN SERVICES OF NY YORK, PC, EXIGENCE MEDICAL OF JAMESTOWN, PLLC, AN EXIGENCE MEDICAL OF OLEAN, PLLC

Plaintiffs,

-against-

AETNA HEALTH, INC. (NEW YORK), AETNA HEALTH INSURANCE COMPANY OF NEW YORK, and AETNA LIFE INSURANCE COMPANY,

Defendants.

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DECISION AND ORDER
INDEX NO.: 651937/2017

Motion Sequence No.: 001

O. PETER SHERWOOD, J.:

Under motion sequence 001, defendants Aetna Health, Inc. (New York), Aetna Health Insurance Company of New York, and Aetna Life Insurance Company (collectively, "Aetna") move to dismiss the amended complaint in its entirety pursuant to CPLR 3211 (a) (3), (7), and (8). For the following reasons, the court grants the motion in its entirety.

BACKGROUND

Plaintiffs are "professional emergency medicine group practice[s]" who staff hospital emergency rooms at various locations throughout the State of New York, except in New York City (amended complaint ¶¶ 8-14, 20). Defendants insure, operate and administer health plans in New York as to which plaintiffs are "non-participating providers," meaning that plaintiffs "did not have an agreement with Aetna to accept discounted rates from Aetna for their services and did not agree to be bound by Aetna's reimbursement policies or rate schedules" (*id.* ¶ 2, 23-26). Here plaintiffs challenge the adequacy of the amount defendants allow in reimbursement ("Claims") for emergency medicine services provided by plaintiffs to patients covered by commercial and Exchange health plans underwritten, operated, and/or administered by Aetna (the "Health Plans") (*id.* ¶ 1). This litigation does not include either Medicare Advantage or managed Medicaid products (*id.* ¶ 2, n.1).

Plaintiffs allege that, by "assuming responsibility for paying for the emergency medical services provided to Aetna Patients covered by Health Plans, Aetna . . . has impliedly agreed, to

pay the reasonable value of those services, based on the standards established by New York law" (*id.* ¶ 28). Specifically, under New York law, Aetna is to compensate plaintiffs for no less than the "usual and customary cost" of emergency medicine services, which under NY FIN SERV § 603 (i), is "the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the [Department of Financial Services] superintendent." Plaintiffs allege that Aetna has been paying plaintiffs for the Non-Participating Claims at amounts "substantially and arbitrarily lower" than they are obligated to do under New York law, at rates that are "not reasonable, nor sufficient to compensate Plaintiffs for the emergency medical services provided to Patients" (*id.* ¶ 37). The only reimbursement claims at issue in this case are those that Aetna adjudicated as covered and allowed as payable by Aetna on or after January 1, 2013 at rates below both: (1) plaintiffs' billed charges; and (2) reasonable value of the Plaintiffs' services (the "Non-Participating Claims") (*id.* ¶ 2).[1] The complaint also expressly excludes any claims that meet the monetary threshold standards for dispute resolution by an independent dispute resolution entity ("IDRE") under NY FIN SERV § 602 (b) (1) (B) and (b) (3) (*i.e.* greater than the monetary threshold set by the superintendent under the Act, but less than 120% of the UCR) (*id.* at 2 n 2). Thus, plaintiffs state that the only claims at issue in this action are those for which plaintiffs have no administrative remedy under the Act.

Plaintiffs have asserted causes of action for (1) breach of an implied-in-fact contract, (2) unjust enrichment (breach of implied-in-law contract), and (3) a declaratory judgment that Aetna must pay plaintiffs the reasonable value for the Non-Participating Claims based upon the "usual and customary costs" as defined by NY FIN SERV §§ 601 *et seq.* Although plaintiffs embrace the standards defined in NY Fin Serv §§ 601*et seq*, plaintiffs allege that all "Non-Participating Claims at issue in this lawsuit are exempt from the Independent Dispute Resolution Entity (IDRE) process established by NY Fin. Serv. Law § 601 *et seq.*" (*id.* ¶ 30).

DISCUSSION

Whether Plaintiffs have a Private Right of Action

[1] The amended complaint emphasizes that this action concerns "only the ***rate of*** payment to which Plaintiffs are entitled and not their ***right to*** receive payment," which is to say that there are no claims arising out of the denial of benefits or coverage under any of the Health Plans (amended complaint ¶ 5).

Defendants contend all three of plaintiffs' causes of action improperly attempt to enforce the provisions of the New York Emergency Medical Services and Surprise Act (the "Act"), but the Act does not provide for a private right of action for providers who dispute the amount of reimbursement (NYSCEF Doc. No. 25 ["defs' mem"] at 6-8, citing NY FIN SERV § 605 [a] [2], [3]).

The primary case relied on by defendants is *Schlessinger v Valspar Corp.* (21 NY3d 166 [2013]), in which holders of a furniture protection plan asserted that General Business Law § 349, which bars enforcement of provisions in service agreements that allow servicers to terminate those agreements at their election under certain circumstances by simply refunding the premium, in lieu of servicing the furniture. Although this provision of the General Business Law provides no private right of action, plaintiffs sought to assert a breach of contract claim under the theory that defendant had breached the parties' contract by denying coverage under the barred, and thus ineffective, provision. After noting that plaintiffs' claim would not have existed absent the provisions in General Business Law § 395–a, the Court of Appeals rejected the claim, holding that "to accept [the] pleading as valid would invite a backdoor private cause of action to enforce the . . . Act in contradiction to our holding that no private right to enforce that statute exists" (*id.* at 171-172 [internal quotation marks and citation omitted]).

Defendants contend that same reasoning applies here. As defendants note (and plaintiffs concede), the Act does not provide for a private right of action, and as defendants contend, plaintiffs' claims would not exist without the Act since the Act itself is the sole source of Aetna's purported duty to pay the claims at the minimum rate asked for.

In opposition, plaintiffs primarily dispute defendants' claim that the causes of action would not exist without the Act. Citing to *Assured Guar. (UK) Ltd. v J.P. Morgan Inv. Mgt. Inc.* (18 NY3d 341 [2011]), plaintiffs note that, while a plaintiff may not assert claims that are "predicated solely on a violation of [an act without a private cause of action] and would not exist but for the statute," where preemption is not an issue, a plaintiff may bring "a common-law claim . . . that is not entirely dependent on [that act] for its viability" (NYSCEF Doc. No. 28 ["pls' mem"] at 14, quoting *Assured Guar.*, 18 NY3d at 353). Plaintiffs contend all three of their claims fall into the latter category on the basis that they seek to recover the "reasonable value" for plaintiffs' services. Accordingly, any references to the Act or the UCR serve simply as a measuring stick by which to determine that "reasonable value." (*Id.* at 7-9.) Thus, plaintiffs

contend they have pled independent causes of action that merely "import" a standard from the Act, as opposed to being predicated on the Act. In support, plaintiffs cite to several cases in which courts have upheld common-law claims that referenced statutory standards either, in the context of a negligence claim, as evidence of the duty of care (*Signature Health Ctr., LLC v State*, 28 Misc 3d 543 [Ct Cl 2010], *affd,* 92 AD3d 11 [3d Dept 2011] [noting that "[s]tatutes, even those that do not create a private right of action, play a role in establishing the reasonableness of an injured person's expectations and the scope of any duty owed by a defendant"]; *Loewy v Stuart Drug & Surgical Supply, Inc.*, Prod Liab Rep (CCH) P 15592 [SD NY Apr. 14, 1999] [aggregating similar cases]), or in the context of a breach of contract claim, because the contract itself expressly required one of the parties to adhere to the statutory standard (*Cox v NAP Const. Co., Inc.*, 10 NY3d 592 [2008] [contractors' agreements with the New York City Housing Authority required contractors to "pay to all laborers and mechanics employed in the Work not less than the wages prevailing in the locality of the Project, as predetermined by the Secretary of Labor of the United States pursuant to the Davis-Bacon Act"]). Other cases plaintiffs cite involved common-law claims which, in and of themselves, made no reference to statute and where the only issue was whether the related statute preempted those claims (*Assured Guar.*, 18 NY3d at 349; *Burns Jackson Miller Summit & Spitzer v Lindner*, 59 NY2d 314, 323 [1983]). Relying primarily on *Cox* (10 NY3d at 592) and *Assured Guar.* (18 NY3d at 353), plaintiffs also discuss at length why the Act does not preempt their claims (pls' mem at 9-14). As defendants note in their reply, however, defendants never argued that plaintiffs' claims are *preempted*, only that they are dependent on a statute that does not allow for a private right of action (*see* NYSCEF Doc. No. 39 ["reply"] at 1, 6).[2]

Analysis

Neither party disputes that a claim that is entirely dependent on the Act fails to state a cause of action. The only dispute is whether plaintiffs' causes of action are wholly dependent on the Act, and thus barred, or whether, as plaintiffs contend, the causes of action are independent common law claims that merely use the Act as a benchmark for an already existing duty. As stated in *Assured Guar.* (18 NY3d at 349), the viability of plaintiffs' claims turns on whether the

[2] Plaintiffs also state that the Court in *Cox* noted that, as is the case here, plaintiffs would be without relief if they did not have a private cause of action (pls' mem at 11, citing *Cox,* 10 NY3d at 605). However, *Cox* took note of this fact only to the extent it lessened the likelihood that the relevant statute was intended to preempt the causes of action in question.

"claim is predicated solely on a violation of the . . . Act or its implementing regulations and would not exist but for the statute" or whether the claim "is not entirely dependent on the . . . Act for its viability."

That a cause of action references or relies on an act without a private right of action is not in and of itself dispositive. A negligence cause of action, for example, may reference such a statute as evidence of the applicable standard of care since "[i]mporting the [statute's] standards in this way does not expand the universe of individuals to whom [the defendant] owes an obligation, it simply helps to define the scope of the duty owed to the individuals already entitled to some degree of protection" (*Loewy v Stuart Drug & Surgical Supply, Inc.*, Prod Liab Rep (CCH) P 15592 [SD NY Apr. 14, 1999]). Similarly, where parties form a contractual agreement to be bound by a standard set forth in such a statute, as was the case in *Cox*, a breach of contract claim based on the failure to abide by that statute is not "wholly dependent" on that statute. Rather, because the parties explicitly agreed to be bound by the standards set forth in that statute, the relevant duty comes from the parties' contract, rather than from the statute and may be enforced on a third party beneficiary. Thus, while the claims in question rely on these statutes, they would still exist without these statutes since, in both instances, the claims in question have independent sources of duty that are not found in the statutes. In short, whether a cause of action that relies on such a statute is viable turns on whether the statute defines an already existing duty, or whether the statute itself is the source of the duty.

In all three of plaintiffs' claims, the Act itself is the source of duty defendants purportedly breached. Plaintiffs' request for a declaratory judgment specifically seeks to bind defendants to the terms of the Act. Under plaintiffs' unjust enrichment claim, the failure to abide by the Act is the sole basis for the purported violation of equity and good conscience. With respect to plaintiffs' breach of contract claim, the sole basis for the implied "minimum" rate for which plaintiffs were to be compensated at is the existence of the Act. While in *Cox*, the plaintiffs relied on an express agreement to adhere to the standards set forth in the statute, in this case, the only alleged source of the implied duty is the the law itself. It should be noted that the same theory of an "implied in fact" contract would have been available in *Schlessinger*, and in any case in which a party is subject to a law that does not give rise to a private cause of action.

Plaintiffs' claim that their causes of action are in fact about the failure to provide "reasonable value," and that the Act is merely a borrowed benchmark, does not alter the analysis.

As used in the complaint, the term "reasonable value" is nothing more than a stand-in for the requirements of the Act. Put differently, there is no discernable difference between a claim that defendants breached by violating the Act (a non-viable cause of action) and plaintiffs' claim that defendants' breached by failing to provide "reasonable value." Accordingly, the complaint must be dismissed in its entirety.

The decision in *Health and Hospitals Corp. v Wellcare of New York*, 35 Misc 250 (Sup Ct NY County 2011) denying a motion to dismiss a cause of action for unjust enrichment asserted by a hospital seeking reimbursement for the cost of emergency services rendered to Medicare recipients is inapposite. At issue in *Cox*, but not here, was the mandate under the Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") for Medicare provider hospitals. The case does not involve, as here, private practice physicians performing services under contract with those hospitals (*see Emerus Hosp. v Health Care Serv. Corp.*, 2016 US Dist LEXIS 32580, at * 13-14 [ND Ill March 14, 2016] [holding EMTALA does not require private physician groups "to provide emergency medical care"]).

The court has considered the parties' remaining arguments and finds them to be academic given the above decision. It is hereby

ORDERED that the motion to dismiss is granted and the complaint is dismissed in its entirety; and it is further

ORDERED that the Clerk of the Court is directed to enter judgment accordingly with costs and disbursements to defendants as taxed by the Clerk of the Court upon presentation of a proper bill of costs.

This constitutes the decision and order of the court.

DATED: November 1, 2017

ENTER,

O. PETER SHERWOOD J.S.C.