UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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NEUROLOGICAL SURGERY, P.C.,

Plaintiff,

- against -

AETNA HEALTH INC. and AETNA HEALTH INSURANCE COMPANY OF NEW YORK,

Defendants.

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MEMORANDUM AND ORDER

2:19-cv-4817 (DRH) (ARL)

APPEARANCES

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HURLEY, Senior District Judge:

INTRODUCTION

Plaintiff Neurological Surgery P.C. ("Plaintiff") brought this action against Defendants Aetna Health Inc. and Aetna Health Insurance Company of New York (collectively "Aetna" or "Defendants") seeking payment, pursuant to the Employee

Retirement Income Security Act ("ERISA") and New York state law, for 200 medical claims for services performed on Aetna health plan members[1] alleging that Aetna has either underpaid or denied full payment on these claims. The claims[2] arise from medically necessary, complex procedures occurring over a four-year span (2012–2016) and implicating 145 different Aetna health plans. Presently before the Court is Aetna's motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6). [DE 21]. For the reasons set forth below, Aetna's motion is granted in part and denied in part.

BACKGROUND

I. Factual Background

Plaintiff is the largest private neurosurgery practice on Long Island and in the New York tri-state area. (Compl. ¶ 1). As a healthcare provider, Plaintiff treats patients with "complex, often emergent, neurological conditions requiring neurosurgical procedures and treatment." (*Id.* ¶ 15). These patients often have health insurance coverage with, or are members of, group health plans sponsored or administered by Aetna. (*Id.* ¶ 17).

Aetna is a health insurance company that creates "provider networks": a group of providers whom Aetna reimburses at pre-determined, contractual rates for services performed for Aetna members. (*Id.* ¶ 5). A provider in a "provider network" is "in-

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[1] The term "members" refers to individuals covered by fully-insured and self-funded Aetna health plans, including any such members, subscribers, or beneficiaries. (*See* Compl. ¶¶ 1, 19, 46).

[2] For the purposes of this Memorandum and Order, the term "claim" is not used synonymously with "cause of action," unless used in that manner in a quotation.

network"; otherwise, a provider is "out-of-network." (*Id.* ¶¶ 5–6). Aetna members may obtain treatment from out-of-network providers. (*Id.* ¶¶ 7, 19). When they do, however, Aetna reimburses at "the usual, customary, and reasonable charges for the services rendered, less any co-payment, co-insurance, member out-of-pocket, or deductible amounts" – the "UCR Rate." (*Id.* ¶¶ 8, 20). The precise reimbursement methodology is set out in each member's plan. (*Id.* ¶ 20).

Plaintiff is out-of-network with Aetna. (*Id.* ¶¶ 9, 23). Before Plaintiff performs medically necessary, complex procedures for Aetna members, the members authorize and assign Plaintiff their rights to receive payment directly from Aetna. (*Id.*). They do so, for example, by executing "assignment of benefits" forms. (*Id.* ¶ 24). With these authorizations and assignments, Plaintiff "engage[s Aetna] in communications or discussions" in order to open a "claim" for reimbursement at the rates in each Aetna member-patient's "applicable health plan." (*Id.* ¶¶ 25, 29, 31–33, 40). Aetna has allegedly failed to pay or, after delay, underpaid on 200 claims between 2012 and 2016. (*Id.* ¶¶ 37–39; *see, e.g.*, *id.* ¶¶ 44–2365). Plaintiff's attempts to collect any outstanding amounts fell "on deaf ears" and yielded "vague letters and promises of proper payment at some uncertain point in the future." (*Id.* ¶¶ 40–41).

The Complaint sets out the details of each claim in the following pattern: (i) the Aetna member's initials; (ii) the date of service; (iii) whether the services were emergency or elective, (iv) the nature of the services (*i.e.*, the diagnosis and procedure, generally); (v) the date on which the member assigned to Plaintiff all rights to receive reimbursement from Aetna for the services provided; (vi) the date on

which Plaintiff first billed Aetna, and the amount of the bill; (vii) the dates on which Plaintiff "communicated" with Aetna, if any; (viii) whether or not Aetna reimbursed Plaintiff, and the amount of reimbursement, if any; (ix) "the reimbursement methodology that Aetna should have applied in accordance with the terms of the applicable plan"; and (x) the dates and outcome of "additional, written appeals" to Aetna seeking further reimbursement, if any. (Compl. ¶¶ 44–2365; *see* Pl. Opp. at 4 [DE 23]). The abundance of details prevents the Court from reciting the particulars succinctly in the body of this Order, though they are important for the analysis below. Instead, the spreadsheet at Appendix A lays out each claim's pertinent facts.[3]

A few observations about the claims are worthy of note. Though Aetna members assigned their reimbursement rights for 198 of the 200 claims, Plaintiff does not reveal the terms of each assignment or attach the assignment contracts themselves. (Compl. ¶¶ 401–09, 491–503 (failing to allege assignment)). Plaintiff identifies a reimbursement methodology for most—but not all—of the claims. (*Compare id.* ¶¶ 53, 65, 77 (detailed methodologies), *with id.* ¶¶ 390–400, 401–09 (no methodology given)). A claim's reimbursement methodology is the only instance where Plaintiff relays the terms of the health plan at issue on that claim. While Plaintiff styles its communications with Aetna as "appeals . . . for additional payment" in which Aetna "[r]ecogniz[ed] [Plaintiff's] status as an assigned beneficiary," Plaintiff never specifies the context and content of these "numerous" communications.

[3] As they have minimal bearing on the Court's analysis, Appendix A does not devote columns to the information in (iii), (iv), and (v).

(*E.g.*, *id.* ¶¶ 51, 63). Plaintiff likewise omits the context and content of its "additional, written appeal[s]." (*E.g.*, *id.* ¶¶ 102, 114).

II. Procedural Background

Plaintiff originated this action in late July 2019 in Nassau County Supreme Court of the State of New York.[4] (Notice of Removal at 1 [DE 1]). Defendants removed this action to federal court on August 22, 2019. (*Id.*). Plaintiff filed its Complaint on August 30, 2019. [DE 5]. Plaintiff brings eight causes of action: (1) recovery of benefits due under an employee benefit plan, enforcement rights under the plan, and clarification of rights and future benefits under the plan, pursuant to ERISA, 29 U.S.C. § 1132; (2) an award of reasonable attorneys' fees and costs pursuant to ERISA, 29 U.S.C. § 1132(g)(1); (3) breach of contract; (4) breach of implied-in-fact contract; (5) unjust enrichment; (6) tortious interference with contract; (7) violation of the New York Prompt Pay Law, N.Y. Ins. Law § 3224-a; and (8) breach of third-party beneficiary contract. (Compl. ¶¶ 2366–432). The first two, as ERISA-based causes of action, are governed by federal law; the rest are governed by New York state law.

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[4] Defendants allege Plaintiff's present suit is the third time it brings an action "over the same subject matter." (Def. Mem. at 3). The first was *Neurological Surgery, P.C. v. Aetna Health Inc.*, No. 16-4524 (E.D.N.Y. 2016), voluntarily dismissed without prejudice via notice pursuant to a Federal Rule of Civil Procedure 41(a)(1)(A)(i). That action was commenced in state court via a summons with notice and then removed. No complaint was filed in that matter. The second was *Neurological Surgery, P.C. v. Aetna Health Inc.*, No. 18-2167 (E.D.N.Y. 2018), voluntarily dismissed without prejudice via stipulation pursuant to Federal Rule of Civil Procedure 41(a)(1)(A)(ii). Its docket includes the complaint at Exhibit D to the Notice of Removal.

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