UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Master File No. 00-1334-MD-MORENO
Tag-Along Case No. 05-23326-CIV-MORENO/TORRES

IN RE: MANAGED CARE LITIGATION
_____,

BLUE SPRINGS INTERNAL
MEDICINE, P.C., *et al.*,

Plaintiffs,

vs.

BLUE CROSS AND BLUE SHIELD
OF KANSAS CITY, *et al.*

Defendants.
_____/

ORDER ON DEFENDANTS' JOINT MOTION
TO DISMISS THE AMENDED COMPLAINT

This matter is before the Court upon Defendants' Joint Motion to Dismiss the Amended Complaint [D.E. 46], Plaintiffs' Memorandum in Opposition [D.E. 58], and Defendants' Reply [D.E. 61]. After careful consideration of the motion, response, reply, and relevant authority, and being otherwise fully advised in the premises, Defendants' Motion to Dismiss is Granted.[1]

[1] The pending motion is being adjudicated by Order for administrative reasons, but the entry of this Order does not preclude Plaintiffs from seeking *de novo* review from the District Judge if they file timely objections to this Order, in which case the Order shall be treated as a Report and Recommendation under S.D. Fla Mag.J. R. 4 and 28 U.S.C. § 636.

I. BACKGROUND

This action was originally a class action filed by Plaintiffs Steven Buie, M.D., a healthcare provider, and Hickman Mills Clinic in the Circuit Court of Jackson County, Missouri on February 17, 2005, against various insurers, on behalf of all licensed physicians and physician associations practicing in the State of Missouri. The complaint asserted five separate state law claims: quantum meruit, breach of contract, unjust enrichment, violation of Missouri "prompt pay" statutes, and violation of Mo. Rev. Stat. § 354.606. Plaintiffs amended their complaint on March 2, 2005 to include three additional state law claims of (1) negligent misrepresentation, (2) fraud, and (3) civil conspiracy.

Contending that Plaintiffs' claims were in reality federal claims (implicating the Employee Retirement Income Security Act ("ERISA") and the Federal Employees Health Benefits Act ("FEHBA")) masquerading as state law claims, Defendants removed the action to the United States District Court for the Western District of Missouri on June 9, 2005. Contemporaneously, Defendants requested a ruling by the Judicial Panel on Multidistrict Litigation ("JPML") that the claims be transferred to the Southern District of Florida based on identical or common questions pending in the cases consolidated in *In re Managed Care Litig*. Defendants sought to stay the matter while the JPML decided whether to transfer the case to Florida. The JPML ultimately granted Defendants' request that the case be transferred to this Court for inclusion in the centralized pretrial proceedings then currently underway before Judge Federico Moreno. The case was transferred to this Court on October 20, 2005.

Following transfer, Judge Moreno placed this action in the civil suspense file on December 20, 2005, with leave to restore it to the active docket upon a party's motion. After status hearings held in 2006 and 2007, the case was lifted from civil suspense and reopened on February 19, 2008. Subsequently, this Court issued a Report and Recommendation recommending denial of Plaintiffs' Motion to Remand, finding that, at minimum, some of Plaintiffs' claims are completely preempted by ERISA Section 502(a) and should be recast as federal claims pursuant to Act's enforcement scheme. [D.E. 80]. Judge Moreno adopted the findings and denied Plaintiffs' Motion to Remand. [D.E. 87].

The pending motion to dismiss[2] asserts that Plaintiffs failed to state a cause of action as to all nine counts. Defendants raise nine arguments to support this contention: (i) Plaintiffs' claims are "defensively" preempted pursuant to ERISA Section 514(a) because they relate to the manner in which an ERISA plan is administered [D.E. 46 at 5]; (ii) Plaintiffs' claims are "completely" preempted pursuant to ERISA Section 502(a) and should be properly recast as ERISA claims pursuant to the Act's enforcement provision [D.E. 46 at 8]; (iii) Plaintiffs' claims that relate to Federal Employee Health Benefits Act ("FEHBA") enrollees are preempted by 5 U.S.C. § 8902(m)(1) [D.E. 46 at 13]; (iv) Count V should be dismissed because injunctive and declaratory relief are remedies and not independent causes of action [D.E. 46 at 15];

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[2] On March 4th, 2009, we recommended granting Defendants' Motion to Compel Arbitration as to Defendants Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. [D.E. 89]. No timely objections to that Report and Recommendation were filed. Thus, the pending motion to dismiss does not pertain to these two Defendants against whom claims were stayed pending the final outcome of arbitration.

(v) quasi-contract claims of quantum meruit (Count I) and unjust enrichment (Count III) should be dismissed because Plaintiffs failed to allege that they have conferred any benefit directly on Defendants [D.E. 46 at 17-20]; (vi) Count IX conspiracy claim should be dismissed because Plaintiffs failed to allege facts identifying an illegal agreement between the Defendants [D.E. 46 at 20]; (vii) Count VI claim for "Providing Incentives to Provide Less than Medically Necessary Care" in violation of Mo. Rev. Stat. § 354.606 and Count IV claims, that arose prior to January 1, 2002, for violation of Missouri Prompt-Pay Statute should be dismissed because the Plaintiffs do not have a private right of actions under these statutes [D.E. 46 at 22-25]; (viii) Count IV claims, that arose after January 1, 2002, should be dismissed because these claims are preempted by ERISA [D.E. 46 at 26]; and (ix) Count VII negligent misrepresentation claim and Count VIII fraud claim should be dismissed because Plaintiffs have failed to plead facts in sufficient detail to comply with Fed. R. Civ. P. 8(a)(2) and 9(b) [D.E. 46 at 27-30].

Plaintiffs oppose the motion responding that: (i) none of the claims asserted in the Amended Complaint are subject to ERISA or FEBHA preemption because Plaintiffs have not sought the enforcement or interpretation of any particular patient's insurance policy and have not alleged the assignment of any patient's claims against the Defendants [D.E. 58 at 6-7]; (ii) quasi-contract claims of unjust enrichment and quantum meruit are sufficiently plead under applicable Missouri law [D.E. 58 at 16]; (iii) Plaintiffs may properly maintain claims under the Missouri Prompt-Pay statutes [D.E. 58 at 19]; (iv) the conspiracy, negligent misrepresentation, and fraud claims are

plead with sufficient particularity [D.E. 58 at 24-29]; (v) claim for declaratory and injunctive relief is available under Missouri law [D.E. 58 at 29-31].

Plaintiffs concede, however, that no express civil cause of action is prescribed under Mo. Rev. Stat. § 354.606. Therefore, Plaintiffs are voluntarily withdrawing Count VI of the Amended Complaint [D.E. 58 at 19].

II. ANALYSIS

The purpose of a motion brought pursuant to Fed. R. Civ. P. 12(b)(6) is to test the facial sufficiency of a complaint. The rule permits dismissal of a complaint that fails to state a claim upon which relief can be granted. It should be read alongside Fed. R. Civ. P. 8(a)(2), which requires "a short and plain statement of the claim showing that the pleader is entitled to relief." Pursuant to *Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1965 (2007), to survive a 12(b)(6) motion to dismiss, a complaint must contain factual allegations which are "enough to raise a right to relief above the speculative level, on the assumption that all the allegations in the complaint are true." Although a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, a plaintiff is still obligated to provide the "grounds" for his entitlement to relief, and "a formulaic recitation of the elements of a cause of action will not do." *Berry v. Budget Rent A Car Systems, Inc.*, 497 F. Supp. 2d 1361, 1364 (S.D. Fla. 2007) (quoting *Twombly*, 127 S. Ct. at 1964-65). Taking the facts as true, a court may grant a motion to dismiss if no construction of the factual allegations will support the cause of action. *Berry*, 497 F. Supp. 2d at 1364 (citing *Marshall Cty. Bd. of Educ. v. Marshall Cty. Gas Dist.*, 992 F.2d 1171, 1174 (11th Cir. 1993)). A well-

pleaded complaint will survive a motion to dismiss "even if it strikes a savvy judge that actual proof of these facts is improbable, and 'that a recovery is very remote and unlikely.'" *Twombly*, 127 S. Ct. at 1965 (internal citation omitted).

A. ERISA and FEHBA Preemption of State Law Claims

ERISA was enacted in order to create a consistent and coherent nationwide framework for regulating employee benefit plans. *See generally Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 99 (1983). Consequently, it expressly displaces or preempts, the application of state laws that bear a relation to the matters addressed in ERISA. It is now a clearly settled law that ERISA preemption comes in two varieties.

On one hand, Section 514(a) preemption, also called "defensive" or "conflict preemption," holds that ERISA "shall supersede any all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Defensive preemption applies broadly to any claim that "relates to" an ERISA plan, and may be pled as "an affirmative defense to state law claims." *In re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1288 (S.D. Fla. 2003) (citing *Butero v. Royal Maccabees Life Incs. Co.,* 174 F.3d 1207, 1211 (11th Cir. 1999)). Defensive preemption, however, does not have jurisdictional implications. In other words, it does not divest a state court of jurisdiction to hear any claim that "relates" to an ERISA plan and does not automatically give rise to federal subject matter jurisdiction warranting removal. *See id.*

On the other hand, Section 502(a) preemption, also called "complete" or "super-preemption," does have jurisdictional implications, but only applies to a narrow band

of ERISA claims. The ERISA statute creates exclusive federal jurisdiction (without regard to the diverse citizenship of the parties or the amount in controversy) over any civil action brought by an ERISA participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a), (e)-(f).

As with Section 502(a), FEHBA also completely preempts state law claims relating to health insurance plans. FEHBA was enacted to provide "a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive government-wide program of insurance for federal employees." *Botsford v. Blue Cross and Blue Shield of Montana, Inc.*, 314 F.3d 390, 394 (9th Cir. 2002) (internal citations omitted). With FEHBA's enactment, Congress also wished to achieve uniform administration of FEHBA plans. *Id.* at 395. Therefore, FEHBA "preempt[s] any State or local law . . . which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1); *see also Carter v. Blue Cross and Blue Shield of Fla., Inc.*, 61 F. Supp. 2d 1237, 1240 (N.D. Fla. 1999) ("Congress has recently resolved the issue of whether FEHBA completely preempts state law relating to health insurance plans by enacting the Federal Employees Health Care Protection Act of 1998 . . . which, *inter alia*, broadened FEHBA's preemption provision.").

B. Quasi-Contractual Claims (Counts I & III)

Counts I and III of the Amended Complaint assert state law claims for quantum meruit and unjust enrichment. These claims allegedly arise out of Defendants' practices associated with reimbursement for Plaintiffs' services provided to Defendants' insureds. *See, e.g.*, Amended Complaint ¶¶ 55-71 [D.E. 34]. The allegations in Count I concede that Plaintiffs have "provided medical services to patients insured by Defendants or Defendants' health plans, without entering a written contractual relationship with Defendants." *Id.* ¶ 101. Thus, because Plaintiffs lack an express contractual relationship with Defendants, they are, by definition, non-participating providers. *In re Managed Care Litig.*, 298 F. Supp. 2d at 1290. There are two distinct subclasses of non-participating providers lacking a contractual relationship: those with assignments from participants or beneficiaries (Provider Assignees) and those without them. *Id.*

In their response, Plaintiffs do not dispute that they possess assignments for benefits from the insured/patients under applicable ERISA plans. Instead, Plaintiffs contend that they do not seek to recover any benefits "based upon any type of 'assignment' from any patient/plan participant." *See* Plaintiffs' Response at 11 [D.E. 58]. They emphasize that the heart of the dispute lies in what is appropriate and required amount of payment due to Plaintiffs, not whether a right to payment exists under any Defendant insurers' benefit plan. *Id.* Thus, according to Plaintiffs, the claims are brought independent of any ERISA plan and the 502(a) preemption does not apply. We, however, disagree.

In order for state law claims to be subject to ERISA complete preemption, the following four elements must be present: (1) a relevant ERISA "plan;" (2) the plaintiff must have standing to sue; (3) the defendant must be an ERISA entity; and (4) the complaint must seek relief akin to what is available under 29 U.S.C. § 1132(a). *Butero*, 174 F.3d at 1212.

There appears to be no dispute that the first and third elements of the *Butero* test are satisfied here. Therefore, it is only necessary to examine whether Plaintiffs have standing to sue under ERISA and whether the complaint seeks relief "akin to" that which is available under ERISA's civil enforcement provision. These two elements are inextricably intertwined in the context of this case. As previously stated, Plaintiffs do not dispute that they have been assigned claims by ERISA participants, but deny the notion that they must rely on those assignments and pursue their claims under ERISA's civil enforcement provision. Thus, the question boils down to whether these purportedly independent claims seek relief akin to that available under ERISA. If they do not, then Plaintiffs do not have to rely on the derivative standing based upon its assignments to assert their state-law claims. If, on the other hand, Plaintiffs' claims do seek relief akin to the relief available under ERISA, then Plaintiffs are bound to exercise their mandatory derivative standing based upon their ERISA assignments.

The gist of Plaintiffs' quasi-contractual claims is Defendants' alleged underpayment for the services provided to Defendants' insureds. Therefore, it is clear that Plaintiffs are attempting to recover benefits due to them for the work provided.

ERISA provides an avenue for the provider/assignee "to recover benefits due to him under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Thus, because Plaintiffs possess assignments under ERISA plans, they have no choice but to pursue their claims under ERISA civil enforcement provision. *Rodriguez v. Health Options, Inc.*, No. 03-20429-CIV-MORENO, at 7 (S.D. Fla. Aug. 27, 2003) ("The Court finds that [Provider] Plaintiff, whether voluntarily or involuntarily, still retains derivative standing to sue under ERISA'[s] statutory scheme.").

The issue whether Defendants properly calculated the amount of reimbursement for a medical procedure under a given plan is clearly within the ERISA civil enforcement provision. Thus, Plaintiffs' quasi-contractual Count I and III claims asserted as non-participating providers[3] can only be pursued via ERISA. Plaintiffs, however, must exhaust available administrative remedies under their ERISA-governed plans before they are allowed to refile these claims in a federal court. *Byrd v. MacPapers, Inc.*, 961 F.2d 157, 160 (11th Cir. 1992).

Therefore, Counts I and III are dismissed without prejudice to the Plaintiffs filing an ERISA suit after exhausting administrative remedies, if they are unsuccessful with their administrative claims.[4]

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[3] Plaintiffs never disputed the assertion that they possess valid assignments under ERISA governed plans. Therefore, we addressed Plaintiffs' claims as claims by non-participating providers with valid assignments. Indeed, claims by non-participating non-assignee Providers are not preempted by ERISA. *In re Managed Care Litig.*, 298 F. Supp. 2d at 1293 ("The claims made by [non-participating providers who do not hold assignments] are not issues relating to the relationship between a beneficiary patient and the plant administrator . . . .")

[4] Because we find FEHBA's "complete" preemptive force to be similar to ERISA Section 502(a), claims for underpayment under FEHBA governed plans are also

C. Breach of Contract Claim (Count II)

Count II of the Amended Complaint alleges that "Defendants have breach their obligation to pay Plaintiffs and class members for medically necessary services in accordance with their contractual obligations." *See* Amended Complaint ¶ 106. ERISA does not preempt Plaintiffs from bringing breach of contract claim on contracts entered between Plaintiffs and Defendants directly, such as "fee-for-service" agreements or other provider contracts. *See In re Managed Care Litig.*, 298 F. Supp. 2d at 1290. Where Section 502(a) is meant to remedy the denial of ERISA benefits, it logically follows that providers, who are not among the parties entitled to bring an ERISA claim under that section, cannot be affected by this type of ERISA's preemptive force if they are merely filing suit for payment under the terms of their independent contracts. *Id.*

Similarly, Plaintiffs' breach of express contract claim is not preempted by Section 514(a). Section 514(a) preempts all state laws insofar as they "relate to" any employee benefit plan. 29 U.S.C. § 1144(a). A state law "relates to" a covered employee plan "if it has a connection with or reference to such a plan." *Dist. of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992).

State law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the Section 514(a). *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994). Thus, Plaintiffs may assert claims for breach of their independent contracts entered between them and

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preempted and need to be enforced via FEHBA's statutory scheme.

the Defendants without triggering Section 514(a) preemption. *See, e.g., In re Managed Care Litig.*, 135 F. Supp. 2d at 1268.

However, after close analysis of the factual allegations in the Amended Complaint, it is not clear whether Count II breach of contract claim is based on an express contract entered between the Provider Plaintiffs and the Insurer Defendants. As previously stated, claims asserted by non-participating providers who possess assignment of benefits from the insureds must pursue their claims via ERISA civil enforcement provision. *See supra* Subsection II.B. Therefore, Count II of the Amended Complaint is dismissed without prejudice. In an event Plaintiffs choose to refile their breach of contract claim, the complaint must clarify the type of express Plaintiff-Defendant contract that the claim is based on.

D. Missouri Prompt-Pay Statutes (Claim IV)

Count IV of the Amended Complaint alleges violations of Missouri Prompt-Pay Statutes Mo. Rev. Stat. § 376.383 *et seq*. Plaintiffs seek money damages for Defendants' alleged continuous violations of their statutory obligations to pay claims in a timely manner.

Under the Missouri Prompt Payment Act ("MPPA"), if an insurer fails to pay, deny, or suspend a claim within a specified amount fo time, a claimant is entitled to interest and penalties. Mo. Rev. Stat. § 376.383. A claimant is defined as "any individual, corporation, legal association, partnership or other legal entity asserting a right to payment . . . under a health benefit plan." Mo. Rev. Stat. § 376.383.1(1). Plaintiffs allege that they have "provided health care services to patients who are

entitled to benefits under Defendants' *healthcare plans*." *See* Amended Complaint ¶ 113 (emphasis added). Therefore, since the patients are entitled to payment under a given plan, Plaintiffs may maintain an action under the MPPA only if they possess assignments to these benefits from the patients.

"[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). Section 514(a) preemption, also called "defensive" or "conflict" preemption, holds that ERISA "shall supercede any all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The provision serves as a federal defense to a plaintiff's state law claims when those claims relate to an employee benefit plan governed by ERISA. Therefore, a state law having a "connection with or reference to" an ERISA-governed plan is preempted by Section 514(a). *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 322 (1997). The Eleventh Circuit stated that "[a] party's state law claim 'relates to' an ERISA benefit plan for purposes of ERISA preemption whenever the alleged conduct at issue is intertwined with the refusal to pay benefits." *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997).

The MMPA allows any individual, entitled to payment under a given plan, to bring a civil action and recover penalties if an insurance company does not pay claims in accordance with Missouri's standards. The Missouri's standards, however, do not

control the timing of insurance reimbursements under ERISA governed plans. Instead, insurer's obligation is governed by the terms of each individual plan. Thus, the MMPA claim is preempted by ERISA. *See Schoedinger v. United Healthcare of the Midwest*, No. 4:04-cv-664 SNL, 2006 WL 3803935, at *6 (E.D. Mo. Nov. 6, 2006) (finding MPPA preempted by ERISA because "[e]nforcing the Missouri statute at issue would alter a plan participant's actual obligations under his or her plan.").

Therefore, Count IV of the Amended Complaint is dismissed with prejudice. Because we recommend dismissal on ERISA preemption grounds, we need not address whether the statute provides an express private right of action after the 2002 amendments.

E. Claim for Injunctive and Declaratory Relief (Count V)

In Count V of the Amended Complaint, Plaintiffs state a claim for declaratory and injunctive relief. At the outset, it is important to note that an "injunctive relief" cannot be plead as a separate claim because it is not a cause of action but a form of relief. *Hames v. City of Miami*, 479 F. Supp. 2d 1276, 1280 n.3 (S.D. Fla. 2007). Therefore, the Court will interpret Count V of the Amended Complaint as one for declaratory judgment that seeks equitable remedy of an injunctive relief.

The claim is based on Chapter 527, Missouri Statutes, which is the state's version of the Declaratory Judgments Act. *See* Mo. Rev. Stat. § 527-010 *et seq*. The state statute is, however, a procedural mechanism within the Statutory Actions and Torts Articles, Title XXXVI, that confers subject matter jurisdiction on Missouri circuit courts. There is nothing in this particular statutory provision that confers any

substantive rights. Therefore, as this is a procedural statute, we cannot apply it to determine whether or not a declaratory action can lie. *See Manual v. Convergys Corp.*, 430 F.3d 1132, 1138 n.3 (11th Cir. 2005) (federal court had to apply the federal Declaratory Judgment Act rather than the state declaratory judgment act).

The "case or controversy" requirement of the Constitution is an important limitation on federal jurisdiction. U.S. Const., art. III, § 2. "To satisfy the case and controversy requirement of Article III, a plaintiff must have suffered some actual injury that can be remedied or redressed by a favorable judicial decision." *National Advertising Co. v. City of Ft. Lauderdale*, 934 F.2d 283, 285-86 (11th Cir. 1991). This requirement shields federal courts from being drawn into disputes as to abstract or hypothetical cases, or ones in which purely advisory opinions affecting a dispute are being sought. *E.g., Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 240 (1937); *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 5000 (1989).

As explained by the Eleventh Circuit:

> The plaintiff must allege facts from which the continuation of the dispute may be reasonably inferred. Additionally, the continuing controversy may not be conjectural, hypothetical, or contingent; it must be real and immediate, and create a definite, rather than speculative threat of future injury.

Emory v. Peeler, 756 F.2d 1547, 1551-52 (11th Cir. 1985). *Accord* 13A C. Wright & A. Miller, *Federal Practice & Procedure*, § 3532.1 at 114 (2d ed.) ("The central perception [of the justiciability doctrines] is that courts should not render decisions absent a genuine need to resolve a real dispute. Unnecessary decisions dissipate judicial energies better conserved for litigants who have a real need for official assistance.").

Similarly, the Declaratory Judgment Act, 28 U.S.C. § 2201, under which Count V of the Amended Complaint must be based, is a grant of jurisdiction only as to those rights and liabilities that are immediate and real, or that are certain to arise. *E.g., Calderon v. Ashmus*, 523 U.S. 740, 746-47 (1998) (no case or controversy where action seeks declaratory relief as to validity of defenses that may or may not be raised in subsequent litigation). A party seeking a declaratory judgment must allege facts in a complaint from which it appears that there is a substantial likelihood that it will suffer injury in the future. *Malowney v. Fed. Collection Deposit Group*, 193 F.3d 1342, 1346 (11th Cir. 1999) (citing *City of Los Angeles v. Lyons*, 461 U.S. 95, 102 (1983); *Cone Corp. v. Florida Dep't of Transp.*, 921 F.2d 1190, 1205 (11th Cir. 1991)).

After close analysis of the allegations found in Count V of the Amended Complaint, it is not clear what the declaratory judgment is based on. Phrased in a conclusory fashion, the allegations only recite reasons why Plaintiffs should be granted an equitable injunctive relief,[5] rather than a remedy at law. The allegations in Count V fail to describe the exact nature of the dispute that exists between the parties. Although the entire complaint, taken as a whole, describes certain substantive issues that could possibly be resolved with the aid of a declaratory judgment action, the Court is left guessing about Count V's precise substantive nature. Finally, Plaintiffs indicate in their response that the declaratory judgment count pertains to "their contractual claims for damages." *See* Plaintiffs' Response at 31. Thus, because we dismissed the

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[5] Irreparable harm, no adequate remedy at law, equities favor Plaintiffs, public interest. *See* Amended Complaint ¶¶ 118-122.

contractual claims, logic dictates that the declaratory judgment action should also be dismissed.

Therefore, Count V of the Amended Complaint is dismissed without prejudice.

F. Negligent Misrepresentation and Fraud Claims (Count VII & VIII)

Defendants move to dismiss both the negligent misrepresentation and fraud claims arguing that the allegations listed in Counts VII and VIII fail to comply with heightened pleading requirements of Fed. R. Civ. P. 9(b).

Contrary to Defendants assertion, these claims are not *per se* preempted by ERISA. Although it is unclear from the Amended Complaint if this is the case, Plaintiffs may maintain claims for negligent misrepresentation and fraud if those claims arose independently as a result of a direct relationship between Plaintiffs and Defendants. *See, e.g., Lordman,* 32 F.3d at 1533-34 (11th Cir. 1994) (plaintiff's state law claim for negligent misrepresentation, based on defendant's representation of coverage to plaintiff, not preempted by ERISA).

Rule 9(b)'s "particularity" requirement "serves an important purpose in fraud actions by alerting defendants to the precise misconduct with which they are charged and protecting defendants against spurious charges of immoral and fraudulent behavior." *Ziemba v. Cascade Intern., Inc.*, 256 F.3d 1194, 1202 (11th Cir. 2001); *see also Friedlander v. Nims*, 755 F.2d 810, 813, n.3 (11th Cir. 1985) (Rule 9(b) serves to "eliminate fraud actions in which all the facts are learned through discovery after the complaint is filed."). Generally, in order to comply with Rule 9(b), a complaint must allege the following four elements: (1) the precise statements, documents or

misrepresentations made; (2) the time and place of and persons responsible for the statement; (3) the content and manner in which the statements misled the plaintiff; and (4) what the defendants gained by the alleged fraud. *Ambrosia Coal & Const. Co. v. Pages Morales*, 482 F.3d 1309, 1316-17 (11th Cir. 2007). Finally, claims of negligent misrepresentation are subject to heightened pleading standard. *Souran v. Travelers Ins. Co.*, 982 F.2d 1497, 1551 (11th Cir. 1993) ("[A]ction for negligent misrepresentation sounds in fraud rather than negligence."); *Baily v. Janssen Pharmaceutica, Inc.*, No. 06-80702-CIV-RYSKAMP/VITUNAC, 2006 WL 3665417, at *7 (S.D. Fla. Nov. 14, 2006) ("Negligent misrepresentation, like fraud, must also be pled with specificity.").

Here, both claims are based on "representations surrounding coding practices, reimbursement rates, and payment schedules." *See* Amended Complaint ¶¶ 128, 136. Although Plaintiffs contend that they "relied on the understanding that they would be paid by . . . Defendants for medically necessary services and procedures according to the CPT codes," the Amended Complaint fails to describe a single instance of such alleged fraudulent statement on a part of any of the Defendants or their agents.

The allegations in the Amended Complaint clearly fail to satisfy the first two elements of the Rule 9(b) heightened pleading requirement. Specifically, the allegations do not precisely describe what statements were made in what documents or oral representations, as well as, the time and place of each such statement and the person responsible for making such statement. *United States ex rel. Clausen v. Lab. Corp. of America, Inc.*, 290 F.3d 1301, 1310 (11th Cir. 2002).

In support of their contention that the allegations in Counts VII and VIII are in compliance with Rule 9(b), Plaintiffs point to *In re Managed Care Litig.*, 298 F. Supp. 2d at 1278, where the Court acknowledged that, on previous occasion, allegations of "downcoding, CPT code manipulation, improper bundling and use of inappropriate criteria to deny or reduce claims satisfied Fed. R. Civ. P. 9(b) and thus properly pled against each Defendant predicate acts of mail and wire fraud constituting a continuing patter of racketeering activity." *In re Managed Care Litig.*, 298 F. Supp. 2d at 1278 (citing *In re Managed Care Litig.*, 135 F. Supp. 2d 1253, 1263 (S.D. Fla. 2001)). In that case, however, plaintiff's supplement to Civil RICO Statement contained "details including specific dates, persons, methods and the resulting harm" with regards to the alleged fraud. *In re Managed Care Litig.*, 135 F. Supp. 2d at 1263. The same is not true here. Therefore, Counts VII and VIII are also dismissed without prejudice.

H. Conspiracy Claim (Count IX)

Finally, in Count IX of the Amended Complaint, Plaintiffs assert a claim for civil conspiracy. Plaintiffs allege that Defendants conspired among themselves to systematically deny, delay and diminish payments to health care providers. *See* Amended Complaint ¶ 151.

Defendants move to dismiss the conspiracy claim arguing that the Amended Complaint fails to allege any specific details, such as th time, place, or persons involved, with respect to the alleged conspiratorial agreement among Defendants. Plaintiffs respond arguing that the ten instances of parallel conduct gives reasonable expectation that discovery will reveal evidence of illegal agreement.

The essence of a conspiracy claim is that each defendant has *agreed* to participate in an illegal conduct. Thus, the "proof of an agreement is at the heart of a conspiracy claim." *In re Managed Care Litig.*, 430 F. Supp. 2d 1336, 1345 (S.D. Fla. 2006). The Supreme Court's recent decision in *Twombly* adds new bite to federal conspiracy pleading requirements. The complaint in *Twombly* relied on allegations of the defendants' parallel behavior to infer conspiracy in an analogous antitrust case. The Supreme Court upheld the dismissal of the complaint stating that mere "conclusory allegations of agreement at some unidentified point does not supply facts adequate to show illegality." *Twombly*, 127 S. Ct. at 1966. The Supreme Court explained that "without that further circumstance pointing toward a meeting of the minds, an account of a defendant's commercial efforts stays in neutral territory." *Id.* The Supreme Court emphasized that the complaint "mentioned no specific time, place, or person involved in the alleged conspiracies" leaving defendants "little idea where to begin" in formulating their answers." *Id.* at 1970. n.10.

We thus turn to the Amended Complaint to determine whether Plaintiffs' allegations pass the *Twombly* test. The Amended Complaint describes a nationwide conspiracy that controls the managed care market in the state of Missouri. Although each Defendant is listed with sufficient specificity, the Plaintiffs fail to provide any specific factual allegations regarding exactly how and when Defendants *agreed* to "systematically deny, delay and diminish payments to health care providers." Indeed, all allegations regarding the agreement are conclusory or are based upon an inference from Defendants' parallel conduct:

- Each defendant, with knowledge and intent, *agreed* to the overall objective of the conspiracy and each defendant *agreed* to commit at least two predicate acts and each defendant verbally *agreed* to participate in the conspiracy.

- Moreover, the conspiracy was successful because each Defendant *agreed* to enact and utilize the same devices and fraudulent tactics to defraud the Class members.

- Numerous common facts and similar activities, which *imply* the existence of a conspiracy, exist among all the Defendants, ...

See Amended Complaint ¶¶ 92-94 (emphasis added). Clearly, these conclusory allegations and inferences from parallel conduct alone are insufficient to survive a 12(b)(6) motion. *Twombly*, 127 S. Ct. at 1966; *see, e.g., Solomon v. Blue Cross and Blue Shield Ass'n*, 574 F. Supp. 2d 1288, 1292 (S.D. Fla. 2008) ("*Twombly* makes clear that the allegations of parallel conduct do not suffice to infer conspiracy.").

The Supreme Court in *Twombly* concluded that allegations of parallel conduct must be placed in a "context that raises a suggestion of a preceding agreement, not merely parallel conduct that could just as well be independent action." *Twombly*, 127 S. Ct. at 1966. The Court added that because resisting competition is a "routine market conduct . . . there is no reason to infer that the companies had agreed among themselves to do what was only natural anyways." *Id.* at 1971. Similarly, even assuming, *arguendo*, that Defendants' actions amounted to fraudulent activities, these acts could still have been in each individual Defendant's economic self interest. *In re Managed Care Litig.*, 430 F. Supp. 2d at 1348. Indeed, the alleged claims processing in violation of CPT would have decreased costs and raise profits for Defendants. *Id.* Every Defendant undoubtedly had an economic interest in decreasing reimbursement

costs. *Id.* Thus, Defendants' allegedly parallel conduct can easily be explained by a theory of rational independent action. *See id.*

Therefore, because the Amended Complaint fails to allege exactly how and when Defendants agreed to commit the fraudulent acts, Count IX is dismissed without prejudice.

III. CONCLUSION

Based on the foregoing, Defendants' Motion to Dismiss [D.E. 46] is **GRANTED** in its entirety.

1. Counts I and III are dismissed **WITHOUT** prejudice to the Plaintiffs filing an ERISA suit after exhausting administrative remedies, if they are unsuccessful with their administrative claim.

2. Counts II, V, VII-IX are dismissed **WITHOUT** prejudice.

3. Per parties' stipulation, Count VI is dismissed **WITH** prejudice.

3. Count IV is dismissed **WITH** prejudice.

4. Although the ERISA claim that conferred the original jurisdiction upon this Court may be absent from the amended complaint, should Plaintiffs choose to file one, for the sake of the judicial economy the Court should exercise supplemental jurisdiction, for now, over the remaining claims.

Again, as stated in *supra* note 1, the Court is disposing of the pending motion by Order for administrative reasons. But in the event timely objections are made to the Order under Local Magistrate Rule 4(b), the District Judge shall treat those objections as ones seeking *de novo* review and treat this Order as a Report and

Recommendation. The Court notes as well that the failure to timely file objections shall bar the parties from attacking on appeal factual findings contained herein. *R.T.C. v. Hallmark Builders, Inc.*, 996 F.2d 1144, 1149 (11th Cir. 1993); *LaConte v. Dugger*, 847 F.2d 745, (11th Cir. 1988); *Nettles v. Wainwright*, 677 F.2d 404, 410 (5th Cir. Unit B 1982) (en banc); 28 U.S.C. § 636(b)(1).

DONE AND SUBMITTED in Chambers at Miami, Florida this 27th day of March, 2009.

/s/ Edwin G. Torres
EDWIN G. TORRES
United States Magistrate Judge