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APPROVAL OF THE APPELLATE DIVISION

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-6033-11T4

THE ASSOCIATION OF NEW JERSEY CHIROPRACTORS, INC., DR. MARK NAJAAR, DC, and DR. THOMAS BRUNO, DC,

Plaintiffs-Appellants,

v.

HORIZON HEALTHCARE SERVICES, INC., d/b/a HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC., and CARE CORE NATIONAL, LLC,

Defendants-Respondents.

Submitted March 19, 2013 - Decided November 4, 2013

Before Judges Ostrer, Kennedy and Mantineo.

On appeal from the Superior Court of New Jersey, Law Division, Somerset County, Docket No. L-215-12.

Law Office of Jeffrey Randolph, L.L.C., attorney for appellants (Jeffrey B. Randolph, on the briefs).

DLA Piper LLP (US), attorneys for respondent Horizon Blue Cross Blue Shield of New Jersey, Inc. and Greenberg Traurig, LLP, attorneys for respondent CareCore National, LLC (Andrew O. Bunn and David E. Sellinger, of counsel and on the joint brief; Kristin A. Pacio and Theodore McEvoy, on the joint brief).

The opinion of the court was delivered by

OSTRER, J.A.D.

This appeal involves a challenge to a "privileging policy" promulgated by Horizon Blue Cross Blue Shield of New Jersey (Horizon). The policy limited the kinds of diagnostic imaging services, including x-rays, that Horizon would reimburse if performed in an office setting by members of its participating provider network. Two chiropractors who are members of the Horizon network, and a non-profit association of chiropractors, challenged the policy. They alleged Horizon's privileging policy violates N.J.S.A. 17B:27-51.1, a 1975 law that requires group health policies to cover services performed by chiropractors if the services are also reimbursed when performed by other health care professionals. Plaintiffs also alleged a breach of contract and the covenant of good faith and fair dealing; and a violation of the monopolization provision of the New Jersey Antitrust Act, N.J.S.A. 56:9-4(a). Plaintiffs included as a defendant Care Core National, LLC (CCN), a benefit management firm that assisted Horizon in developing the privileging policy.

The trial court granted defendants summary judgment and dismissed plaintiffs' amended complaint with prejudice. Judge Yolanda Ciccone held that plaintiffs had no private right of action under N.J.S.A. 17B:27-51.1. Moreover, Horizon did not

violate the statute, because it governs group health insurance policies, not provider agreements, which the privileging policy amended. The court also found no breach of contract, as the provider agreement authorized Horizon to determine covered services. Finally, the court held that plaintiffs failed to allege sufficient facts to support their antitrust claims.

Having reviewed plaintiffs' arguments in light of the record and applicable law, we affirm in part, and remand in part.

I.

We comment first on the procedural setting of the trial court's order. In lieu of an answer, defendants filed a motion to dismiss plaintiffs' complaint pursuant to Rule 4:6-2(e). Aside from providing the court with various unpublished judicial and administrative decisions, defendants included with their motion only the referenced privileging policy and the participating provider agreements between Horizon and the two plaintiff-chiropractors, Mark Najaar, D.C., and Thomas Bruno, D.C.

Inclusion of documents referenced in a complaint does not convert a motion to dismiss into a motion for summary judgment. See Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) (stating that in evaluating a motion to dismiss, a court may

consider documents upon which the claim is based); N.J. Citizen Action, Inc. v. Cnty. of Bergen, 391 N.J. Super. 596, 605 (App. Div.) (stating that "consideration of the documents referred to in the complaint . . . does not convert defendants' R. 4:6-2(e) motions into motions for summary judgment"), certif. denied, 192 N.J. 597 (2007). Nonetheless, plaintiffs responded that defendants' motion should be deemed one for summary judgment, asserting the contracts and the unpublished authority constituted matters outside the pleadings. However, in opposing defendants' motion, plaintiffs did not present the court with any cognizable evidence. See R. 1:6-6 (discussing evidence on motions). They did file an amended pleading, which deleted a claim under the Unfair Claims Settlement Practices Act, N.J.S.A. 17B:30-13.1, and clarified that the association did not join in the contract claim. The trial court consequently treated defendants' motion as one for summary judgment.

Dr. Bruno and Dr. Najaar are participating Horizon chiropractors pursuant to participating provider agreements. Plaintiffs do not dispute that Dr. Bruno's provider agreement, originally entered into in 1983, required him to accept such rates for services as Horizon determined. Since 2005, pursuant to a specialty provider agreement, Dr. Bruno consented to abide by rules and procedures that would limit the types of services

he could provide for reimbursement, and Horizon could amend those rules and procedures at any time. The specialty provider agreement states:

> You [Dr. Bruno] warrant that You have reviewed the policies, rules and procedures of Horizon and Affiliates as set forth in the applicable provider manual that Horizon will provide to You which is incorporated herein by reference and made a part hereof. You acknowledge that such policies, rules and procedures may be revised from time to time . . . . You agree to participate in, cooperate with and comply with all applicable administrative policies, rules and procedures established or to be established by Horizon and Affiliates . . . . In addition, You acknowledge that Horizon or its designee shall have final authority to determine whether a service is a Covered Service . . . .
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> . . . .
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> You acknowledge that You shall not be paid under the following circumstances: . . . services You performed when you failed to comply with Horizon's or an Affiliate's policies, rules and procedures, including but not limited to services which Horizon's or an Affiliate's policies, rules and procedures require to be directed to other Participating Providers, even if You typically could have performed such services in Your office. You agree to accept an adjustment in Payment imposed in connection with any of Horizon's or an Affiliate's quality improvement, utilization management and provider incentive programs, and similar programs.

The record includes a less extensive agreement between Horizon and Dr. Najaar. He agreed to be a participating

provider, and to abide by Horizon's bylaws, rules and regulations. The agreement addresses payment rates for in-hospital services and other professional services. The agreement governed what he could charge "when [he] perform[ed] any professional services that are eligible under any of our contracts[.]"

First effective November 30, 2009, but revised as recently as December 22, 2010, Horizon's privileging policy on diagnostic imaging "designate[d] which imaging procedures are permitted in [a] Primary Care Physician[']s, Specialty Physician[']s and Other Health Care Professional's office by provider practice specialty." The policy describes the permitted imaging procedures, and identifies them by Current Procedural Terminology (CPT) codes.[1] The policy covers a range of provider specialties, including not only chiropractors, but also, among many others, primary care physicians, cardiologists, surgeons of various kinds, oncologists, obstetricians and gynecologists, orthopedists, podiatrists, and urologists. Within some specialties, the policy permitted certain diagnostic imaging

[1] Health care providers generally bill patients for services under CPT code designations. Each service has its own CPT code. See Am. Med. Ass'n, About CPT, http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page (last visited Oct. 30, 2013).

procedures only if the specialist possessed additional credentials, such as a board certification. The policy permitted chiropractors to perform "spine imaging," and referenced various spine-imaging CPT codes.

The policy stated, "Diagnostic imaging services that are not listed under the ordering physician's specialty must be referred to either a participating freestanding radiology site or a participating hospital outpatient setting." The policy advised participating providers, "[Y]ou must ensure compliance to [sic] the above mentioned policy as this could affect what radiology services you would be privileged to perform." The policy excluded certain Horizon "products," including programs for federal employees, Medigap, and Horizon NJ Health.

Plaintiffs asserted that limiting chiropractors to spinal imaging studies precluded them from performing various other imaging studies that they are licensed to perform, which includes "x-rays of the osseous system." N.J.A.C. 13:44E-1.1(d)(1) (2012).[2] They alleged the policy consequently barred them from performing studies that may be necessary to provide appropriate care. For example, plaintiffs objected that the policy did not permit chiropractors to perform x-rays of the

[2] The regulation was amended on January 7, 2013, to further expand the types of x-rays that chiropractors may perform. See 43 N.J.R. 3076(a), 3078 (Nov. 21, 2011).

shoulder. They noted that certain other specialists, such as orthopedists, and rheumatologists, were permitted under the policy to perform x-ray studies that chiropractors were not, such as x-rays of the lower extremities, pelvis, and ribs. Plaintiffs alleged that CCN assisted Horizon in developing the privileging policy.

In support of their antitrust claim, plaintiffs alleged Horizon provides health insurance to 3.6 million persons in New Jersey. They alleged Horizon (1) "has a dominant share of the health care insurance market both for fully-funded plans as well as self-funded plans" and (2) "has the market power to set artificially low reimbursement rates and to restrict the output and reimbursement of health care providers who participate with the Horizon plans[.]" Plaintiffs did not quantify Horizon's "dominant share," nor did they further define what they meant by "health insurance market" for fully funded and self-funded plans. Plaintiffs alleged that CCN acted in concert with Horizon and shared in Horizon's market power. Plaintiffs asserted, "Defendants[']actions aforesaid constitute specific, knowing, and intentional monopolization of, and attempt to monopolize, and/or a conspiracy to monopolize the relevant market for health insurance plans in the State of New Jersey . . . ."

II.

A.

Judge Ciccone correctly found that plaintiffs do not have a private right of action to enforce N.J.S.A. 17B:27-51.1. "A private cause of action is essential when the plaintiff seeks damages for injury or loss suffered as a consequence of another's violation of a statute or to compel another private party to comply with a statute." N.J. Dental Ass'n v. Metro. Life Ins. Co., 424 N.J. Super. 160, 165 (App. Div.), certif. denied, 210 N.J. 261 (2012).

The statute, adopted in 1975 governs contracts of group health insurance. The statute provides:

> Notwithstanding any provision of a policy or contract of group health insurance, hereafter delivered or issued for delivery in this State, whenever such a policy or contract provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, a person covered under such group health policy or contract or the chiropractor rendering such service shall be entitled to reimbursement for such service when the said service is performed by a chiropractor. The foregoing provision shall be liberally construed in favor of reimbursement of chiropractors.
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> [L. 1975, c. 125, § 1 (codified at N.J.S.A. 17B:27-51.1).]

A companion bill provided the same protection to persons insured under individual health policies. L. 1975, c. 111, § 1 (codified at N.J.S.A. 17B:26-2(f)).[3]

The statute does not expressly authorize private enforcement actions. Thus, plaintiffs' right of action depends upon our inferring it. However, our courts "have been reluctant to infer a statutory private right of action where the Legislature has not expressly provided for such action." R.J. Gaydos Ins. Agency v. Nat'l Consumer Ins. Co., 168 N.J. 255, 271 (2001). The Court has adopted a three-part test for determining whether a statute implies a private cause of action:

> To determine if a statute confers an implied private right of action, courts 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.
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> [Id. at 272.]

A court's primary mission is to determine legislative intent. Id. at 272-73.

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[3] A third bill proposed to amend the medical service corporation law to treat doctors of chiropractic as participating physicians. Assembly Bill 21, 196th Leg. (1974). The proposal was not adopted until 1977. L. 1977, c. 297, § 3 (codified at N.J.S.A. 17:48A-32).

Applying the three-part test, we find no implied private right of action vested in providers of chiropractic services. First, plaintiffs are not "member[s] of the class for whose special benefit the statute was enacted." Id. at 272. The legislation was designed to empower health care consumers, insured under group policies, to secure covered services from licensed chiropractors. See Statement to Assembly Bill 23, 196th Leg. (1975) ("The purpose of this bill is to provide the health care consumer who is insured by a group health policy with payment by the company issuing the health insurance policy, for medical services rendered to him by a licensed chiropractor within the scope of his license."); Statement to Assembly Bill 22, 196th Leg. (1975) (stating same purpose for legislation addressing individual policies); Public Hearing on Assembly Nos. 21, 22, and 23 Before the Senate Comm. on Labor, Indus. & Professions, 196th Leg., at 2 (1975) (statement of Joseph A. LeFante, Assemblyman) (according to the bill's sponsor, the purpose of bill was to "give the consumer, who elects to use chiropractic services, reimbursement for his expenditures").

Second, the legislation expressly applies to the terms of insurance contracts between insurers and an insured or group of insureds. The statute expressly entitles the consumers to reimbursement. It governs any "policy or contract of group

health insurance." N.J.S.A. 17B:27-51.1. The statute does not address the rights of providers, nor agreements between an insurer and providers. Moreover, neither in the brief statements accompanying the legislation, nor in the more extensive public hearing, did the sponsor or witnesses expressly address enforcement of the rights the legislation established. We note that N.J.S.A. 17B:27-51.1 is comparable to similar provisions the Legislature has adopted to assure health insurance consumers reimbursement for services received by psychologists, N.J.S.A. 17B:27-50; optometrists, N.J.S.A. 17B:27-51; and registered nurses, N.J.S.A. 17B:27-51.1a. In none of these enactments has the Legislature granted providers a private right of action, nor have our courts found one.

Third, plaintiffs have not demonstrated that it would be consistent with the "legislative scheme" to infer a private remedy, whether one focuses solely on the 1975 law, or considers the law in the context of the extensive statutory and regulatory framework governing group health insurance. As we have noted, there is nothing in the legislative history of the 1975 law that reflects an intention to endow chiropractors with a right of action.

Also, viewing the 1975 law in a wider context, the Department of Banking and Insurance (Department) exercises

extensive regulatory authority over group health insurance policy forms. See N.J.S.A. 17B:25-18.2, 27-49, 48E-13.2. Also, the Health Care Quality Act, N.J.S.A. 26:2S-1 to -25, and the implementing regulations, N.J.A.C. 11:24A-1.1 to -5.2, which include civil administrative enforcement provisions, constitute an extensive regulatory scheme governing preferred provider networks. It would create tension with the Department's extensive regulatory authority to permit providers to contest compliance with N.J.S.A. 17B:27-51.1 by way of a private civil action. Cf. R.J. Gaydos, supra, 168 N.J. at 275 ("Implied remedies are unlikely to be intended by a Legislature that enacts a comprehensive legislative scheme including an integrated system of procedures for enforcement." (citation omitted)).[4]

Nor do we discern any error in the trial court's decision to decline declaratory relief, an equitable remedy granted within the court's discretion. See In re Resolution of State Comm'n of Investigation, 108 N.J. 35, 46 (1987); see also State v. Eatontown Borough, 366 N.J. Super. 626, 637 (App. Div. 2004) ("Generally, it rests in the sound discretion of the trial court whether declaratory relief under the Act should be granted.").

[4] We do not address whether a consumer may seek relief in a private action based on rights established in N.J.S.A. 17B:27-51.1. That issue is not before us.

A declaratory judgment action may not be used as a substitute for an appeal. Ibid. Likewise, plaintiffs are not entitled to use the declaratory judgment as a substitute for a private right of action. Cf. In re Resolution of State Comm'n. of Investigation, supra, 108 N.J. at 46 (affirming the denial of declaratory judgment where, absent a private right of action, the court would be unable to grant affirmative relief); In re A.N., 430 N.J. Super. 235, 245-46 (App. Div. 2013) (holding that Chancery Division did not have jurisdiction under N.J.S.A. 2A:16-55 to make determination of Medicaid eligibility, a decision vested in the Division of Medical Assistance and Health Services).

Other jurisdictions have reached a similar conclusion that declaratory relief is unavailable when there is no private right of action. See Pono v. Molokai Ranch, Ltd., 194 P.3d 1126, 1148 (Haw. Ct. App. 2008) ("[I]n order for a private citizen to seek a declaratory judgment that a statute has been violated, the private citizen must, as a threshold matter, have a private right of action to enforce the statute."); Gore v. Ind. Ins. Co., 876 N.E.2d 156, 165-66 (Ill. App. Ct. 2007) (finding plaintiff lacked standing to bring declaratory judgment action because statute at issue did not confer private right of action); Nichols v. Kansas Political Action Comm., 11 P.3d 1134,

1146-47 (Kan. 2000) (refusing to grant declaratory relief under consumer fraud statute because it contained no private right of action); Bos. Med. Ctr. Corp. v. Sec'y of the Exec. Office of Health & Human Servs., 974 N.E.2d 1114, 1134 (Mass. 2012) (stating that a declaratory judgment "cannot be used to circumvent a legislative judgment" denying private right of action); Alliance for Metro. Stability v. Metro. Council, 671 N.W.2d 905, 916 (Minn. Ct. App. 2003) (stating that where "[t]here is no private right to enforce" statute, the "Uniform Declaratory Judgments Act cannot create a cause of action that does not otherwise exist").

We note as well that plaintiffs did not join in the action any consumers, in whose interests the 1975 law was enacted, and who would be most directly affected. See N.J.S.A. 2A:16-56 ("When declaratory relief is sought, all persons having . . . any interest which would be affected by the declaration shall be made parties to the proceeding."); Med. Soc'y of N.J. v. Amerihealth HMO, Inc., 376 N.J. Super. 48, 58-60 (App. Div. 2005).

In sum, the trial court correctly dismissed the count of the complaint alleging a violation of N.J.S.A. 17B:27-51.1, because the statute does not confer a private right of action.

B.

We also find no error in the court's dismissal with prejudice of Dr. Bruno's and Dr. Najaar's contract claims.[5] The two doctors allege that defendants' conduct — consisting of the adoption of the privileging policy — constitutes a breach of Horizon's provider agreements, as well as the covenant of good faith and fair dealing.

We begin with the doctors' claim that defendants breached the explicit terms of their contracts. Defendants sought dismissal on the grounds that Horizon expressly reserved the power in its provider agreement to adopt a policy like the one plaintiffs challenged, and the doctors failed to identify in their complaint the contractual duty that defendants allegedly breached. In opposition, the doctors did not identify the contractual duty that the privileging policy allegedly violated. Nor did the doctors cure the omission in their initial brief on appeal.

After defendants renewed their argument before us, the doctors in reply for the first time argued that implementation of the privileging policy constituted a breach of paragraph 9.4

[5] Plaintiff Association of New Jersey Chiropractors did not join in the contract count of the amended complaint.

of the provider agreement. The section requires the parties to abide by law, stating:

> This agreement shall be governed by the laws of the State of New Jersey. The invalidity or unenforceability of any term or conditions hereof shall in no way effect the validity or enforceability of any other term or provision. Both parties agree to comply with all applicable state, federal and local laws and regulations, and You agree to cooperate in compliance activities related thereto. This Agreement shall not impose any obligations upon You which require You to violate any law, statute, rule or regulation governing Your licensure.
>
> [(Emphasis added).]

The doctors essentially argue that this paragraph converts a violation of N.J.S.A. 17B:27-51.1 into a breach of contract.

We question whether the parties intended by this general provision — which is found only in Dr. Bruno's agreement — to create a right of action to seek relief pursuant to the 1975 statute that otherwise does not provide one. By the doctors' reading, paragraph 9.4 would grant them a right to seek relief in a breach of contract action under the Unfair Claims Settlement Practices Act, although it is well-settled that there is no private right of action under that statute. See Pierzga v. Ohio Cas. Group of Ins. Cos., 208 N.J. Super. 40, 47 (App. Div.), certif. denied, 104 N.J. 399 (1986). Moreover, one might argue that the contractual duty to "comply" with state law

includes the duty to observe the limitations on rights of action imposed by law.

However, we shall not resolve these issues relating to paragraph 9.4, as we decline to address an argument that was not raised before the trial court, and was raised for the first time before us in a reply brief. "Raising an issue for the first time in a reply brief is improper" because the trial court has not considered it and the parties have not "properly addressed" it. Borough of Berlin v. Remington & Vernick Eng'rs, 337 N.J. Super. 590, 596 (App. Div.), certif. denied, 168 N.J. 294 (2001); see also Nieder v. Royal Indem. Ins. Co., 62 N.J. 229, 234 (1973) ("It is a well-settled principle that our appellate courts will decline to consider questions or issues not properly presented to the trial court when an opportunity for such a presentation is available . . . .").

The court also did not err in dismissing the doctors' claim that defendants breached the implied covenant of good faith and fair dealing. The doctors generally asserted that "[d]efendants[']] conduct aforesaid constitutes . . . breach of the implied covenant . . . ." We may assume that the referenced conduct consisted of Horizon's implementation of the challenged privileging policy. However, on a motion for summary judgment, a plaintiff's conclusory allegations do not suffice. Brill v.

Guardian Life Ins. Co. of Am., 142 N.J. 520, 529 (1995). The doctors were obliged to demonstrate how Horizon acted in bad faith, or with malice, to deprive them of the intended fruits of their provider contracts. Where a contract vests a party with discretion, "an allegation of bad faith or unfair dealing should not be permitted to be advanced in the abstract and absent improper motive." Wilson v. Amerada Hess Corp., 168 N.J. 236, 251 (2001). "Without bad motive or intention, discretionary decisions that happen to result in economic disadvantage to the other party are of no legal significance." Ibid.

To support their position, plaintiff's rely on R.J. Gaydos, supra, in which the Court found that the plaintiff — an automobile insurance agency that claimed it was terminated in violation of the New Jersey Fair Automobile Insurance Reform Act (FAIRA), N.J.S.A. 17:33B-1 to -63 — could pursue a covenant of good faith and fair dealing claim notwithstanding that the plaintiff had no private right of action under FAIRA. 168 N.J. at 280-81. FAIRA generally required insurers to accept all applicants for coverage. Id. at 268-69. The plaintiff argued that the defendant insurer terminated its agency because, in compliance with the law, it wrote policies that resulted in unwelcome costs to the insurer. Id. at 261-65. The Court found that FAIRA created a standard for dealing, the violation of

which could constitute a breach of the implied covenant. Id. at 281-82. However, in keeping with the absence of a private right of action, the Court ordered the Law Division to remand the case to the Department to determine whether the defendant insurer violated FAIRA. Id. at 282. If the Department found on remand that the defendant violated FAIRA, then the plaintiff could pursue its common law claim of breach of the covenant in a civil action. Id. at 284.

However, we do not equate a violation of N.J.S.A. 17B:27-51.1 with a violation of the covenant of good faith and fair dealing implied in the doctors' provider agreements. In R.J. Gaydos, supra, the issue was whether FAIRA directly prohibited the agency's termination. FAIRA barred insurers from penalizing its agents because of the poor experience of the risks they accepted. 168 N.J. at 270 (discussing N.J.S.A. 17:33B-18b). By contrast, the connection between the statute here and claimed breach of the covenant is not as direct. N.J.S.A. 17B:27-51.1 governs the terms of group insurance contracts, not provider agreements. The privileging policy prohibits network chiropractors from obtaining reimbursement for certain imaging services in their offices. But, it does not deny coverage for group health insureds who obtain such services from out-of-network chiropractors.

Also, the challenged action in R.J. Gaydos was termination of the agency contract. That necessarily prevented the agent from enjoying "'the full fruits of [its] contract'" with the insurer. Supra, 168 N.J. at 277 (quoting Ass'n Grp. Life, Inc. v. Catholic War Veterans, 61 N.J. 150, 153 (1972)). No further allegations or proofs were needed to establish the loss of contract benefits. However, the privileging policy involves at most a limitation on the kinds of imaging studies a network provider may perform. On the other hand, membership in the network — and the incentives Horizon creates for utilization of network members — may create offsetting benefits in terms of increased patient volume and income. Plaintiffs have not presented any evidence that the privileging policy denies them the fruits of their contract.

Finally, regarding the doctors' contract claim against CCN, we add that plaintiffs' contract claim also lacked merit because the doctors have no contractual relationship with them, and CCN owed them no contractual duty. See Comly v. First Camden Nat'l Bank & Trust Co., 22 N.J. Misc. 123, 127 (Sup. Ct. 1944) ("[A]n action on a contract cannot be maintained against a person who is not a party to it."). Plaintiffs' claim that they are intended third-party beneficiaries of the contract between

Horizon and CCN lacks sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

C.

Finally, we affirm the trial court's dismissal of plaintiffs' monopolization claims under the New Jersey Antitrust Act. Plaintiffs allege defendants violated the monopolization provision of our state's antitrust act, N.J.S.A. 56:9-4(a), which makes it "unlawful for any person to monopolize, or attempt to monopolize, or to combine or conspire with any person or persons, to monopolize trade or commerce in any relevant market within this State."[6] Under this section, "[a] defendant is prohibited from using its monopoly power to gain a competitive advantage by destroying or eliminating its competitors." Patel v. Soriano, 369 N.J. Super. 192, 238-39 (App. Div.), certif. denied, 182 N.J. 141 (2004).

We discern several grounds for dismissal of plaintiffs' claim. While plaintiffs alleged Horizon insured 3.6 million persons, they failed to define the relevant market. Queen City Pizza v. Domino's Pizza, Inc., 124 F.3d, 430, 436 (3d Cir. 1997)

[6] The federal analog is Section 2 of the Sherman Act, which states, "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . . ." 15 U.S.C.A. § 2.

(stating failure to plead a proper relevant market is grounds for summary dismissal), cert. denied, 523 U.S. 1059, 118 S. Ct. 1385, 140 L. Ed. 2d 645 (1998). Nor did plaintiffs allege, let alone prove, that Horizon possesses sufficient market share to monopolize, or attempt to monopolize the market. See Patel, supra, 369 N.J. Super. at 239 ("The likelihood of achieving a monopoly is demonstrated through a market share sufficient to create a monopoly."). See also Acme Mkts., Inc. v. Wharton Hardware & Supply Corp., 890 F. Supp. 1230, 1241 (D.N.J. 1995) (recognizing threshold market shares for rejecting or presuming attempt to monopolize).

Plaintiffs also have not alleged, nor presented evidence sufficient to conclude that defendants have willfully acquired monopoly power, or have the specific intent to monopolize; essential elements of the claim. See, e.g., Urdinaran v. Aarons, 115 F. Supp. 2d 484, 491 (D.N.J. 2000) (quoting Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 481, 112 S. Ct. 2072, 2089, 119 L. Ed. 2d 265, 292-93 (1992)) (stating that to establish monopoly, plaintiff must show "'willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen or historic accident,'" and in order to show attempt or conspiracy to monopolize, a plaintiff

must show "specific intent"). However, a health insurer's "alleged use of market power to obtain discounts for its customers from health care providers does not constitute willful acquisition or maintenance of monopoly power for purposes of a Section 2 claim." Griffiths v. Blue Cross & Blue Shield of Ala., 147 F. Supp. 2d 1203, 1216 (N.D. Ala. 2001) (citing Austin v. Blue Cross & Blue Shield of Ala., 903 F.2d 1385, 1390 (11th Cir. 1990)); Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 931 (1st Cir. 1984), cert. denied, 471 U.S. 1029, 105 S. Ct. 2040, 85 L. Ed. 2d 322 (1985); Travelers Ins. Co. v. Blue Cross of W. Pa., 481 F.2d 80, 84 (3d Cir.), cert. denied, 414 U.S. 1093, 94 S. Ct. 724, 38 L. Ed. 2d 550 (1973).

Plaintiffs are not sellers of health insurance in competition with Horizon; rather, they are sellers of health care services reimbursed by Horizon. Although patients seek out plaintiffs' services, Horizon is effectively a purchaser. See Kartell, supra, 749 F.2d at 925-26. In Griffiths, supra, the plaintiffs alleged that Blue Cross and Blue Shield of Alabama (BCBSA) used its market strength by setting "'predatory and punitively low reimbursements'" and "eliminate[ed] coverage for certain services afforded by chiropractors while maintaining coverage for comparable services provided by physical therapists." 147 F. Supp. 2d at 1207-08. The plaintiff claimed

violations of Section 1 — restraint of trade — and Section 2 — monopolization — of the Sherman Act, 15 U.S.C.A. §§ 1, 2. The court granted BCBSA's motion to dismiss the Section 2 claim, although it denied its motion with respect to the Section 1 claim.[7] The court's reasoning regarding the plaintiff's monopolization claim applies with equal force here, and we quote it at length:

> Nonetheless, it is plain that nothing Plaintiffs claim that Blue Cross has done to chiropractors could be perceived as an attempt to create, preserve, or extend its alleged monopoly in the relevant market, as required to establish a Section 2 claim. Plaintiffs do not assert that they are actual or potential competitors with Blue Cross in the allegedly monopolized Alabama health care insurance market. Nor do Plaintiffs suggest either that Blue Cross is an actual or potential competitor in the health care provision market in which Plaintiffs and other chiropractors compete or that such market is in jeopardy of being monopolized by anyone. The Court can discern nothing in Blue Cross's alleged unfavorable treatment of chiropractors that could possibly be seen as excluding

[7] As plaintiffs here do not allege that Horizon has engaged in illegal restraint of trade under the analogous provision of our Antitrust Act, N.J.S.A. 56:9-3, we need not address the basis for the court's decision on Section 1. However, we note that the court recognized, "It is well established that an insurer such as Blue Cross, who in effect purchases health care services on behalf of its subscribers, does not violate Section 1 by using its market power to negotiate even sharply discounted fees that healthcare providers agree to accept as full payment for services." Griffiths, supra, 147 F. Supp. 2d at 1210 (surveying authority).

> competition in the relevant market. See Addino v. Genessee Valley Medical Care, Inc., 593 F. Supp. 892, 901 (W.D.N.Y. 1984) (holding that a plaintiff-podiatrist failed to state a claim in averring that an insurer with alleged monopoly power refused to deal with podiatrists unless they accept "arbitrarily" reduced reimbursement rates because the complaint failed to provide any logical link between the insurer's reduction of podiatric reimbursement rates and the insurer's retention or enhancement of its market power). As Professor Areeda has stated, "It requires a long stretch to call an individual refusal to deal 'monopolizing' when it does nothing to increase the refuser's monopoly power and nothing to increase his position in any market." P. Areeda, Antitrust Law § 736, at 274 (1978). . . . Indeed, it would appear that to the extent that Blue Cross has unilaterally limited the availability of benefits for chiropractic care, such would appear to create an opportunity for a competitor to increase its share of the Alabama insurance market by providing more comprehensive chiropractic coverage. See Kenneth L. Glazer, Abbot B. Lipsky, Jr., Unilateral Refusals to Deal Under Section 2 of the Sherman Act, 63 Antitrust L.J. 749, 783-84 (Spring 1995).
>
> [Griffiths, supra, 147 F. Supp. 2d at 1217-18.]

See also Westchester Radiological Assocs., P.C. v. Empire Blue Cross & Blue Shield, Inc., 707 F. Supp. 708, 715-16 (S.D.N.Y.) (granting summary judgment dismissing radiologists' claim that Blue Cross entity in New York violated Sherman Act Section 2 by using its market power to obtain radiologist services solely through hospitals, and "to extract low prices" because "[t]here

is no evidence that Blue Cross has interfered in any way with any competitor's ability to obtain similar terms from sellers"), aff'd o.b., 884 F.2d 707 (2d Cir. 1989), cert. denied, 493 U.S. 1095, 110 S. Ct. 1169, 107 L. Ed. 2d 1071 (1990).[8]

In sum, we affirm the trial court's decision dismissing plaintiffs' antitrust claims with prejudice.

D.

Lastly, we consider plaintiffs' request that we remand to the Commissioner their complaint regarding the alleged violation of N.J.S.A. 17B:27-51.1, if we find they lack a private action. Rule 1:13-4(a) provides, in pertinent part, that

> [I]f any court is without jurisdiction of the subject matter of an action or issue therein . . . it shall, on motion or on its own initiative, order the action, with the record and all papers on file, transferred to the proper court or administrative agency, if any, in the State. The action shall then be proceeded upon as if it had been originally commenced in that court or agency.

[8] Defendants do not argue, and therefore we do not address whether Horizon's challenged activities are exempt under the New Jersey Antitrust Act. See N.J.S.A. 56:9-5b(4) (exempting "the activities . . . of any insurer . . . to the extent such activities are subject to regulation by the Commissioner of Banking and Insurance"); N.J.S.A. 56:9-5b(5) (exempting "bona fide . . . charitable activities of any not for profit corporation . . . established exclusively for . . . charitable purposes); N.J.S.A. 56:9-5c (exempting "any activity directed, authorized or permitted by any law of this State" that conflicts with the New Jersey Antitrust Act).

[Ibid.]

We foresee no prejudice to Horizon, as it has insisted throughout the litigation that the proper forum for a complaint of a violation of N.J.S.A. 17B:27-51.1 is the Department. Defendants argue that the matter should not be remanded because the claim lacks substantive merit; they argue the statute applies to group insurance contracts and not provider agreements. The Commissioner, in the first instance, should address that argument. However, we see no basis to remand to the Commissioner plaintiffs' complaint against CCN, which is not in privity with plaintiffs.

Therefore, we conclude that, in the interests of justice and pursuant to Rule 1:13-4(a), count one of plaintiffs' complaint alleging a violation of N.J.S.A. 17B:27-51.1 by Horizon should be transferred to the Department of Banking and Insurance. We remand this matter to the Law Division for the limited purpose of entering a transfer order.

Affirmed in part, remanded in part.