

**Batas v Prudential Insurance Co. of America**

2004 NY Slip Op 30023(U)

September 8, 2004

Supreme Court, New York County

Docket Number:

Judge: Herman Cahn

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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: HERMAN CARR

PART 49

Justice

Musette Batas

INDEX NO. 107881 / 97

MOTION DATE 11/20/01

MOTION SEQ. NO. 006

MOTION CAL. NO. \_\_\_\_\_

- v -  
Prudential NS Co

The following papers, numbered 1 to \_\_\_\_\_ were read on this motion to/for \_\_\_\_\_

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...

Answering Affidavits — Exhibits \_\_\_\_\_

Replying Affidavits \_\_\_\_\_

PAPERS NUMBERED

Cross-Motion:  Yes  No

Upon the foregoing papers, it is ordered that this motion

**MOTION IS DECIDED IN ACCORDANCE WITH ACCOMPANYING MEMORANDUM DECISION IN MOTION SEQUENCE .....**

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE

Dated: 9/8/04

[Signature]  
J.S.C.

Check one:  FINAL DISPOSITION  NON-FINAL DISPOSITION

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NEW YORK: IAS PART 49

-----X

MUSETTE BATAS and NANCY T. VOGEL, on  
their own behalf and on behalf of all  
others similarly situated,

Plaintiffs,

-against-

Index No.  
107881/97

THE PRUDENTIAL INSURANCE COMPANY OF  
AMERICA and PRUDENTIAL HEALTH CARE  
PLAN OF NEW YORK, INC.,

Defendants.

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CAHN, J.,

Motion sequence numbers 006, 007 and 008 are consolidated  
for disposition.

In motion sequence 006, plaintiffs Musette Batas and Nancy  
T. Vogel, subscribers and/or participants in health care plans  
offered or administered by defendant Prudential Insurance Company  
of America, or its wholly-owned subsidiary, Prudential Health  
Care Plan of New York, Inc. (together Prudential), seek class  
certification of their claims for breach of contract, fraud and  
deceptive business practices. Vogel seeks certification of a  
separate subclass, comprised of participants in a self-funded  
employee benefit plan administered by Prudential, on an  
additional claim for tortious interference with contract.

In motion sequence 007 and 008, plaintiffs seek leave to  
file a second supplemental affidavit in support of their motion  
for class certification. Plaintiffs also seek sanctions for  
Prudential's allegedly materially false representations to the

court in connection with its opposition to plaintiffs' class-action motion.

#### **BACKGROUND**

The facts underlying the action were detailed in a May 20, 1999 decision, familiarity with which is presumed. Briefly, plaintiff Batas receives health care coverage through her husband's managed health care contract with a Prudential subsidiary. Plaintiff Vogel receives health care benefits through the Concordia Health Plan (CHP), a self-funded benefit plan provided by her employer, the Lutheran Church-Missouri Synod (the Synod), which is administered by Prudential.

#### **Plaintiffs' Claims:**

The complaint alleges that, through its subscriber contracts, Prudential promises to provide subscribers with all medical care that it "deem[s] to be medically necessary in accordance with the 'prevailing [medical] opinion within the appropriate specialty of the . . . medical profession'" (Complaint, at 2).<sup>1</sup> Plaintiffs argue that, at a minimum, these

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<sup>1</sup>Specifically, the Batas's subscriber agreement, alleged to be typical of all agreements in Prudential's health care plans, provides that Prudential will not provide coverage for a service, as being "needed and appropriately provided," unless the insurer determines that it meets the following requirements:

(a) It is furnished or authorized by a Participating Physician for the diagnosis or treatment of a Sickness or Injury or for the maintenance of good health.

(b) The prevailing opinion within the appropriate

subscriber contracts obligate Prudential to make a determination to deny care, as not medically necessary, only if the determination is made by an appropriately trained physician based on prevailing medical opinion, and relying on authoritative medical sources.

Plaintiffs contend that, the procedures and guidelines Prudential utilizes in making "medical necessity" determinations permit denials of care to be made by personnel who are not qualified to make such determinations, based upon medical guidelines, prepared by Milliman & Robertson (M&R), an actuarial company, which do not reflect generally accepted standards of

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medical specialty is that it is safe and effective for its intended use, and that its omission would adversely affect the patient's medical condition.

(c) It is furnished by a provider with appropriate training and facilities to furnish that particular service.

The agreement further provides that Prudential will determine whether such requirements have been met, based on the following:

Published reports in authoritative medical literature; Regulations, reports, publications or evaluations issued by governmental agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the Food and Drug Administration (FDA);

Listings in ...[certain] drug compendia ...; and

Other authoritative medical sources to the extent that [Prudential] determines them to be necessary.

(See, Prudential Appendix I: Batas Contract, at 18.)

medical care.<sup>2</sup> They allege that they were each denied promised care, based on medical necessity determinations that were made using these inadequate procedures and guidelines, in breach of their subscriber contracts.

Neither plaintiff claims to have suffered any adverse physical consequences or out-of-pocket expenses from Prudential's denial of care. Therefore, they seek only restitution of the premiums they paid and/or disgorgement of Prudential's profits. In addition, they seek compensatory and punitive damages for Prudential's alleged fraudulent misrepresentations regarding the material terms and conditions of the offered benefits, and treble damages, up to a maximum of \$1000 per class member, for Prudential's alleged violations of General Business Law §§ 349 and 350.

Vogel also seeks damages for Prudential's tortious interference with her health care contract with the Synod. She alleges that Prudential tortiously interfered with that contract by requiring the pre-authorization of treatment or a concurrent review of medical necessity, in circumstances where the policy provided that such decisions could be made by an in-network

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<sup>2</sup>Plaintiffs argue that Prudential has instituted and uses uniform procedures for implementing its health care contracts via its adoption of a "National Utilization Management Policy" (see, Hufford Revised Aff. Vol 1: Ex. 1), that allegedly outlines the procedures each plan must use in making medical necessity determinations.

primary care physician.

**Motion for Class Certification:**

Plaintiffs now seek certification of a nationwide class consisting of all subscribers to Prudential's health care plans. Plaintiffs contend that certification of a nationwide class is appropriate, on their breach of contract claim, as Prudential (1) uses the same, or substantially similar, contract language to define medical necessity in most, if not all, of its subscriber agreements nationwide, and (2) has adopted and utilizes uniform procedures and guidelines for determining whether proposed or ongoing medical care is medically necessary. In addition, they contend that all Prudential subscribers, and not just those who were denied promised care, should be included in the proposed class, as Prudential has failed to provide any of its subscribers with the type or quality of insurance for which they had contracted and paid. Instead, plaintiffs allege, Prudential provides its subscribers with a lesser level of benefits than promised in the contracts.

Plaintiffs argue that their claims of fraud and deceptive business practices are suitable for a nationwide class as well, although, for purposes of class certification, plaintiffs contend that it would be more appropriate for this court to apply New Jersey's common law of fraudulent inducement and its Consumer Fraud Act (CFA), in place of the originally pleaded New York

common-law fraud and GBL §§ 349 and 350 claims. Plaintiffs argue that substitution of the New Jersey claims is appropriate because each of these claims arise out of a common course of conduct, developed and implemented by Prudential from its headquarters in New Jersey. Thus, New Jersey will have the greater interest in seeing its laws applied.

Plaintiffs additionally argue that there is no prejudice to Prudential from such a substitution, because each of the proposed substitute claims arises out of the same operative facts, and will be proven by the same evidence, as the claims originally pleaded under New York law. They contend that, should the court permit the substitution, the complaint can simply be "deemed" amended to assert claims under New Jersey's CFA and common law.

Finally, plaintiffs argue that certification of a nationwide subclass, comprised of all participants in the CHP, is appropriate, since all participants in the CHP were covered by the same contract, and all were necessarily affected by Prudential's tortious interference with that contract, whether or not they were denied care or treatment. They argue that since they are only seeking minimal damages, i.e., restitution of premiums or disgorgement of profits, pursuing individual claims would be impracticable, and a class action is the superior method of adjudication.

Accordingly, in motion sequence 006, plaintiffs propose to

certify the following class:

All individuals who at any time between February 14, 1992 and the present were subscribers to healthcare plans insured or administered by the Prudential Insurance Company of America or one of its current or former healthcare subsidiaries to the extent such healthcare plans are exempt from the Employee Retirement Income Security Act of 1974 (ERISA).<sup>3</sup>

Plaintiffs also propose to certify the following subclass:

All individuals who at any time between July 1, 1993 and the present have been subscribers to the CHP, a self-funded health plan offered by the Lutheran Church-Missouri Synod, and whose healthcare plan has been administered by the Prudential Insurance Company of America or one of its current or former healthcare subsidiaries.<sup>4</sup>

In motion sequence numbers 007 and 008, plaintiffs seek leave to file further papers in support of their motion. They also seek sanctions against Prudential for allegedly making false representations to this court in opposing that motion. Specifically, plaintiffs allege that Prudential has attempted to mislead the court by making materially false representations regarding the existence and/or prevalence of variations in its various subscriber contracts, and in the procedures and

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<sup>3</sup>The February 14, 1992 starting date was chosen since it was the date on which Prudential entered into agreements to utilize the Milliman & Robertson guidelines. However, Batas allegedly did not become a subscriber in a Prudential plan until 1995; Vogel allegedly did not become covered under Prudential's point of service plan until January 1, 1994. Additionally, although the class is defined to include present subscribers, Prudential sold its managed care operations on August 6, 1999.

<sup>4</sup>The proposed starting date of July 1, 1993, represents the date of the Administrative Agreement between CHP and Prudential.

guidelines that it uses to make medical necessity determinations.

## **DISCUSSION**

### Motion Sequence Numbers 007 and 008

As Prudential does not oppose the motions to file further papers in support of the class-action motion, those aspects of the motions are granted.

The demand for sanctions is, however, denied. While the language contained in the relevant provisions found in many of Prudential's subscriber contracts may be similar, if not identical not all the contracts are the same. Even if those contracts were excluded from the case, it is not misleading to point out the differences, given that plaintiffs' class definition makes no distinction between contracts.

In addition, even if the language in the policies were identical, they may not necessarily be interpreted identically from state to state, due to the impact of differing state regulations and health care mandates on the interpretation of what constitutes medically necessary care. A state's health care mandates will necessarily be incorporated into, or grafted onto, the provider's health care contracts, affecting, at least to some degree, the determination of what constitutes medically necessary care. The resulting variations could be sufficiently material to justify denial of class certification, based on lack of uniformity. Therefore, even though the variations in many of the

subscriber contracts may appear minor, defendants' representations regarding the existence and prevalence of variations, as a whole, are not so misleading as to warrant the imposition of sanctions.

Motion Sequence Number 006 - for a Class Action Determination:

In determining whether an action should proceed as a class action, the court must consider whether the class is so numerous that joinder of all members is impracticable; whether common questions of law and fact predominate; whether plaintiffs' claims are typical of the class; whether plaintiffs will fairly and adequately protect the interests of the class; and whether a class action is the superior method for the fair and efficient adjudication of the controversy (see CPLR 901 [a]; Small v Lorillard Tobacco Co., 94 NY2d 43, 53 [1999]). If the above prerequisites are satisfied, the court must then consider the factors set out in CPLR 902: the possible interest of class members in maintaining separate actions and the feasibility thereof; the existence of pending litigation regarding the same controversy; the desirability of the proposed class forum; and, the difficulties likely to be encountered in the management of a class action (CPLR 902 [1]-[5]). Plaintiffs bear the burden of establishing that the prerequisites are met (Bettan v Geico Gen. Ins. Co., 296 AD2d 469 [2<sup>d</sup> Dept 2002]).

Prudential argues that class certification is not

[\* II] .

appropriate here. Plaintiffs seek relief on a novel breach of contract theory that would permit class members to recover damages without having to establish that they had ever been denied any benefit or coverage, and thus, that they had sustained any actual injury. Further, Prudential argues that class certification should be denied because plaintiffs' allegation, that Prudential uniformly adopted and applied the M&R guidelines without variation, is not sustainable in light of the evidence in the record. It additionally argues that variations in the definition of medical necessity among its various health plan contracts, coupled with differences in the applicable contract, regulations and statistics among the states, preclude certification of a nationwide class.

Prudential further argues that common issues of fact will not predominate over individual issues with respect to the various claims. Specifically, individualized issues of whether the M&R guidelines dictated the outcome of the medical necessity determination in any given case; whether the final medical necessity determination in any given case was made by a properly qualified person; and whether the denied care was medically necessary, all require individual determinations of fact.

In addition, Prudential contends that individualized issues will predominate with respect to the fraud claims, since there is no evidence that all class members were exposed to the same

information prior to joining a Prudential health plan. Therefore, individualized inquiry will be required to determine the materials on which each individual subscriber allegedly relied in becoming or remaining a Prudential subscriber.

Another argument advanced against class certification is that the named plaintiffs' claims are not typical, in that neither of the named plaintiffs sustained out-of-pocket expense or were exposed to specific misrepresentations alleged to have been made to induce individuals to become or remain subscribers. The lack of typicality indicates that a class action is not a superior method of adjudicating these claims.

Finally, Prudential opposes the application to substitute New Jersey claims for the New York claims. Prudential notes that both plaintiffs allegedly sustained injuries in New York, and argues that, under New York choice of law provisions, it is the law of the place of the tort that will generally govern.

**Rulings:**

Insofar as the proposed class includes all participants in, or subscribers to, Prudential's healthcare plans, regardless of whether these individuals were ever denied promised care or treatment based on the allegedly improper procedures and guidelines, the proposed class is overbroad. When the Appellate Division sustained this court's determination that plaintiffs' allegations stated a cause of action for breach of contract, it

did so on finding that, "[a]lthough plaintiffs sustained no out-of-pocket costs, actual injury is sufficiently alleged in the non-receipt of promised health care, for which restitution of premiums paid may be an appropriate remedy." Thus, at least with respect to plaintiffs' contract-based claims, the proposed class should be limited to only those subscribers or plan participants who were denied some promised care or coverage, and thus sustained some actual injury. This determination is in accord with those of other courts that have considered, and rejected, claims that would permit subscribers to recover damages, arising out of the alleged breach of a health care contract, without showing that they were actually denied some promised benefit (see e.g. Maio v Aetna, Inc., 221 F3d 472 [3<sup>d</sup> Cir 2000]; Doe v Blue Cross Blue Shield of Maryland, Inc., 173 F Supp 2d 398 [D Md 2001]; In re Managed Care Litig., 150 F Supp 2d 1330 [SD Fla 2001]; Eisen v Independence Blue Cross, 2002 WL 1803721 [Pa Comm Pl 2002]).

In the alternative, plaintiffs argue that if class members are required to have sustained some injury, the court should still certify a class comprised of those subscribers who were denied care or treatment based on medical necessity determinations that were made using the allegedly inadequate guidelines and procedures. Plaintiffs argue that this court could identify such class members, and certify a class, along

lines similar to those used in Selby v Principal Mut. Life Ins. Co. (197 FRD 48 [SD NY 2000]).

In Selby, plaintiffs had challenged their defendant insurer's "on-line" review process, in which a single diagnosis code was assigned to every insurance claim based solely on the first diagnosis listed on the claim form, even though the claim form may have listed several diagnoses in connection with a particular service or procedure. If that single assigned code fell within a plan's exclusion, the whole claim was automatically denied, without any effort to determine whether the other diagnoses might be covered. The Selby plaintiffs sought an injunction to require that the claims of all class members be reprocessed using multiple diagnosis codes, as well as restitution for any wrongfully denied claims.

The Selby court found that the class, as it was defined,<sup>5</sup> allowed the court to identify class members based on fact determinations already made and contained in the insurer's files; thus, the legal issue, whether the practice of eliminating and disregarding diagnoses in an insured's claim violated ERISA, predominated over individual issues, such as the specifics of a

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<sup>5</sup>The class was defined to include all plan participants and beneficiaries who were "denied benefits for reasons related to the diagnosis submitted by their physician where a single diagnosis was input by [the insurer] into its computer system even though the submitting physician submitted more than one diagnosis as the basis for payment of the claim" (Selby, at 55).

particular insured's policy or medical condition. The court found that, if it were to determine that the review process violated ERISA, then its decision would trigger the requested injunctive relief, which would require the reprocessing of all class members' claims, and would result in the automatic payment of many improperly denied claims, without further court action.

Plaintiffs argue that, similarly, Prudential's files could be used to identify those subscribers (a) who were subjected to the allegedly inadequate guidelines and procedures utilized by Prudential in making medical necessity determinations, and (b) whose coverage was denied, at least in part, based on the use of the M&R guidelines and/or the determination of a person who was not an appropriate clinical peer. Plaintiffs contend that, if the court later determined that the procedures and guidelines used to make these medical necessity determinations were, indeed, inadequate, the court could then award damages based simply on the use of these allegedly inadequate procedures, or, as in Selby, order Prudential to reprocess all of the class members' claims, and then award damages. Plaintiffs contend that since they are only challenging the process by which Prudential makes its medical necessity determinations, and not the medical necessity determinations themselves, it will not be necessary for this court to examine the individual medical condition of each class member, or to determine whether that individual was

entitled to additional care, before awarding damages.

Here, however, before the court can award damages based on the breach of a subscriber's contract, it must first determine that the subscriber sustained an actual injury, i.e., that the subscriber was denied promised care, which, under the terms of the policy, means all "medically necessary" care. Accordingly, it will not be sufficient for the court merely to determine that a medical necessity determination was inappropriately made; it must also determine that the care or treatment that was denied was promised, i.e., medically necessary care. Virtually all courts, addressing these kinds of issues, have held that such an inquiry is claim specific, and presents insufficient common issues for class-wide adjudication (see e.g. Selby, 197 FRD 48, supra; see also Doe v Blue Cross Blue Shield of Maryland, Inc., 173 F Supp 2d 398, supra; Pecere v Empire Blue Cross and Blue Shield, 194 FRD 66 [ED NY 2000]; Doe v Guardian Life Ins. Co. of Am., 145 FRD 466 [ND Ill 1992]; McDonald v The Prudential Ins. Co. of Am., 1999 WL 102796 [ND Ill 1999]).

In addition, unlike Selby, where reprocessing claims involved reviewing information that was already contained in a subscribers file, and resulted in the automatic payment of many claims, here, reprocessing of class members' claims would require that new medical necessity determinations be made in each case; damages could be awarded only if it were then determined that the

denied care had been medically necessary. Such individualized inquiry would clearly defeat the class action's goal of saving judicial time and resources (Mitchell v Barrios-Paoli, 253 AD2d 281 [1<sup>st</sup> Dept 1999]; Sirica v Cellular Tel. Co., 231 AD2d 470 [1<sup>st</sup> Dept 1996]).<sup>6</sup>

Further, the evidence submitted on this motion amply demonstrates that the process by which Prudential makes its medical necessity determinations, is not necessarily uniform. Although Prudential may predominantly rely on the M&R guidelines, the evidence shows that it does not rely exclusively on those guidelines. Additionally, although concurrent review nurses or other clinical reviewers may be involved in the first level of review, Prudential's utilization management policy, which plaintiffs have identified as governing the uniform procedures used in making medical necessity determinations, requires that a medical director or physician designee review all requests for medical services that a clinical reviewer is unable to approve. It appears that the claims of the named plaintiffs were reviewed

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<sup>6</sup>Plaintiffs are, of course, free to proceed with this claim on an individual basis.

The court notes that, while plaintiffs' challenge to the procedures and coverage criteria used by Prudential in arriving at its determination of a claim may have merit, a broad rule as to the procedures, etc. to be used, is better imposed by the Legislature or a properly authorized administrative agency. Both such groups have broad fact finding powers and policy making authority.

by such a physician. Plaintiffs argue that such review was still inadequate, as it was not made by the appropriate clinical peer. Here too, however, the determination as to whether any specific physician or medical director is the appropriate clinical peer will depend, largely, on the nature of the subscriber's medical condition, requiring individualized determinations.

**The CHP Subclass:**

The motion to certify a subclass, on its claim for tortious interference with contract, is granted. This sole claim turns on a common issue, whether Prudential was authorized to require preauthorization of treatment, or concurrent review of medical necessity, when such care or treatment had been sought through an in-network physician. Should this issue be resolved against Prudential, those subscribers who can establish that they were denied treatment or care under such circumstances, would arguably be entitled to recover, regardless of whether Prudential would have found such care to be medically necessary.

Additionally, issues arising out of variations in the applicable contract terms or state regulatory law are not present here, where it is undisputed that all participants in the CHP were covered by the same contract; that Prudential was retained to administer the CHP pursuant to a single agreement; and that both of these contracts are governed expressly by Missouri law.

Further, Prudential does not contend that the numerosity

requirement has not been met. Although the named plaintiff has made no claim for personal injuries or emotional distress, class members with such claims would be free to opt out and pursue such claims independently. Given that the individual damages sought on this claim are relatively small, a class action would be a most effective method of adjudicating these claims. The court does not agree with Prudential's contention, that soliciting the plan's Board of Managers to bring suit on behalf of plan members would necessarily be a superior method of adjudication.

Therefore, since plaintiffs have sufficiently met their burden of establishing the prerequisites for the subclass, the motion to certify will be granted as to this claim. However, membership in the subclass is limited to those participants in the CHP as of January 1, 1994 (the date when plaintiff Vogel's coverage commenced), who sustained some actual injury, i.e., who sought care or treatment through an in-network primary care physician, but were, nevertheless, denied care or treatment as a result of pre-authorization or concurrent review procedures conducted by Prudential.

Plaintiffs' motion to certify a class based on their common-law fraud and deceptive business practices claims is denied. Certification of each of these claims is not warranted, as plaintiffs have identified no materials or alleged misrepresentations to which all class members, including

plaintiffs, would have been exposed prior to deciding whether to become or remain Prudential subscribers.

Additionally, the court notes that certification of plaintiffs' common-law fraud claim would not be warranted, as this claim is based on the same misrepresentations, contained in their subscriber contracts, upon which plaintiffs base their breach of contract claim, and thus is largely duplicative thereof (Rockefeller Univ. v Tishman Constr. Corp. of N.Y., 240 AD2d 341 [1<sup>st</sup> Dept], lv denied 91 NY2d 803 [1997]). Moreover, reliance, which is required for common-law fraud, may not be presumed where, as here, a host of individual factors could have influenced a class member's decision to purchase coverage from a particular insurer (Hazelhurst v Brita Prods. Co., 295 AD2d 240 [1<sup>st</sup> Dept 2002]). In any event, even if these claims were tenable, because New York choice of law generally provides that the place of the tort governs actions for fraud, the law of the state in which each class member was defrauded or deceived would apply, making an efficient adjudication of these claims unlikely.

Plaintiffs did not seek to certify a nationwide class on the GBL §§ 349 and 350 claims; nor could they, as the statute protects consumers only in deceptive transactions that take place in New York State (see Goshen v The Mutual Life Ins. Co. of N.Y., 98 NY2d 314 [2002]).

Plaintiffs' request to certify a nationwide class under

New Jersey's Consumer Fraud Act would be denied in any event. Even if the claim had merit, plaintiffs have not convinced the court that substitution of this claim would not be prejudicial to Prudential since, according to plaintiffs (1) New Jersey's deceptive business practices statute has a six-year statute of limitations, significantly longer than the three-year statute of limitations for claims brought under New York's GBL, and (2) New Jersey's Consumer Fraud Act, unlike the GBL, applies to conduct occurring outside the state and allows mandatory treble damages to be pursued on a class-wide basis. Thus, Prudential potentially would be exposed to not only a greater number of claims, but increased damages. In addition, although the alleged deceptive misrepresentations, model guidelines, and claims review may have been promulgated, at least in part, in New Jersey, that State is not the place the alleged deception and injuries to subscribers would have occurred. Plaintiffs have failed to provide a sufficient legal basis on which the court could "deem" the New Jersey statute applicable to all subscribers, nationwide, rather than applying the law of the state in which the injury occurred.

To the extent that plaintiffs seek, in the alternative, certification of a more limited class, consisting only of New York subscribers, on their GBL claims, the motion would likewise be denied. Because, in their complaint, plaintiffs seek treble

damages in addition to actual damages, they are barred from maintaining this claim as a class action (see CPLR 901 [b]; Makastchian v Oxford Health Plans, Inc., 281 AD2d 197 [1<sup>st</sup> Dept 2001]; Ridge Meadows Homeowners' Assn., Inc. v Tara Dev. Co., 242 AD2d 947 [4<sup>th</sup> Dept 1997]). Even if plaintiffs were to strike that portion of the GBL claim seeking such relief, a claimant under GBL § 349 must still be able to prove that the challenged act or practice was consumer-oriented; that it was misleading in a material way; and that the plaintiff suffered injury as a result of the deceptive act (Stutman v Chemical Bank, 95 NY2d 24 [2000]). "[A] plaintiff must prove 'actual' injury to recover under the statute, though not necessarily pecuniary harm" (id. at 29).

As already indicated, any determination regarding the alleged non-receipt of promised care would require individualized inquiry. Additionally, to the extent that plaintiffs contend, in the alternative, that they could be entitled to reimbursement for their alleged "overpayment of premiums" based on Prudential's alleged misrepresentations and deception regarding the offered benefits (see Plaintiffs' Reply Memorandum, at 39), such a claim appears to constitute a collateral challenge to the reasonableness of the filed rate, thus implicating the "filed

rate doctrine."<sup>7</sup> Even if plaintiffs could remedy all of the other defects with respect to this claim, this issue would have to be addressed before certification could be considered.

Accordingly, it is

ORDERED that plaintiffs' motions for leave to file a second supplemental affidavit and supporting documents in further support of their motion for class certification (Mot. Seq. Nos. 007 and 008) are granted solely as to that relief, and the motion is otherwise denied.

Plaintiffs' motion for class certification (Mot. Seq. No. 006) is granted only as to the claim made on behalf of the proposed Concordia Health Plan subclass.

Vogel is found an adequate representative of the class. Her claims are typical of the class claims. Joinder of all members of the class is impractical. A class action is the superior method for the fair and efficient adjudication of the controversy.

The sub-class will be defined as follows:

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<sup>7</sup>As noted in this court's May 20, 1999 decision, the Filed Rate Doctrine forbids, inter alia, a party from recovering damages "when the measure of damages is determined by comparing the approved rate and the rate that allegedly would have been approved absent the wrongful conduct" (H.J. Inc. v Northwestern Bell Tel. Co., 954 F2d 485, 488 [8<sup>th</sup> Cir], cert denied 504 US 957 [1992]); Matter of Empire Blue Cross and Blue Shield Customer Litig., 164 Misc 2d 350 [Sup Ct, NY County 1994], affd Minihane v Weissman, 226 AD2d 152 [1<sup>st</sup> Dept 1996]).

All individuals who at any time between January 1, 1994 and the present have been subscribers to the CHP, a self-funded health plan offered by the Lutheran Church-Missouri Synod, whose healthcare plan has been administered by the Prudential Insurance Company of America or one is its current or former healthcare subsidiaries, who sought care or treatment through an in-network primary care physician, but were denied care or treatment solely as a result of the pre-authorization or concurrent review procedures conducted by Prudential.

Settle Order.

Dated: September 8, 2004

ENTER:

  
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J.S.C.