SHORT FORM ORDER

ORIGINAL

SUPREME COURT - STATE OF NEW YORK

Present:

HON. STEPHEN A. BUCARIA
Justice

TRIAL/IAS, PART 1
NASSAU COUNTY

JORDAN S. JOSEPHSON and JORDAN S. JOSEPHSON, M.D., P.C.,

Plaintiffs,

INDEX No. 0443/07

MOTION DATE: Aug. 8, 2014
Motion Sequence # 017, 018, 019, 020

-against-

OXFORD HEALTH INSURANCE, INC., OXFORD HEALTH PLANS (NY), INC. and OXFORD HEALTH PLANS LLC,

Defendants.

The following papers read on this motion:

Notice of Motion..... XXXX
Affirmation/Affidavit in Support..... XXXXXX
Affirmation in Opposition..... XXX
Affirmation in Further Support..... X
Reply Affirmation..... X
Memorandum of Law..... XXXX
Reply Memorandum of Law..... XX

Motion (sequence # 17) by defendants for summary judgment is **granted** in part and **denied** in part. Motion (sequence # 18) by defendants to strike plaintiffs' jury demand is **granted**. Motion (sequence # 19) by plaintiffs for leave to renew defendants' motion to dismiss the seventh cause of action is **granted** to the extent indicated below. Motion

(sequence # 20) by plaintiffs to strike certain of defendants' affidavits and exhibits is **denied**.

Plaintiff Dr. Jordan Josephson is an ear, nose, and throat physician with a specialty in endoscopic sinus surgery. Dr. Josephson practices as a professional corporation, plaintiff Jordan S. Josephson, MD, PC. Defendant Oxford Health Insurance, Inc. offers a variety of health insurance plans. These plans provide coverage by a "network" of health care providers, who perform services for a set fee, and partial reimbursement for services performed on an "out-of-network" basis. For out-of-network providers, the plans generally reimburse 70 or 80% of the amount which Oxford determines is the usual, customary, and reasonable rate for the service.

Although Dr. Josephson is not a member of Oxford's network of physicians, he provides treatment to patients covered by Oxford plans on an out-of-network basis. Dr. Josephson requests his Oxford patients to execute assignments of their rights to reimbursement under the policy as full or partial payment for his services.

According to Dr. Josephson, many patients who have not responded to antibiotic therapy and allergy intervention require functional endoscopic sinus surgery. Following the sinus surgery, Dr. Josephson typically performs a procedure known as a "debridgement" in order to ensure that the sinus cavity remains open.

Dr. Josephson alleges that beginning in the mid-1990's Oxford failed to reimburse him at usual and customary rates, and in some cases provided no reimbursement for his services. In particular, Oxford failed to reimburse Dr. Josephson for a great number of debridgement procedures on the ground that they were not medically necessary. Dr. Josephson further alleges that Oxford employees have made remarks to his patients, disparaging his competence as a physician and encouraging the patients to seek treatment from other health care providers.

This action was commenced on January 9, 2007 by filing a summons with notice. A verified complaint was filed on June 12, 2007. An amended verified complaint was filed around December 7, 2011, and a second amended verified complaint was filed around November 6, 2012.

By order dated April 18, 2013, the court dismissed for failure to state a cause of action plaintiffs' first cause of action for breach of an express contract, second cause of action for breach of an implied-in-fact contract, third cause of action for breach of the implied covenant

of good faith, sixth cause of action for misrepresentation, and seventh cause of action for violation of Insurance Law § 3224-a.

As to the fourth cause of action for unjust enrichment, the court denied defendants' motion to dismiss for failure to state a cause of action. In the absence of an actual agreement between Oxford and the out-of-network providers, an out-of-network provider could maintain an action for unjust enrichment (***IDT Corp. v Morgan Stanley***, 12 NY3d 132, 142 [2009]). However, the court granted defendants' motion to dismiss plaintiffs' unjust enrichment claim based on statute of limitations, except as to medical services performed within six years of the commencement of the action.

As to the fifth cause of action for tortious interference, the court granted defendants' motion to dismiss for failure to state a cause of action to the extent that it alleged a claim for tortious interference with Dr. Josephson's contractual relationships with his patients. However, the court denied defendants' motion to dismiss the fifth cause of action to the extent that it alleged a claim for tortious interference with Dr. Josephson's prospective economic relations with his patients. Dr. Josephson alleged that Oxford applied economic pressure directed toward his patients by threatening not to pay claims in full, unless the patients used another physician (***Carvel Corp v Noonan***, 3 NY3d 182, 191 [2004]).

As to plaintiffs' eighth cause of action based on the Employee Retirement Income Security Act, the court dismissed, based upon the six year statute of limitations, so much of the claim as was based upon health insurance claims filed by Dr. Josephson's professional corporation prior to January 9, 2001.

By order dated September 27, 2013, the court, on reargument, granted defendants' motion to dismiss so much of the eighth cause of action as was based upon claims filed by Dr. Josephson prior to January 9, 2001. The court determined that the statute of limitations was not tolled based upon Dr. Josephson's purported membership in a class action brought by the American Medical Association. The court further granted defendants' motion to dismiss plaintiffs' claim for tortious interference with Dr. Josephson's prospective economic relations with his patients to the extent it was based on conduct occurring prior to January 9, 2004.

Defendants move for summary judgment dismissing the balance of the second amended complaint. Defendants move to strike plaintiffs' jury demand. Plaintiffs move for leave to renew defendants' motion to dismiss the seventh cause of action, which is asserted

pursuant to New York Insurance Law § 3224-a (the "Prompt Pay Law"). Plaintiffs move to strike certain portions of defendants' affidavits and the accompanying exhibits.

Insurance Law § 3224-a establishes standards for prompt, fair, and equitable settlement of health insurance claims. The statute sets forth time frames within which an insurer must either pay the claim, notify the claimant of the reason for denying a claim, or request additional information. The court previously dismissed plaintiffs' seventh cause of action on the ground that there was no implied right of action under Insurance Law § 3224-a.

Plaintiffs move for leave to renew defendants' motion to dismiss plaintiffs' claim pursuant to Insurance Law § 3224-a based upon an intervening change in the law, a decision of the Appellate Division in ***Maimonides Med Ctr v First United Amer Life Ins. Co.***, 116 AD3d 207 [2d Dept 2014]). In ***Maimonides***, the court held that a private right of action for violation of the statute is to be implied. The ***Maimonides*** decision was issued March 5, 2014. Contrary to defendants' argument, plaintiffs' motion for leave to renew, which was made on June 25, 2014, is not untimely.

Alternatively, defendants argue that plaintiffs' claim pursuant to the Prompt Pay Law is preempted by ERISA. Section 514 of ERISA preempts state laws relating to employee benefit plans. Because state prompt pay laws relate to employee benefit plans they are preempted by ERISA (***America's Health Ins. Plans v Hudgens***, 742 F.3d 1319 [11th Cir. 2014]). The plan in ***Maimonides*** was a "governmental plan," providing supplemental Medicare coverage, which is exempt from ERISA (See **Smith v Regional Transit Auth**, 2014 U.S. App. LEXIS 11841 [5th Cir 2014]). Thus, New York is not preempted from applying its Prompt Pay statute to such claims. In the present case, defendants assert that 157 of the 165 Oxford members whose claims are at issue are covered by ERISA plans. Thus, any implied cause of action under Insurance Law § 3224-a for failure to pay claims for those 157 members promptly is preempted by the federal statute. Nevertheless, Dr. Josephson is not left without a remedy because he has asserted a claim pursuant to ERISA. As to the claims for the eight Oxford members who are not covered by ERISA plans, an implied cause of action for violation of Insurance Law § 3224-a is not preempted. Plaintiffs' motion for leave to renew defendants' motion to dismiss the seventh cause of action is **granted**. Upon renewal, defendants' motion to dismiss the seventh cause of action is **denied** as to those members not covered by ERISA plans.

Plaintiffs move to strike paragraphs 5-7 of the affidavit of Jacqueline Rivera, who is the manager of fraud, waste, and abuse operations for Optum, Inc., which is an affiliate of Oxford Health Insurance. Ms. Rivera asserts that Oxford did not give the insureds

permission to assign their claims to Dr. Josephson. Plaintiffs argue that those portions of Rivera's affidavit are contradicted by her deposition testimony.

Plaintiffs move to strike the affidavit of Maryann Britto, who is a legal case information analyst for United HealthGroup, Inc., another Oxford affiliate. Ms. Britto obtained documents concerning the types of plans in which various Oxford members were enrolled and the dates of service. Plaintiffs object to Ms. Britto's affidavit on the ground that she was not identified as a witness by Oxford and her deposition was never taken.

Finally, plaintiff's move to strike the affirmation of defendants' counsel, Peter McNamara, Esq., on the ground that it contains legal argument. Mr. McNamara's affirmation identifies the documents upon which defendants rely and summarizes defendants' factual claims and legal arguments.

As demonstrated below, it is irrelevant whether Oxford gave permission for the assignments. Moreover, any conflict between Ms. Rivera's affidavit and her deposition testimony merely raises an issue of fact (See ***6243 Jericho Realty Corp. v AutoZone, Inc.***, 27 AD3d 447 [2d Dept 2006]). Plaintiffs' motion to strike Ms. Rivera's affidavit and accompanying exhibits is **denied**.

In accordance with the liberal discovery policy of CPLR § 3101, Ms. Britto's identity as a witness should have been disclosed (***Rivera v Glen Oaks Village Owners, Inc.***, 41 AD3d 817 [2d Dept 2007]). However, because her testimony relates to the authentication of business records, plaintiffs have not been prejudiced by their lack of an opportunity to conduct Ms. Britto's deposition. Plaintiffs' motion to strike the affidavit of Maryann Britto and accompanying exhibits is **denied**.

Although an attorney's affirmation should not assert personal knowledge of facts in issue, it may serve as a vehicle for the submission of documentary evidence (***New York v Grecco***, 43 AD3d 397 [2d Dept 2007]). Plaintiffs' motion to strike the affirmation of Peter McNamara, Esq. and accompanying exhibits is **denied**.

Defendants move for summary judgment dismissing plaintiffs' claims pursuant to ERISA, as well as their claims for unjust enrichment and tortious interference with prospective business relations. Defendants argue that Dr. Josephson does not have standing to pursue an ERISA claim because Oxford did not give written consent for the benefits under the plans to be assigned. Alternatively, with respect to the ERISA claims, defendants argue that their benefit determinations were not arbitrary and capricious. Defendants argue that,

as to the 157 members covered by ERISA plans, plaintiffs claims for unjust enrichment and tortious interference are preempted.

ERISA § 502(a)(1)(b) provides that a civil action may be brought by a "participant or beneficiary" to recover benefits due under the terms of the plan. As a narrow exception to ERISA's standing requirements, healthcare providers who are assignees of beneficiaries have standing to assert ERISA claims (***Montefiore Med Ctr v Teamsters Local 272***, 642 F.3d 321 [2d Cir 2011]).

Defendants assert that virtually all of the ERISA members' certificates of coverage contain a provision that any benefits under the plan are not assignable by any member without Oxford's written consent. However, Gen Obligations Law § 13-101 in pertinent part provides that any claim or demand can be transferred, except where transfer is expressly forbidden by state or federal statute or would contravene public policy. The assignment of health-related insurance benefits is not against public policy (***Medical Soc. v Serio***, 100 NY2d 854, 871 [2003]). Thus, the prohibition on assignment contained in the ERISA plans is not binding upon Dr. Josephson. Accordingly, defendants' motion for summary judgment dismissing plaintiffs' ERISA claims for lack of standing is **denied**.

ERISA will preempt state law actions asserting a right to payment, that is an issue of coverage, as opposed to merely the amount of payment (***Montefiore Med. Ctr. v Teamsters Local 272***, 642 F.3d at 331). The present action involves Dr. Josephson's right to be paid for the abridgment procedure, as opposed to merely the amount of payment. Under ERISA, state law claims which are not based upon an independent duty are preempted (***North Shore LIJ v Teamsters***, 953 F. Supp.2d 419 [EDNY 2013]). The court concludes that plaintiff's claim for unjust enrichment is not based upon a duty independent of Oxford's duty to pay benefits pursuant to the ERISA plan. Accordingly, defendants' motion for summary judgment dismissing plaintiffs' claim for unjust enrichment is **granted** as to the services performed for the 157 members covered by ERISA plans. However, as to services performed for the eight members not covered by ERISA plans, there is no preemption. Accordingly, as to the eight members not covered by ERISA plans, defendants' motion for summary judgment dismissing plaintiffs' claim for unjust enrichment is **denied**.

Plaintiffs' claim for tortious interference with prospective economic relations is based on the duty to refrain from "culpable conduct," such as fraud, misrepresentation, or economic pressure (***Carvel Corp. v Noonan***, 3 NY3d 182, 191 [2004]). The court concludes that plaintiffs' claim for tortious interference is based upon a duty independent of the ERISA plan

and is not preempted. Defendants' motion for summary judgment dismissing plaintiffs' claim for tortious interference with prospective business relations is **denied**.

A denial of benefits challenged under ERISA § 502(a)(1)(b) is to be reviewed under a de novo standard, unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan (***Firestone Tire & Rubber Co. v Bruch***, 489 U.S. 101 [1989]). Often the entity that administers the plan, such as an employer or insurance company, both determines whether the employee is eligible and pays benefits out of its own pocket (***Metropolitan Life Ins. Co. v Glenn***, 554 U.S. 105 [2008]). This dual role creates a conflict of interest (Id). A reviewing court should consider the conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits (Id).

In the present case, Oxford both determines coverage for the sinus surgery procedures, including debridgement, and pays the claim out of its own pocket. Defendants have not established prima facie that the plan documents confer discretionary authority on Oxford to determine eligibility for benefits. Moreover, even assuming that Oxford had discretionary authority, in view of the inherent conflict of interest, Oxford has not established prima facie that it did not abuse its discretion in denying coverage for the debridgment procedures. Defendants' motion for summary judgment dismissing plaintiffs' ERISA claims is **denied**.

Cases involving ERISA benefits are inherently equitable in nature, not contractual (***DeFelice v Amer. Intn'l. Life Ins. Co.***, 112 F.3d 61, 64 [2d Cir 1997]). No right to jury trial attaches to such claims (Id). The joinder by plaintiff of legal and equitable claims arising from the same transaction results in a waiver of the right to trial by jury with respect to the legal claims (***Horizon Asset Management v Duffy***, 106 AD3d 594 [1st Dept 2013]). By joining their ERISA claim with their legal claims for breach of contract and tortious interference, plaintiffs waived their right to a jury trial with respect to the legal claims. Furthermore, having waived the right to a jury trial, plaintiffs have no right to a jury with respect to defendants' counterclaims. Defendants' motion to strike plaintiffs' jury demand is **granted**.

So ordered.

Dated AUG 2 6 2014

Stephen A. Bucaro
J.S.C.

ENTERED
AUG 28 2014
NASSAU COUNTY
COUNTY CLERK'S OFFICE

07-000443

NASSAU INDEX #_____
FILED

AUG 28 2014

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