Tirana v AXA Equitable Life Ins. Co.
2014 NY Slip Op 31769(U)
July 9, 2014
Sup Ct, NY County
Docket Number: 153109/2012
Judge: Ellen M. Coin
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 63

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BARDYL R. TIRANA,

Plaintiff,

Index No. 153109/2012
Motion Date: 2/26/2014
Sequence No.: 001

-against-

AXA EQUITABLE LIFE INSURANCE COMPANY,

Defendant.

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Appearances:

For Plaintiff:
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For Defendant:
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Papers	Papers Numbered
Notice of Motion-Affidavits-Memorandum of Law-Exhibits........................	1
Notice of Cross-motion and Answering Affidavits-Exhibits................................	2
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Ellen M. Coin, A.J.S.C.:

Plaintiff Bardyl R. Tirana moves pursuant to CPLR 3212 for summary judgment against defendant AXA Equitable Life Insurance Company. Plaintiff seeks a declaratory judgment, specific performance, an injunction, and statutory relief under General Business Law §349 and Insurance Law §2601, as well as monetary damages. Defendant cross-moves for summary judgment dismissing the complaint.

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This action arises out of defendant's alleged failure and refusal to perform its obligations under an individual lifetime medical insurance policy (the Policy). The dispute concerns the Policy's deductible provision, the Policy's "reasonable and customary charges" provision, and defendant's demands for "Explanation of Benefits" (EOBs) from Medicare.

Defendant first issued the Policy to plaintiff in October 1990. The Policy is lifetime renewable and covers both plaintiff and his wife. Plaintiff and his wife are now Medicare Parts A and B recipients, but have continued to elect to extend the Policy as additional insurance.

It is undisputed that the Policy provides for unlimited major medical benefits, subject to a deductible. The benefit percentage paid under the Policy is 80%, and after $2,500 of out-of-pocket expenses (which excludes the deductible amount) are incurred, the benefit percentage goes up to 100%. The Policy provides that covered charges will not exceed more than the "reasonable and customary" charges for the locality in which the services, supplies, and/or treatments are provided or rendered. In order to determine whether charges are "reasonable and customary," defendant uses the FAIR Health system database (the FAIR Health Database). Defendant alleges that the FAIR Health Database is approved by the New York State Attorney General and the New York State Insurance Department.

Plaintiff asserts that from 2009 to the present, he submitted claims for benefits in accordance with the terms of the Policy, but defendant failed to pay him the amounts due on the claims submitted. Specifically, plaintiff asserts that defendant wrongfully denied coverage to plaintiff and his wife based on defendant's misapplication of the Policy's "reasonable and customary" provision. Plaintiff submitted claims for Paul Pellicci, MD, David Blumenthal, MD, Gregory Lutz, MD, and Marc Friedman, MPST, all of whom were not covered by Medicare. Defendant denied coverage for substantial percentages of the fees for these professionals on the basis that the amounts exceeded the "reasonable and customary" allowance.

Plaintiff also asserts that from January 1, 2009 to the present, defendant failed to reimburse him for the amount of the basic deductible, even though Medicare paid more than $3,000 to plaintiff's providers during each of those years. Plaintiff also claims that in 2011, after defendant's move of its claims office to Texas, it began to wrongfully deny many of plaintiff's claims based on an absence of Medicare EOBs, which plaintiff argues are not required under the Policy.

Analysis

Summary judgment will be granted if it is clear that no triable issue of fact exists (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]). The burden is on the moving party to make a

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prima facie showing of entitlement to summary judgment as a matter of law (*Zuckerman v City of New York,* 49 NY2d 557, 562 [1980]). If a prima facie showing has been made, the burden shifts to the opposing party to produce evidentiary proof sufficient to establish the existence of a triable issue of fact (*Alvarez v Prospect Hosp.,* 68 NY2d at 324; *Zuckerman,* 49 NY2d at 562).

Breach of Contract

1. *Deductible Provision*

The Policy defines "Deductible Amount" as

> "the amount of covered charges that must be incurred in each calender year by a covered person (including a newborn child) before benefits are payable under this policy. The deductible amount is the greater of the basic deductible shown on page 3 [the basic deductible is $3,000] or the amount of benefits provided for covered charges by other medical expense coverage"

(notice of motion, exhibit D at 3B).

"Other Medical Expense Coverage" "means coverage furnished for hospital, surgical, or other medical expenses by [among others] Medicare" (*id.*). Plaintiff argues that this unambiguous language clearly provides that he will be reimbursed the amount of the basic deductible withheld during the calendar year if Medicare pays more than $3,000 of benefits for plaintiff and/or his wife's covered charges. The court disagrees.

"The interpretation of written contracts which are clear and explicit is a matter for the courts to resolve" (*Eden Music Corp.*

v *Times Sq. Music Publs. Co.*, 127 AD2d 161, 164 [1st Dept 1987] [citation omitted]). "A contract is unambiguous if the language it uses has a definite and precise meaning" (*Greenfield v Philles Records,Inc.*, 98 NY2d 562, 569 [2002] [internal quotation marks and citation omitted]). "[I]f the agreement on its face is reasonably susceptible of only one meaning, a court is not free to alter the contract to reflect its personal notions of fairness and equity" (*id.* at 569-570).

The language of the Policy's provision covering the deductible has a definite and precise meaning and is unambiguous. It reads that the Policy's deductible is the greater of two amounts: the basic deductible amount of $3,000 or the amount of benefits provided for covered charges by Medicare. Thus, if Medicare paid benefits of $4,000 for a particular calendar year, that would be the deductible amount. This provision merely creates two alternative methods of calculating the deductible amount. It does not, as plaintiff argues, provide for reimbursement of the deductible amount if Medicare paid more than $3,000 of benefits for plaintiff and/or his wife's covered charges. There is no requirement under the Policy providing for a reimbursement of the deductible. Therefore, so much of the breach of contract claim as is based on the failure to pay plaintiff the deductible amount is dismissed.

2. *Reasonable and Customary Charges Provision*

Plaintiff asserts that from January 2009 to the present, defendant has wrongfully denied coverage to plaintiff and his wife based on defendant's misapplication of the Policy's "reasonable and customary" provision. Plaintiff submitted claims for Paul Pellicci, MD, David Blumenthal, MD, Gregory Lutz, MD, and Marc Friedman, MPST, all of whom were not covered by Medicare. For each of these claims, defendant denied a substantial portion of coverage on the basis that the amounts exceeded the "reasonable and customary" allowance.

In regard to plaintiff's claims involving Dr. Pellicci, Dr. Blumenthal and Marc Friedman, plaintiff admits in his motion papers that after commencement of the litigation, defendant paid the full balance due under his claims. Thus, these claims are moot. However, a dispute still exists as to Dr. Lutz's charges, as well as to the processing of all future claims.

The Policy states that

> "[c]overed charges will not exceed the reasonable and customary charges for the services, supplies, and treatments in the locality in which they are provided or rendered"

(notice of motion, exhibit D at 3C).

The Policy further states that

> "[t]he terms charges, fees or expenses, as they relate to health care, will not include any amount, as determined by [defendant], ... for more than what is reasonable and customary in the locale where incurred. Reasonable and customary charges means the usual

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> charges for services, treatments, and supplies based on the following: 1. The nature and complexity of the services and treatments; 2. The usual charges made by other doctors, facilities, agencies, or institutions for similar services, supplies, or treatments in the same locale where incurred"

(*id.*).

Plaintiff argues that defendant is not adhering to the plain language of the "reasonable and customary" provision, because it is not itself determining the nature and complexity of the services and the charges for other doctors in the locale. Instead, defendant relies on an outside database (the Fair Health Database) to make such determinations without any assurance that this database accurately reflects the level of quality of medical services that plaintiff receives from his providers.

In support of its cross-motion defendant relies on an affidavit of Marguerite M. Fitzgerald,[1] a registered nurse, who works for defendant in the position of Individual Health Policy Manager. Nurse Fitzgerald alleges that "the FAIR Health is a not-for-profit entity which has been approved by the New York State Attorney General and the New York State Insurance Department. . . The FAIR Health database provides survey information regarding provider charges for specific services (CPT Codes) in a specific zip code area. . . [T]he FAIR Health database is designed to account for the nature and complexity of

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[1]The Court notes that the Fitzgerald affidavit, sworn to in North Carolina, lacks the certification required by CPLR §2309(c).

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the services provided. . .. [with] [r]elative values tak[ing]into account . . .[]the time intensity, level of skill and training required[]. . ." (Affidavit of Marguerite M. Fitzgerald, sworn to November 7, 2013, ¶s 8,9 at 4). Defendant offers no other material evidence regarding the FAIR Health Database.

Nurse Fitzgerald's affidavit is, without more, insufficient to establish propriety of the use of the FAIR Health Database to satisfy the "reasonable and customary" charge analysis pursuant to this individual policy contract. Defendant has not submitted any evidence regarding the methodology of data collection and analysis underlying the FAIR Health Database, as well as accuracy of data generation, with respect to the requirements of plaintiff's individual contract. As plaintiff's individual agreement is not part of a group policy or a network plan, defendant's obligation to establish the accuracy of the data generated by the FAIR Health Database cannot rest on such imprimatur as it may have received from the New York State Attorney General's Office. Accordingly, defendant has not established that the FAIR Health Database is appropriate for implementation with plaintiff's individual coverage agreement.

Further, defendant's attempt to explain the sharp discounting of plaintiff's providers' fees by suggesting that in prior years defendant did not implement the "reasonable and customary" charge clause is unpersuasive, as such speculation is

undocumented. Accordingly, existence of a material issue of fact as to the accuracy of the FAIR Health Database precludes the grant of summary judgment to either side.

3. *Medicare EOB Demands*

Plaintiff claims that in 2011, after defendant's move of its claims office to Texas, it began to wrongfully deny many of his claims based on an absence of Medicare EOBs. Plaintiff argues that submission of Medicare EOBs is not required under the Policy, and that by denying claims for a failure to submit EOBs, defendant breached the Policy.

While the Policy does not specifically provide for submission of Medicare EOBs, it does require that "proper written proof of loss" must be received before any payment of benefits will be made (notice of motion, exhibit D at 15).

Defendant has shown that the Medicare EOBs are a proper and necessary form of proof of loss, because they are used to determine its liability on the claim and its payment obligation, if any. Plaintiff has not made a valid showing as to why these documents would not be proper proof of loss besides his conclusory argument that defendant does not need this information. Defendant has not breached any obligations under the Policy by requiring Medicare EOBs as proof of loss and may request it in the future. Nothing in this decision shall imply that the policy requires plaintiff to seek services of medical

practitioners who accept Medicare. The Court only holds that when plaintiff does visit a Medicare provider, an EOB must be furnished to defendant.

Therefore, so much of plaintiff's breach of contract claim as is based on the defendant's demand for EOBs is dismissed.

Breach of the Covenant of Good Faith and Fair Dealing

"Implicit in all contracts is a covenant of good faith and fair dealing in the course of contract performance" (*Dalton v Educational Testing Serv.*, 87 NY2d 384, 389 [1995], citing *Van Valkenburgh, Nooger & Neville v Hayden Publ. Co.*, 30 NY2d 34, 45, cert denied 409 US 875 [1972]). "'[N]either party shall do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract' (*Kirke La Shelle Co. v The Paul Armstrong Co.*, 263 NY 79, 87 [1933])].

The covenant, however, does not create an obligation independent of, and in addition to, the ones contained in a contract, and is duplicative of the breach of contract claim if it is based on a breach of another substantive provision in the contract (*e.g. AJW Partners LLC v Itronics Inc.*, 68 AD3d 567,568 [1st Dept 2009]). Here, plaintiff's claim for breach of the implied covenant of good faith and fair dealing is based on the alleged failure to reimburse his medical expenses pursuant to the policy, and must thus be dismissed as duplicative.

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Anticipatory Breach of Contract

Plaintiff also argues that defendant maintained an untenable construction of the meaning of the Policy, repudiating the Policy. Plaintiff asserts that defendant has committed an anticipatory breach of the Policy. However, at issue in this action is not defendant's interpretation of the contract, but its performance thereunder. Accordingly, this cause of action is dismissed as duplicative as well.

General Business Law § 349

Plaintiff asserts that defendant has violated and continues to violate General Business Law § 349 by breaching its obligations under the Policy, using the FAIR database in determining "reasonable and customary" charges, misrepresenting facts and Policy provisions, not settling claims in good faith, and compelling plaintiff to institute this action.

General Business Law §349(a) prohibits any "[d]eceptive acts or practices in the conduct of any business, trade or commerce..." This statute is directed at wrongs against the consuming public (*see B.S.L. One Owners Corp. v Key Intl. Mfg. Inc.*, 225 AD2d 643, 644 [2d Dept 1996]). To establish a claim under this section, a plaintiff must show that the acts or practices are consumer oriented (*see Sheth v New York Life Ins. Co.*, 273 AD2d 72, 73 [1st Dept 2000]) and are deceptive or misleading in a material way (*Zurakov v Register.Com, Inc.*, 304

AD2d 176, 180 [1st Dept 2003]). In order for conduct to be considered consumer oriented, the conduct must have a broad impact on consumers at large (*see New York Univ. v Continental Ins. Co.*, 87 NY2d 308, 320 [1995]).

Plaintiff has not established conduct that had a broad impact on consumers at large. All of plaintiff's claims involve the individual contract between plaintiff and defendant, not group health coverage. "Private contract disputes [do] not fall within the ambit of the statute" (*Oswego Laborers' Local 214 Pension Fund v Marine Midland Bank,* 85 NY2d 20, 25 [1995]).

Further, plaintiff's submissions are devoid of proof of deceptive conduct or misleading conduct. While defendant's use of the FAIR Database might not meet its contractual obligations to plaintiff, it does not naturally result in an inference of deception. This claim is thus dismissed.

<u>Insurance Law § 2601</u>

Insurance Law § 2601 prohibits insurers from engaging in unfair claim settlement practices. New York, however, does not recognize a private cause of action under this section (*Rocanova v Equitable Life Assur. Socy.* of U.S., 83 NY2d 603, 614 [1994]). Although plaintiff has not included this claim in any version of his pleading and mentions Section 2601 only in his memorandum of law, the Court would have dismissed it had it been properly

brought.

In accordance with the foregoing, it is hereby

ORDERED that plaintiff Bardyl R. Tirana's motion for summary judgment is denied; and it is further

ORDERED that AXA Equitable Life Insurance Company's cross-motion for summary judgment is granted to the extent that (1) so much of plaintiff's claim for breach of contract as is predicated on (a) failure to pay him the deductible amounts and (b) denial of claims for failure to to submit Medicare Explanation of Benefits is dismissed; (2) plaintiff's claim for breach of the implied covenant of good faith and fair dealing is dismissed, (3) plaintiff's claim for anticipatory breach of contract is dismissed; (4) plaintiff's claim for violation of General Business Law §349 is dismissed; (5) plaintiff's claim pursuant to Insurance Law §2601 is dismissed; and the cross-motion is otherwise denied.

Dated: July 9, 2014

ENTER:

Ellen M. Coin, A.J.S.C.