2003 WL 27381731 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Essex County

SUTTER,
v.
HORIZON BLUE CROSS/BLUE SHIELD OF NJ.

No. L-3685-02.
February 13, 2003.

Trial Order

Epstein, Becker & Green, PC, Two Gateway Center, 12th Floor, Newark, NJ 07102-5003.

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James S. Rothschild, Jr., Judge.

***1** Dear Counsel:

The Court has before it motions by defendant to dismiss and by plaintiff for class certification. To put these matters into perspective, a very brief recitation of facts is necessary.

I. *FACTS*

John Ivan Sutter, M.D., P.A. individually, and on behalf of all others similarly situated, sued defendants Horizon Blue Cross Blue Shield of New Jersey, Inc. ("Horizon"), Cigna Health Care of New Jersey, Inc., CIGNA Corp., United Health Care of New Jersey, United Health Care Insurance Co., Oxford Health Plans Inc. and Health Net of the Northeast Inc.. Dr. Sutter brings the action on behalf of "Sub-Classes", defined as all New Jersey health care providers who rendered or have rendered medical services for patients that are members of health care plans sponsored by the defendants. Dr. Sutter defines "providers" to include "individual physicians, medical practices, hospitals and related entities" (Amended Complaint ¶ 4.)

There are seven Counts in the Amended Complaint. The First Count reads in breach of contract. The Second alleges breach of the implied duty of good faith and fair dealing. The Third Count is based on statutory violations of New Jersey's Prompt Payment Act and Health Care Information Networks and Technologies Act ("HINT Act"). (The Prompt Payment Act and the HINT Act are, jointly, referred to as the prompt payment laws.) The Fourth Count is for reformation. The Fifth Count alleges statutory violations of the New Jersey Consumer Fraud Act. The Sixth Count pleads unjust enrichment, and the Seventh Count pleads conversion. In a previous decision of this Court, the Seventh Count, with little objection from the plaintiff, was dismissed.

The relevant section of the HINT Act, N.J.S.A. 17B:26-9.1, reads in pertinent part:
(6) Payment of an eligible claim … shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day … following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event the payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day … for claims submitted by electronic means and the 40th calendar day for claims submitted by other than

electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

The relevant section of the Prompt Payment Act, N.J.S.A. 17B:30-32, reads as follows:
a. Payment of a capitation payment to a health care provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if, the health care provider is not in violation of the terms of the contract; and the health care provider has supplied such information to the insurer as may be required under the contract before payment is to be made.

***2** b. An overdue payment shall bear simple interest at the rate of 10% per annum.

The most concise explanation of the specific practices Dr. Sutter complains of is contained at page 5 of Dr. Sutter's Brief in Opposition to Defendant's Motion to Dismiss:

> Specifically, the named plaintiff, Dr. Sutter, alleges that Horizon engaged (and continues to engage) in the following continuing and wrongful systematic conduct: (1) failure to make prompt and timely payment of medical claims; (2) refusal to provide compensation for approved medical procedures by improperly contending that the procedures were routinely included in another procedure performed on the same date of service - - known as "bundling" of claims; (3) unilateral and retroactive reduction of the compensation paid for approved medical services by altering the procedure code (*i.e.*, the CPT code as developed and sanctioned by the American Medical Association) to a procedure of less complexity - - known as "downcoding" of claims; and (4) refusal to pay the appropriate compensation in cases where additional medical services are required to treat more complex medical conditions or separate and unrelated conditions - - known as the refusal to recognize 'modifiers."

The parties have jointly informed the court that, in terms of dollars at issue, it is probable that each of the bundling, downcoding and modifier claims are by themselves more serious than the prompt payment claims. The court mentions this to put in context Horizon's arguments as to failure to exhaust administrative remedies and lack of a private cause of action, both of which, as a practical matter, only refer to the prompt payment claims.

The Hon. Mary C. Jacobson, J.S.C. severed plaintiff's claims against the various defendants, leaving only this case against Horizon. Apparently, the other cases are in arbitration in one instance and Federal Court in the others. The principal motions before this court are Horizon's motion to dismiss and plaintiff's motion for class certification. The court will begin with Horizon's motion to dismiss.

II. *Horizon's Motion to Dismiss*

A. *State Grounds*

Horizon has asserted numerous reasons why plaintiff's Complaint, or portions thereof, should be dismissed. The court will address first the claim that Dr. Sutter did not exhaust State administrative remedies under New Jersey's Prompt Payment Act and HINT Act, and that neither of these Acts create a private cause of action.

1. *Failure to Exhaust State Administrative Remedies*

The threshold matter one should address, in determining whether a cause of action based partially on the prompt payment laws should first be heard by an administrative agency, is the basic question of whether the Legislative had the power to enact the prompt payment laws. Put differently, are the questions of how much interest a debtor should owe a creditor in New Jersey, and when should interest commence running, subject matters left to the Supreme Court, not the Legislature? (Presumably for different strategic reasons, neither Dr. Sutter nor Horizon discussed this issue.) The genesis of this dispute is Article VI, Section II, paragraph 3 of the 1947 Constitution which states that "The Supreme Court shall make rules governing the administration of all courts in the State and, subject to law, the practice and procedure in all such courts."

***3** The seminal case construing Article VI, Section II, paragraph 3, is *Winberry v. Salisbury*, 5 NJ 240 (1950). In *Winberry* Chief Justice Vanderbilt stated that the only way to give rational significance to the phrase "subject to law" is to "construe it as the equivalent of substantive law as distinguished from pleading and practice." *Id.* at 247. Accordingly, he held that the Legislative overstepped its powers when it enacted a law allowing one year to appeal an adverse trial court decision, particularly in the face of a Supreme Court Rule which allowed only 45 days.

Not surprisingly, the question of whether pre-judgment interest - - and this case involves pre-judgment interest - - is within the powers of the Supreme Court or the Legislature has been controversial in this State. Chief Justice Weintraub acknowledged as much in *Busik v. Levine*, 63 N.J. 351 (1973) when the Court had before it the constitutionality of *R.* 4:42-11(b) which authorizes pre-judgment interest in tort cases. He began by noting that interest has been addressed by **both** the Legislature, as in usury statutes, and the courts. *Id.* at 356-57. He also noted that of the eight states which had Legislatively provided for pre-judgment interest in tort actions, five had denominated the matter procedural, one called it a matter of "remedies" and one called it "damages" in the substantive law section of its laws. *Id.* at 370-71. (Presumably, one state labeled interest as purely substantive.) He went on to conclude, not that interest is necessarily and exclusively procedural, but that the subject matter concerned both substance and procedure, and that in the context of spiraling tort litigation, "it surely cannot be said to have been palpably inappropriate to think of pre-judgment interest as a matter of procedure … notwithstanding that the rule has also a 'substantive' impact upon the dollar result." *Id.* at 371.

The most important aspect of *Busik*, other than its holding, was Chief Justice Weintraub's refusal to rule that the Supreme Court had exclusive jurisdiction over interest:

> It is insisted we cannot uphold the rule for prejudgment interest without also deciding whether the rule comes within the *Winberry* dictum that the Court's authority as to practice and procedure is exclusive. We see no need to meet that issue. The sole question is whether the Court may treat the subject by a rule rather than by a judicial decision despite the substantive aspect of the subject. The issue of exclusivity involves a touchy matter, the relations among the three branch of government. It will be time enough to talk about exclusively when there is an impasse and no way around it. A coordinate branch should not invite a test of strength by proclamation. Our form of government works best when all branches avoid staking out the boundaries which separate their powers. *Id.* at 373

The Chief Justice went as far as to indicate note that the Court would accept statutory limitations in this area:
In some instances our rules expressly accept statutory provisions relating to the same subject matters. See *R.* 4:27-2; *R.* 4:42-8(a); *R.* 4:52-7; *R.* 4:59-1; R. 4:83-1. After the adoption of the pre-judgment interest rule here involved, the Legislature enacted the New Jersey Tort Claims Act., N.J.S.A. 59:1-1, et seq., which provides in N.J.S.A, 59:9-2a that "No interest shall accrue prior to the entry of judgment against a public entity or public employee." We have approved an amendment to our rule of Court which will except that situation. *Id.*

***4** In this court's opinion, we are not herein faced with "an impasse and no way around it". Rather, *R.*4:42-11(b) governs pre-judgment interest in tort cases in general. The prompt payment laws deal with pre-judgment interest in one very limited type of contract case: suits by medical providers against medical payers. This court notes that since the Supreme Court has not enacted a Rule dealing with contract cases, it is certainly possible the Court would not be eager to declare a Legislative pronouncement in this area to be illegal. Taking into account the normal reluctance of courts to declare a statute unconstitutional - - a reluctance which is even greater at the trial level – and reading *Busik* as carefully as we can, this court will not predict that an appellate tribunal would find the prompt payment laws to be beyond the power of the Legislature. See, *Alan J. Cornblatt, P.A. v. Barow*, 153 N.J. 218, 248 (1998) where the Court refused to rule that the Affidavit of Merit

Bill violated the Constitution. The Affidavit of Merit Bill, the Tort Claims Act, and the prompt payment laws could legitimately be reviewed as Legislative efforts to solve *specific* problems in a manner which infringes very little on the Supreme Court's *general* procedural hegemony. For all these reasons, the court has determined that the prompt payment laws are not unconstitutional. The court will thereupon address the exhaustion of remedies argument on the merits.

Upon being informed of the exhaustion of remedies argument, the court wrote the Commissioner of the Department of Banking and Insurance ("the Department"), as well as the Deputy Attorney General responsible for representing the Department, asking for the Department's views on the question of whether the Department should address some or all of the case before this court does so. Both parties consented to this procedure. A copy of this court's December 6, 2002 letter to the Department is annexed hereto. On January 16, the Department, through Deputy Attorney General Michael E. Goldman, responded to this court. The Department responded that Dr. Sutter's claim is essentially a private contractual dispute which would be appropriately litigated by the parties. In regard to the HINT and Prompt Pay Statutes, the Department stated "there is nothing in either the HINT or Prompt Pay provisions which would preclude a provider who believes that he or she has not been paid in accordance with his or her contract with Horizon from seeking private redress for an action against the payer."

The Department specifically addressed what it believes to be its role concerning Horizon:
"Moreover the Department has already exercised its jurisdiction over Horizon in the context of the HINT and Prompt Payment statutes. *N.J.S.A.* 17B:30-30, 31 and *N.J.A.C.* 11:22-1.10 require carriers to submit quarterly reports and annual claims audits to, interalia, the Department. Based upon its review of the audit, the Department may if necessary require the carrier to implement a plan of remediation. Horizon has, in fact, filed the required reports and audit. Based on those documents, the plan of remediation has been mandated by the Department and, the Department has been informed, is being implemented by Horizon."

Finally, the Department addressed N.J.S.A. 17:48E-10(e), the statute that requires any dispute between a health service corporation and a provider with whom the health service corporation has a contract be submitted to the Commissioner for his determination. In regard to that provision, the Department stated that it was permissive and could not reasonably be interpreted to mean the Department must resolve all disputes between a health service corporation and a physician. For these reasons, the Department declined to exercise jurisdiction over the dispute between Dr. Sutter and Horizon. A copy of that letter is annexed hereto.

This court is impressed by two decisions which held that somewhat comparable matters should be addressed by the Department. The court is referring to the Appellate Division decision in *Rahway Hospital vs. Horizon Blue Cross Blue Shield of New Jersey*, and Judge Yannotti's thoughtful trial court decision in *Englewood Hospital vs. Horizon Blue Cross Blue Shield of New Jersey*. While the two cases involved different issues from those herein– the relative rights of Horizon, hospitals and patients after a termination of a contract between Horizon and a hospital - - the court recognizes that both opinions gave great deference to the Department's expertise in this general area. In addition, Judge Yannotti overrode the views of an Assistant Commissioner of the Department who stated that the issues raised in the dispute appeared to be primarily contractual in nature, that the Department had no expertise over many of the issues involved in that dispute, and that the relevant statutes were discretionary and did not require the Commissioner to resolve all disputes between a health service corporation and a provider. The court agrees with Judge Yannotti that it is not necessarily bound by the Department's views.

***5** On the other hand, as a practical matter, the Department's belief that it should not hear these claims does concern the court. More than this court, the department is aware of its ability to address all of these matters. Further, Dr. Sutter's claims, whether addressed singularly or as part of a class, do involve innumerable factual determinations. While it is difficult to compare this case with the *Rahway* and *Englewood* cases, the court believes that this case would involve many more factual determinations than either of those. The court also believes that Dr. Sutter's prompt payment claims could be addressed as well or better by it, rather than by the Department, particularly as the Department has indicated that it is lacking a special expertise to address prompt payment. The Department may possess expertise to determine the appropriate relationship between payers and providers when a hospital closes, as in *Englewood* and *Rahway*, but one doubts the Department has any special expertise to read the five sentences which comprise the relevant portions of N.J.S.A. 17B:26-9.1. and N.J.S.A. l7:B36-32.[1] Finally, to send the matter to the Department now might well be a moot act that would delay rather than effectuate justice. This is particularly ture in a cae such as Dr. Sutter's where threee of the four claims (downsizing, bundling

and modifiers) are relatively clearly not submect to the Department's primary jurisdiction. See footnote 1 herein. Accordingly, this court will not dismiss the prompt payment portions of the Complaint based upon the theory that primary jurisdiction rests with the Department.

2. *Private Cause of Action*

However, this does not end all discussion of the state law problems because the defendant is also alleging that there is no private cause of action under New Jersey's Prompt Payment Act and HINT Act.

The Supreme Court set out the framework for determining whether a private cause of action should be implied from a statute in *R.J. Gaydos Ins. Agency v. National Consumer Co.*, 168 N.J. 255 (2001). In *Gaydos*, the Supreme Court cited to the United States Supreme Court decision in *Cort v. Ash*, 422 U.S. 66 (1975), to explain the three part analysis:
"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." 168 N.J. at 272,

As to the first *Cort* test, the plaintiff is relatively clearly a member of a class for whose special benefit the prompt payment laws were enacted. These laws were written, at least partially, to compel payers to promptly pay claims to providers for medical services to plan members. The applicable statutes and regulations require the payment of claims to providers within 30 or 40 days and obligate the health service systems to pay 10% interest to the providers for untimely paid claims. See page 2, *supra*. Horizon acknowledges the applicability of these laws in its provider office manual:
One requirement of the New Jersey statute on prompt pay is that all New Jersey insurance companies, health, hospital, medical an dental services corporations, HMOs and Dental Provider Organizations and their agents for payment (all known as payers) process claims in a timely manner.

Known as prompt pay, the mandate became effective for all claims received December 1999, and after, replaces previous prompt pay laws. (See Exhibit 3 attached to Horizon's Corrected Exhibits at 24).

The second *Cort* factor, the Legislature's intent, presents a closer issue, since the Legislature did not clearly evince its intent. Dr. Sutter appears to argue that the structure of the statute, and regulations propounded pursuant to N.J.S.A. 17B:30-33, imply that the Legislature intended to allow private causes of action. See N.J.A.C. 11:22-1.8 which mandates appeal mechanisms to allow the provider to "review" payment disputes.

> (b) Every carrier shall offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process. N.J.A.C. 11:22-1.8(b).

***6** The ADR procedures are non-binding. N.J.A.C. 11:22-1.8(b)(3). ("The decision of the ADR mechanism shall be non-binding unless the parties agree otherwise."). Thus, in cases such as this where no agreement exists to make an external ADR mechanism binding, there would logically be a right to continue to pursue the rights in another forum. If this were not the case, Horizon's internal "appeal" mechanism would effectively be binding because there would be no right to pursue prompt payment, and interest, in any other forum. That may not be what the Legislature intended, since it would place the providers in a situation where the payer refuses to pay timely or with interest but the provider has no means to enforce his or her rights. As Horizon points out in its cogent brief section concerning the State Health Benefits Commission, both *N.J. Mfrs. Ins. Co. v. Longo*, 303 N.J. Super. 286 (App. Div. 1999) and *Midlantic Nat'l. Bank v. The Peerless Ins.* 253 N.J. Super. 137 (App. Div. 1992) stand for proposition that statutes must be read in a common sense manner. A common sense reading precludes a reading that the Legislature intended a right without a remedy.

Although this is not controlling, similar courts in other jurisdictions have held that healthcare providers may not be left in a

situation where they have a right to timely payment and interest, but no means of enforcing those rights. *See In Re Managed Care Litigation*, 135 F. Supp. 1253, 1267-68 (S.D. Fla. 2001), *North Florida Obstetrical & Gynecological Assn. v. Prudential Healthcare Plan, Inc.*, Case No. 98-807- CIV-J-2C, slip op. At 11 (M.D. Fla. 1999). The Legislature may have logically felt similarly.

Ascertaining Legislative is not easy herein. Nevertheless, the statutory and regulatory framework implies that the Legislature wanted to allow private causes of action. Put differently, the Legislature allowed the Department to mandate that every carrier provide a mechanism (arbitration) for providers to sue payers. Since the Legislature intended at least one "private cause of action", it is logical the Legislative would be amenable to another, as the two "causes of action" (arbitration and litigation) have the same effect on the Department and on the relationship between payer and provider.[2]

The third *Cort* factor concerns the question of whether a private cause of action is consistent with the purpose of the statute. Dr. Sutter argues that a private cause of action is not merely consistent with the purpose of the Prompt Payment laws but essential to vindicate the rights established. To rule otherwise, he contends, would cause the plaintiff, and the members of the plaintiff's class, to be without a legitimate remedy to enforce that right. Dr. Sutter cites a long line of cases that held that equity will not permit a wrong to be suffered without affording the appropriate remedy. *See Graziano v. Grant*, 326 N.J. Super. 328, 342 (App. Div. 1999); and *Loigman vs. Kings Landing Condominium Association Inc.*, 324 N.J. Super, 97, 108 (Chan. Div. 1999).

A reading of the statute raises serious questions as to whether the Legislature intended the penalties it set up to be so exhaustive and severe as to preclude all private remedies. N.J.S.A. 17B:30-30(b) states;
"after reviewing an audit the commissioner may, if he deems necessary: require the implementation of a plan of remedial action by the payer, require that a payer's claims processing procedures be monitored by a private auditing firm … or both."

The statute then goes on to state that:
"if, following an audit, the implementation of a plan of remediation of the monitoring of the payer's claims processing procedures, the commissioner determines that … an unreasonably large or disproportionate number of eligible claims continues to be rejected, denied, or not paid in a timely fashion … or a payer has failed to pay interest as required pursuant to law, the commissioner shall impose a civil penalty of not more than $10,000 upon the payer …"

***7** This Court will take notice of Dr. Sutter's allegation that he has thousands of late payment claims (which could theoretically be multiplied by 30,000 other providers). In these circumstances, one can easily argue that the statute provides an adequate remedy.[3] In sum, there can be no convincing argument that the Legislature believed it had created a sole exclusive remedy that would be hindered by private actions. Equally important, it would seem that private causes of action, or the threat thereof, would further that goal since the Legislative wanted providers to be paid promptly, and there are 30,000 providers in the State.

In conclusion, under the *Cort* factors, the court believes that plaintiff is a member of the class for whose special benefit the statute was enacted, and that there is at least some evidence that the legislature intended to create a private cause of action. The third *Cort* test - - whether a private cause of action is consistent with the legislative scheme - - also favors Dr. Sutter because this court is convinced that the legislative goals would be achieved much more effectively *with* a private cause of action rather than without a private cause of action. (emphasis added)

The above analysis is of no moment, unless it is consistent with the holding in *Gaydos*, *supra*. The *Gaydos* Court held that the Fair Automobile Insurance Reform Act ("FAIRA") that regulates New Jersey's automobile insurance system "does not create a private cause of action for an agent to pursue a claim that it was wrongly terminated as a result of an insurer's alleged FAIRA violations," *supra* at 279. The Court held that motorists, *not agents*, were the class for whom special benefit the FAIRA was enacted. (emphasis added) Justice Stein also noted that the FAIRA creates such comprehensive procedures for resolving complaints from drivers who feel they were improperly denied insurance coverage and, as such, one should not conclude the Legislature wished to allow private causes of action, *supra* at 280. Justice Stein further held that to allow "agents to bypass FAIRA's regulatory and statutory schemes and litigate alleged FAIRA violations … without the [Department's] participation could undermine the State's ability to properly regulate the automobile insurance industry" *supra* at 281.

This court believes the HINT and Prompt Payment statutes differ markedly from the FAIRA. First, the HINT and Prompt Payment statutes were written at least partially to benefit providers, while the FAIRA was not written to benefit agents. Second, the FAIRA did not have provisions allowing any non regulatory action, unlike the present statutes and regulations under consideration that provide for arbitration. Third, one can easily see how the Legislature may believe that private causes of action could interfere with the delicate FAIRA regulations, while it is very difficult to see how the Legislature would be concerned about relatively routine suits by providers to collect principal and interest. Those suits would do little more than mirror common law breach of contract suits that generally contain interest claims.[4] Put differently, since the Legislature did not prohibit Dr. Sutter from suing Horizon for non payment, why would it Legislature did not prohibit Dr. Sutter from suing Horizon for non payment, why would it prohibit him from suing for non payment plus interest? Finally, this court could analyze the issue at hand differently: if this court were to award Dr. Sutter interest at a rate higher or lower than that set out in the Statutes, or at rate calculated differently, would not this court be violating the intent of the Legislature? Thus, the court believes its conclusion is consistent with *Gaydos*.[5]

***8** Accordingly, Dr. Sutter's claim under the Prompt Payment Act and the HINT Act will not be dismissed. Defendant's argument to dismiss based on the lack of a private cause of action under the Prompt Payment Act and the HINT Act is not joined by a similar argument concerning bundling, down coding, or the refusal to recognize modifiers. Defendant concedes that these causes of action (if valid) are simple contractual claims. Thus, all of Dr. Sutter's contract claims will remain in this case.

3. *Failure to Exhaust Internal Administrative Remedies*

In opposition to this argument, Dr. Sutter points to Horizon's current manual, entitled "Traditional Provider Network Office Manual" arguing that it does not set forth or identify any "internal appeal mechanism" for providers. This may well be significant because this new manual "replaces all other manuals previously published by Horizon" and expressly "include[s]" and incorporates all of Horizon's insurance products at issue in this case. Thus there is at least an argument that there is no longer any mechanism for Dr. Sutter to proceed internally.

Assuming that Dr. Sutter is mistaken, and that the insurance provider office manual does Dr. Sutter argues that there is ambiguity as to which office procedures control each of the particular plans offered by the defendant. The court does not believe this alleged ambiguity would void the entire internal appeals mechanism. None of the familiar cases cited by Dr. Sutter are close enough to compel the conclusion that the entire appeals mechanism should be abrogated because of arguable ambiguities.

Dr. Sutter's argument that exhaustion is not required when it would be futile or there is a public interest requiring prompt judicial resolution is strong. In that regard paragraphs 4 and 5 of Dr. Sutter's certification are instructive:
Contrary to the express payment provisions in my agreement, however, Horizon has consistently failed and continues to fail to reimburse me timely or appropriately on a significant percentage of submitted claims. **I estimate that over the years I have appealed between 25% and 30% of the claims I have submitted to the defendant, corresponding to thousands of improperly processed untimely paid claims.**

A significant percentage of the non-captioned claims I have submitted to the defendant have had to be re-submitted numerous times before any payment is made, let alone correct payment or with the appropriate amount of interest. On many occasions, the interest, when it is included, was calculated incorrectly from the date the claim was re-submitted as opposed to the date of initial submission. On yet many other occasions, claims are simply not paid at all, without any explanation from Horizon. Most attempts by me or my staff to obtain information from the defendant about claims that have been appealed or are outstanding for other reasons, often results in no information or inaccurate information.

(emphasis added)

When one recognizes how difficult it must be for Dr. Sutter to conduct his practice while undergoing these thousands of

appeals, one may well conclude it would be unfair to force Dr. Sutter to continue to file countless appeals. In addition, it is unlikely that Dr. Sutter would receive a fair and impartial hearing before any internal Horizon review process. The lack of a neutral, internal process is evident from the Horizon Participating Providers Office Manual; it allows providers to submit claims on appeal "only once by [Horizon] medical administration, the decision is final, and there are no further appeal rights." Finally, one understands from this lawsuit that the downcoding, bundling and modifier issues are matters about which both the payers and the providers of this state feel strongly and which have monumental precedential importance. In those circumstances, it is unlikely one could expect a fair and impartial decision from an internal appeals mechanism.

***9** Dr. Sutter's public policy argument also has merit. It is agreed that the downcoding, bundling, modifier and perhaps even prompt payment interest issues are of enormous importance to providers and payers in this state. It also appears that there are 30,000 providers and numerous payers involved. Therefore, to cause all of the 30,000 payers to seek internal administrative redress might well be unfair and contrary to the public interest. (This does not mean it would necessarily be unfair to make them sue individually, rather than as a class; that decision will require much more information.)

For all of these reasons, the court will not dismiss Dr. Sutter's claim for failure to pursue internal administrative remedies.

4. *New Jersey Consumer Fraud Act*

Horizon moves to dismiss the Fifth Count of Dr. Sutter's Complaint that alleges violations of New Jersey's Unfair Trade Practices Act, N.J.S.A. 56:8-1 et seq., also known as The Consumer Fraud Act. First, there is no disagreement on the Prompt Payment Act or HINT Act aspect of this motion. Both parties agree that the Legislature has now determined the appropriate penalty for late payment or non payment which is 10%. Any attempt to award less interest, under an analogy to the Court Rules, or more interest, by adding the penalty provision of the Consumer Fraud Act, would violate Legislative intent. That portion of the Fifth Count must therefore be dismissed.

The parties' briefs on the remainder of the Fifth Count address the familiar arguments of whether the Consumer Fraud Act applies to a heavily regulated activity such as medical care insurance, with both sides quoting the cases normally cited for and against that proposition. The court need not address those issues because the court is convinced that the plaintiff was not involved in consumer transactions to which The Consumer Fraud Act applies.

To be a consumer transaction under the Consumer Fraud Act, the purchaser must use the goods and, in the course of such use, diminish or destroy their utility. See *City Check Cashing, Inc. v. The Nat'l. State Bank*, 244 N.J.Super, 304, 309 (App. Div. 1990); *Arc Networks v. Gold Phone Card*, 333 N.J.Super. 587, 591 (Law Div. 2000). The claimant must consume the good rather than resell, transform or incorporate the goods for sale. In *City Check Cashing*, the plaintiff acquired cash from the defendant and then sold it to customers for a fee. 244 N.J.Super. at 306. The plaintiff's transactions with defendant did not affect the "utility of the cash". *Id.* at 309. Both Judge Wefing and the Appellate Division ruled the plaintiff had not acted as a consumer in the transaction, and the Act did not apply to the transaction at issue:
"to be a consumer respecting the transaction in question, the business entity must be "one who uses (economic) goods, and so diminishes or destroys their utilities." (*Hundred East Credit Corp. v. Eric Schuster*, 212 N.J.Super. at 355, 515 A.2d 246 (quoting Webster's New International Dictionary (2d ed.)). In the transaction here, plaintiff essentially was buying cash from defendant at wholesale to sell to its check-cashing customers at retail. Plaintiff did not diminish or destroy the utility of the cash and therefore did not consume it. Thus Judge Wefing correctly ruled that plaintiff is not a consumer protected by the Act." *Id.*

In *Arc*, Judge Perri held that the Act did not apply to the relationship between Arc, a provider of computer network and bulk telephone switching services, and counterclaimant Gold Phone, a distributor of prepaid telephone cards. 333 N.J.Super at 591-92. The *Arc* court held that the services purchased by Gold Phone were not available to the general public, but only to a limited segment of the population that purchased phone cards.[6] *Id.* More importantly, the court held that the transaction between Arc and Gold Phone was not a typical consumer transaction, and that Gold Phone therefore was not a consumer within the meaning of the Statute:

***10** "Gold Phone argues that its position is distinguishable from that of the plaintiff in City Check Cashing because it "consumed" Arc's services by supplying Gold Phone cards to its own employees for their use. Gold Phone's attempt to obtain standing under the Act on this basis belies both the essential nature of its cause of action and the damages it seeks by way of its counterclaim. Gold Phone's purpose in contracting for Arc's services was to resell those services to purchasers of its phone cards. Its own use of the cards was at best incidental to the essential purposes of the contact. More importantly, Gold Phone's claim against Arc is not for damages it personally sustained based on individual card use. Its claim is for business losses resulting from Arc's failure to perform under the contract and Arc's alleged failure to issue appropriate credits to Gold Phone's customer accounts." *Id.*

As Horizon points out, Dr. Sutter is neither a purchaser nor a consumer of any goods or services from Horizon. Dr. Sutter sells services. (Horizon implies that his services do not constitute consumer transactions; since *Waterloov Gutter Protection Systems Co., Inc. v. Absolute Gutter Protection*, 64 F. Supp. 2d 398 (D.N.J. 1999),held that professionals may be liable under the Act, it is possible Horizon is wrong on this, but the court need not reach that issue.) It is an extraordinary stretch to claim, as Dr. Sutter does, that he "purchases" Horizon's patient list. Further, the value of his health care services can not be affected by Horizon. Nor does Dr. Sutter "consume" Horizon's patient lists. The list remains exactly as it was both before and after Dr. Sutter's services are rendered. Since Dr. Sutter is not a consumer of the patient list, and since the patient list is not "consumable" by him, the transactions about which he complains are not subject to the Act.

See similarly, *BOC Group v. Lammus Crest*, 251 N.J.Super. 271 (Law Div. 1991) where the trial court dismissed a Consumer Fraud Act allegation by a buyer of a sophisticated petroleum refining process, noting that this "clearly [is] not the type of situation contemplated by the Consumer Fraud Act" *Id.* at 280. The court believes that the purchase of the right to use a patient list by a physician, hospital, medical group (or by 30,000 physicians, hospitals, medical groups) was likewise not, in the contemplation of the Legislature, a consumer transaction encompassed by the Act.

Cases such as *City Check Cashing*, *Arc*, and *BOC Group* have at least one common trait: the unsuccessful claimant used the goods acquired (cash, telephone services, a petroleum refining process) in order to "resell" for its own business purposes. These cases are different from cases such as *Lemelledo v. Beneficial Management*, 150 N.J. 255 (1997), where a mother was made to buy loan insurance when she applied for a college loan for her daughter, and *Cox v. Sears Roebuck & Co*, 138 N.J. 2 (194) where Sears Roebuck allegedly defrauded an 82 year old man on a home repair contract.. Not surprisingly, the first group of cases were found not to state Consumer Fraud Act claims. Dr. Sutter clearly used the Horizon patient lists for his business purposes and just as clearly does not state a Consumer Fraud Act claim.[7]

There is one additional reason this court does not believe that the transactions Dr. Sutter complains of fall under the Consumer Fraud Act. In arguing against ERISA preemption (see *infra*), Dr. Sutter correctly argues that the transactions at issue are relatively common breach of contract actions. Courts have traditionally held that a Legislative Act designed to increase penalties for fraudulent activities should not normally encompass garden variety or traditional breach of contract actions. *See Maxim Sewerage Corp. v. Monmouth Ridings*, 273 N.J.Super. 84 (1993); *Marshall-Silver Construction Co., Inc. v. Mendel*, 894 F.2d 593, 597 (3d Cir. 1990). Dr. Sutter cannot have it both ways. This is yet another reason that the Fifth Count should be dismissed.

5. *The Duty of Good Faith and Fair Pealing*

***11** As the court indicated during oral argument, the court's view as to the viability of Dr. Sutter's Consumer Fraud Act complaints did not coincide with court's views as to the viability of Dr. Sutter's claim for a violation of the duty of good faith and fair dealing. *Wilson*, and to a somewhat lesser extent, *R.J. Gaydos*, re-emphasized that every New Jersey contract includes the duty of good faith and fair dealing. *Wilson v. Amerada Hess Corp.*, 168 N.J. 236 (2002); *R.J. Gaydos Ins. v. Nat. Consumer Co.*, 168 N.J. 255 (2001). That duty had its origin at least as far back as *Aronsohn v. Mandara*, 98 N.J. 92 (1984). For defendant to dismiss those allegations would require, at least in a case such as this where the allegations are so strongly worded, proof that the defendant did not act outrageously or in bad faith. That proof cannot be obtained without extensive discovery. For that reason, the Second Count, alleging a breach of duty of good faith and fair dealing, will remain in this case at this time.

B. *Federal Grounds*

1. *FEHBA*

Horizon argues that Dr. Sutter's New Jersey contract claims for payment of services to participants in the Federal Employee Health Benefit Program ("FEHBP") relate to and are therefore preempted by the Federal Employee Health Benefit Act ("FEHBA"). Horizon goes on to state that such claims are further barred by Dr. Sutter's failure to exhaust mandatory FEHBP administrative procedures which, if he were dissatisfied with the outcome, would culminate in federal civil action in which the Office of Personnel Management ("OPM") is the sole defendant. The court believes Horizon's argument to be valid. *See United States of America v. State of West Virginia*, Civ. Act. No. 2:99-1138 (S.D.W.V., Aug. 5, 2002). Nevertheless, the court has ascertained that claims relating to FEHBP participants constitute a relatively small percentage (almost certainly less than 10%) of the total claims asserted by Dr. Sutter. The court will resolve this matter by dismissing all claims relating to FEHBP participants, whether the action proceeds solely as to Dr. Sutter or as to a larger class.

2. *M & C Program*

Horizon also asserts Dr. Sutter failed to exhaust administrative remedies under the M & C Program which was established by Congress in 1997 to provide both basic medicare benefits and certain mandatory supplemental benefits to eligible persons through M & C plans administered by M & C organizations. As is the case with FEHBA, the M & C Program has highly detailed administrative procedures. These procedures culminate in hearings before an Administrative Law Judge, an appeals board, and then a final judicial review before a United States District Court. The court takes notice of the fact that Dr. Sutter is a pediatrician, which means that very few, if any, of his patients participate in Medicare. His certification states that he has no current medicare patients and does not participate in the M & C program. As with the FEHBA claims, any such claims will be dismissed whether asserted by Dr. Sutter or members of a class. Similarly to FEHBA, such dismissal does not mandate dismissal of the entire lawsuit.

3. *ERISA Plan*

The more difficult preemption problem is Horizon's claim that ERISA preempts the plaintiff's state law claim. The most systematic discussion of this issue was provided by Judge Frederico Moreno of the United States District Court for the Southern District of Florida in *Managed Care Litigation* MDL #1334, That case is similar to, but much larger than, this case. The plaintiffs were 600,000 doctors across the United States. (Judge Moreno also had before him plaintiff patients but did not have hospital plaintiffs.) The defendants were several organizations similar to Horizon, including both CIGNA and United Health Care that were originally defendants in this lawsuit. Judge Moreno's analysis of the motion by defendants to dismiss plaintiff's contract claims on the ground of ERISA preemption deserves careful scrutiny herein:
***12** Anticipating that the Plaintiffs will amend their Complaint, the Defendants respond that the Plaintiffs' contract claims are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144. ERISA applies to any employee benefit plan, provided that it is established or maintained by an employer or employee organization engaged in commerce or in any industry or activity affecting commerce. 29 U.S.C. § 1002(a). The statute explicitly includes plans provided through the purchase of insurance. 29 U.S.C. § 1002(1). The preemption section states that this federal statute "shall supersede any and all state laws insofar as they may now or thereafter relate to any employment plan" covered by ERISA. 29 U.S.C. § 1144(a). A state law "relates to" a covered employee benefit plan "if it has a connection with or reference to such a plan." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129, 113 S. Ct. 580, 121 L.Ed.2d 513 (1992), quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983).

In *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994), the Eleventh Circuit agreed with the position

of *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990), that "state law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the Act." *Lordmann Enterprises*, 32 F.3d at 1533. In this case, the Provider Plaintiffs assert that they seek to enforce the terms and conditions of their own contracts with the Defendants, rather than assignments from ERISA beneficiaries. Amended Complaint, ¶ 297. See also *Variety Children's Hospital Inc. v. Blue Cross/Blue Shield*, 942 F.Supp. 562, 568 (S.D.Fla. 1996) (claim not preempted where provider plaintiff brought suit in its independent status as a third-party rather than as an assignee of benefits).

After his statutory analysis, Judge Moreno addressed the public policy reasons why ERISA should not preempt this type of suit:

The policy argument set forth in *Memorial Hospital* and adopted by the Court in
Lordmann Enterprises elucidate the wisdom of this result. First, preemption of provider contract claims would "defeat rather than promote" ERISA's goal to "protect the interest of employees and beneficiaries covered by benefit plans." *Lordmann Enterprises*, 32 F.3d at 1533. The Court theorized that as a result of preemption, health care providers would therefore act to protect themselves by denying care or raising fees. *Id*. Second, health care providers are not within the scope of ERISA. *Id*. Although employer and employees traded their right to bring a state cause of action in exchange for the benefits of ERISA, the statute does not provide a cause of action for health care providers with no viable civil remedy. *Id.* at 1533-34. The Court therefore holds that the Plaintiffs may bring their contract claims free of the shadow of ERISA preemption.

Judge Moreno's reasoning has been almost universally adopted. *See Medical and Chirurgical Faculty of the State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F.Supp.2d 618, 619-20 (M.D. 2002) where Judge Nickerson noted:

> Courts have, with near unanimity, found that independent state law claims of third party health care providers are not preempted by ERISA. *See e.g.*, *In Home Health. Inc. v. Prudential Ins. Co. of America*, 101 F.3d 600, 606 (8th Cir.1996); *The Meadows v. Employer Health Ins.*, 47 F.3d 1006 (9th Cir.1995): *Lordmann Enterprises, Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752 (10th Cir.1991): *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir.1990).

This court does not wish to lengthen this already lengthy opinion by revisiting each and every argument and sub argument Judge Moreno, Judge Nickerson and others reviewed in determining that ERISA does not preempt a typical provider – payer suit such as this. To do so would add to the wasted judicial ink Judge Cobb observed in *Foley v. Southwest Texas HMO, Inc.*, 226 F.Supp.2d 886 (E.D.Tex. 2002), "Much judicial ink has been painstakeningly expended construing the preemption language of ERISA" (quoting an earlier opinion of his own court) *Id.* It may be more useful to merely note that competent counsel on both sides have failed to discover any pure provider - payer suits where ERISA was held to preempt.

***13** As Judge Cobb noted in *Foley*, "Both parties admit that if plaintiffs had a contract with the defendants, the plaintiffs could bring a valid breach of contract claim against the HMO's if they did not make payments as required by the contract." *Id.* at 895. (Unfortunately, the parties herein agree on very little, including this point; nevertheless, the law on straight forward payer - provider suits is quite clear). One difficulty arises when the plaintiff's claims are actually assignments from patients. In that situation numerous courts found there to be preemption, but that does not appear to be the case herein. Further, as the Ninth Circuit observed in *Blue Cross of California v. Anesthesia Care Assoc. Medical Group Inc.*, 127 F.3d 1045 (9th Cir. 1999) that when the dispute is over the amount of payment, not the right to payment, it is governed by the contract and is not preempted by ERISA. Such is the case herein. There is no ERISA preemption.

III. *Motion for Class Certification*

The pertinent Rule regarding class actions, *R* 4:32-1, reads as follows:

Requirements for Maintaining Class Action
(a) General Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of paragraph (a) are satisfied, and in addition:

(1) the prosecution of separate actions by of against individual members of the class would create a risk either of (A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or (B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The factors pertinent to the finds include: first, the interest of members of the class in individually controlling the prosecution or defense of separate actions; second the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; third, the difficulties likely to be encountered in the management of a class action.

Dr. Sutter wants the court to certify the class based on his Complaint alone, but class action certification decisions should not generally be made on the allegations of a complaint alone. *Riley v. New Rapids Carpet Center*, 61 N.J. 218, 294 A.2d 7 (1972), citing *Becksted v. Superior Court of Los Angeles*, 21 Cal.App.3d 708 (Ct. App. 1971). (Dr. Sutter cites *Riley* as well, but, as will be discussed, *infra*, *Riley* is more supportive of the Horizon position herein.) The burden of establishing class status is on the plaintiff, and the court must undertake a rigorous analysis to ascertain whether the requirements for certification have been met. *R.* 4:32-1; *Goasdone v. American Cyanamid Corp.*, 354 N.J.Super. 519 (N.J.Super.L. 2002). In addition to the pleadings, the discovery taken is relevant to the determination of a motion for class certification. *Varcallo v. Mass. Mut. Life Ins. Co.*, 332 N.J.Super. 31 (App.Div. 2000). As Horizon points out, in arguing against certification without an opportunity for class action discovery, courts should conduct the discovery necessary to make the appropriate factual findings concerning certification. *Sheldon v. Pargo, Inc.*, 582 F.2d 1298, 1313 (4th Cir. 1978); *Newton v. Merrill Lynch, Pierce, Fenner & Smith*, 259 F.2d 154, 166 (3rd Cir. 2001); (where the court noted that before deciding whether to allow a case to proceed as a class action … [courts] should make whatever factual and legal inquiries are necessary); and *See*, *Kamm v. California City Dev. Co.*, 509 F.2d 205 (9th Cir. 1975).

***14** *Both* parties must be allowed to conduct limited discovery on class certification to adequately inform the court as to the complex factual issues involved in making a class action determination under *R.* 4:32-1. To give some obvious examples, Dr. Sutter does not distinguish among the various types and categories of providers, whether they be hospitals, heart surgeons or pediatricians. One might assume, to continue this illustration, that surgeons could have different types of claims than internists. Nor does he account for the different compensation arrangements providers may have with Horizon or the different ways Horizon treats them. Dr. Sutter assumes that St. Barnabas Medical Center, a neurosurgeon, and he have the same contract with Horizon, submit claims similarly, and have their claims adjudicated, processed and paid the same way. Discovery will reveal whether these assumptions - - which will help determine both the appropriateness of class certification and Dr. Sutter's appropriateness as a representative - - are true.

Horizon is entitled to explore this issue so that Horizon can demonstrate whether Dr. Sutter can adequately represent the apparently divergent interests and characteristics of his proposed class. On the other hand, Dr. Sutter may be able to learn in discovery whether Horizon entered into similar arrangements with all of these providers and treated them all similarly. It is also possible that the parties will discover that some of the providers were treated similarly on some aspects of the

Complaint, such as Prompt Payment or bundling, but not on others such as downcoding or modifiers.

Dr. Sutter relies on *In Re Managed Care Litigation*, MDL No. 1334 (filed September 26, 2002) ("Managed Care Litigation") to support his belief that his 30,000 members class of physicians, medical groups and hospitals should be certified. In the *Managed Care Litigation*, the certified class consisted of physicians (and patients) only. There were no hospitals or "other providers" in the class, unlike the class proposed by Dr. Sutter. Further, the class certification motion in the *Managed Care Litigation* case was considered **after** class discovery had been completed.

Dr. Sutter also relies on *dicta* from *Riley*, to the extent that "a court should be slow to hold that a suit may not proceed as a class action." 61 N.J. at 228. However, the Supreme Court in *Riley* held that discovery was necessary to properly determine class certification and hence, **remanded** the case to the trial court. This court shall do the same.

Kaiser v. CIGNA Corp., 2001 WL 1772650 (Ill Mar. 29, 2001), is also not persuasive. In that case, the court narrowly defined the class to include only those providers who had a specific fee arrangement with the CIGNA and submitted claims that were audited by the CIGNA's ClaimCheck computer software program **after** holding a hearing. *Id.* Here, the class criteria proposed by Dr. Sutter does not include any such limitations. This is not to say, of course, that the court may not eventually certify a class, either as broad as Dr. Sutter contends, or more narrowly as in *Kaiser*.

As Horizon points out, before a class action may be certified, the trial court must undertake "a 'rigorous analysis' and [be] satisfied that the prerequisites of Rule 23(a), the federal equivalent of R. 4:32-1 have been met." *Carroll v. Cellco Partnership*, 313 N.J. Super. 488, 495 (1998) (quoting *General Telephone Co. v. Falcon*, 457 U.S. 147, 161 (1982)). *Carroll* is instructive, but is not dispositive. There, the trial court certified a class action against a cellular phone provider in a case which at least arguably met the requirements of R. 4:32-1. The Appellate Division reversed and remanded, ordering the trial court to conduct an inquiry on whether manageability and predominance issues favored or disfavored class certification, and whether other case management techniques were preferable. The Appellate Division would have every reason to reverse this court if it did not make the diligent inquiry ordered in *Carroll*. This court cannot make that diligent inquiry without the information the parties will obtain in discovery. Therefore, the Motion for Class Certification is denied without prejudice pending further class certification discovery.

***15** Very truly yours,

<<signature>>

JAMES S. ROTHSCHILD, JR., JSC

Footnotes

1 The Department may have more expertise than the court on downsizing, bundling, and modifiers, but (a) it has indicated it does not want to address those issues and (b) there are no statutes or regulations addressing those issues, which makes any primary jurisdiction argument difficult to maintain.

2 Horizon points out that the Commissioner prefers arbitration to litigation "to ensure that claim disputes are resolved more expeditiously and at less expense." In re Public Hearing Regarding Prompt Payment Rules; Decision and Order, N.J. Ins. Order A-2000-151. To say that the Commissioner prefers arbitration to litigation is not to say that litigation is foreclosed where there is no neutral, binding, arbitral process.

3 Defendant has not pointed to any instance were the Department has, in practice, called for payments of interest to physicians.

4 Plaintiff argues that he should have a common law cause of action for interest. While the contract does not read as clearly as one might like, there is nothing in it foreclosing the ability of Dr. Sutter to obtain interest on late payments. As Judge Pressler points out, "Prejudgment interest may run on contract claims… in accordance with equitable principles." Pressler, Current N.J. Court Rules, Comment *R.* 4:42-11[9]. The court notes *Trocki Plastic Surg. v. Bartkowski*, 344 N.J. Super 399 (App. Div. 2001), where the Appellate Division held that a provider was due interest from the date services were rendered. Although that case was governed by an agreement which may well have been clearer than the agreement herein, it is at least arguable that a provider has a common law right to prejudgment interest.

[5] Although not dispositive, it should be noted that the Department agrees with this conclusion. See page7, *surpa*. It should also be noted that the entire discussion may have been unnecessary, because Horizon at least arguably incorporated the prompt pay statutes in its provider office manual which apparently is part of the Horizon - provider contract See page 10. *supra*

[6] This distinction may or may not serve as an alternative basis of the court's ruling. That is, the services at issue (the patient list) were not available to the general public, as is normally required under the Act. On the other hand, the services were available to a substantial portion of the general public (30,000 providers). However, the court need not decide this issue because of its ruling that Dr. Sutter was not a consumer.

[7] *Hundred East Credit Corp. v. Eric Schuster*, 2112 N.J. Super. 350 (App. Div. 1986) is troublesome on this point, but Schuster did not resell the computers; he is closer to the *Lemelledo* and *Cox* plaintiffs in that regard. *Perth Amboy Iron Works v. Am. Home*, 226 N.J. Super. 200 (App. Div. 1988) is even more troublesome; suffice it to say, the court does not understand how to reconcile the Consumer Fraud Act and Magnuson-Moss Act aspects of that decision, let alone how to reconcile the decision with the above discussed cases.

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