UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH GREENE, PAMELA MAZZA, and DEBORAH SCHUTT on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

HEALTHFIRST PHSP, INC.,

Defendant.

Case No. 25-cv-09058 (ER)

MOTION TO DISMISS THE SECOND AMENDED COMPLAINT

ORAL ARGUMENT REQUESTED

PLEASE TAKE NOTICE that upon the annexed Declaration of Joshua H. Pike dated June 4, 2026 and the exhibits annexed thereto, the accompanying Memorandum of Law dated June 4, 2026, and all the pleadings and proceedings heretofore had herein, Defendant Healthfirst PHSP, Inc., by and through its attorneys, Sher Tremonte LLP, will move this Court, at a time and date to be set by the Court, at the Thurgood Marshall United States Courthouse, 40 Foley Square, Courtroom 619, New York, New York 10007, for an order granting this motion, pursuant to Fed. R. Civ. P. 12(b)(1) and Fed. R. Civ. P. 12(b)(6), to dismiss Plaintiffs' Second Amended Complaint.

Dated: New York, New York
June 4, 2026

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MEMORANDUM OF LAW IN SUPPORT OF HEALTHFIRST PHSP, INC.'S MOTION TO DISMISS THE SECOND AMENDED COMPLAINT

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Defendant Healthfirst PHSP, Inc. ("Healthfirst"), by and through its undersigned counsel, Sher Tremonte LLP, respectfully brings this motion pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6) to dismiss the Second Amended Complaint (the "Complaint" or "SAC"), ECF No. 21, filed by Plaintiffs Joseph Greene, Pamela Mazza, and Deborah Schutt.

PRELIMINARY STATEMENT

This case should be dismissed because Plaintiffs cannot assert any viable claim that arises under federal law, and there is no independent basis for jurisdiction over Plaintiffs' state-law claims. Plaintiffs assert claims under New York State statutes, under New York State common law, and under agreements governed by New York contract law — quintessentially state-law claims. Plaintiffs attempt to infuse their Complaint — in particular, their first cause of action for breach-of-contract — with federal regulatory obligations. But these references to federal law do not confer jurisdiction because the claim, no matter how it is pled, does not *arise under* federal law. Even if the claim supported federal jurisdiction, it would be subject to immediate dismissal for failure to state a claim. Either way, Plaintiffs' first cause of action should be dismissed, and their other causes of action have no conceivable independent basis for subject matter jurisdiction. Accordingly, whether under Rule 12(b)(1) or Rule 12(b)(6), the first cause of action and, accordingly, the Complaint in its entirety, should be dismissed.

Plaintiffs are current or former insureds, or "members," under health insurance plans administered by Healthfirst. The Healthfirst family of health insurance companies was founded by New York-area hospitals in the 1990s to improve access to high-quality health care for low-income New Yorkers. Healthfirst is a not-for-profit corporation that administers New York State-sponsored health insurance programs (including Medicaid) and government-subsidized health insurance plans to New York State residents. In their Complaint, Plaintiffs alleged that, after enrolling with Healthfirst, they were unsuccessful in obtaining mental health care treatment

through Healthfirst's provider network. They allege that Healthfirst's published directory of providers contained extensive inaccuracies as to health care providers' contact information, in-network status, and availability. These inaccuracies, Plaintiffs allege, caused Plaintiffs to incur costs in the form of time spent trying to locate providers, money spent on services from out-of-network providers, and delayed care. Plaintiffs also assert that they were induced to join Healthfirst, rather than some other health plan, due to Healthfirst's allegedly misstating the size, availability, and quality of its mental health provider network.[1]

But this Court need not reach the merits of Plaintiffs' claims because this action must be dismissed for lack of subject matter jurisdiction pursuant to Rule 12(b)(1). Plaintiffs allege that this Court has jurisdiction under 28 U.S.C. § 1331, but their claims are all creatures of state law: breach of contract, fraud, negligent misrepresentation, unjust enrichment, and violation of New York consumer protection and insurance laws. Plaintiffs' references to federal statutes do not transform these state-law counts into claims arising under federal law.

In particular, Plaintiffs make a concerted, but unsuccessful, attempt to invoke "arising under" jurisdiction in their first cause of action. There, Plaintiffs assert that Healthfirst breached its contracts with New York State, which in turn contain various requirements to comply with federal law. Although the Supreme Court has acknowledged a "special and small category" of state law claims that can be said to arise under federal law, the Complaint falls well short of the mark. The federal regulations cited by Plaintiffs are among numerous obligations they have put

[1] In reality, Plaintiffs have filed this case in the wake of a well-documented strain on the availability of mental healthcare services against a yearslong surge in demand. Indeed, putative class plaintiffs have brought lawsuits against much of the health insurance industry, with the same or similar allegations, including some by Plaintiffs' counsel. *See, e.g.*, *Doe v. Carelon Behav. Health, Inc.*, No. 25-CV-03489 (S.D.N.Y.); *American Psychiatric Ass'n v. EmblemHealth, Inc.*, No. 25-CV-10783 (S.D.N.Y.); *Roiz v. Blue Shield of California Life & Health Ins. Co.*, No. 25-CV-09978 (N.D. Cal.); *Mazzola v. Anthem Health Plans, Inc.*, No. 25-CV-01433 (D. Conn.); *Doe v. Anthem Healthchoice Assurance, Inc.*, No. 24-CV-08012 (S.D.N.Y.).

in issue, including express contractual provisions and state law obligations. It is clear that none of Plaintiffs' causes of action will turn on a necessary or substantial issue of federal law, as the Supreme Court requires for this rare species of federal question jurisdiction.

Even if this Court were to find that it somehow had subject matter jurisdiction over Plaintiffs' first cause of action, that claim should nonetheless be dismissed on the pleadings. The first cause of action is based exclusively on contracts between Healthfirst and New York State, and Plaintiffs have no standing to enforce the State's contract rights. Plaintiffs purport to assert rights as third-party beneficiaries, but there is a strong presumption against that doctrine in the case of government contracts, where the state has ample tools for protecting members of the public. Nothing in those agreements suggests that health plan members (such as Plaintiffs) were intended third-party beneficiaries. Rather, each State contract either expressly requires Healthfirst to have in place a *separate* contract with every member, or it disavows third-party beneficiary rights entirely. Such provisions preclude Plaintiffs from enforcing the State's contractual rights as would-be third-party beneficiaries. Because Plaintiffs have no standing to enforce the State's contractual rights against Healthfirst, the entire first cause of action, even if jurisdictionally before this Court, should be dismissed for failure to state a claim.

Whether the first cause of action is dismissed for jurisdictional reasons or on the merits, none of the remaining causes of action can keep this case in this Court. Plaintiffs' remaining causes of action (two through nine) each assert claims under contract, a New York statute, or state common law. Although references to federal obligations are sprinkled among various theories, the resolution of the remaining causes of action does not depend on, let alone involve, the evaluation of federal law.

BACKGROUND[2]

A. Healthfirst's Plans and Corresponding Contracts

Defendant Healthfirst PHSP, Inc. ("Healthfirst") is a not-for-profit corporation providing health insurance to New York residents. SAC ¶ 15. It administers various healthcare insurance plans including, as relevant here, the Healthfirst Essential Plans ("EPs"), the Healthfirst Leaf Plans (which are Qualified Health Plans, also referred to as "QHPs"), and the Healthfirst Medicaid Managed Care ("MMC") Plan. *Id.* ¶¶ 107-29.

Healthfirst's MMC Plan is available to Medicaid-eligible New York residents. *Id.* ¶ 127. It has no premium and no deductible, and New York State pays a capitated rate to Healthfirst for each MMC Plan enrollee. *Id.* ¶ 128. Healthfirst's EPs are available to New Yorkers who are not eligible for Medicaid, but who are below specified income levels.[3] *Id.* ¶¶ 117, 122. EP members pay no premium and no deductible and, similar to the MMC Plan, New York State pays Healthfirst a set rate for each EP enrollee. *Id.* ¶¶ 118, 123. Healthfirst's QHPs, including the Gold Leaf Premier Plan and the Silver Leaf Premier Plus Plan, provide insurance for New York residents who are not eligible for Medicaid or the EPs.[4] Members enroll in EPs and QHPs through the New York State of Health marketplace. *Id.* ¶ 102. Members enroll in MMC Plans through New York's official Medicaid portal.[5]

To administer the MMC Plans, EPs, and QHPs, Healthfirst contracts with New York State. *See id.* ¶ 102; *see also* Declaration of Joshua H. Pike in Support of Motion to Dismiss ("Pike

[2] Unless otherwise indicated, the facts set forth in this section are based on the allegations in the Second Amended Complaint and are assumed to be true solely for purposes of this Motion.

[3] N.Y. State of Health, Essential Plan Information (last accessed June 4, 2026), https://info.nystateofhealth.ny.gov/EssentialPlan.

[4] N.Y. State of Health, Qualified Health Plans Information (last accessed June 4, 2026), https://info.nystateofhealth.ny.gov/QualifiedHealthPlans.

[5] N.Y. Medicaid Choice, How to Enroll (last accessed June 4, 2026), https://nymedicaidchoice.com/en/how-enroll.

Decl.") ¶¶ 7, 11, 20. There is a contract between Healthfirst and New York State for each of these plans. *Id.*; *see also* Pike Decl. ¶¶ 7-9, 11-13, 20-22, Exs. 1-4, 7-8.[6]

Members of the EPs and QHPs have individual contracts with Healthfirst that define the rights of members and obligations of Healthfirst with respect to the members' healthcare benefits. *See* Pike Decl. ¶¶ 14, 23, Exs. 5-6, 9-10. Those contracts expressly provide: "This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us." *See* Pike Decl. ¶ 17, 26, Exs. 5-6, 9-10. In contrast, there are no contracts between members and Healthfirst for the MMC Plan. *See* Pike Decl. ¶ 10.

B. Plaintiffs' Allegations

Plaintiffs Joseph Greene, Pamela Mazza, and Deborah Schutt are all members of Healthfirst plans. Plaintiff Greene was enrolled in the Healthfirst Gold Leaf Premier plan (a QHP) from January 2023 to March 2024; the Healthfirst Essential Plan 200-250 from April 2024 to August 2025; and the Healthfirst Essential Plan 1 since September 2025. SAC ¶ 12. Plaintiff Mazza was enrolled in the Healthfirst MMC Plan from January 2024 to September 2025 and the Healthfirst Essential Plan 2 since September 2025. *Id.* ¶ 13. Plaintiff Schutt was enrolled in the Healthfirst Gold Leaf Premier plan from October 2022 through December 2023; the Healthfirst Silver Leaf Premier Plus plan from January 2024 through December 2025; and the Healthfirst Bronze Leaf Premier plan since January 2026 (all QHPs). *Id.* ¶ 14.

[6] Plaintiffs attach to the SAC a copy of the model contract between an insurer and New York State governing EPs and allege that this contract is the model for "the governing contracts between Healthfirst and New York State." SAC ¶ 215; SAC Ex. 1, ECF No. 21-1. Healthfirst's actual contracts with New York State for all three programs (MMC, EP and QHP) for each relevant period are submitted as part of this motion in the accompanying Declaration of Joshua H. Pike, including links to the online versions of certain larger agreements where available. *See* Pike Decl. ¶¶ 8, 9, 13 & Exs. 1-4, 7-8. Healthfirst also attaches the contracts that individual members had with Healthfirst. *See* Pike Decl., Exs. 5-6, 9-10.

Plaintiffs allege that Healthfirst's directory of in-network providers contains inaccurate information regarding behavioral health providers, including by listing some providers that are not in-network and by listing inaccurate information for others, such as incorrect contact information or whether the provider is taking new patients. *See, e.g.*, *id.* ¶¶ 4-5, 130, 139-40. Plaintiffs also allege that Healthfirst failed to help them locate accessible, in-network mental health care. *See, e.g.*, *id.* ¶ 249. Plaintiffs assert that these alleged provider directory inaccuracies induced them to choose Healthfirst plans rather than plans offered by other insurers and ultimately damaged them by causing them to incur the costs of searching for providers, using out-of-network providers and paying more expensive, out-of-network rates, or delaying behavioral health treatment. *See, e.g.*, *id.* ¶¶ 7-8, 63-65, 138, 185, 199, 253.

Based on these allegations, Plaintiffs assert nine causes of action: (1) breach of contract based on contracts between Healthfirst and New York State; (2) breach of contract based on contracts between Plaintiffs and Healthfirst; (3) breach of the implied covenant of good faith and fair dealing based on contracts between Plaintiffs and Healthfirst; (4) violation of the New York Deceptive Acts & Practices Act, N.Y. Gen. Bus. Law ("GBL") § 349; (5) violation of the New York False Advertising Act, GBL § 350; (6) violation of N.Y. Ins. Law § 4226; (7) fraudulent misrepresentation; (8) negligent misrepresentation; and (9) unjust enrichment.

C. Procedural Background

Plaintiff Greene commenced this putative class action on November 3, 2025. Complaint, ECF No. 4. On January 16, 2026, Healthfirst filed a pre-motion conference letter in anticipation of bringing a motion to dismiss the Complaint. ECF No. 15. In response, Plaintiff Greene indicated his intent to amend the Complaint, ECF No. 16, and on February 6, 2026, the Amended Complaint was filed, adding Plaintiffs Mazza and Schutt, ECF No. 18.

On February 19, 2026, Healthfirst and Plaintiffs jointly requested an extension of Healthfirst's deadline to respond to the Amended Complaint, following the Court's resolution of a motion to dismiss in *Doe v. Carelon Behavioral Health, Inc.*, No. 25-CV-03489, an action raising similar claims. ECF No. 19. The Court granted the parties' request and, on March 31, 2026, granted in part and denied in part the *Carelon* motion to dismiss. 2026 WL 880639, at *1 (S.D.N.Y. Mar. 31, 2026). On May 13, 2026, following a conference with the Court, Plaintiffs filed the instant Second Amended Complaint. ECF No. 21.

ARGUMENT

I. THE SECOND AMENDED COMPLAINT SHOULD BE DISMISSED FOR LACK OF SUBJECT MATTER JURISDICTION UNDER RULE 12(B)(1)

"A case is properly dismissed for lack of subject matter jurisdiction under Rule 12(b)(1) when the district court lacks the statutory or constitutional power to adjudicate it." *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000). To survive a motion brought under Rule 12(b)(1), the party invoking jurisdiction "has the burden of proving by a preponderance of the evidence that [subject matter jurisdiction] exists." *Id.* While a court must "accept as true all material factual allegations in the complaint," it must refrain from "drawing from the pleadings inferences favorable to the party asserting [jurisdiction]." *Shipping Fin. Serv. Corp. v. Drakos*, 140 F.3d 129, 131 (2d Cir. 1998); *see also APWU v. Potter*, 343 F.3d 619, 623 (2d Cir. 2003).

The Second Amended Complaint should be dismissed for lack of subject matter jurisdiction pursuant to Federal Rule of Civil Procedure 12(b)(1) because no cause of action confers jurisdiction under 28 U.S.C. § 1331, Plaintiffs' only proffered basis of jurisdiction. SAC ¶ 10.[7]

[7] There can be no subject matter jurisdiction under 28 U.S.C. § 1332, because the parties are not diverse: Plaintiffs are all citizens of New York, SAC ¶¶ 12-14, and Healthfirst is a corporation organized under the laws of New York and headquartered in New York, Pike Decl. ¶ 2. Moreover, Plaintiffs correctly declined to cite statutory provisions for diversity jurisdiction in class actions. *See* 28 U.S.C. § 1332(d). Healthfirst insures only residents of New York State, Pike Decl. ¶ 5, and any defined class would be composed entirely,

Federal subject matter jurisdiction is a creature of statute. Section 1331 of U.S. Code, Title 28, provides that "[t]he district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." Most commonly, a claim "arises under" federal law when federal law creates the cause of action. *See Gunn v. Minton*, 568 U.S. 251, 257 (2013) (citing *American Well Works Co. v. Layne & Bowler Co.*, 241 U.S. 257, 260 (1916)).

Federal jurisdiction may also extend to state-law claims that necessarily turn on a substantial and disputed question of federal law, but the doctrine is narrowly applied. *See Gunn*, 568 U.S. at 258 (describing "slim category" of cases subject to federal court jurisdiction). As set forth in *Gunn v. Minton*, federal jurisdiction exists over a state law claim only where each of four separate requirements is met, namely "if a federal issue is: (1) necessarily raised, (2) actually disputed, (3) substantial, and (4) capable of resolution in federal court without disrupting the federal-state balance approved by Congress." *Id.*; *see also Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 313-14 (2005). The Supreme Court has cautioned that such state claims represent a "special and small category." *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 699 (2006).

Here, none of the causes of action asserted by Plaintiffs come remotely close to satisfying this exacting standard.

A. The First Cause of Action Does Not Confer Federal Question Jurisdiction

The federal laws cited in Plaintiffs' first cause of action are insufficient to support federal jurisdiction. In their attempt to infuse federal law issues into the Complaint, Plaintiffs are

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or almost entirely, of citizens of New York, the same state of citizenship as the only named defendant, and the state where this action was filed. *See* 28 U.S.C. § 1332(d)(4).

singularly focused on their first cause of action for breach of contract. On examination, there is no issue of federal law present to the extent and in the manner necessary under *Gunn v. Minton*.

In their first cause of action, Plaintiffs allege that Healthfirst breached its contractual obligations to the State to maintain an adequate provider network and an accurate provider directory for mental health services. Plaintiffs allege that "[t]he contracts between New York State and Healthfirst require Healthfirst to provide … insurance benefits in compliance with federal law," which includes the Affordable Care Act's requirement to maintain an adequate network and publish an accurate provider directory, as well as the Mental Health Parity and Addiction Equity Act's requirement to provide mental health benefits on terms as favorable as other benefits, such as medical and surgical benefits. SAC ¶¶ 221-29. Plaintiffs assert that Healthfirst has breached its contracts with New York State by maintaining deficient networks and directories of mental healthcare providers, which in turn violates these federal statutory requirements. SAC ¶¶ 224, 226, 228-30.

Plaintiffs' first cause of action falls woefully short of the *Gunn* standard for a state-law claim to "arise under" federal law.

Most glaringly, the federal laws cited in the first cause of action are not necessary to the claim. As the Second Circuit has explained, "[w]here a federal issue is present as only one of multiple theories that could support a particular claim, … this is insufficient to create federal jurisdiction." *Anghel v. Ruskin Moscou Faltischek, P.C.*, 598 F. App'x 805, 807 (2d Cir. 2015) (internal quotation omitted); *see also Kennedy v. UnitedHealth Grp. Inc.*, No. 25-CV-432 (PAE), 2025 WL 1725147, at *5 (S.D.N.Y. June 20, 2025) (where complaint cited federal law "as one among multiple sources of … legal obligations," claim did not arise under federal law); *New York ex rel. Rasmusen v. Citigroup Inc.*, 220 F. Supp. 3d 523, 527-28 (S.D.N.Y. 2016) ("As [relator]

theoretically could prevail on this claim without determination of any federal question, the complaint does not *necessarily* raise a federal issue." (emphasis in original)).

Here, Plaintiffs make clear that the first cause of action does not depend solely on federal law. Plaintiffs' theory of breach is that Healthfirst "fail[ed] to contract with a sufficient number of mental health providers" and "fail[ed] to provide an accurate, and regularly updated, directory of in-network providers." SAC ¶¶ 224, 226. To the extent Healthfirst is accused of violating any obligations on these subjects, however, the Complaint makes clear that Plaintiffs have not based those obligations solely, or even principally, on federal law. Elsewhere, Plaintiffs cite numerous state-law obligations regarding network adequacy, including concrete benchmarks of geographic availability. *See* SAC ¶ 32 & nn.25, 27 (citing N.Y. Ins. Law § 3241(a)(1) and N.Y. Ins. Law § 4804(a)). Indeed, Plaintiffs point out that New York's provider directory requirements are "even more rigorous" than federal law. SAC ¶ 24 ("In New York, state law requires insurers to take even more rigorous steps to ensure that their provider directories are accurate.").

Moreover, the contract that Plaintiffs attached as the basis for this claim forecloses any argument that federal law is "necessary." The EP model contract with New York State, attached to the SAC as Exhibit 1, independently addresses network adequacy and provider directories with detailed contractual provisions. *See* SAC Ex. 1, Appx. C, at 26-27 (ECF pages 62-63) (provider directory requirements), 13-16 (ECF pages 49-52) (network composition, adequacy and review provisions); *id.*, Appx. D at 43-45 (ECF pages 134-36) (network adequacy requirements), 47-48 (ECF pages 138-39) (provider directory requirements).[8] The contract also refers to state law

[8] The same obligations are also set forth in Healthfirst's other contracts with New York State, which are referenced in, but not attached to, the Complaint. These include the New York State contract for QHPs, s*ee* Pike Decl., Ex. 8, Appx. C, at 27 (provider directory requirements), 11-13 (network adequacy and review provisions), Appx. D, at 37-40 (network adequacy requirements), 40-41 (provider directory requirements); *see also id.*, Ex. 7, Appx. C, at 27-28, 12-14; *id.*, Appx. D, at 40-44, 45, the New York State contract for EPs, *see id.*, Ex. 4, Appx. C, at 26-27 (provider directory requirements), 12-16 (network adequacy,

requirements in detail. *See, e.g.*, SAC Ex. 1, Appx. D at 47 (ECF No. 138) (citing N.Y. Ins. Law §§ 3217-1(a)17, 4324(a)(17) and N.Y. Pub. Health Law § 4408(r)). And in the body of the first cause of action itself, Plaintiffs refer to "compliance with federal . . . laws" as one of several relevant contractual obligations. SAC ¶ 220 (alleging that relevant contracts "require Defendant to provide Plaintiffs with benefits—an accurate mental health provider directory, the administration of mental health benefits in compliance with federal and state laws, and an adequate network of accessible mental health providers—which Defendant failed to deliver."). It would defy the content of the Complaint, including the agreements attached or referenced therein, to suggest that this breach claim turns on a "necessary" issue of federal law. For this reason alone, the claim cannot support "arising under" jurisdiction.

Separately, the first cause of action falls short of the third and fourth requirements for "arising under" jurisdiction: that a dispute be substantial and consistent with the normal state-federal judicial balance approved by Congress. The third inquiry, "substantiality," looks not to the importance of an issue to the case, but "to the importance of the issue to the federal system as a whole." *Gunn*, 568 U.S. at 260. The fourth inquiry "is concerned with the appropriate balance of federal and state judicial responsibilities." *Id.* at 264 (internal quotations omitted). Courts have observed that neither of these requirements are met where the resolution of a claim, rather than turning on an issue of pure law, is fact-intensive and situation-specific. *See Fracasse v. People's United Bank*, 747 F.3d 141, 145 (2d Cir. 2014) ("[A] pure question of law is more likely to be a substantial federal question" (internal quotation omitted)); *see also Empire Healthchoice Assur.,*

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composition, and review provisions), Appx. D, at 43-46 (network adequacy requirements), 47 (provider directory requirements); *see also id.*, Ex. 3, Appx. C, at 12-17, 28-29, Appx. D, at 43-47, 47-48, and the New York State contract for MMC Plans, *see* Pike Decl., Ex. 2, § 13.2 (provider directory requirements), § 21.1 (network requirements), § 21.19 (behavioral health network requirements); *see also id.* Ex. 1, §§ 13.2, 21.1, 21.19.

Inc., 547 U.S. at 699-700 (rejecting argument that plaintiff's claim for reimbursement arose under federal law and distinguishing *Grable* as a "dispute … centered on the action of a federal agency … and its compatibility with a federal statute," and presenting "a nearly pure issue of law" that "could be settled once and for all and thereafter would govern numerous tax sale cases" (internal quotations omitted)). In contrast, the rare cases in which a state-law claim qualifies for "arising under" jurisdiction have involved discrete, purely legal issues. *See, e.g. Tantaros v. Fox News Network, LLC*, 12 F.4th 135, 146 (2d Cir. 2021) (finding jurisdiction where "[t]he federal question is a purely legal one concerning the preemptive effect of a federal statute"); *New York City Health & Hosps. Corp. v. WellCare of New York, Inc.*, 769 F. Supp. 2d 250, 256 (S.D.N.Y. 2011) (analyzing reimbursement rates required by Medicare laws and regulations).

Here, like in *Empire Healthchoice*, Plaintiffs are asserting breaches against Healthfirst that are necessarily fact-bound and situation-specific. Plaintiffs are challenging the accuracy of directories, and the adequacy of the underlying network, that include thousands of providers – on behalf of several different members (or classes of them), at different times under different health plans, with different medical needs. Even if discovery produces an undisputed factual record, the outcome of this case will be inherently situation-specific, unlikely to be "controlling in numerous other cases." 547 U.S. at 700; *see also Kennedy*, 2025 WL 1725147, at *6 ("Allowing state courts to resolve whether and to what extent [federal law] imposes obligations on the hospitals at which [plaintiff] performed emergency medicine does not stand to undermine the development of a uniform body of [health insurance] law." (internal quotation omitted)).

In this context, any disputes of federal law that arise in this case will not be substantial to the federal system, nor beyond the usual experience of state courts. The emergence of federal issues is unremarkable in highly regulated industries, where state contracts, state statutes or state

common law are routinely litigated against a federal regulatory backdrop. The Second Circuit made this clear in one action where a defendant was accused of falsely representing, as part of a state-law contract, its compliance with federal securities laws. *Liana Carrier Ltd. v. Pure Biofuels Corp.,* 672 F. App'x 85, 91-92 (2d Cir. 2016). Plaintiffs argued "arising under" jurisdiction on the grounds that their contract claim "turns entirely on whether [relevant] SEC Reports complied in all material respects with the requirements of the Securities Act and the Exchange Act." *Id.* at 91 (internal quotation omitted). The Second Circuit disagreed:

> It is uncontested that Plaintiffs-Appellants' state law cause of action is structured as a run-of-the-mill state law contract claim, governed by state law standards and analyzed using the familiar elements applied in a New York breach of contract action. The fact that the state court's analysis of breach will necessarily turn on the requirements of federal securities law does not change the underlying nature of Plaintiffs-Appellants' claims, which are determined as a matter of course by the state courts every day – and whose resolution of any embedded federal issue, if decisive to the case, would ultimately be subject to possible Supreme Court review.

Id. at 92.

The same is true here. The underlying nature of Plaintiffs' claim is breach of contract, which, even if it involves reference to federal statutes, does not raise issues of substantial importance to the federal system, or present an issue unsuitable for resolution in state court. Plaintiffs are asserting a state breach-of-contract claim, and it does not confer jurisdiction in federal court.

B. The Second through Ninth Causes of Action Do Not Confer Federal Question Jurisdiction

None of Plaintiffs' remaining claims raise a federal question, let alone necessarily raise a federal question, to satisfy 28 U.S.C. § 1331.

1. Contractual Claims (Causes of Action Two and Three)

The Second Amended Complaint's second and third causes of action are premised on Healthfirst's alleged breach of its contractual obligations, and implied covenant of good faith and

fair dealing, arising out of its "Plan Contract[s]" with each Plaintiff. SAC ¶¶ 233, 246. Specifically, Plaintiffs allege that Healthfirst breached its obligations to sufficiently "[c]over outpatient mental health care services," maintain an accurate provider directory, "adhere to the protocol established by the contracts for resolving Access Complaints," and "support Plaintiffs in locating accessible, in-network care." SAC ¶¶ 235-36, 242, 247, 249.

These claims arise from obligations that Plaintiffs allege are explicitly stated in or implied by Healthfirst's Plan Contracts. In other words, the resolution of these claims does not depend on, or even involve, the evaluation of federal law. Indeed, there is no mention of federal law in Plaintiffs' second or third causes of action. *See* SAC ¶¶ 232-53.

2. State Statutory Claims (Causes of Action Four, Five, and Six)

The fourth, fifth, and sixth causes of action allege violations of New York statutory law and do not require the resolution of federal questions. Plaintiffs' GBL claims (the fourth and fifth causes of action) are premised on Healthfirst's allegedly false representations and omissions concerning the adequacy of its behavioral health network, the accuracy of its provider directory, the sufficiency of its mental health care coverage, and the likelihood that a member seeking mental health care would have to obtain care out-of-network and the costs related to such care. SAC ¶¶ 262-63, 277-78. Plaintiffs' insurance law claim (the sixth cause of action) is based on alleged misrepresentations of the terms, benefits, and advantages of the Plaintiffs' plans. SAC ¶ 285. All of these claims fundamentally allege misrepresentations by Healthfirst, none of which require reference to federal law. Rather, to establish a violation of GBL §§ 349 and 350, Plaintiffs must prove that a reasonable consumer would have been misled by Healthfirst's representations or advertisements. *See Chufen Chen v. Dunkin' Brands, Inc.*, 954 F.3d 492, 500 (2d Cir. 2020). Likewise, a health insurer violates Insurance Law § 4226(a)(1) by "misrepresenting the terms,

benefits or advantages of any of its policies or contracts." N.Y. Ins. Law § 4226(a)(1). None of these claims requires an assessment of federal law.

Plaintiffs cite federal obligations in pleading these causes of action, but mere mentions cannot change the jurisdictional outcome. In their GBL Section 349 claim, for example, Plaintiffs cite federal law three times. *See* SAC ¶ 256 ("Defendant violated GBL § 349 by failing to provide Plaintiffs and the Class with the accurate information about in-network providers required by federal law"); *id.* ¶ 264 (representations conveyed that provider directory was accurate and broad, "as federal law requires"); *id.* ¶ 268 (violation of GBL § 349 intended "to create the appearance of network adequacy and compliance with state and federal law"). Plaintiffs make similar allegations as part of their GBL Section 350 claims. *See id.* ¶¶ 271, 275, 282. (Plaintiffs do not cite any federal law as part of their Insurance Law claim. *See* SAC ¶¶ 283-89.) Stray references to federal law, however, do not transform what are fundamentally state law claims. *See Caggiano v. Pfizer Inc.*, 384 F. Supp. 2d 689, 690 (S.D.N.Y. 2005) (granting motion to remand and rejecting argument that complaint asserting "classic state-law claims" that were "peppered" with federal law violations arose under federal law); *Segal v. Varonis Sys., Inc.*, 601 F. Supp. 2d 551, 554 (S.D.N.Y. 2009) (references to federal law were "contextual allegations" that did not convert state claim into federal claim); *New York by James v. Nat'l Gen. Holdings Corp.*, No. 25-CV-3608 (LAK) (RWL), 2025 WL 3085244, at *3 (S.D.N.Y. Aug. 4, 2025) ("[T]he mere mention of a federal statute in a state law cause of action does not, by itself, create federal question jurisdiction."), *report and recommendation adopted*, No. 25-CV-3608 (LAK), 2025 WL 3013095 (S.D.N.Y. Oct. 28, 2025). Plaintiffs' state statutory claims do not provide a basis for federal question jurisdiction.

3. State Common Law Claims (Causes of Action Seven, Eight, and Nine)

For similar reasons, there is no basis for federal jurisdiction in Plaintiffs' remaining common law claims. Like Plaintiffs' GBL claims, the fraud and negligent misrepresentation

claims (the seventh and eighth causes of action, respectively) are premised on allegedly false or misleading statements regarding the adequacy of the provider network and accuracy of the provider directory. SAC ¶¶ 294-95, 309-10. They contain only stray references to federal law that do not transform what are fundamentally state law claims into federal claims. *See Caggiano*, 384 F. Supp. 2d at 690. Assessing whether Healthfirst intentionally, or negligently, made false representations or omitted material information, whether Plaintiffs justifiably relied on such information, and whether Plaintiffs were injured as a result, does not raise a question of federal law, let alone an issue of federal law that is necessary or substantial. *See Varga v. McGraw Hill Fin., Inc.*, 36 F. Supp. 3d 377, 382 (S.D.N.Y. 2014) (federal jurisdiction lacking where defendant's compliance with federal law was "incidental" to fraud claim); *In re Oxycontin Antitrust Litig.*, 821 F. Supp. 2d 591, 598 (S.D.N.Y. 2011) (commonwealth's alleged obligation to cover costs of OxyContin under federal Medicaid law not necessarily raised in fraud claim).

The same is true of the unjust enrichment claim (the ninth cause of action), which, like the GBL and fraud claims, refers to federal law only in passing. *See, e.g.*, SAC ¶ 319 ("Defendant's inflated mental health provider network makes it appear that it complies with federal and state statutory and regulatory requirements"). Assessing whether Healthfirst was enriched at Plaintiffs' expense, and whether it would be inequitable to allow Healthfirst to retain such benefits, does not require analysis of federal laws. *See Briarpatch Ltd., L.P v. Phoenix Pictures, Inc.*, 373 F.3d 296, 306 (2d Cir. 2004) (discussing elements of unjust enrichment).

In sum, none of Plaintiffs' causes of action arise under federal law, and the Second Amended Complaint should be dismissed in its entirety for lack of subject matter jurisdiction.

II. IN THE ALTERNATIVE, EVEN IF THE FIRST CAUSE OF ACTION CONFERS JURISDICTION, IT SHOULD BE DISMISSED FOR FAILURE TO STATE A CLAIM

Even if the Court finds that the first cause of action "arises under" federal law, that claim should still be dismissed for failure to state a claim pursuant to Federal Rule of Civil Procedure 12(b)(6). Specifically, plaintiffs have no plausible standing to enforce New York State's contractual rights as third-party beneficiaries. In addition, to the extent it is based on federal law, the claim is an impermissible attempt to litigate alleged federal rights in the absence of a private civil remedy. Upon dismissing this claim, the Court should also decline to exercise supplemental jurisdiction over the remaining causes of action.

To survive a motion to dismiss pursuant to 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A claim is plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* While a court must accept all factual allegations in the complaint as true and draw all reasonable inferences in the plaintiff's favor, *see Lynch v. City of N.Y.*, 952 F.3d 67, 75 (2d Cir. 2020), a court is not "bound to accept conclusory allegations or legal conclusions masquerading as factual conclusions," *Faber v. Metro. Life Ins. Co.*, 648 F.3d 98, 104 (2d Cir. 2011) (internal quotation omitted). In ruling on the motion, the complaint "is deemed to include any written instrument attached to it as an exhibit or any statements or documents incorporated in it by reference," as well as any document "upon which [the plaintiff] solely relies and which is integral to the complaint." *Int'l Audiotext Network, Inc. v. AT&T Co.*, 62 F.3d 69, 72 (2d Cir. 1995). The Court is not "constrained to accept the allegations of the complaint in respect of the construction of [an] [a]greement." *Id.*

With respect to contract claims asserted by would-be third-party beneficiaries, dismissal "is appropriate where the contract rules out any intent to benefit the claimant." *Subaru Distributors Corp. v. Subaru of Am., Inc.*, 425 F.3d 119, 124 (2d Cir. 2005) (affirming dismissal of breach of contract claim where contract precluded inference that plaintiff was intended beneficiary of contract); *see also Doe v. Carelon Behav. Health, Inc.*, No. 25-CV-03489 (ER), 2026 WL 880639, at *12 (S.D.N.Y. Mar. 31, 2026) (dismissing third-party beneficiary claim where "language of the Contract makes clear that enforcement by the Plaintiffs is not intended"); *Anwar v. Fairfield Greenwich Ltd.*, 728 F. Supp. 2d 372, 458 (S.D.N.Y. 2010) (dismissing third-party beneficiary claim where contract "fail[ed] to show an intent to confer third-party beneficiary status on Plaintiffs").

A. Healthfirst's Contracts with New York State Do Not Manifest an Intent for Enforcement by Third Parties

It is well established that a third party to an agreement can enforce rights under that agreement only where its "terms clearly evidence[ ] an intent to permit enforcement by the third party in question." *Hillside Metro Assocs., LLC v. JPMorgan Chase Bank, Nat. Ass'n*, 747 F.3d 44, 49 (2d Cir. 2014) (internal quotation omitted). Moreover, there is a "heightened standard for evaluating intended third party beneficiary status" for government contracts. *Fero v. Excellus Health Plan, Inc.*, 236 F. Supp. 3d 735, 767 (W.D.N.Y. 2017). In that context, a plaintiff must show that "'a direct action against the promisor is consistent with the terms of the contract and with the policy of the law authorizing the contract and prescribing remedies for its breach.'" *Id.* (quoting Restatement (Second) of Contracts § 313 cmt. a (1981)). In other words, for government contracts, "individual members of the public are treated as incidental beneficiaries unless a different intention is manifested." *Hillside Metro Assocs., LLC*, 747 F.3d at 49 (quoting Restatement (Second) of Contracts § 313 cmt. a).

Here, Plaintiffs cannot plausibly plead claims as third-party beneficiaries. As part of their first cause of action, Plaintiffs invoke three contracts — the contracts governing the EPs, QHPs, and MMC Plans — all of which are government contracts between Healthfirst and New York State. None of these contracts manifests an intent to allow Plaintiffs to enforce New York State's rights as third-party beneficiaries.

As for the QHP and EP contracts, the terms of the contract plainly refute any intended enforcement by third-party plan members. *First*, the QHP and EP contracts both expressly require Healthfirst to enter into separate contracts with each member. *See, e.g.*, SAC Ex. 1, Appx. C, at 7 (defining "Subscriber Contract" as the contract between contractor, *i.e.*, Healthfirst, and subscriber, *i.e.*, the enrollee in the plan, that "details the provision of health care coverage under this Agreement"); Pike Decl., Ex. 7, Appx. C at 8 (same); Pike Decl., Ex. 8, Appx. C at 8 (same); Pike Decl., Ex. 3, Appx. C at 7 (same); Pike Decl., Ex. 4, Appx. C at 7; *see also* SAC Ex. 1, Appx. C, at 25 ("CONTRACTOR must provide all Enrollees an information package as required by 45 C.F.R. 156.265(e), including a Subscriber Contract"); Pike Decl., Ex. 7, Appx. C, at 26 (same); Pike Decl., Ex. 3, Appx. C, at 27 (same); Pike Decl., Ex. 4, Appx. C, at 24 (same); Pike Decl., Ex. 8, Appx. C, at 28 ("The CONTRACTOR shall issue to a new Enrollee … a Subscriber Contract"). In other words, the QHP and EP contracts both make clear that members' contractual rights will reside in a separate agreement, rather than in the state contract itself. *See Debary v. Harrah's Operating Co.*, 465 F. Supp. 2d 250, 268 (S.D.N.Y. 2006) (finding plaintiff was not third-party beneficiary where "[the plaintiff's] rights were clearly defined" in separate agreement), *aff'd sub nom. Catskill Dev., L.L.C. v. Park Place Ent. Corp.*, 547 F.3d 115 (2d Cir. 2008); *4 Hour Wireless v. Smith*, No. 01-CV-9133 (RO), 2002 WL 31654963, at *1 (S.D.N.Y. Nov. 22, 2002) (plaintiff not third-party beneficiary of contract where separate agreement governed its rights).

Second, there is nothing in any of the contracts to affirmatively support — much less "clearly evidence" — an intention that New York State's contractual rights be enforceable by individual plan members. Members are not explicitly designated as third-party beneficiaries, nor given any explicit enforcement rights in the State contracts. The Complaint alleges that "Plaintiffs and other Class members, are mentioned throughout the contracts." SAC ¶ 218. To be clear, neither Plaintiffs nor any individual members are specifically named in Healthfirst's contracts with the State. The contracts refer, instead, to members generally — *i.e.*, potential current and future subscribers to a government health program. Such a public benefit contract is presumed *not* to carry direct enforcement rights for individual participants, "unless a different intention is manifested." *Hillside Metro Assocs., LLC*, 747 F.3d at 49. More fundamentally, the mere mention of members is not sufficient to confer third-party rights. *See Debary*, 465 F. Supp. 2d at 266 ("If the LPA specifically mentioned Monticello by name one hundred times, that alone would not constitute sufficient evidence that parties to the LPA intended for Monticello to be a third-party beneficiary."); *see also Anwar*, 728 F. Supp. 2d at 457-58 (holding that contract's "deafening silence" on third-party beneficiary rights demonstrated lack of intent to confer benefits on third party).

Third, the individual member contracts have integration clauses, directly contradicting the existence of other (third-party beneficiary) contractual rights. Each member contract expressly provides that it "constitutes the entire agreement" between the member and Healthfirst. Pike Decl., Ex. 5 at 1; Ex. 9 at 1; Exs. 6, 10; *see Debary*, 465 F. Supp. 2d at 267-68 (integration clause in contract with plaintiff signaled that plaintiff was not intended third-party beneficiary of separate contract); *In re Lehman Bros. Holdings Inc.*, 515 B.R. 171, 178 (Bankr. S.D.N.Y. 2014) (same).

Finally, as for the contract between New York State and Healthfirst governing the administration of MMC Plans, under which there are no subscriber agreements, there is an express disclaimer of third-party beneficiary rights:

> 31. NO THIRD PARTY BENEFICIARIES
>
> Only the parties to this Agreement and their successors in interest and assigns have any rights or remedies under or by reason of this Agreement.

Pike Decl., Ex. 1, Appx. C, § 31; Ex. 2, Appx. C, § 31. "[W]here a provision exists in an agreement expressly negating an intent to permit enforcement by third parties, that provision is decisive." *India.Com, Inc. v. Dalal*, 412 F.3d 315, 321 (2d Cir. 2005) (internal quotation and ellipsis omitted); *see also Kafka v. Wells Fargo Sec., LLC*, No. 23-1281-CV, 2024 WL 4533332, at *4 (2d Cir. Oct. 21, 2024) (affirming dismissal of third-party beneficiary claim where contract expressly disclaimed third-party rights); *Wilson v. Dantas*, 746 F.3d 530, 537 (2d Cir. 2014) (same). Indeed, this Court, when confronted with an express disclaimer of third-party beneficiary rights in *Carelon Behavioral Health, Inc.*, found that such disclaimer "clearly evince[ed] an intent to prohibit third-party enforcement" and ultimately rejected plaintiff's third-party beneficiary theory. 2026 WL 880639, at *11. Here too, the express disclaimer of third-party beneficiary rights in the MMC contract is "decisive." *India.Com, Inc.*, 412 F.3d at 321.

B. Plaintiffs' Third-Party Beneficiary Claim Is an Impermissible End Run Around Federal Statutes' Lack of Private Rights of Action

Plaintiffs' first claim fails for the separate reason that permitting Plaintiffs to proceed on a third-party beneficiary theory would improperly undermine Congressional intent, because each of the federal statutory provisions upon which Plaintiffs premise their first claim lacks a private right of action.

It is well established that Plaintiffs cannot use third-party breach of contract claims as an end run around a statute's lack of a private right of action. *See Grochowski v. Phoenix Const.*, 318

F.3d 80, 86 (2d Cir. 2003) (rejecting plaintiffs' attempt to sue as third-party beneficiaries under contracts that incorporated federal statutory wage requirements, holding that such a claim would be "an impermissible 'end run' around the" statute's lack of a private right of action). Indeed, the Supreme Court held, under strikingly similar circumstances to those present here, that a statute's lack of a private right of action precluded a breach of contract claim where such claim was based on the breach of a provision incorporating the statute.

In *Astra USA, Inc. v. Santa Clara County*, healthcare facilities covered under Section 340B of the Public Health Services Act ("PHSA"), which imposes ceilings on prices drug manufacturers could charge to the facilities, alleged that Astra and other manufacturers charged prices over the federal ceilings, violating the PHSA and therefore breaching their contracts with the Department of Health and Human Services ("HHS"). 563 U.S. 110, 113 (2011). In asserting their claims, the facilities argued that they were intended third-party beneficiaries of the manufacturers' contracts with HHS. *Id.* at 116-17. The Court held that the facilities could not sue as third-party beneficiaries because the PHSA did not have a private right of action, and the suits were thus "incompatible with the statutory regime" established by Congress. *Id.* at 113; *see also id.* at 114 (observing that if the facilities "may not sue under the statute, it would make scant sense to allow them to sue on a form contract implementing the statute, setting out terms identical to those contained in the statute.").

Courts in this Circuit have applied *Astra* in other healthcare-related contexts. For example, in *New York City Health & Hospitals Corporation v. WellCare of New York, Inc.*, the court dismissed a third-party breach of contract claim brought by a provider against a health plan, based on the plan's alleged violation of Medicare laws incorporated in a contract between the plan and the Centers for Medicare & Medicaid Services. 801 F. Supp. 2d 126, 137-40 (S.D.N.Y. 2011). The

Court relied on *Astra*, reasoning that allowing the claim to proceed would improperly undermine Congress's decision against allowing private individuals to enforce Medicare laws. *Id.* at 137; *see also SpecialtyCare Inc. v. Meritain Health, Inc.*, No. 25-CV-198 (MN), 2026 WL 353259, at *5 (D. Del. Feb. 9, 2026) (dismissing plaintiffs' state law claims because sole theory of wrongdoing was that defendant failed to comply with the No Surprises Act, which did not contain a private right of action, and permitting common law claims to proceed on this theory would upend Congressional intent), *report and recommendation adopted*, No. 25-CV-198 (MN), 2026 WL 745341 (D. Del. Mar. 17, 2026).

Here, like in *Astra* and *WellCare*, allowing Plaintiffs' contract claim to proceed would undermine the enforcement scheme selected by Congress. In the guise of enforcing the contractual rights of New York State, purportedly as third-party beneficiaries, Plaintiffs seek to hold Healthfirst liable for alleged violations of various federal laws. Those federal laws, however, by their terms, are not enforceable by Plaintiffs through private litigation. There is no private right of action under the relevant provisions of the Affordable Care Act,[9] the Mental Health Parity and Addiction Equity Act,[10] the No Surprises Act, the Public Health Service Act, and the Internal Revenue Code. SAC ¶ 222. Indeed, courts within this Circuit have affirmatively concluded that there is no standalone private right of action under the Mental Health Parity and Addition Equity Act. *See Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248, 255 (S.D.N.Y. 2018); *Munnelly v. Fordham Univ. Faculty*, 316 F. Supp. 3d 714, 728 (S.D.N.Y. 2018). Similarly,

[9] The ACA has a limited private right of action under its nondiscrimination provision, *see Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 218 (2022) (observing it was "beyond dispute" that private individuals may sue to enforce non-discrimination provision in ACA, 42 U.S.C. § 18116), but it does not otherwise have a general private right of action.

[10] Courts have held that ERISA (which Plaintiffs also claim was violated) provides a private right of action for enforcing certain Mental Health Parity and Addiction Equity Act violations. *See Gallagher*, 339 F. Supp. 3d at 255. But ERISA does not apply here, because Plaintiffs have not alleged that they were members of a group health insurance plan.

courts have held that there is no general private right under the Internal Revenue Code. *See Seabury v. City of New York*, No. 06-CV-1477 (NGG), 2006 WL 1367396, at *5 (E.D.N.Y. 2006) ("Private citizens cannot enforce the provisions of the Tax Code," because "[t]hat is the duty of the Secretary of the Treasury and the Commissioner of the Internal Revenue Service, who are charged with the responsibility of administering and enforcing the Tax Code.").[11]

Permitting Plaintiffs to sue as third parties for breach of contract based on the violation of federal statutory provisions that lack a private right of action would thus constitute an improper end-run around Congress's affirmative choice to avoid vesting private citizens with the power to enforce statutory provisions aimed at regulating the plans at issue. Accordingly, this Court should conclude that Plaintiffs are not intended third-party beneficiaries under Healthfirst's contracts with New York State and dismiss the first cause of action.

C. The Court Should Decline to Exercise Supplemental Jurisdiction over Plaintiffs' State-Law Claims

The Second Circuit instructs that "[a] district court usually should decline the exercise of supplemental jurisdiction when all federal claims have been dismissed at the pleading stage." *Waronker v. Hempstead Union Free Sch. Dist.*, 788 F. App'x 788, 795 (2d Cir. 2019) (quoting *Denney v. Deutsche Bank AG*, 443 F.3d 253, 266 (2d Cir. 2006)). Should this Court conclude that Plaintiffs' first cause of action – the only cause of action for which Plaintiffs have made a concerted attempt to style as arising under federal law – confers federal question jurisdiction, this Court

[11] Courts within this Circuit are split on whether there is a private right of action to enforce the NSA's IDR provisions, *compare Guardian Flight LLC v. Aetna Life Ins. Co.*, 789 F. Supp. 3d 214, 229 (D. Conn. 2025) (holding that NSA creates private cause of action to enforce IDR awards) *with Farkas, M.D., LLC v. Horizon Blue Cross Blue Shield of New Jersey*, 790 F. Supp. 3d 129, 137 (E.D.N.Y. 2025) (holding that NSA lacks private right of action to enforce IDR award), but the undersigned has not located a single case holding that there is a private right of action to enforce the NSA's provisions regarding directory accuracy.

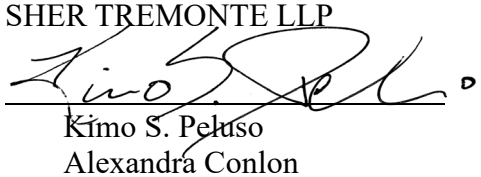
should nevertheless dismiss the first cause of action for the reasons discussed above and decline to exercise supplemental jurisdiction over Plaintiffs' remaining state law claims.

CONCLUSION

For the foregoing reasons, Defendant respectfully requests that the Court dismiss Plaintiffs' Second Amended Complaint in its entirety pursuant to Rule 12(b)(1) or, in the alternative, dismiss the first cause of action pursuant to Rule 12(b)(6) and decline to exercise supplemental jurisdiction over the remaining causes of action.

Dated: New York, New York
June 4, 2026

SHER TREMONTE LLP



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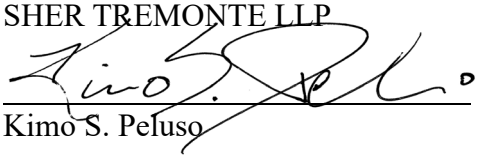
CERTIFICATE OF COMPLIANCE

The undersigned counsel of record for Defendant Healthfirst PHSP, Inc. certifies that the foregoing brief complies with the 25-page limit set forth in Rule 2(B)(i) of the Court's Individual Practices.

Dated: New York, New York
June 4, 2026

Respectfully submitted,

SHER TREMONTE LLP



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