SHER TREMONTE LLP

BY ECF

January 16, 2026

The Honorable Edgardo Ramos
United States District Court for the
Southern District of New York
40 Foley Square
New York, New York 10007

Re: *Joseph Greene v. Healthfirst PHSP, Inc.*
No. 25-cv-09058 (ER)

Dear Judge Ramos:

For Defendant Healthfirst PHSP, Inc. ("Healthfirst"), we write pursuant to the Court's Individual Practices, Rule 2(A)(ii), regarding our anticipated motion to dismiss the Complaint (ECF No. 4) under Federal Rule 12(b)(6).[1]

Healthfirst is a private not-for-profit corporation that administers health insurance plans sponsored or subsidized through government health assistance programs. As a managed care organization, Healthfirst principally administers health insurance benefits to Medicaid enrollees who subscribe to Healthfirst (thereby becoming Healthfirst "members"), coverage that Healthfirst provides pursuant to its contracts with the New York State Department of Health. Healthfirst also administers government-subsidized health plans available through the New York State Health Insurance Marketplace.

This case arises from Plaintiff's allegations that he was unable to access in-network mental health providers under a Healthfirst insurance plan into which he enrolled in January 2023. He enrolled in a second Healthfirst plan in April 2024, and a third Healthfirst plan in September 2025. He alleges a single communication with Healthfirst about his access issues in 2023 under the first plan, and no communications under the second or third plan. Complaint ¶ 11, 50.

Plaintiff alleges that Healthfirst's directory of its in-network providers (the "Directory") contains incorrect information about various mental health providers, including as to their contact information, their availability, and their network status. *Id.* ¶¶ 4-7. Plaintiff brings this action individually and putatively on behalf of a class of all similarly-situated individuals. *Id.* ¶¶ 124-25. Plaintiff asserts nine causes of action, each of which is addressed below. Without limitation, for the reasons that follow, each of Plaintiff's causes of action must be dismissed.

Breach of Healthfirst's Contract with New York State (Count 1). Plaintiff's first breach of contract claim must be dismissed because Plaintiff fails to plead the existence of a contract that he has the right to enforce. Plaintiff claims the breach of an alleged contract that Healthfirst has

[1] To the extent relevant to the Court's consideration, there is a fully briefed motion to dismiss before Your Honor in *Doe v. Carelon Behavioral Health, Inc.*, No. 25-cv-03489, brought by Plaintiff's counsel, involving many similar allegations against an unrelated defendant.

with New York State, Compl. ¶ 143, to which Plaintiff claims to be an intended third-party beneficiary, *id.* ¶ 138. This cause of action should be dismissed for at least three reasons. First, Plaintiff fails to sufficiently identify the alleged contract or contract(s) with New York State. *Theracare of New York, Inc. v. 11-20 46th Rd. Owner LLC*, 651 F. Supp. 3d 637, 644 (E.D.N.Y. 2023). Second, Plaintiff fails to allege any facts to support the legal conclusion that he is a third-party beneficiary. *Hillside Metro Assocs., LLC v. JPMorgan Chase Bank, N.A.*, 747 F.3d 44, 49 (2d Cir. 2014) (third party to an agreement can only enforce it where "the contract terms 'clearly evidence[] an intent to permit enforcement by the third party' in question"). Third, to the extent Plaintiff identifies a particular contract to support his claim, the terms of such contract are unlikely to support any rights for non-parties. Indeed, Healthfirst's contracts with New York State tend to expressly disclaim any enforcement by non-parties, which precludes third-party beneficiary claims under New York law. *JTRE Manhattan Ave. LLC v. Cap. One, N.A.*, 585 F. Supp. 3d 474, 482 (S.D.N.Y. 2022) (dismissing claim where contract disclaimed rights of third parties).

Breach of Plaintiff's Contract and of the Implied Covenant (Counts 2, 3). Plaintiff brings a second breach of contract claim premised on his direct contractual relationship with Healthfirst, and a third claim for breach of the implied covenant. Compl. ¶¶ 152, 157-159.

Plaintiff does not clearly identify the contract upon which his second and third counts are based,[2] a deficiency that could presumably be addressed by repleading. Relatedly, although Plaintiff purports to sue over three separate health plans, he asserts conduct supposedly amounting to a breach only under one of them. Plaintiff quotes from a contractual protocol that he claims Healthfirst breached by not returning his phone call and by not notifying him of certain information. *Id.* ¶¶ 158-59. But Plaintiff alleges only one attempt to contact Healthfirst, triggering that protocol, sometime in 2023, under his Gold Leaf Premier plan contract. *Id.* ¶¶ 50. There are no allegations suggesting any similar breaches under his subsequent contracts with Healthfirst for the Essential 200-250 plan, and for the Essential Plan 1. *Id.* ¶¶ 11, 65-74. Separately, Plaintiff quotes "coverage" obligations, *id.* ¶ 153, but the Complaint contains no allegations that Healthfirst refused to cover any of his plan benefits, for example, by rejecting an authorization request or denying payment to a provider. And there are no allegations that Plaintiff sought, much less was denied, any mental health benefits under his Essential 200-250 or Essential Plan 1 contracts. Plaintiff's second and third causes of action should be dismissed or significantly narrowed as to the actual contract at issue, and as to the specific obligations alleged to have been breached.

GBL § 349 and § 350 (Counts 4 and 5). Plaintiff alleges that Healthfirst violated GBL §§ 349 and 350 by failing to provide Plaintiff with accurate information about in-network providers. Compl. ¶¶ 169, 183. To state a claim under GBL § 349 and § 350, the plaintiff must allege, among

[2] Plaintiff alleges that he enrolled in three separate Healthfirst plans since January 2023. Compl. ¶ 11. This would mean that he had three separate contracts with Healthfirst, over three separate time periods, although Plaintiff conflates them as "the contract" in his pleading. *E.g.*, *id.* ¶¶ 154-55. He does not attach copies of the relevant contract(s), and does not allege when or how he entered into such contracts. *Abu Dhabi Com. Bank v. Morgan Stanley & Co. Inc.*, 651 F. Supp. 2d 155, 183-84 (S.D.N.Y. 2009) (dismissing where complaint alleged existence of contract but failed to allege critical facts concerning the contract's formation, including "what constituted an offer and acceptance of the contract").

other things, that plaintiff has been "injured as a result" of the conduct that violated the law. *Chufen Chen v. Dunkin' Brands, Inc.*, 954 F.3d 492, 500 (2d Cir. 2020). Plaintiff, who enrolled and re-enrolled with Healthfirst for at least three years, fails to plausibly allege that he was injured as a result of the alleged false and misleading representations about Healthfirst's network, and elsewhere makes clear that he remained a Healthfirst member long after access issues were known to him. *See e.g.*, Compl. ¶ 179 (injuries include, among other things, "significant out-of-pocket expenses," "reduce[d] spending on necessities and other life costs," lack of access to mental health care, and so on); *but see id.* ¶¶ 50-52 (during Plaintiff's first year of enrollment, Plaintiff learned that Healthfirst Directory was unreliable and turned to out-of-network coverage).

NY Ins. Law § 4226, Fraud, and Negligent Misrepresentation (Counts 6, 7, 8). Plaintiff alleges that Healthfirst violated N.Y. Ins. Law § 4226 and made intentional and negligent misrepresentations by misstating the breadth and access to its in-network mental health providers to induce him to enroll in its healthcare plans. Plaintiff's § 4226 and negligent misrepresentation claims, which sound in fraud, and Plaintiff's fraudulent misrepresentation claim are subject to Rule 9(b)'s heightened pleading requirements. *Brach Fam. Found., Inc. v. AXA Equitable Life Ins. Co.*, 2016 WL 7351675, at *4–5 (S.D.N.Y. Dec. 19, 2016); *Schwartzco Enters. LLC v. TMH Mgmt., LLC*, 60 F. Supp. 3d 331, 350 (E.D.N.Y. 2014). Under that standard, all three claims fail because the Complaint is insufficiently specific and particular regarding the alleged knowingly false statements that Plaintiff claims he relied on to his detriment and because the Complaint fails to establish such reliance was justifiable. *See Sanchez v. ASA Coll., Inc.*, 2015 WL 3540836, at *5 (S.D.N.Y. June 5, 2015) (collecting cases dismissing fraud claims under Rule 9(b), explaining Plaintiff "must do more than say that the statements were false . . . they must demonstrate with specificity why and how that is so.") (citation omitted).

Unjust Enrichment (Count 9). Plaintiff claims that Healthfirst has been unjustly enriched through premiums that Healthfirst was paid by Plaintiff and by New York State for administering Plaintiff's benefits in the Essential Plan, and through avoiding the cost of Plaintiff's out-of-network mental health care. Compl. ¶¶ 224-226. To the extent any of Plaintiff's claims are governed by a contract (as Plaintiff alleges), including the contract between Healthfirst and New York State, Plaintiff's unjust enrichment claim must be dismissed. *Ahmed v. Cigna Health Mgmt., Inc.*, 2024 WL 3345819, at *6 (S.D.N.Y. July 8, 2024). This is true even if Plaintiff himself is not a party to the contract, because the existence of an agreement governing the subject matter precludes the application of quasi-contract doctrines.

Respectfully submitted,

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