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 Civ. 9058 (ER)

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

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Plaintiffs Joseph Greene, Pamela Mazza, and Deborah Schut respectfully submit this memorandum of law in opposition to defendant Healthfirst PHSP, Inc.'s motion to dismiss the Second Amended Complaint ("Mot.").

PRELIMINARY STATEMENT

Healthfirst's motion to dismiss is a transparent attempt to remove this case from a perceived unfavorable forum. In its pre-motion letter summarizing the arguments it would make in its motion to dismiss Plaintiffs' original complaint, Healthfirst made no mention of the jurisdictional argument it now presses. After Plaintiffs amended their complaint to address the non-jurisdictional arguments that Healthfirst had raised, the parties agreed to stay litigation pending this Court's decision on the pending motion to dismiss in *Carelon*, which raised many of the same arguments that Healthfirst had previewed in its pre-motion letter. Ultimately, this Court denied Carelon's motion in large part, and Plaintiffs amended their complaint to address other issues identified in the Court's decision.

Healthfirst, desperate to avoid Carelon's fate, now argues for the first time that the Court lacks jurisdiction to hear this case. The Court should reject this obvious ploy to escape the implications of the *Carelon* decision. If Healthfirst sincerely believes the Court lacks jurisdiction, it should explain why it failed to raise that issue before the *Carelon* decision. In any event, for the reasons set forth below, Healthfirst's arguments for dismissal should be rejected: Plaintiffs have adequately alleged that this Court has jurisdiction, and they have stated a claim in Count One of their Second Amended Complaint—the only claim on which Healthfirst seeks dismissal.

BACKGROUND

Healthfirst PHSP, Inc. ("Healthfirst") is a health insurer offering and administering several plans to New York residents, including the Healthfirst Essential Plans, several Qualified Health Plans (also known as the Leaf Plans), and the Healthfirst Medicaid Managed Care Plan. Second

Amended Complaint ("SAC") ¶ 15. As such, Healthfirst is subject to numerous federal laws that govern the administration of health insurance plans, including the Affordable Care Act, the No Surprises Act, and the Mental Health Parity and Addiction Equity Act. *Id.* ¶¶ 22–23, 29–31.

These laws require, among other things, that Healthfirst ensure the adequacy of its provider network to meet the care needs of its members, publish and maintain an accurate directory of the providers in that network, and offer behavioral health benefits on equally favorable terms to the medical and surgical benefits covered by its plans. *Id.* In its contracts with New York State to provide health insurance to state residents on the New York State of Health marketplace, Healthfirst agrees to abide by these federal laws. *Id.* ¶¶ 102, 103(b), 222 ("The contracts require Defendant to comply with … the Affordable Care Act, Mental Health Parity and Addiction Equity Act, … No Surprises Act, [and] Employee Retirement Income Security Act"); see also Ex. 3[1] at 154 (certifying that Healthfirst will "always strictly adhere to all applicable federal laws, regulations, and instruction[s] as they currently exist and may hereafter be amended or enacted, including the following: The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act, Public Law 111-152, as amended. The two laws are collectively referred to as the Affordable Care Act ('ACA'); ... 45 C.F.R. Parts 155 and 156 Marketplace Establishment Standards and Other Related Standards Under the Affordable Care Act, Insurance Standards Under the Affordable Care Act, Including Standards Related to Exchanges").

Healthfirst falls far short of these duties. In-network mental health care is nearly impossible to access on Healthfirst's plans because the company does not contract with sufficient

[1] All citations to "Ex." are to the exhibits attached to the declaration of Joshua H. Pike, Dkt. 24. All page citations refer to the page number in the ECF header, not the internal pagination of the exhibit.

providers to meet its members' needs. SAC ¶¶ 161, 224. Healthfirst conceals this inadequacy, making it even harder for members to find care, by falsely reporting providers as in-network and available to serve new patients when, in reality, they are not. *Id.* ¶¶ 139, 140, 142. As a result of these violations of federal law, Plaintiffs and the Class members they seek to represent have struggled to find mental health care while enrolled in Healthfirst's plans. *Id.* ¶¶ 171, 231.

Plaintiffs filed this case in November 2025, alleging that, in addition to violating several state consumer protection laws, Healthfirst had breached its contractual obligation to its members by failing to comply with these federal laws. Healthfirst notified Plaintiffs and the Court in a pre-motion letter that it intended to file a motion to dismiss the complaint on the ground that Plaintiffs had failed to state a claim for the relief they sought. Dkt. No. 15. Plaintiffs then amended their complaint to address certain issues identified in Healthfirst's pre-motion letter, which did not include any argument with respect to this Court's subject-matter jurisdiction. Dkt. No. 18. Simultaneously, counsel for Plaintiffs have been litigating a nearly identical case in this Court involving Carelon, a third-party administrator for an unrelated health insurance plan. *See Doe v. Carelon Behavioral Health, Inc.,* No. 25-cv-03489. To avoid unnecessary litigation and expense, the parties here sought permission from the Court to stay further proceedings on Plaintiffs' First Amended Complaint until the Court ruled on the pending motion to dismiss in *Carelon*. Dkt. No. 19. The parties proposed that, following a decision on Carelon's motion to dismiss, Plaintiffs could file a Second Amended Complaint to address issues identified in the Carelon litigation. *Id.* The Court granted the parties' request. Dkt. No. 20.

Shortly thereafter, this Court ruled that the case against Carelon could move forward, rejecting many of the same arguments that Healthfirst raised in its pre-motion letter in this case. *See Doe v. Carelon Behav. Health, Inc.*, 2026 WL 880639 (S.D.N.Y. Mar. 31, 2026). Plaintiffs

then filed a Second Amended Complaint ("SAC") clarifying their arguments in light of the Court's decision in *Carelon*. Dkt. No. 21. Facing a class action in a Court that had recently ruled in favor of plaintiffs in a strikingly similar case, Healthfirst filed the instant motion seeking to dismiss Plaintiffs' case on jurisdictional grounds, an argument it had not previously raised. Dkt. Nos. 22, 23.

ARGUMENT

I. Federal Jurisdiction Exists Because Plaintiffs' Breach of Contract Claim Arises Under Federal Law

Because Plaintiffs' breach of contract claim raises several significant issues of federal law that must be resolved to decide the claim, and because the resolution of this claim would not disrupt the balance of state and federal responsibilities, federal jurisdiction exists over this case. Congress has granted federal district courts subject-matter jurisdiction over "all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. This jurisdictional grant extends not only to cases involving federal causes of action, but also to cases in which a state-law cause of action turns on an issue of federal law. In these instances, federal question jurisdiction exists "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." *Gunn v. Minton*, 568 U.S. 251, 258 (2013). Defendant does not contest that the second prong is satisfied but disputes the remaining three prongs. Because the federal issues embedded in Plaintiffs' breach of contract claim satisfy all four elements, the exercise of federal jurisdiction is proper.

A. The Federal Issue Is Necessarily Raised and Actually Disputed

Healthfirst argues that no federal issue is necessarily raised in the breach of contract claim because federal law provides one of multiple sources of the legal obligations that it has violated.

See Mot. at 9–10. In support of this argument, Healthfirst cites portions of the Second Amended Complaint that identify state laws and contractual provisions related to network size and directory accuracy, arguing that these requirements also serve as the basis for Plaintiffs' breach of contract claim. *See id*. In reality, Plaintiffs' breach of contract claim is straightforward: Healthfirst failed to comply with multiple federal laws with which its contract required it to comply.

Healthfirst's argument that Plaintiffs' breach of contract claim "does not depend solely on federal law," Mot. at 10, is incorrect when viewed alongside the SAC. The SAC alleges that Healthfirst is contractually obligated to comply with federal laws and regulations, including those specifically enumerated that mandate network adequacy, directory accuracy, and mental health parity. *See* SAC ¶ 222; Ex. 3 at 154 (contract requiring Healthfirst to "strictly adhere to all applicable federal laws, regulations, and instruction … including … the Affordable Care Act ('ACA') [and] 45 C.F.R. Parts 155 and 156," which require network adequacy, directory accuracy, and mental health parity). The SAC further alleges:

> Defendant has violated applicable federal laws (and, by extension, its contractual obligations to Plaintiffs and the Class) by, among other things, failing to ensure mental health network adequacy; failing to create and maintain an accurate provider directory; failing to regularly verify the accuracy of its provider network within the statutorily required timeframe, validate participation by individual providers, and remove providers from the directory who could not be verified; and providing mental health and substance use disorder benefits on less favorable terms than medical and surgical benefits.

SAC ¶ 230. Federal jurisdiction over Plaintiffs' breach of contract claim is proper because the claim is premised exclusively on Healthfirst's failure to comply with federal law as incorporated into the contract. *See New York ex rel. Jacobson v. Wells Fargo Nat'l Bank*, 824 F.3d 308, 315–16 (2d Cir. 2016) (A "state-law claim 'necessarily' raises federal questions where the claim is affirmatively 'premised' on a violation of federal law."). The only theory that Plaintiffs have put forward with respect to their first cause of action is that Healthfirst has failed to abide by the federal

law requirements incorporated into the contract. In order to determine whether Plaintiffs can prevail on this count, therefore, the court must necessarily determine whether Healthfirst has breached any of these federal laws.

It is well-established that, when assessing the basis for subject-matter jurisdiction, the plaintiff is "the master of the complaint." *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 399 (1987). To avoid litigating in this Court, Healthfirst attempts to inject alternative state law bases into Plaintiffs' breach of contract claim by arguing that the federal law violations identified by Plaintiffs are also violations of state law.[2] But this argument ignores the long-standing rule that a case arises under federal law "only when the *plaintiff's statement of his own cause of action* shows that it is based upon those laws or that Constitution." *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 6 (2003) (quoting *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 152 (1908)) (emphasis added). Healthfirst cannot overcome Plaintiffs' choice to file in federal court by putting forward its own independent theory of how its actions have breached the contract. Because Plaintiffs' contract claim is exclusively premised on violations of federal law embedded in Healthfirst's contract, these issues must necessarily be resolved in order to decide the claim. *See Broder v. Cablevision Sys. Corp*., 418 F.3d 187, 194–95 (2d Cir. 2005) (finding that a federal issue was "apparent from the face of the complaint" and therefore supported federal jurisdiction where plaintiff's breach of contract claim was premised on a violation of federal law "incorporated by reference into the contract").

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[2] Even if the contractual requirement that Healthfirst comply with state law were relevant to Plaintiffs' breach of contract claim, those state laws do not provide the same relevant protections as the federal laws at issue in Plaintiffs' claim. For instance, whereas the enumerated federal laws (including the Affordable Care Act and 45 C.F.R. Parts 155 and 156) require Healthfirst to provide mental health benefits on terms no less favorable than medical and surgical benefits (*i.e.*, mental health parity), *see id*., the state laws mentioned in the contract do not.

Although Healthfirst does not address this prong in its motion, the federal issues underlying the breach of contract claim are also actually disputed. The effect of these laws is "the central point of dispute" in this litigation. *Gunn*, 568 U.S. at 259; *Jacobson*, 824 F.3d at 316. The parties' disagreement on Healthfirst's compliance with federal network adequacy, directory accuracy, or mental health parity requirements raise "just the sort of 'dispute … respecting the … effect of [federal] law' that *Grable* envisioned." *Gunn*, 568 U.S. at 259 (quoting *Grable & Sons Metal Products, Inc. v. Darue Eng'g & Mfg*., 545 U.S. 308, 313 (2005)). Unless Healthfirst is willing to concede that its conduct has violated these laws, the federal issues remain actively and actually disputed.

B. The Federal Issue Is Substantial

Plaintiffs' breach of contract claim also easily satisfies the third requirement for federal jurisdiction because it raises multiple substantial issues of federal law. As the Supreme Court described in *Gunn v. Minton*, this element requires "something more" than an issue of significance to the parties. 568 U.S. at 264. Rather, the state-law claim must necessarily raise an issue that is significant to the federal system as a whole. *See id*.; *see also Grable*, 545 U.S. at 313 ("[F]ederal jurisdiction demands not only a contested federal issue, but a substantial one, indicating a serious federal interest in claiming the advantages thought to be inherent in a federal forum.").

In *Gunn*, a patent law issue embedded in the plaintiff's state law legal malpractice claim was not substantial, in large part because it was entirely backward-looking. Due to the nature of the malpractice standard, the case presented a "hypothetical 'case within a case'" that asked whether the result of the plaintiff's patent litigation would have been different had his attorneys raised a particular argument. *Gunn*, 568 U.S. at 261. Regardless of how a state or federal court decided this question, the case would have no bearing on the plaintiff's patent or the landscape of federal patent law. *See id*. In this posture, any misapplication of federal patent law by the state

courts would "soon be resolved within the federal system," minimizing any concern about achieving uniformity in the interpretation of federal law. *Id.* at 262.

Here, by contrast, Plaintiffs' breach of contract claim presents multiple forward-looking issues of federal law, including issues of first impression, that impact the entire healthcare system, which is of critical national importance. *See NASDAQ OMX Group, Inc. v. UBS, Sec., LLC*, 770 F.3d 1010, 1024 (2d Cir. 2014) (holding that state law claims raised substantial federal question because of the "central role stock exchanges play in the national system of securities markets"); *Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks*, 118th Cong. (2023) (statement of Sen. Ron Wyden, Chairman, S. Comm. on Fin.) (stating that "the widespread existence of ghost networks" was creating a "widespread problem in the health care system").[3] The contracts at issue—Healthfirst's contracts for its Qualified Health Plans and Essential Plans—are based on New York State's model contracts for all insurers offering these plans on the state marketplace. And the federal laws and regulations underlying those contractual requirements—which protect fundamental access-to-care rights—profoundly affect all Americans as well as the entire health insurance industry, which receives hundreds of billions of dollars annually in federal funding.[4] As a result, the federal issues underlying Plaintiffs' claims apply far beyond Healthfirst's relationship with these particular plaintiffs. A decision in this case would therefore help illuminate the federal healthcare rights of every American and the federal obligations of every health insurer. Moreover, because some of

[3] https://www.finance.senate.gov/imo/media/doc/Wyden%20Ghost%20Networks%20Hearing%20Remarks%205.3.23.pdf.

[4] *See* Congressional Budget Office, *Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections* (June 2024) at 3, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

the federal network adequacy, directory accuracy, and mental health parity statutory requirements in this case have yet to come before a federal court, a state court would not have the benefit of any federal precedent if it were required to adjudicate these claims. *See Gunn*, 568 U.S. at 262 (finding federal jurisdiction lacking in part because of federal courts' expectation that state courts will "hew closely to the pertinent federal precedents" in the area of patent law).

Healthfirst attempts to distract from the significance of the federal issues involved in Plaintiffs' contract claim by overstating the extent to which the issues are "fact-bound and situation-specific." Mot. at 12. Because the claim involves contract language that is identical across Healthfirst's QHPs and EPs, the fact that Plaintiffs bring this claim "on behalf of several different members (or classes of them), at different times under different health plans, with different medical needs," Mot. at 12, has nothing to do with the merits of the claim itself. The contractual provisions at issue relate only to Healthfirst's conduct, have not materially changed over the course of the Class Period, and apply uniformly across all of its QHPs and EPs. The health needs and circumstances of individual Plaintiffs are therefore irrelevant to the evaluation of the contract claim. While some factual determinations are necessary to evaluate Healthfirst's compliance with the federal requirements embedded in the contracts, any factual inquiry pales in comparison to the significant federal legal issues involved in evaluating the claim.

Healthfirst also argues that the only cases that have qualified for federal jurisdiction under *Grable* have involved "discrete, purely legal issues," Mot. at 12, but that misrepresents the universe of claims that have given rise to federal jurisdiction. Courts routinely find federal jurisdiction even when the federal issue involved is "not 'a purely legal one.'" *Ball v. Baker*, 2022 WL 17808785, at *12 (S.D.N.Y. Dec. 19, 2022) (quoting *Tantaros v. Fox News Network, LLC*, 12 F.4th 135, 145 (2d Cir. 2021)) (finding a substantial issue of federal law after noting that neither

Second Circuit nor Supreme Court precedent "makes 'a nearly pure issue of law' a prerequisite to the third prong"). Rather than requiring a purely legal issue, federal jurisdiction is appropriate when the plaintiffs' claim "'implicates the substantial federal question of whether [defendant]'s conduct was consistent with its regulatory responsibilities' ... imposed by federal law." *Pritika v. Moore*, 91 F. Supp. 3d 553, 558 (S.D.N.Y. 2015) (quoting *In re Facebook, Inc., IPO Securities and Derivative Litigation*, 922 F. Supp. 2d 475, 482–83 (S.D.N.Y. 2013)). This is the precise framing of Plaintiffs' breach of contract claim.

The Second Circuit's decision in *NASDAQ OMX Group, Inc.* is instructive. In that case, federal jurisdiction was found to be proper over an action by UBS Securities against NASDAQ for breach of contract, breach of the implied duty of good faith and fair dealing, and gross negligence related to an IPO that NASDAQ conducted. In particular, the substantiality requirement was found to be satisfied because the state law claims "implicate[d] one of 'the most fundamental functions of a national securities exchange'" as opposed to some tangential feature, like personnel disciplinary procedures. 770 F.3d at 1027 (quoting SEC Release No. 34-69655, at *1). Because the alleged federal violations involved "a massive failure of NASDAQ's systems" implicating "NASDAQ's performance of its critical, federally mandated duty," the issue could not "be deemed less than substantial." *Id*.

Here, Healthfirst's failures to maintain an adequate network of providers, supply an accurate directory, and meaningfully cover mental health care all go to the fundamental responsibility of a federally regulated health insurer: to enable its members to access health care. Plaintiffs do not allege that Healthfirst has breached its contract by failing to cover an individual service or by missing a single statutory deadline, but rather that the company's failures have been so pervasive that Plaintiffs and countless others have been unable to find the care that they

desperately need. Healthfirst, a recipient of significant federal subsidies for the provision of health insurance, has systematically failed to maintain an adequate network to meet its members' needs, verify and publish an accurate directory of providers, and cover mental health services on equally favorable terms as it does medical services—failures which jeopardize the stability of the federal health insurance system and the health of the company's hundreds of thousands of enrollees. The magnitude, regulatory complexity, and economic scale of Healthfirst's failings rise to the level of the "serious federal interest in claiming the advantages thought to be inherent in a federal forum" that courts have previously recognized. *Grable*, 545 U.S. at 313.

C. Resolution in Federal Court Would Not Disturb the Federal-State Balance

Although Healthfirst makes no effort to distinguish its arguments on the third and fourth prongs of the *Grable-Gunn* test, the exercise of federal jurisdiction in this case would not disturb the balance of state and federal juridical responsibilities. This prong "focuses principally on the nature of the claim, the traditional forum for such a claim, and the volume of cases that would be affected." *Jacobson*, 824 F.3d at 316. "Absent a special state interest in a category of litigation, or an express congressional preference to avoid federal adjudication, federal questions that implicate substantial federal interests ... 'sensibly belong[] in a federal court.'" *Tantaros*, 12 F.4th at 146 (quoting *Jacobson*, 824 F.3d at 316).

Here, the nature of the claim and traditional forum do not require state court jurisdiction, and Healthfirst has identified no "special state interest" weighing against the exercise of federal jurisdiction. In *Gunn*, the Supreme Court recognized that states have a "special responsibility for maintaining standards among members of the licensed professions," which suggested that federal jurisdiction would be improper over the plaintiff's legal malpractice claim even if the claim involved a necessarily disputed element of patent law. 568 U.S. at 264 (quoting *Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447, 460 (1978)). Without suggesting that any similar state

responsibility is implicated here, Healthfirst argues that federal jurisdiction is inappropriate because state courts regularly hear breach of contract claims. *See* Mot. at 12. But it cannot be the case that all contract claims belong in state court because of some special state interest, particularly when the Second Circuit has already blessed the exercise of federal jurisdiction over contract claims raising a federal question. *See, e.g.*, *NASDAQ*, 770 F.3d at 1027. As a result, even when state law provides the cause of action, federal jurisdiction is appropriate where, as here, "underneath the state law raiment is a dispute of federal nature, implicating federal statutes, federal regulatory schemes, and federal spending." *Ball*, 2022 WL 17808785, at *15.

Likewise, "exercising federal jurisdiction over this case will not divert many cases from state court." *Tantaros*, 12 F.4th at 147. This is because the exercise of federal jurisdiction over this contract claim will not affect "more than a tiny fraction of state [contract] actions, as it is the rare such action that hinges on the proper interpretation of federal [] law." *Jacobson*, 824 F.3d at 318. As a result, a federal court exercising jurisdiction over a state contract claim that raises a federal issue will have minimal impact on "the normal currents of litigation." *Grable*, 545 U.S. at 319.

Whether considered under the third or fourth prong, the complex regulatory environment giving rise to Plaintiffs' contract claim also weighs in favor of federal jurisdiction. Although Healthfirst argues that federal issues are commonplace in contract disputes involving highly regulated industries, *see* Mot. at 12–13, the unpublished case that it cites for this proposition involved a "run-of-the-mill state law contract claim" that did not raise a substantial issue of federal law. *See Liana Carrier Ltd. v. Pure Biofuels Corp.*, 672 F. App'x 85, 92 (2d Cir. 2016). Healthfirst's argument is also inconsistent with numerous other cases finding that a claim's implication of a complex federal regulatory scheme is indicative of the significant federal interests

at stake. *See Jacobson*, 824 F.3d at 318 (finding federal jurisdiction because "[t]he statute, the implementing regulations, and the additional regulatory guidance are necessarily complex, and they govern what is now a trillion-dollar national market" (internal citations omitted)); *see also New York City Health & Hosps. Corp. v. Wellcare*, 769 F. Supp. 2d 250, 259 (S.D.N.Y. 2011) ("The complex federal regulatory scheme applicable to MA Organizations similarly calls for the 'hope of uniformity that a federal forum offers on federal issues.'" (quoting *Grable*, 545 U.S. at 312)); *see also id.* (describing the "intricate federal regulatory scheme" involved in *West Virginia v. Eli Lilly & Co*., 476 F. Supp. 2d 230 (E.D.N.Y. 2007), as "[c]inching the case for federal jurisdiction"). When a complex regulatory scheme is intricately involved in a state law claim, as is the case here, "minimizing uncertainty over" the federal legal landscape "fully 'justif[ies] resort to the experience, solicitude, and hope of uniformity that a federal forum offers on federal issues.'" *Jacobson*, 824 F.3d at 318 (quoting *Grable*, 545 U.S. at 312). This is particularly true "where, as here, a party's efforts to have that federal law duty assessed by reference to state law principles—e.g., good faith, fair dealing, negligence—could undermine Congress's expectations for uniformity" in the health insurance plans at issue here. *NASDAQ*, 770 F.3d at 1031.

In the absence of a "special state interest," "and with no indication of congressional preference for state-court adjudication of these critical federal issues, the exercise of federal jurisdiction in this case is fully consistent with the ordinary division of labor between federal and state courts." *Jacobson,* 824 F.3d at 318. Because Plaintiffs' claim necessarily raises disputed and substantial issues of federal law that can be resolved in federal court without disrupting the balance of federal and state responsibilities, the claim warrants "resort to the experience, solicitude, and hope of uniformity that a federal forum offers." *Tantaros*, 12 F.4th at 147 (quoting *Grable*, 545 U.S. at 312).

II. Plaintiffs State a Claim for Breach of Contract

On the merits, Plaintiffs have stated a claim for breach of contract on Count I of the Second Amended Complaint. Healthfirst labors mightily to show that Plaintiffs are not third-party beneficiaries of its contract with New York State, but that contract exists solely to provide individuals like Plaintiffs with health insurance, which suffices to make them third-party beneficiaries. Alternatively, Healthfirst contends that Plaintiffs cannot pursue a third-party contract claim premised on a violation of federal law, but that, too, misstates the legal standard. The Court should therefore deny Healthfirst's motion insofar as it seeks dismissal on the merits of Plaintiffs' first cause of action.

A. Plaintiffs Are Third-Party Beneficiaries of Healthfirst's Contract with New York State

Contrary to Healthfirst's argument, Plaintiffs are third-party beneficiaries of Healthfirst's contracts with New York State. *See* Mot. at 17–21. It could hardly be otherwise. Under New York law, "a third party will be deemed an intended beneficiary where performance is rendered directly to it under the terms of the contract." *Levin v. Tiber Holding Corp.*, 277 F.3d 243, 249 (2d Cir. 2002) (citing *Flickinger v. Harold C. Brown & Co.*, 947 F.2d 595, 600 (2d Cir. 1991)). Here, the contracts provide in great detail that Healthfirst, as the insurer, will provide insurance services directly to enrollees like Plaintiffs. *See, e.g.*, Ex. 3 at 46 (Essential Plan contract providing that Healthfirst will provide "services to Enrollees pursuant to this Agreement"); *id.* at 47 (Healthfirst warrants it is licensed to provide health insurance in the State of New York and must offer "all variations of the Essential plan product" to eligible enrollees); *id.* at 48–54 (establishing requirements that Healthfirst must follow in providing health insurance to enrollees); *id.* at 60 (requiring Healthfirst to "accept new Essential Plan enrollments all year"); *id.* at 65–66 (setting forth in detail certain rights enrollees have vis-à-vis Healthfirst). Materially identical provisions

appear in Healthfirst's contract with the State to provide so-called Qualified Health Plans, requiring Healthfirst to provide health insurance services to eligible enrollees. *See* Ex. 7 at 47–51, 54–55, 58–66. And neither contract has any disclaimer of third-party beneficiaries.[5]

This is not a case in which the contract is "'deafening[ly] silent' on third-party beneficiary rights," Mot. at 20, creating uncertainty with respect to the parties' intentions. Rather, the contract contains several pages entitled "Enrollee Rights and Notification" detailing Healthfirst's obligations to its members. *See* Ex. 3 at 65 (describing numerous "Enrollee Rights" under the contract, including that Healthfirst provide Enrollees with specific information, abide by directory maintenance standards, and notify Enrollees of updates to its provider directory). Nor is this an instance in which the parties to the contract have disclaimed third-party beneficiary status. To the contrary, as Healthfirst notes, its contract with New York State to offer the Medicaid Managed Care Plan contains such a disclaimer, Mot. at 21, but such a provision is conspicuously absent from the contracts that Plaintiffs seek to enforce here. In the absence of such a disclaimer, the contracts' extensive discussion of plan members and their rights strongly indicates an intent by New York State and Healthfirst to allow plan members to enforce the agreements. *See Quadrant Structured Prods. Co., Ltd. v Vertin*, 23 N.Y.3d 549, 560 (2014) ("[I]f parties to a contract omit terms—particularly, terms that are readily found in other, similar contracts—the inescapable conclusion is that the parties intended the omission."). Plaintiffs are therefore third-party beneficiaries of New York's contracts with Healthfirst to provide enrollees with health insurance.

[5] Plaintiffs do not dispute, however, that they cannot pursue a third-party beneficiary claim with respect to New York's contract with Healthfirst to provide services under the Medicaid Managed Care ("MMC") plan. Only Plaintiff Mazza was enrolled in such a plan (in 2024 and part of 2025), and she more recently enrolled in a Healthfirst "Essential Plan." *See* SAC ¶¶ 13, 69.

In *Carelon*, this Court recently dismissed a contract claim by enrollees because the defendant there (1) had a disclaimer of third-party beneficiaries in its contract with New York State and (2) merely provided administrative services and therefore was "not Plaintiffs' insurer." *Carelon*, 2026 WL 880639, at *10–12. Here, on the other hand, the Essential Plan and Qualified Health Plan contracts do not disclaim rights in third-party beneficiaries. Nor is there any dispute that Healthfirst operates as Plaintiffs' health insurer. *See* SAC ¶¶ 49, 69, 81 (Healthfirst issued insurance policies to Plaintiffs); Mot. at 4 (stating that Healthfirst "provid[es] health insurance to New York residents"); Dkt. 24 ¶¶ 2, 4 (Pike declaration describing Healthfirst as a "health insurance compan[y]" that provides health insurance "to our insureds as 'members'"); Ex. 3 at 47 (warranting that Healthfirst is licensed "to provide health insurance in New York"); Ex. 7 at 48 (same). *Carelon* thus supports Plaintiffs' ability to enforce their contractual rights against Healthfirst based on provisions in its contract with the State.

Healthfirst's contrary arguments are unavailing. It principally argues that Plaintiffs cannot be third-party beneficiaries of Healthfirst's contracts with the State because Plaintiffs also have individual agreements with Healthfirst. *See* Mot. at 19–20. Not so. The Second Circuit has held that a party "plainly" was an intended third-party beneficiary of an agreement, even where he had his own separate contract with the defendant, when the contract under which he sued indicated an intent to confer benefits on the plaintiff. *Septembertide Publ'g, B.V. v. Stein & Day, Inc.*, 884 F.2d 675, 679–80 (2d Cir. 1989); *accord In re Publishers Consortium, Inc.*, 345 F. App'x 710, 712 (2d Cir. 2009). As already explained, that precisely describes Healthfirst's contracts with New York State, which exist solely to provide health insurance services to enrollees like Plaintiffs. Because a health insurer, by its nature, provides health insurance *only* to enrollees like Plaintiffs—not to the incorporeal State—the "surrounding circumstances" make clear that Plaintiffs are the

"immediate beneficiary" of Healthfirst's promises to New York State. *Albert v. DistroKid LLC*, 2026 WL 710041, at *11 (S.D.N.Y. Mar. 13, 2026) (internal quotation marks omitted). Indeed, "[i]t is hard to imagine how [Healthfirst] could make its intent clearer." *Id.* at *12. And although Healthfirst claims that the reference to individual member contracts (in its contract with New York State) weighs against recognizing Plaintiffs as third-party beneficiaries, the Second Circuit has held that such cross-references are *proof* of third-party beneficiary status insofar as they reflect an intent by the promisor to benefit the plaintiff. *See Septembertide Publ'g*, 884 F.2d at 679; *cf.* Mot. at 19.

Next, Healthfirst suggests that the individual member contracts' integration clauses foreclose Plaintiffs' rights as third-party beneficiaries, but that is likewise incorrect. Mot. at 20. A merger or integration clause is not conclusive where, as here, other factors point in favor of third-party beneficiary status. Judge Failla, for example, recently held that although such a clause might "weigh in [the defendant's] favor," it was counterbalanced by "key provisions of the agreement, as well as relevant surrounding circumstances, that evince an intent to make the [] Agreement enforceable by Plaintiff," namely that the contract indicated that performance would be made to the plaintiff. *Albert*, 2026 WL 710041, at *11; *see also Haier Am. Trading, LLC v. Samsung Elecs., Co.*, 2018 WL 4288617, at *16 n.8 (N.D.N.Y. Sept. 7, 2018) ("The Court rejects, however, Defendants' argument that a merger agreement in the licensing agreement disclaims any prior obligations and precludes the instant third-party benefit claim. If Plaintiff had pled the existence of a contract creating a third-party benefit, Plaintiff would have pled a contract to which Plaintiff was not a party. The Court fails to see how a merger clause in a separate agreement that includes Plaintiff can cover an agreement to which Plaintiff was not a party."). So too here, the

integration clause in Plaintiffs' individual contracts does not extinguish rights they have in Healthfirst's contract with New York.

Healthfirst downplays the contracts' in-depth discussion of plan enrollees and Healthfirst's obligations to them by arguing that Plaintiffs cannot be third-party beneficiaries because they are not specifically named in the contract. *See* Mot. at 20. But there is no requirement that the third party be "specifically mentioned in a contract to be considered a third-party beneficiary." *Newman & Schwartz v. Asplundh Tree Expert Co.*, 102 F.3d 660, 663 (2d Cir. 1996); *accord Catz v. Precision Global Consulting*, 2021 WL 1600097, at *12 (S.D.N.Y. Apr. 23, 2021) (Ramos, *J.*). Indeed, it is not even necessary that the promisor be aware of the beneficiary's existence, so long as the plaintiff "is within the class of intended beneficiaries of the contract even if not named or known of at the time." *Bancorp Servs., LLC v. Am. Gen. Life Ins. Co.*, 2016 WL 4916969, at *7 (S.D.N.Y. Feb. 11, 2016) (internal quotation marks omitted). That is precisely how Healthfirst's contracts with New York State are structured: to provide health insurance benefits to as-yet unknown insureds, who will receive the benefit of Healthfirst's performance. *See supra* at 14–15. Thus, it is of no moment that the contracts refer "to members generally." Mot. at 20.

Finally, Plaintiffs are intended third-party beneficiaries even though they seek to enforce a contract entered into by the State. *Cf.* Mot. at 18, 20. Healthfirst suggests that Plaintiffs must satisfy a heightened standard to enforce government contracts intended to benefit the public by showing a specific manifestation in the contract to benefit the plaintiff. But as the Second Circuit has recounted, New York takes the position that "a member of the public may be an intended third-party beneficiary of a public contract, in the Attorney General's view, where (a) the contract expressly and primarily benefits an identified segment of the public, *see Koch v. Consl. Edison Co. of N.Y.*, 62 N.Y.2d 548, 558–59 (1984), and (b) the promisor must render its performance

directly to the third party, *see Levin v. Tiber Holding Corp.*, 277 F.3d 243, 249 (2d Cir. 2002)." *Whitehaven S.F., LLC v. Spangler*, 633 F. App'x 544, 547 (2d Cir. 2015).

Just so here. Plaintiffs are not mere members of the public having no relation to the contract; they are an identifiable class of persons who enrolled in the health insurance plans that the State contracts with Healthfirst to provide. When government contracts benefit a defined class of people, that defined class can sue to enforce the contract as third-party beneficiaries. *See, e.g.*, *Koch*, 62 N.Y.2d at 559 (holding that plaintiffs were third-party beneficiaries of contracts between Con Edison and public entity because they "were precisely the consumers for whose benefit ... the agreements [were] made"); *McNeill v. N.Y.C. Hous. Auth.*, 719 F. Supp. 233, 248–49 (S.D.N.Y. 1989) (Walker, *J.*) (holding Section 8 tenants were intended third-party beneficiaries of contracts between landlords and housing authority and could enforce those contracts); *Gonzalez v. St. Margaret's House Hous. Dev. Fund Corp.*, 620 F. Supp. 806, 810 (S.D.N.Y. 1985) (Leval, *J.*) (same, for contract between landlord and federal government).

In short, Plaintiffs qualify as intended third-party beneficiaries of Healthfirst's contract with New York State.

B. Plaintiffs' Claims Are Not an "End Run" Around the Lack of a Private Right of Action

Alternatively, Healthfirst suggests that Plaintiffs' contract claim should be dismissed as an impermissible end run around the lack of a private right of action in federal statutes referenced in Healthfirst's contract. Mot. at 21–24. Not so. Certain of the relevant federal statutes, referenced in Plaintiffs' complaint, *do* contain a private right of action. There is therefore no bar to pursuing such claims on a breach-of-contract theory. And if, as Healthfirst claims, certain of those statutes do not apply to Healthfirst at all, the incorporation of those statutes in Healthfirst's contract with New York State permits Plaintiffs to enforce them under the contract. Even if there were no private

right of action in any of the federal statutes at issue, that absence alone would not prohibit Plaintiffs from pursuing a breach of contract claim premised on violations of those statutes.

As Plaintiffs allege and Healthfirst does not dispute, Healthfirst's contracts with New York State require Healthfirst to comply with all applicable federal law. *See, e.g.*, SAC ¶¶ 22–23 (enumerating requirement in No Surprises Act and Affordable Care Act that providers maintain an up-to-date provider directory); *id.* ¶¶ 30–31 (enumerating requirements under Mental Health Parity and Addiction Equity Act); *id.* ¶¶ 222–27 (summarizing relevant federal laws in first cause of action); *see also* Ex. 3 at 46, 50, 74 (Essential Plan contract requiring Healthfirst to comply with federal law); Ex. 7 at 47, 49, 72 (same for Qualified Health Plan).

Contrary to Healthfirst's argument, certain of those federal laws do contain private causes of action—most particularly, those sections of ERISA that incorporate provisions of the No Surprises Act and Mental Health Parity and Addiction Equity Act ("Parity Act"). *See* SAC ¶ 222 (alleging that Healthfirst is required to comply with, *inter alia*, section 720 of ERISA and the Parity Act). Section 720 of ERISA, codified at 29 U.S.C. § 1185i, imposes the same requirements to update and verify the provider directory that Plaintiffs seek to enforce here. And no one can dispute that ERISA authorizes a private right of action to enforce the statute. *See* 29 U.S.C. § 1132(a)(3) (permitting ERISA plan participants "to enjoin any act or practice which violates any provision of this subchapter"). The same is true for relevant provisions of the Parity Act, which require health insurers to treat mental health conditions comparably to physical health conditions—including with respect to the accuracy of provider directories. *See* 42 U.S.C. § 300gg-26(3)(A), 29 U.S.C. § 1185a(3)(A); *see also* 45 C.F.R. §§ 146.136(c)(4)(iii)(C)(4), 146.136(c)(4)(vi)(J) (to comply with Parity Act, insurer must ensure that mental health provider directory is accurate). That provision can likewise be enforced in a private suit. *See, e.g.*, *Gary*

K. v. Anthem Blue Cross & Blue Shield, 2025 WL 2782409, at *5–7 (S.D.N.Y. Sept. 30, 2025) (denying motion to dismiss Parity Act claim); *Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248, 255–59 (S.D.N.Y. 2018) (same).

Because relevant federal statutes authorize private suits, this case does not raise the concerns voiced in *Astra USA, Inc. v. Santa Clara County*, 563 U.S. 110 (2011). In that case, the Supreme Court held that when a federal contractor entered a contract that memorialized its obligations under federal law, that contract could not be used by a third-party beneficiary to enforce those federal law requirements. The Court reasoned that such a contract action would be inconsistent with "[t]he absence of a private right to enforce" the statute and the statute's vesting of all oversight in the federal government. *Id.* at 118; *accord Grochowski v. Phoenix Constr.*, 318 F.3d 80, 85–86 (2d Cir. 2003) (rejecting argument that contract claim could be premised on violation of federal statute that lacked a private right of action, which would be "an impermissible 'end run'" around the absence of a cause of action).

The Supreme Court could not have been clearer that it reached this conclusion so as not to interfere with Congress's decision not to authorize private suits. *See Astra*, 563 U.S. at 117 (emphasizing that "Congress vested authority to oversee compliance with the [relevant program] in HHS and assigned no auxiliary enforcement role to covered entities"); *id.* at 118 ("The absence of a private right to enforce [the statute] would be rendered meaningless if" plaintiffs "could overcome that obstacle by suing to enforce the contract's" incorporation of federal law instead.). Indeed, each of the cases cited by Healthfirst follows the same pattern—dismissal of a contract claim only because it would constitute an impermissible end run around the absence of a cause of action to enforce the federal statute. *See* Mot. at 22–24. No such concerns are present here. *See Sterk v. Redbox Automated Retail, LLC*, 2012 WL 1419071, at *3 (N.D. Ill. Apr. 24, 2012)

(explaining that "[e]ven under the reasoning of *Astra*," plaintiffs could bring breach of contract claim to enforce statute that itself contained a private right of action).

Healthfirst acknowledges that ERISA "provides a private right of action for enforcing" the Parity Act and does not dispute that such a private right of action obviates the concerns present in *Astra* and similar cases. Mot. at 23 n.10. But even if ERISA were inapplicable to Healthfirst's plans, dismissal of Plaintiffs' contract claim would still be improper. In that case, Healthfirst would have agreed in its contract with New York State to comply with additional federal laws beyond those that would have applied absent the contract. But *Astra* cabined its holding by emphasizing that the contract at issue there merely "recite[d] the responsibilities" that the federal statute already imposed, that the contract simply "confirm[ed] a statutory obligation," and that the contract "contain[ed] no negotiable terms." 563 U.S. at 113, 118. Because the requirements of the contract and the statute were coextensive, the contracts merely "serve[d] as the means by which drug manufacturers opt[ed] into the statutory scheme," suggesting that third-party enforcement was not intended. *Id.* at 118. Courts have thus held that when a contract incorporates statutes that would not otherwise govern, a third-party beneficiary claim can proceed. *See Ortiz v. Consolidated Edison Co.*, 2024 WL 3086161, at *21 (S.D.N.Y. June 7, 2024) ("[W]here a private sector contract calls for the payment of prevailing wages, the third-party beneficiary doctrine provides workers with a remedy under New York law, even though Section 220 is otherwise inapplicable."), *report & recommendation adopted*, 2024 WL 3105686 (S.D.N.Y. June 24, 2024); *In re Anthem, Inc. Data Breach Litig.*, 162 F. Supp. 3d 953, 1010 (N.D. Cal. 2016) (holding that, under *Astra*, federal employees could sue Anthem as third-party beneficiaries to enforce terms in federal contract that exceeded what federal law strictly required).

Even if all of the federal laws at issue lacked a private right of action, *Astra* would not prevent Plaintiffs from pursuing a breach of contract claim premised on violations of those laws. In *Astra*, the Supreme Court emphasized several other aspects of the statutory scheme that indicated congressional intent to prohibit enforcement via state law causes of action. First, the Court noted that, by centralizing enforcement under the statute in the federal government, Congress had signaled its intention to create a singular nationwide enforcement structure that would benefit from the special expertise developed by the Department of Health and Human Services. *See* 563 U.S. at 119–20. Also weighing against private enforcement was the fact that Congress had barred HHS from disclosing relevant pricing information, suggesting that private individuals were not meant to have the information needed to litigate a claim for a violation of the statute. *See id*. at 121. In *Astra*, it was the lack of a private right of action in combination with these other features of the federal enforcement structure that weighed against allowing enforcement through a breach of contract action.

None of these additional considerations comes into play here. Rather than centralizing oversight of these laws in a single federal agency, Congress has *dispersed* oversight, granting authority to the states to monitor compliance in their marketplaces. *See, e.g.*, 42 U.S.C. § 300gg-22 (providing for overlapping state and federal enforcement of certain federal requirements in the individual and group health plan market). Similarly, Congress has not barred the public from obtaining the relevant information needed to identify a violation of these laws. Although Healthfirst conceals its non-compliance with federal law, it is not the federal laws themselves that make it difficult to identify or prosecute a violation. To the extent that Plaintiffs lack a private right of action under the federal statutes here, that alone is not determinative.

The Second Circuit's post-*Astra* precedents bear this out. For example, in *NASDAQ*, the Second Circuit allowed plaintiffs to bring a breach of contract claim premised on violations of federal law which contained no private right of action. There, although it was "undisputed that the Exchange Act does not provide for a private cause of action for violations of stock exchange rules," 770 F.3d at 1046–47 (Straub, *J.*, dissenting), the Court permitted plaintiffs to bring a breach of contract claim for violation of those rules. *See id.* at 1028 (majority opinion). Although Judge Straub, in dissent, criticized the Court's decision to permit the plaintiffs to pursue the case in the absence of a private right of action, *see id.* at 1046–47 (Straub, *J.*, dissenting), the majority determined that this factor was no bar to the plaintiffs' claim. *Id.* at 1028 (majority opinion).

In short, there is nothing impermissible about the contract claim that Plaintiffs have pleaded.

CONCLUSION

For the foregoing reasons, Healthfirst's motion to dismiss should be denied in its entirety. If the Court grants Healthfirst's motion in whole or in part, Plaintiffs respectfully request leave to amend. *See Loreley Financing (Jersey) No. 3 Ltd. v. Wells Fargo Secs., LLC*, 797 F.3d 160, 190–91 (2d Cir. 2015) (explaining that plaintiffs should ordinarily be granted leave to amend if Court grants motion to dismiss). If the Court dismisses any claim for lack of subject-matter jurisdiction without leave to amend, such dismissal must be without prejudice. *See Harty v. W. Point Realty, Inc.*, 28 F.4th 435, 444–45 (2d Cir. 2022); *accord Phhhoto Inc. v. Meta Platforms, Inc.*, 123 F.4th 592, 601 n.4 (2d Cir. 2024).

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this sixteenth day of July 2026.

/s/ Steve Cohen