UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

HARTFORD HEALTHCARE CORPORATION; HARTFORD HOSPITAL; THE HOSPITAL OF CENTRAL CONNECTICUT AT NEW BRITAIN GENERAL AND BRADLEY MEMORIAL; MIDSTATE MEDICAL CENTER; THE WILLIAM W. BACKUS HOSPITAL; WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC., and CARLOS DAVID GONZALEZ, Plaintiffs, vs. ANTHEM HEALTH PLANS, INC. d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, Defendant.	Case No. 3:17-cv-01686-JCH Hon. Janet C. Hall

DEFENDANT ANTHEM HEALTH PLANS, INC.'S MEMORANDUM OF LAW IN SUPPORT OF ITS EMERGENCY MOTION TO DISMISS PLAINTIFFS'AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Defendant Anthem Health Plans, Inc. ("Anthem"), by and through its undersigned attorneys, hereby respectfully submits the following Memorandum of Law in support of its Emergency Motion to Dismiss the Amended Complaint for Declaratory and Injunctive Relief ("Amended Complaint") filed by Plaintiffs Hartford Healthcare Corporation, Hartford Hospital, The Hospital of Central Connecticut at New Britain General and Bradley Memorial, Midstate Medical Center, The William W. Backus Hospital, Windham Community Memorial Hospital, Inc., and Carlos David Gonzalez (collectively, "Plaintiffs"). For the reasons stated herein, the Court should dismiss the Amended Complaint with prejudice for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) and for lack of subject-matter jurisdiction under

Federal Rule of Civil Procedure 12(b)(1).

INTRODUCTION

At the Court's initial status conference on October 10, Anthem informed the Court that it intended to file a Motion to Dismiss because all of the claims in Plaintiffs' Complaint suffer from fundamental and fatal legal defects. Anthem filed such an emergency Motion to Dismiss on October 16. Plaintiffs filed an Amended Complaint on October 19, but the Amended Complaint does not cure any of these defects in the claims from the original Complaint. Moreover, the four new claims added by Plaintiffs in the Amended Complaint suffer either from the same defects as the claims in the original Complaint or new legal defects that provide additional grounds for emergency dismissal. Even worse, as will be addressed in detail herein (including the only recently brought ERISA and breach of implied contract claims), the new individual Plaintiff is *not* asserted in this action as being an Anthem member, nor is his employer group asserted as being an Anthem client, and his only purported irreparable harm is that he *might* have an emergency room department visit in the future that would potentially involve the Plaintiff Hospitals and a direct payment to him by supposedly Anthem for those possible out-of-network services.

Again, here, Plaintiffs do not have a private right of action under either of the statutes upon which they continue to base their claims—the Affordable Care Act (the "ACA") and Connecticut General Statutes § 38a-477aa(b)(3)(A). Neither of these statutes expressly authorizes private rights of action. Nor can a private right of action be implied under either statute. In fact, the tests devised by federal and Connecticut courts to determine whether an implied right of action exists decisively confirm that neither Congress nor the Connecticut legislature intended to create such rights with respect to the statutes at issue here. As a result,

Plaintiffs' claims for declaratory judgment and injunctive relief—the only relief sought by Plaintiffs in this case—should be dismissed with prejudice for failure to state a claim upon which relief can be granted and/or because the Court lacks subject matter jurisdiction.

Even if Plaintiffs did have a private right of action under the emergency services provisions in the ACA and/or the Connecticut statute (which they do not), Plaintiffs still could not state a claim upon which relief could be granted under any set of facts. Simply put, neither statute mandates direct payment to an out-of-network provider who renders emergency services.

Plaintiffs' claims for injunctive relief also fail to state any claim upon which relief can be granted for the separate and independent reason that Plaintiffs fail to allege any irreparable harm for which injunctive relief is warranted. Instead, Plaintiffs' Amended Complaint alleges purely economic losses purportedly caused by the speculative "administrative burden" associated with obtaining the payments Anthem made directly to its members for out-of-network emergency services performed by Plaintiffs. Most of the "administrative burden" alleged in the Amended Complaint relates to Plaintiffs' status as out-of-network providers and their intentional efforts to balance bill their patients for amounts above and beyond those paid by Anthem, not the direction of the initial payment made by Anthem.

These are threshold legal questions that should be resolved now. Should Anthem prevail on the defenses asserted in this emergency Motion to Dismiss, the case is over. Conducting a trial on the merits of claims that have no legal basis appears to be emboldening Plaintiffs and will waste the Court's time and resources. Likewise, having an expedited trial necessarily diverts the parties' critical energies away from the complex negotiation of a possible new provider agreement between Anthem and Plaintiffs that would render all of the claims in the Amended Complaint moot. For all these reasons, Plaintiffs' claims should be dismissed with prejudice, and

the case should not proceed to a trial on the merits.

BACKGROUND

Plaintiffs are hospitals located in Connecticut that are part of an integrated health system (collectively, "Hartford"), as well as one individual, Carlos David Gonzalez. (Am. Compl. at ¶¶ 7-13.) Hartford provides emergency medical services to Connecticut residents. (*Id.* at ¶ 19.) Anthem provides health insurance and health benefit plan claims administration services to Connecticut residents. (*Id.* at ¶¶ 1, 22.)

Until October 1, 2017, Plaintiffs had a "participating provider agreement" with Anthem, pursuant to which Anthem paid Plaintiffs negotiated rates for services Plaintiffs provided to individuals with insurance policies issued by Anthem or health benefit plans for which Anthem provides administrative services (the "Members"). (Am. Compl., at ¶¶ 24, 26-27.) The parties' agreement expired as of September 30, 2017. (*Id.* at ¶ 27.)

As of October 1, 2017, Plaintiffs chose not to participate in Anthem's provider network, meaning that Anthem no longer has a contractual obligation to pay Plaintiffs negotiated rates, and instead pays for services provided to Members according to the provisions of their health benefit plans and applicable laws. (Am. Compl., at ¶ 25.) Plaintiffs allege that Members "routinely" assign to Plaintiffs "all rights they have as beneficiaries of [Anthem's] health plans," but they do not attach any such assignments to their Complaint or even recite the language in these assignments. (*Id.* at ¶ 30.)

Plaintiffs allege that Anthem told them that, "starting October 1, 2017, it will no [longer] directly pay Hartford Healthcare for health care services that Hartford Healthcare provides to Defendant's members and beneficiaries," but instead will directly pay the Members in accordance with the out-of-network provisions of Anthem's Member benefit plans. (Am.

Compl., at ¶¶ 25, 32-33.)

Plaintiffs allege that Anthem's direct payment of healthcare benefits to Members for emergency medical services provided by Plaintiffs violates the Affordable Care Act, 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) (the "ACA"), and Connecticut General Statutes § 38a-477(b)(3)(A).[1] (Am. Compl., at ¶¶ 36-39.) According to Plaintiffs, Anthem's direct payments to Members will impose an additional "administrative requirement" on coverage for out-of-network emergency services in that Members must send the payments they receive from Anthem to Plaintiffs. (*Id.* at ¶¶ 40-43.) Plaintiffs allege this "administrative requirement" violates Anthem's obligations under federal and state statutes and regulations. (*Id.*)

Plaintiffs speculate that, due to Anthem's direct payments, Members will choose to delay emergency medical treatment or seek such treatment from hospitals other than Plaintiffs. (Am. Compl. at ¶ 46.) Plaintiffs also suggest that Anthem's direct payments will cause Plaintiffs to experience delays in receiving payments for emergency medical services and to expend extra time and resources to pursue payment from Members. (*Id.* at ¶¶ 48-49.)

The Amended Complaint adds Carlos David Gonzalez as a new plaintiff. The Amended Complaint alleges that Mr. Gonzalez is an individual who resides in East Hartford, Connecticut. (Am. Compl. ¶ 13.) The Amended Complaint, however, does not allege that Mr. Gonzalez is an Anthem member, nor is there any good faith basis for such an allegation. The Amended Complaint merely alleges that Mr. Gonzalez is "a member of a health plan which he receives through his employment at Aspen Square Management." (*Id.*, ¶ 52.) The Amended Complaint alleges only on "information and belief" that this purported plan is governed by the Employee

[1] Plaintiffs appear to assert a violation of Connecticut General Statutes § 38a-477(b)(3)(A) only as to three of the hospitals, and only to the extent that individual emergency medical physicians' services are "bundled" into those hospitals' charges included on healthcare benefits claims submitted to Anthem for emergency medical services. (Am. Compl. at ¶¶ 77, 83.)

Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, as amended ("ERISA") and that Anthem serves as the claims administrator within the State of Connecticut for Aspen Square Management's plan. (*Id.* at ¶ 53.)

According to the Amended Complaint, Mr. Gonzalez has received emergency medical services at Hartford Hospital "in the past," and he purportedly "reasonably anticipates" that he will seek emergency medical treatment from Hartford HealthCare "in the near future." (Am. Compl. at ¶ 54, 89-90.) The Amended Complaint alleges that if Mr. Gonzalez seeks emergency services from Plaintiffs in the future, and if Anthem pays benefits directly to him, he (or someone on his behalf) will be irreparably injured by being forced to cash Anthem's check and to write a check to Hartford. (*Id.* at ¶ 55.) The Amended Complaint alleges that he will be further injured if he has to follow up with Anthem if payments are late or to exercise his appeal rights under his plan. (*Id.*) The Amended Complaint does not allege that Hartford Hospital or any other Plaintiff has ever obtained an assignment of any kind from Mr. Gonzalez for *any* emergency services.

Based on these speculative allegations, Plaintiffs seek declarations (without citing to any statute or rule authorizing such relief) from this Court that Anthem's direct payments to Members for emergency medical services provided by Plaintiffs violate the ACA and Connecticut General Statutes § 38a-477(b)(3)(A). (Am. Compl., First and Third Claims for Relief.) Plaintiffs also seek injunctions under the ACA and Connecticut General Statutes § 38a-477(b)(3)(A) requiring Anthem to pay healthcare benefits directly to Plaintiffs, instead of Anthem's Members, for out-of-network emergency services provided by Plaintiffs. (*Id.*, Second and Fourth Claims for Relief.) Plaintiffs also assert claims under Sections 502(a)(1)(B) and 502(a)(3) of ERISA (*id.*, Fifth and Sixth Claims for Relief), and for breach of contractual

obligations assigned to Hartford by Anthem's members and breach of implied-in-fact contracts. (*Id.*, Seventh and Eighth Claims for Relief).

LEGAL STANDARDS

Anthem seeks dismissal of the Amended Complaint for failure to state a claim, under Federal Rule of Civil Procedure 12(b)(6). In resolving a Rule 12(b)(6) motion, the Court must accept all factual allegations as true and draw all reasonable inferences in favor of Plaintiffs. *Keiler v. Harlequin Enters., Ltd.*, 751 F.3d 64, 68 (2d Cir. 2014) (citations omitted). "To survive a motion to dismiss [under Rule 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, 679 (2009) (internal quotation marks and citation omitted). "A claim has facial plausibility 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.* "Factual allegations must be enough to raise a right to relief above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 554-55 (2007), citing 5C Wright & A. Miller, Federal Practice and Procedure § 1216 (3d ed 2004) ("[T]he pleading must contain something more…than…a statement of facts that merely creates a suspicion [of] a legally cognizable right of action"). The Court is not required to accept legal conclusions as true for purposes of Rule 12(b)(6). *Keiler*, 751 F.3d at 68 (citations omitted).

Anthem also seeks dismissal of Plaintiffs' First and Third Claims for Relief for lack of subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1). When a motion to dismiss based on Rule 12(b)(1) is based on the allegations in the complaint, "[t]he task of the district court is to determine whether the Pleading alleges facts that affirmatively and plausibly suggest that the plaintiff has standing to sue." *Carter v. HealthPort Tech., Inc.*, 822 F.3d 47, 56-57 (2d Cir. 2016) (citation and internal quotation marks omitted). A motion to dismiss a

declaratory judgment action for failure to allege an "actual controversy" is properly brought under Rule 12(b)(1). *See Liberty Mut. Ins. Co. v. Travelers Indem. Co. of Ill.*, 138 Fed. Appx. 348, 349 (2d Cir. 2005) (affirming dismissal of declaratory judgment action under Rule 12(b)(1) for failure to establish "actual controversy").

ARGUMENT

I. Plaintiffs Do Not Have an Express or Implied Private Right of Action Under the ACA.

Plaintiffs fail to state a claim under the ACA, as it does not provide an express or implied private right of action to enforce Section 300gg-19a(b)(1)(ii)(I). *See Republic of Iraq v. ABB AG*, 768 F.3d 145, 171 (2d Cir. 2014) (affirming dismissal under Rule 12(b)(6) due to absence of private right of action in federal statute). "[P]rivate rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). However, there is no express private enforcement mechanism within the ACA that entitles a private plaintiff – much less a hospital – to enforce the "Patient Protections" provisions in Section 300gg-19a(b)(1)(ii)(I). Moreover, every court that has addressed this question has determined that the ACA does not provide a private right of action. *See Mills v. Bluecross Blueshield of Tenn., Inc.*, 2017 WL 78488, at *6 (E.D. Tenn. Jan. 9, 2017) ("[Congress] expressly left enforcement of these requirements [including 42 U.S.C. § 300gg-19] to the state and the Secretary of Health and Human Services, not individuals"); *New York State Psychiatric Ass'n, Inc. v. UnitedHealth Group*, 980 F. Supp. 2d 527, 544 (S.D.N.Y. 2013) ("[T]he ACA does not provide for any independent private right of action to enforce its provisions."), *aff'd in part, vacated & remanded in part on other grounds*, 798 F.3d 125 (2d Cir. 2015); *Association of N. Jersey v. Horizon Healthcare Servs., Inc.*, 2017 WL 2560350, at *4-5 (D.N.J. June 13, 2017) (addressing Section 300-gg-5(a)); *Dominion Pathology Labs , P.C. v. Anthem Health Plans of Va., Inc*., 111 F. Supp.

3d 731, 736 (E.D. Va. 2015) (same); *In re Bradford*, 534 B.R. 839, 856 (M.D. Ga. Bankr. 2015) (addressing ACA's individual mandate provisions).

Nor did Congress create a private right of action to enforce Section 300gg-19a(b)(1)(ii)(I) by implication. Congress "rarely" creates private rights of action by implication. *See Republic of Iraq*, 768 F.3d at 171. "Unless Congress speaks with a clear voice and manifests an unambiguous intent to confer individual rights," a court may not infer a private right of action. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002). To determine whether a statute creates an implied private right of action, "[t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy." *Alexander*, 532 U.S. at 286. Accordingly, the Court must look at the "text and structure of the statute" to discern Congress' intent. *Lindsay v. Ass'n of Prof. Flight Attendants*, 581 F.3d 47, 50 (2d Cir. 2009) (citation omitted). While the Court must focus its "analysis on the single question of whether congressional intent to create a private cause of action can be found in the relevant statute," it can look to the factors the Supreme Court set out in *Cort v. Ash* "to illuminate [its] analysis of congressional intent." *M.F. v. State of N.Y. Executive Dept. Div. of Parole*, 640 F.3d 491, 495 (2d Cir. 2014) (citations omitted). Those factors are:

> First, is the plaintiff one of the class for whose especial benefit the statute was enacted – that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Id., quoting *Cort v. Ash*, 422 U.S. 66, 78 (1975). The text and structure of the ACA, as well as the *Cort* factors, establish that Congress did not intend to create an implied private right of action to enforce Section 300gg-19a(b)(1)(ii)(I).

A. Mr. Gonzalez Does Not Have a Right of Action Under the ACA Independent of His Alleged Rights Under ERISA.

Anthem acknowledges that individual participants and beneficiaries of ERISA-governed plans may have a cause of action to enforce provisions of the ACA under ERISA's enforcement provisions, to the extent that the ACA's requirements are incorporated into ERISA through 29 U.S.C. § 1185d. However, to the extent Mr. Gonzalez asserts causes of action under ERISA based on alleged violations of the ACA in Plaintiffs' Fifth and Sixth Claims for Relief, he is limited to remedies provided under ERISA, and does not have a separate and independent cause of action under the ACA. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 214-15 (2004); *Healthcare Strategies, Inc. v. ING Life Ins. & Annuity Co*., 2012 WL 10242276, at *15 (D. Conn. Sept. 27, 2012). Plaintiffs seem to recognize the narrowness of such a remedy, as they do not appear to seek any relief specific to Mr. Gonzalez in their First and Second Claims for Relief. (*See* Am. Compl. at pp. 12-15, 27-28 (seeking relief only for "Hartford HealthCare").) As Anthem argues infra, Mr. Gonzalez does not state a claim for relief under ERISA.

B. The Text and Structure of the Federal Statute Do Not Provide a Basis for Implying a Private Right of Action for Plaintiffs.

Nothing in Section 300gg-19a(b)(1)(ii)(I) or the ACA in general supports the conclusion that Congress intended to provide any parties—neither hospitals such as Hartford nor individuals such as Mr. Gonzalez—with a private right of action. "Statutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of persons." *Alexander*, 532 U.S. at 289. "For a statute to create … private rights, its text must be phrased in terms of the persons benefitted." *Gonzaga Univ.*, 536 U.S. at 283-84 (internal quotation marks omitted). Section 300gg-19a(b)(1)(ii)(I)'s text focuses on "the person regulated," imposing requirements upon group health plans and health insurance issuers:

(b) Coverage of emergency services

> (1) In general
>
> If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B)) --
>
> * * *
>
> (C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee--
>
> * * *
>
> (ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

42 U.S.C. § 300gg-19a(b)(1)(ii)(I). Notably, the provisions are not phrased as "patients are entitled to…," but rather as "the plan or issuer shall" or "shall not." *Id.* Similarly, the implementing regulations that Plaintiffs also cite provide that "the plan or issuer … must provide coverage for services in the following manner…" and do not provide any right or entitlement to patients like Mr. Gonzalez, much less hospitals like Hartford. 26 C.F.R. § 54.9815-2719A(b)(2)(iii); 29 C.F.R. § 2590.715-2719A(b)(2)(iii); 45 C.F.R. § 147.138(b)(2)(iii).[2] Such

[2] The regulations are of little relevance to the analysis, however. Plaintiffs must identify a private right of action originating in the statute, not the regulation, and "must also show that the regulation applies—but does not expand—the statute." *Abrahams v. MTA Long Island Bus*, 644 F.3d 110, 118 (2d Cir. 2011). The ACA regulations require plans and issuers to provide coverage for emergency services "without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers." 26 C.F.R. § 54.9815-2719A(b)(2)(iii); 29 C.F.R. § 2590.715-2719A(b)(2)(iii); 45 C.F.R. § 147.138(b)(2)(iii). Plaintiffs' claims under the ACA are based upon this language, not the language of the statute itself, which only prohibits more restrictive requirements for preauthorization for out-of-network emergency services. 42 U.S.C. § 300gg-19a(b)(1)(ii)(I). "Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not."

language—which focuses only on the regulated parties—does not imply a private right of action. *Lindsay*, 581 F.3d at 53.

The statute's structure also does not imply a private right of action. "The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others." *Alexander*, 532 U.S. at 290. Here, the ACA specifically authorizes states and the Secretary of Labor to take actions to enforce the provisions in Chapter 6A, Subchapter XXV, Part A, where Section 300gg-19a is found. 42 U.S.C. § 300gg-22. Moreover, Congress authorized private actions to enforce other, specific provisions of the ACA, such as Section 1557, which grants individuals the right to sue for discrimination in certain health programs or activities. 42 U.S.C. § 18116. However, Congress did not do so with respect to Section 300gg-19a(b)(1)(ii)(I). Given that Congress provided non-private remedies to enforce Section 300gg-19a and provided private remedies to enforce other provisions of the statute, "the statute as finally enacted … provide[s] strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S.41, 54 (1987) (citation omitted); *see also Lindsay*, 581 F.3d at 53 ("Congress's failure to provide similarly for private enforcement signals caution in inferring any such right of action.").

C. The *Cort* Factors Also Do Not Support Implying a Private Right of Action.

Though Congress' intent is clear from the text and structure of the statute, the four *Cort* factors further bolster the conclusion that Congress did not intend to create an implied private right of action to enforce Section 300gg-19a(b)(1)(ii)(I). Regarding the first factor, as hospitals, Hartford is not of the class for whose benefit Congress enacted Section 300gg-19a(b)(1)(ii)(I). Notably, the statute is entitled "Patient Protections," and its emergency services requirements

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Alexander, 532 U.S. at 291. Accordingly, Plaintiffs may not use the language of the regulation to imply a private right of action that the statute does not provide. *Id.*; *Abrahams*, 644 F.3d at 118.

dictate requirements and limitations with which plans and issuers must comply when providing coverage of emergency services to patients. 42 U.S.C. § 300gg-19a(b)(1)(ii)(I). The statute is concerned with the relationship between plans/issuers and the individuals to whom they provide coverage. Hartford is not a party to the patient's group plan or insurance policy, and thus has no interest protected by the statute. *See Lindsay*, 581 F.3d at 54-55 (finding statute that indirectly benefited individual employees nevertheless was not aimed at relationship between individual employee and employer). Accordingly, the first *Cort* factor favors finding no implied private cause of action for Hartford.

As noted above, the second factor—whether there is any indication of legislative intent to create or deny an implied right of action—likewise favors finding no private right of action. *See supra*.

The third factor—whether implying a private remedy for Hartford is consistent with the underlying statutory purpose—also militates against implying a private right of action for Hartford. Section 300gg-19a is found in Title 42, Chapter 6A, Subchapter XXV ("Requirements Relating to Health Insurance Coverage"), Part A ("Individual and Group Market Reforms"), Subpart II ("Improving Coverage"), and is itself entitled "Patient Protections." 42 U.S.C. § 300gg-19a(b)(1)(ii)(I). Thus, Section 300gg-19a(b)(1)(ii)(I) is meant to provide patients protections in the context of their relationships with their health insurers. Allowing a party such as a hospital, which is not among the class for whose benefit Congress enacted Section 300gg-19a(b)(1)(ii)(I), to sue to obtain direct payment from an insurer is not consistent with and does nothing to further the statute's purpose.

The fourth *Cort* factor—is the cause of action one traditionally relegated to state law—also does not favor finding a private right of action, insofar as insurance is traditionally regulated

by state law and has only recently been subject to regulation under the ACA and other federal laws. *See Smith v. Dearborn Fin. Servs., Inc.*, 982 F.2d 976, 980 (6th Cir. 1993) (that insurance products are typically regulated by the state weighs against implying private right of action); 15 U.S.C. § 1012(a) ("The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.").

* * *

In summary, Congress did not provide Plaintiffs with an express private right of action to enforce Section 300gg-19a(b)(1)(ii)(I), and the text and structure of the statute do not indicate in any way that Congress intended to create an implied private right of action. Accordingly, the Court should promptly dismiss Plaintiffs' First and Second Claims for Relief with prejudice.

II. Plaintiffs Do Not Have an Express or Implied Private Right of Action Under Connecticut General Statutes § 38a-477aa(b)(3)(A).

Just as Plaintiffs do not have a private right of action under the ACA, they likewise have no right of action under Connecticut General Statutes § 38a-477aa(b)(3)(A). The statute does not include an express private right of action. As a result, Plaintiffs bear the "burden of demonstrating that such an action is created implicitly in the statute." *Rollins v. People's Bank Corp.*, 925 A.2d 315, 319 (Conn. 2007) (citation omitted). Plaintiffs must overcome "the presumption in Connecticut that private enforcement does not exist unless expressly provided in the statute…." *Asylum Hill Problem Solving Revitalization Ass'n v. King*, 890 A.2d 522, 527 (Conn. 2006) (citations omitted). The three-part test under Connecticut law for determining whether a statute implies a private right of action, commonly called the *Napoletano* test,[3] is similar to the *Cort* factors:

[3] *See Napoletano v. CIGNA Healthcare of Conn., Inc.*, 680 A.2d 127 (Conn. 1996), *overruled on other grounds by Batte-Holmgren v. Comm'r of Pub. Health*, 914 A.2d 996 (Conn. 2007).

1) Is the plaintiff one of the class for whose benefit the statute was enacted?

2) Is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?

3) Is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?

Id. at 528 (citation omitted). The "ultimate question is whether there is sufficient evidence that the legislature intended to authorize these plaintiffs to bring a private cause of action despite having failed expressly to provide for one." *Id.* (citation omitted). Plaintiffs must demonstrate that all three factors favor recognizing a private right of action. *Id.* Plaintiffs, however, cannot demonstrate that any of the three *Napoletano* factors favor implying a private right of action.

A. Plaintiffs Are Not Within a Class for Whose Benefit the Statute Was Enacted.

Plaintiffs are not within the class for whose benefit the legislature enacted Section 38a-477aa(b)(3)(A). First, the statute does not provide any benefit to hospitals like Hartford. For instance, Section 38a-477aa(b)(3)(A) is found in Title 38a ("Insurance"), Chapter 700c ("Health Insurance"), Section 38a-477aa ("Cost-sharing and health care provider reimbursements for emergency services and surprise bills"). The statute provides in relevant part:

> (3) (A) If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse such health care provider the greatest of the following amounts: (i) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services; or (iii) the amount Medicare would reimburse for such services.

Conn. Gen. Stat. § 38a-477aa(b)(3)(A). The statute defines "health care provider" as "*an individual* licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive." Conn. Gen. Stat. § 38a-477aa(a)(4) (emphasis added). The licensing requirements in the chapters referenced in the statute apply only

to individual licensed medical providers, and not to hospitals like Hartford. Notably, the legislature refers to "health care provider and facilities" repeatedly throughout Chapter 700C, where "health care provider" is as defined in Section 38a-477aa and "facility" is used to refer to a hospital, as defined in Section 38a-591a. *See* Conn. Gen. Stat. §§ 38a-472f(5), (7), (13), (18); 38a-477g(a); 38a-477h(a). Thus, Section 38a-477aa(b)(3)(A), by its express terms, does not apply to hospitals. It applies only when an individual with a license to provide health care services, such as a physician, bills a health carrier directly for emergency services, and the individual is not in the health carrier's network of providers. *Id.*

Second, the statute also does not "unambiguously confer" any rights to patients like Mr. Gonzalez, because it is not "phrased in terms of the persons benefited," as is required under Connecticut law to imply a private right of action. *Asylum Hill*, 890 A.2d at 537 (citations omitted). That a statute may benefit an individual is not sufficient to confer an enforceable right to the individual. *Id.* Here, as with the federal ACA statute, the statutory language directs what the "health carrier shall" do, and is "not a directive to benefit the public generally with respect to a specific right." Conn. Gen. Stat. § 38a-477aa(b)(3)(A); *Asylum Hill*, 890 A.2d at 539. Nor is it "a prohibition on certain acts against the public." *Id.* The Supreme Court of Connecticut held that statutory language providing that agencies "shall administer" housing and urban development programs in particular ways did not "create an unambiguous right vested in the plaintiffs." *Id.* Similarly, Section 38a-477aa(b)(3)(A) provides that a carrier "shall reimburse" health care providers in particular ways. Conn. Gen. Stat. § 38a-477aa(b)(3)(A). In short, the statute does not create any individual entitlement, which unambiguously demonstrates that the legislature intended to create an individually enforceable private right of action. *Asylum Hill*, 890 A.2d at 539.

In a weak attempt to shoehorn themselves within the definition of "health care provider" that clearly only applies to individual physicians, Plaintiffs allege that three of the hospitals sometimes include physician charges as part of their "bundled" rate for emergency services on healthcare benefits claims submitted to Anthem. (Am. Compl. at ¶¶ 77, 83.) Even if this is true, the statute does not apply to claims submitted by hospitals such as Hartford—as noted above, it only comes into play when the individual physicians "bill the health carrier directly," because only such physicians fall within the definition of "health care provider" in the statute. Conn. Gen. Stat. §§ 38a-477aa(a)(4), (b)(3)(A). Moreover, Plaintiffs' theory does not explain how they would have a right to sue when it is the individual physicians' charges that are at issue—the legislature excluded hospitals such as Plaintiffs from the definition of "health care provider." Conn. Gen. Stat. § 38a-477aa(a)(4). Nothing in the statute permits a hospital to bundle an individual physician's charges into its own bill and then assert any rights that physician may have under the statute.[4] Based on the literal construction of the statute, Plaintiffs are not in the class the legislature sought to benefit, and thus the first *Napoletano* factor does not favor finding an implied right of action.

B. Section 38a-477aa's Legislative History Does Not Indicate Any Intent to Provide a Private Right of Action.

The legislative history of the statute also does not favor a private right of action, as it is silent on the issue of whether it intended to provide "health care providers" or patients with a remedy. There simply is no support for an assertion that the statute was intended in any way to give providers or patients any private remedies. Instead, the legislative history of Senate Bill 811 reveals that the legislature's primary concern in enacting Section 38a-477aa was to address

[4] The relief Plaintiffs seek under the Connecticut statute is overbroad even under Plaintiffs' reading of the statute, as Plaintiffs ask the Court in the Third and Fourth Claims for Relief for a declaration and injunction that would require Anthem to pay Plaintiffs directly, regardless of whether Plaintiffs have bundled physician services in their claims. (Am. Compl. at p. 28.)

patients affected by "surprise bills," where a patient seeks emergency services at an in-network hospital but is treated by an out-of-network physician, and thus unwittingly becomes liable for the portion of that physician's bill not covered by the patient's benefit plan or insurance. *See* 58 H.R. Proc., Pt. 20, 2015 Sess., p. 6717, remarks of Rep. Matt Ritter[5] ("[T]he whole purpose of the bill is to take away for the consumer that the surprise component is not there and it'll be resolved between the provider and the insurer depending on what the three various categories are [in Section 38a-477aa(b)(3)(A)."); 58 S. Proc., Pt. 9, 2015 Sess., p. 2714, remarks of Sen. Martin Looney ("Again, on the issue of surprise billing, the amendment deals with Section 10 by providing that it will apply only to emergency services or to where an insured is undergoing a procedure at an in-network facility and an out-of-network physician performed services without that person's knowledge.").[6]

Despite the emphasis on patients, however, the legislature did not provide patients with a private right of action. The legislature elsewhere provided private rights of action to enforce other provisions of Chapter 700C. *See, e.g.,* Conn. Gen. Stat. §§ 38a-470(f) (authorizing private action for carriers, employees or employers to contest worker's compensation liens); 38a-591d(g)(2) (authorizing private action for patients for violation of utilization review and benefit determination requirements). Since the legislature is "always presumed to know all the existing statutes and the effect that its action or non-action will have upon any one of them," its failure to provide for private enforcement of Section 38a-477aa must be presumed to be intentional. *Asylum Hill*, 890 A.2d at 533 (citation omitted).

Nothing in the legislative history of the bill indicates any intent by the legislature to

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[5] The transcripts of legislative hearings cited here are publicly available at https://ctstatelibrary.org/leghistory/ (last visited October 11, 2017).

[6] Section 38a-477aa was initially Section 10 of the bill, but was Section 9 in the bill as passed by the legislature.

provide a private right of action to physicians, much less hospitals. Accordingly, the second *Napoletano* factor does not favor implying a private right of action.

C. The Purposes of the Legislative Scheme Are Inconsistent with Implying a Private Right of Action.

Implying a private right of action is also inconsistent with the underlying purposes of the legislative scheme. The existence of other enforcement mechanisms within the statutory scheme is "strong, if not conclusive, evidence of legislative intent *not* to create additional implied remedies under the statute." *Provencher v. Town of Enfield*, 936 A.2d 625, 634 n.10 (Conn. 2007) (emphasis in original). In Chapter 700C of Title 38a, the legislature authorized the Commissioner of Insurance to adopt regulations to enforce many of the statutory scheme's requirements. *See, e.g.*, Conn. Gen. Stat. §§ 38a-481(a)-(b) (authorizing commissioner to adopt implementing regulations); 38a-495a(g)-(l) (same); 38a-505(1)-(3) (same); 38a-513(a)(1) (same). As noted above, other provisions in Chapter 700C expressly provide for private enforcement. Conn. Gen. Stat. §§ 38a-470(f), 38a-591d(g)(2).

Where the legislature has created a statutory scheme that provides administrative remedies and private rights of action for some provisions but not for others, the Court cannot "engraft an enforcement mechanism that overrides the legislature's apparent intent to reserve that authority to the executive and legislative branches." *Asylum Hill*, 890 A.2d at 534. Chapter 700C of Title 38a reflects the legislature's balancing of rights and remedies, and the legislature chose not to provide a private remedy for violation of Section 38a-477aa(b)(3)(A), though it clearly chose to do so with respect to other statutes within the scheme. Accordingly, the underlying statutory scheme does not favor implying a private right of action. *Id.*

Given that Plaintiffs cannot satisfy even one, much less all, of the *Napoletano* factors, the Court should promptly dismiss their Third and Fourth Claims for Relief with prejudice.

III. The Court Lacks Subject Matter Jurisdiction over Plaintiffs' Claims for Declaratory Relief.

If the Court determines that there is no private right of action under the ACA or the Connecticut statute, Plaintiffs' Amended Complaint should also be dismissed with prejudice because such a determination deprives this Court of subject matter jurisdiction over Plaintiffs' claims for declaratory judgment. (Am. Compl., First, Third, Fifth and Seventh Claims for Relief.)

Whether under the federal Declaratory Judgment Act ("DJA"), 28 U.S.C. § 2201, or under Connecticut law, Plaintiffs fail to establish that this Court has subject matter jurisdiction over their claims, because they do not and cannot allege the "actual controversy" required for the Court to have jurisdiction. *S. Jackson & Son, Inc. v. Coffee, Sugar & Cocoa Exch. Inc.*, 24 F.3d 427, 431 (2d Cir. 1994); *Roy v. Mulcahy*, 288 A.2d 64, 66 (Conn. 1971). Plaintiffs seek "a declaration that Defendant's actions, as of October 1, 2017, in refusing to pay [Plaintiffs] directly for medically necessary emergency services that [Plaintiffs] provide[] to [Anthem's] members and beneficiaries" violates Connecticut General Statutes § 38a-477aa(b)(3)(A) and the ACA. (Am. Compl. at ¶¶ 63, 79, 104, 136.) Since those statutes do not provide Plaintiffs with a private right of action, there is no "actual controversy" for the Court to decide.

An actual controversy exists only where "there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." *Maryland Cas. Co. v. Pac. Coal & Oil Co.*, 312 U.S. 270, 273 (1941). The DJA does not provide an independent cause of action, but only provides a remedy, and therefore "a court may only enter a declaratory judgment in favor of a party who has a substantive claim of right to such relief." *In re Joint Eastern & Southern Dist. Asbestos Litig.*, 14 F.3d 726, 731 (2d Cir. 1993). If the statute under which the plaintiff purports to sue does not

provide the plaintiff with a private right of action, there is no "actual controversy" for the Court to decide and the Court lacks subject matter jurisdiction. *Schilling v. Rogers*, 363 U.S. 666, 677 (1960); *see also ASL Assocs. v. Zoning Com'n of Town of Marlborough*, 559 A.2d 236, 239 (Conn. App. Ct. 1989) (finding no jurisdiction where plaintiff failed to allege any action or threat of action in violation of state law).

The statutes under which Plaintiffs sue do not authorize private rights of action, and thus Plaintiffs fail to establish the "substantive claim of right" necessary to create subject matter jurisdiction. *In re Joint Eastern & Southern Asbestos Litig.*, 14 F.3d at 731. Plaintiffs' allegations that the ACA and Connecticut General Statutes § 38a-477aa(b)(3)(A) require Anthem to pay them directly are contradicted by the statutes themselves, which do not provide Plaintiffs with a private right of action. *See supra*. Given that Plaintiffs lack a legal right to the relief they seek, they cannot establish that this Court has subject matter jurisdiction, and therefore the Court should dismiss Plaintiff's First, Third, Fifth and Seventh Claims for Relief with prejudice. *See Dehaney v. Chagnon*, No. 3:17-cv-308 (JAM), 2017 WL 2661624, at *4 (D. Conn. June 20, 2017) (dismissing declaratory judgment action where plaintiff had no private right of action under 42 U.S.C. § 15601); *Aldi v. Wells Fargo Bank, N.A.*, No. 3:14-cv-89-WWE, 2015 WL 3650297, at *6-7 (D. Conn. Feb. 17, 2015) (dismissing declaratory judgment action where plaintiff did not have private right of action under 12 U.S.C. § 1715z-20).

IV. The Statutes and Regulations at Issue Do Not Prohibit Anthem from Paying Benefits Directly to Members.

Even if Plaintiffs had a private right of action under the emergency services provisions in the ACA and/or the Connecticut statute, the claims in their Amended Complaint based on these statutes should still be dismissed with prejudice for failure to state a claim, because neither statute prohibits Anthem from directly paying Members instead of out-of-network hospitals like

Hartford for emergency services.

Contrary to Plaintiffs' allegations, Section 300gg-19a of the ACA does not prohibit Anthem from directly paying Members. In fact, the only thing it prohibits is requiring prior authorization for emergency services and placing different limitations ***on coverage*** issued to participants and beneficiaries for out-of-network emergency services than for in-network emergency services. 42 U.S.C. § 300gg-19a(b)(1)(ii)(I). The regulations also do not prohibit direct payment to Members. By their express terms, the regulations govern the "manner" in which plans or issuers "provide coverage for emergency services." 26 C.F.R. § 54.9815-2719A(b)(2)(iii); 29 C.F.R. § 2590.715-2719A(b)(2)(iii); 45 C.F.R. § 147.138(b)(2)(iii). In short, where the payment first goes simply bears no relation to whether a Member has coverage and it does not in any way prevent the Member from obtaining out-of-network emergency services. In promulgating the regulations, the agencies clarified that their intent was to prohibit requirements—such as prior authorization—that would prevent patients from obtaining emergency services from out-of-network providers:

> These provisions will help to ensure that patients receive covered emergency care when they need it, especially in situations where prior authorization cannot be obtained due to exigent circumstances or an in-network provider is not available to provide the services. They also will protect patients from the substantial financial burden that can be imposed when differing copayment or coinsurance arrangements apply to in-network and out-of-network care.

Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act, 80 Fed. Reg. 72192, 72217-18 (Nov. 18, 2015) (codified at 26 C.F.R. part 54, 29 C.F.R. part 2590, 45 C.F.R. parts 144, 146 and 147). Notably, the agencies specifically state that these regulations do not prohibit hospitals from balance billing patients or require plans or issuers to cover balance bills, which is a significant difference between how in-network and out-

of-network emergency claims are treated after services are rendered. *See id.* at 72213 ("[T]he statute does not require plans or issuers to cover balance billed amounts, nor does it prohibit balance billing."). Accordingly, the regulation does not prohibit Anthem from covering only a portion of Plaintiffs' charges, resulting in balance bills to Members, even though those Members would only owe plan cost-shares if they obtained emergency services from an in-network provider. *Id.* That the regulations are not intended to eliminate the difference in the amount of charges the plan covers depending on whether the provider is in- or out-of-network demonstrates that "administrative requirements" cannot be read broadly to include issues relating to the direction of payment of benefits, but rather must be confined to issues of "coverage" of services. Plaintiffs' assertion that "coverage" refers to something more than "what the plan covers" is counter to the plain meaning of the term, as well as its use in the statute and regulation, and thus is implausible. Plaintiffs' over-expansive reading of the regulation is not permissible. *See Abrahams*, 644 F.3d at 118 (regulation may only apply, and not expand, rights provided by statute)..

Nor does the Connecticut statute impose any obligation on Anthem to pay benefits to hospitals like Hartford. In the first instance, as noted above, the statute unambiguously does not apply to hospitals like Hartford. Moreover, the statute requires a health carrier to "reimburse such health care provider" when a patient obtains emergency services from an out-of-network "health care provider," but does not specify that the carrier is to reimburse the provider directly. Conn. Gen. Stat. § 38a-477(b)(3)(A). Had the Connecticut legislature intended to include such a requirement, it certainly knew how to do so. For instance, elsewhere in Chapter 700C, it required insurers to pay ambulance services directly. Conn. Gen. Stat. §§ 38a-498(b)(1), 38a-525(b)(1) ("Each such group health insurance policy shall provide that any payment by such company,

corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service.…"). Had the legislature intended to require carriers to pay patient benefits directly to providers, it would have used the same words it used elsewhere in the statutory scheme. *See Hartford/Windsor Healthcare Props, LLC. v. City of Hartford*, 3 A.3d 56, 65 (Conn. 2010) (that legislature used specific term elsewhere in statutory scheme and failed to do so in statute at issue suggests omission was purposeful). The omission of the word "directly" in Section 38a-477(b)(3)(A) as it relates to payments thus should be interpreted as intentional. *Id.* This conclusion is supported by the statute itself, which is primarily concerned with the amounts plans and issuers must pay for out-of-network emergency services, not with who they pay in the first instance. Conn. Gen. Stat. § 38a-477(b)(3)(A). The statute simply does not prohibit Anthem from paying benefits to Members.

V. ERISA Preempts Plaintiffs' Claims Under the Connecticut Statute as Applied to ERISA-Governed Plans.

Connecticut General Statutes § 38a-477(b)(3)(A) is preempted by ERISA to the extent that it purports to require ERISA-governed plans to pay out-of-network providers directly. ERISA preempts state laws that "relate to … employee benefit plan[s]." 29 U.S.C. § 1144(a). A state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) (citation omitted). A state law has an impermissible "connection with" an ERISA plan if the "state law … governs … a central matter of plan administration or interferes with nationally uniform plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, --- U.S. ---, 136 S.Ct. 936, 943 (2016) (quotation marks omitted). For instance, the Supreme Court recently held that a Vermont statute requiring periodic reports was preempted by ERISA because it intruded on a "central matter of plan administration" and interfered with nationally uniform plan administration. *Id.* at 945.

There is no more central matter of plan administration than the plan's payment of benefits to participants and beneficiaries. Plaintiffs seek to use Section 38a-477(b)(3)(A) to fundamentally alter the way that ERISA-governed plans that Anthem administers will pay benefits for out-of-network emergency services in Connecticut, and thus Section 38a-477(b)(3)(A) (at least as Plaintiffs ask the Court to interpret it) has an impermissible "connection with" ERISA plans. *Id.* Accordingly, Section 38a-477(b)(3)(A) is preempted as applied to ERISA-governed plans that Anthem administers, and the Court should dismiss Plaintiffs' Third, Fourth and Seventh Claims for Relief with prejudice to the extent Plaintiffs seek relief with respect to any ERISA-governed plans that Anthem administers.[7] *Id.*

VI. Plaintiffs' ERISA Claims Fail for Multiple Reasons.

Plaintiffs now attempt to assert causes of action under Sections 502(a)(1)(B) and 502(a)(3) of ERISA, but their claims fail for a number of reasons. First, Hartford has not established its capacity to assert an ERISA claim as an assignee of any Member above a speculative level, because it has not identified even a single Member who has assigned its rights to sue under ERISA to Hartford. Second, the Section 502(a)(1)(B) claim fails to identify any benefit denied to any Member, and thus does not state a plausible claim for relief. Third, Plaintiffs' Section 502(a)(3) claim fails because Plaintiffs fail to plausibly allege any right to "appropriate equitable relief" given that the statutes on which they rely do not obligate Anthem to pay Hartford directly.

A. Hartford Does Not Allege Its Capacity to Assert an ERISA Claim as an Assignee, and Lacks Article III Standing to Obtain the Relief It Seeks.

[7] Section 38a-477(b)(3)(A) is not saved from preemption by ERISA's "Savings Clause," 29 U.S.C. § 1144(b)(2)(A), because it does not substantially affect the risk-pooling arrangement between insurer and insured. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003). If, as Plaintiffs assert, it requires administrators like Anthem to pay benefits for emergency services directly to out-of-network providers, Section 38a-477(b)(3)(A) does not change the amount of benefits paid or otherwise impact the plan's risk in any way.

Hartford has not alleged that it has been assigned any rights by any particular Member, and thus has not established a basis for it to sue by assignment. Some circuit courts (though not the Second Circuit) have viewed the issue of whether a medical provider has a valid assignment of a participant's rights as presenting a question of whether the provider falls within the "zone of interests" that ERISA regulates and thus states a claim under Rule 12(b)(6), rather than as a question of prudential standing. *See, e.g., Pennsylvania Chiropractic Ass'n v. Independence Hosp. Indem. Plan, Inc*., 802 F.3d 926, 928 (7th Cir. 2015), *citing Lexmark Int'l, Inc. v. Static Control Components, Inc.*, --- U.S. ---, 134 S.Ct. 1377, 1386 (2014). *Compare Rojas v. Cigna Health & Life Ins. Co*., 793 F.3d 253, 258-59 (2d Cir. 2015) (addressing whether provider had valid assignment in terms of "standing"). Given that Hartford has not identified even one Member who assigned his or her rights to Hartford, it has not established it is within the "zone of interests" ERISA regulates, and thus fails to state a claim under Rule 12(b)(6). *Pennsylvania Chiropractic Ass'n*, 802 F.3d at 928.

To the extent courts have analyzed the issue as one of prudential standing, Hartford has an affirmative burden to allege facts that "affirmatively and plausibly suggest that it has standing to sue," and it has failed to meet that burden with respect to its Fifth and Sixth Claims for Relief. *Amidax Trading Grp. v. S.W.I.F.T. SCRL*, 671 F.3d 140, 145 (2d Cir. 2011) (citations omitted). To have prudential standing to sue, a "plaintiff generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Rajamin v. Deutsche Bank Nat'l Tr. Co.*, 757 F.3d 79, 86 (2d Cir. 2014) (internal quotation marks omitted). As a hospital network, Hartford is not within the class of parties to whom Congress provided remedies under ERISA. *American Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 360-61 (2d Cir. 2016); *see also Harris Trust & Sav. Bank v. Salomon Smith*

Barney Inc., 530 U.S. 238, 247 (2000) (Section 502(a) "demonstrates Congress' care in delineating the universe of *plaintiffs* who may bring certain civil actions," *i.e.*, participants, beneficiaries or fiduciaries) (emphasis in original). The only avenue for Hartford to sue under ERISA is through a valid assignment of a Member's rights under the statute, obtained in consideration for medical services rendered by Hartford to the Member. *American Psychiatric Ass'n*, 821 F.3d at 360-61. "[S]imply asserting that claims … have been assigned … is insufficient by itself to give [a provider] … a cause of action under [ERISA]." *Id.* at 361-62.

Hartford's assignment allegations are insufficient to secure a right to obtain relief under ERISA above a speculative level, given that it alleges only that "Hartford HealthCare's patients … routinely assign to Hartford HealthCare all rights they have as beneficiaries of Defendant's health plans in exchange for emergency medical services." (Am. Compl. at ¶¶ 92, 110.) Hartford does not allege that any particular Member has assigned its rights to sue under ERISA to Hartford. (*Id.*) Notably, Hartford does not allege that it has any capacity to assert an ERISA claim as an assignee of any Member's rights under a particular plan. (*Id.*) Facing similarly vague allegations, district courts have dismissed ERISA causes of action. *See NJSR Surgical Ctr., LLC v. Horizon Blue Cross Blue Shield of N. Jersey, Inc.*, 979 F. Supp. 2d 513, 523 (D.N.J. 2013) (allegation that "the Patients provided assignments of benefits to the Plaintiffs" found insufficient to allege ERISA standing, citing other cases); *Methodist Hosp. of S. Calif. v. Blue Cross of Calif.*, 2010 WL 11508022, at *5 (C.D. Cal. Feb. 26, 2010) (allegation that hospital "has standing to these claims as the assignee of patients' benefits under defendants' health plans" lacked sufficient "factual enhancement").

Notably, in the cases cited above, the plaintiffs apparently had alleged at least some details regarding the patients and plans at issue. Plaintiffs' Amended Complaint is even more

threadbare. Given that Hartford has absolutely no right to seek remedies under ERISA without a valid assignment, it must establish its capacity to assert an ERISA claim with sufficient factual allegations identifying the Members, their plans, and the specific terms of the assignment. *NJSR Surgical Ctr.*, 979 F. Supp. 2d at 523.

Further, even if Hartford does have assignments of some sort from *Anthem's* Members, it still would not be entitled to injunctive and declaratory relief under ERISA, as any such assignment could not grant Hartford the right to seek such forward-looking relief on behalf of Members. *See Premier Health Ctr., P.C. v. UnitedHealth Grp*., 292 F.R.D. 204, 218-19 (D.N.J. 2013) ("[A]n assignment of benefits from a patient for services rendered by a given healthcare provider cannot logically imply the right to assert ERISA claims for injunctive relief on behalf of that patient for services that he or she may receive from other providers in the future."); *Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc*., 775 F. Supp.2d 730, 736 (S.D.N.Y. 2011) (assignment of benefits—*i.e.*, money damages—not sufficient to confer right to seek injunctive and declaratory relief on behalf of patient).

Moreover, all of the benefit plans that Anthem insures prohibit Members from assigning their rights under the plan to health care providers and either direct Anthem to pay Members directly for out-of-network services or grant it discretion to determine whether to pay providers directly for such services. (*See* Dkt. 58, Disclosure Regarding Anti-Assignment Provisions.) *See McCulloch Orthopaedic Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 147 (2d Cir. 2017) (adopting "reasoning of the majority of federal courts that have concluded than an assignment is ineffectual if the [ERISA benefit] plan contains an unambiguous anti-assignment provision")(citations omitted); *Neuroaxis Neurosurgical Assocs., P.C. v. Costco Wholesale Co.*, 919 F. Supp. 2d 345, 356 (S.D.N.Y. 2013) ("federal courts routinely enforce anti-assignment clauses in ERISA-

governed welfare plans").

Plaintiffs also lack Article III standing to sue to redress alleged ERISA violations relating to anyone other than the specific Members on whose behalf they purport to sue. Article III of the Constitution limits the jurisdiction of federal courts to "cases" and "controversies." U.S. Const. Art. III, § 2, cl. 1. To demonstrate Article III standing, Plaintiffs must have suffered an injury-in-fact, there must be a causal connection between the injury and conduct at issue, and the injury must be likely to be redressed by a favorable decision. *Susan B. Anthony List v. Driehaus*, --- U.S. ---, 134 S.Ct. 2334, 2341 (2014); *Kendall v. Emps. Ret. Plan of Avon Prods.*, 561 F.3d 112, 117-18 (2d Cir. 2009). "If an ERISA plaintiff brings claims concerning plans in which she did not participate she lacks the requisite redressability or injury-in-fact to give her standing to sue." *Dezelan v. Voya Retirement Ins. & Annuity Co.*, 2017 WL 2909714, at *6 (D. Conn. July 6, 2017) (collecting cases); *see also Ehrman v. Standard Ins. Co.*, 2007 WL 1288465, at *5 (N.D. Cal. May 2, 2007) (striking Section 502(a)(1)(B) claim seeking benefits for "any and all plan participants," and not just plaintiff).

Here, Plaintiffs seek wide-ranging declaratory and injunctive relief under ERISA that, if granted, would require extensive changes in fundamental procedures for all ERISA plans that Anthem administers, not just those belonging to the Members on whose behalf Plaintiffs purport to sue. (*See* Am. Compl. at p. 28.) Plaintiffs do not, and cannot, allege that they possess assignments from every one of Anthem's Members in Connecticut, both today and in the conceivable future, which is what would be necessary to obtain such broad relief. Even if Plaintiffs could properly allege its capacity to assert ERISA claims on behalf of particular, identified Members, they would not have Article III standing to pursue the relief they seek under ERISA. *Dezelan*, 2017 WL 2909714, at *6. *See also Waldman Pub. Corp. v. Landoll, Inc.*, 43

F.3d 775, 785 (2d Cir. 1994) (injunctive or declaratory relief must necessarily be narrowly tailored).

B. Plaintiffs May Not Seek Remedies Unrelated to Benefits Under Section 502(a)(1)(B).

Plaintiffs have no right to relief under Section 502(a)(1)(B), because they do not allege any Member was wrongfully denied benefits, which is the only circumstance in which a participant or beneficiary may obtain relief under that provision. Section 502(a)(1)(B) allows a "participant or beneficiary" to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). "To prevail on a claim under § 502(a)(1)(B), a plaintiff must show that: (1) the plan is covered by ERISA; (2) plaintiff is a participant or beneficiary of the plan; and (3) plaintiff was wrongfully denied a benefit owed under the plan." *Giordano v. Thompson*, 564 F.3d 163, 168 (2d Cir. 2009). Accordingly, Section 502(a)(1)(B) "affords relief when benefits claims are denied in violation of ERISA plan terms." *New York Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527, 538 (S.D.N.Y. 2013), *affirmed in part, vacated in part by* 798 F.3d 125 (2d Cir. 2015); *see also Nechis v. Oxford Health Plans, Inc.*, 328 F. Supp. 2d 469, 479 (S.D.N.Y. 2004) ("Under § 502(a)(1)(B), '[t]he relief expressly provided is to secure benefits under the plan'") (quoting *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196, 198 (1st Cir. 1997)).

Plaintiffs, however, are not suing to secure plan benefits. They do not allege that Anthem has failed to pay any benefits owed under any plan. Instead, they seek a declaration that Anthem's refusal "to pay [Hartford] directly for medically necessary emergency medical services that [Hartford] provides to Defendant's members and beneficiaries … violate the Affordable Care Act and its implementing regulations, as incorporated into ERISA." (*See* Am.

Compl. at p. 28.) Plaintiffs also specifically allege that they seek clarification of their rights under the ACA, and not their rights to benefits under the terms of a plan. (*Id.* at ¶¶ 100-01.) Such relief is not available under Section 502(a)(1)(B). *New York State Psychiatric Ass'n*, 980 F. Supp. 2d at 538.

Since the declaration Plaintiffs request does not seek to clarify Plaintiffs' rights to future benefits under any plan, Section 502(a)(1)(B) is inapplicable and the Court should dismiss Plaintiffs' Fifth Claim for Relief with prejudice.

C. Plaintiffs Fail to Plausibly Allege Basis for Injunctive Relief Under Section 502(a)(3).

Plaintiffs seek an injunction requiring Anthem to perform what Plaintiffs allege are its obligations under ERISA (and the ACA, to the extent incorporated into ERISA). (Am. Compl. at p. 28.) Section 502(a)(3) authorizes plan participants, beneficiaries or fiduciaries to seek an injunction barring "any act or practice that violates any provision of this subchapter or the terms of the plan…." 29 U.S.C. § 1132(a)(3)(A). As established elsewhere in this brief, the ACA does not prohibit the action Plaintiffs seek to enjoin, which is the payment of plan benefits to a member for out-of-network emergency services. Accordingly, Plaintiffs fail to allege any "act or practice that violates" ERISA, and thus fail to state a claim.

Even if Plaintiffs could allege any conduct by Anthem that violates ERISA, however, they fail to allege a proper basis for a Section 502(a)(3) claim against Anthem. ERISA "defines an administrator … as a fiduciary only 'to the extent' that he acts in such a capacity in relation to a plan." *Pegram v. Hedrich*, 530 U.S. 211, 225-26 (2000) (quoting 29 U.S.C. § 1002(21)(A)). However, Hartford is not seeking injunctive and declaratory relief regarding the terms of any particular ERISA plan and does not allege that Anthem has any fiduciary obligations or discretionary powers with respect to any particular plan. (*See generally* Am. Compl.)

Specifically, Hartford does not allege that Anthem has discretion under any particular plan to determine to whom benefits should be paid. Similarly, though Mr. Gonzalez alleges that Anthem "serves as [his] plan's claims administrator within the State of Connecticut, and in such capacity has discretion to adjudicate and pay employee health benefits thereunder," he does not allege that his plan vests Anthem with the discretion to determine to whom plan benefits for service rendered by out-of-network providers must be paid. (*Id.* at ¶ 53.) Such allegations are insufficient to state a plausible claim for relief under Section 502(a)(3). *See New York State Psychiatric Ass'n*, 798 F.3d 125, 135 (2d Cir. 2015) (affirming dismissal of Section 502(a)(3) claim where plaintiff failed to identify any plan or terms of plans, or administrator's role).[8]

In addition, and as laid out in more detail below as to all of Plaintiffs' claims for injunctive relief, Plaintiffs fail to allege irreparable injury and other necessary elements of a claim for injunctive relief. *See infra*. The Court thus should dismiss Plaintiffs' Sixth Claim for Relief for failure to state a claim.

VII. Plaintiffs' Seventh Claim for Relief Fails to State a Claim Based on Assignments of Benefits.

Plaintiffs' original Complaint alleged in passing that patients "routinely assign to Hartford HealthCare all rights they have as beneficiaries of Defendant's health plans" and that these assignments obligate Anthem to pay Hartford directly for services Hartford provides to these patients. (Am. Compl. at ¶ 30.) The Complaint, however, did not purport to assert any causes of action based on these assignments. The Amended Complaint re-alleges that patients "routinely assign" all rights they have as beneficiaries under their health plans, and now purports to assert a cause of action based on these assignments. The Seventh Claim for Relief alleges

[8] Though the Second Circuit did not detail the plaintiff's pleading deficiencies, the district court specified that the plaintiff—like Hartford here—failed to identify any patients, plans, employers, or the defendant's role with respect to each plan at issue. *New York State Psychiatric Ass'n*, 980 F. Supp. 2d at 547-48.

breach of unidentified contracts to which Hartford is not a party, somehow asserting that Anthem's "failure to comply with the Affordable Care Act and Connecticut law constitutes a breach of [Anthem's] contractual obligations to Hartford HealthCare, as assignee of the members and beneficiaries of [Anthem's] health plans." (*Id.* at ¶ 131.)

The Seventh Claim for Relief should be dismissed with prejudice for failure to state a claim for which relief can be granted for the following reasons.

First, the allegations regarding assignments in the Amended Complaint do not allege "sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Iqbal*, 556 U.S. at 679. The Amended Complaint does not allege that any particular Anthem Member has assigned his or her benefits under their benefits plan to Hartford for emergency services rendered by Hartford after it became an out-of-network provider on October 1. The only patient specifically mentioned in the Amended Complaint (Mr. Gonzalez) is not an Anthem Member, and the Amended Complaint does not allege otherwise.[9] The Amended Complaint alleges that Mr. Gonzalez received emergency services from Hartford Hospital "in the past," Am. Compl. at ¶ 54, but this presumably occurred during the time period in which Hartford would have received a direct payment from Anthem as a result of its in-network status. The Amended Complaint does not even allege that Mr. Gonzalez assigned the benefits under his plan for these past emergency services to Hartford.

[9] Although it is not entirely clear, it appears that the Amended Complaint alleges, based on "information and belief," both that Mr. Gonzalez's benefits plan is governed by ERISA and that Anthem "serves as the plan's claims administrator within the State of Connecticut, and as such capacity has discretion to adjudicate and pay employee health benefits thereunder." (Am. Comp. at ¶ 53.) Such an allegation is insufficient to survive a motion to dismiss under the *Twombly*/*Iqbal* pleading standard because such a fact is not "particularly within the possession and control of the defendant." *Arista Records LLC v. Doe*, 604 F.3d 110, 120 (2d Cir. 2010). Who serves as the claims administrator of his plan is something that is reasonably known by the newly added plaintiff, Mr. Gonzalez.

The Amended Complaint alleges that patients "routinely" assign their rights to benefits under their plans to Hartford, Am. Compl. at ¶ 30, but this generic and vague allegation is insufficient to satisfy the pleading requirement under *Iqbal*. A patient is not legally required to assign his or her benefits to a hospital, and the Amended Complaint carefully avoids alleging that Hartford *always* obtains an assignment of benefits from patients who receive emergency services. Based on these allegations, there is absolutely no basis for the sweeping relief sought by Plaintiffs in the form of a declaration and permanent injunction that Hartford is entitled to direct payment for emergency services in every case.

Second, there are benefits plans that Anthem administers or insures that prohibit Members from assigning their rights under the plan to health care providers and direct Anthem either to pay Members directly for out-of-network services or grant Anthem the discretion to determine whether to pay out-of-network providers directly for such services. *See, e.g.*, Dkt. 58, Anthem's Disclosure Regarding Anti-Assignment Provisions (stating for the time period including September 30, 2017 to October 31, 2017, "no plans have contracts of insurance with Anthem Health Plans, Inc. that do not contain an anti-assignment provision"). *See McCulloch*, 857 F.3d at 147; *Neuroaxis*, 919 F. Supp. 2d at 35; *see also Rumbin v. Utica Mut. Ins. Co*., 757 A.2d 526, 530 (Conn. 2000) (courts generally uphold express anti-assignment clauses).

Third, to the extent the Seventh Claim for Relief purports to be based on alleged violations of the provisions in the ACA and the Connecticut statute regarding emergency services, Congress and the Connecticut legislature did not create a private right of action under either statute. The existence of assignments from patients cannot create a private right of action that does not otherwise exist. An assignee "stands in the shoes" of the assignor. *National Loan Invs. Ltd. P'ship. v. Heritage Square Assocs.*, 733 A.2d 876, 879 (Conn. Ct. App. 1999);

Reynolds v. Ramos, 449 A.2d 182, 185 n.5 (Conn. 1982). As a result, "[a]n assignee has no greater rights or immunities than the assignor would have had if there had been no assignment." *Shoreline Comm'ns, Inc. v. Norwich*, 797 A.2d 1165, 1172 (Conn. Ct. App. 2002). The patients' rights to benefits under their health plans do not include a private right of action under either the ACA or the Connecticut statute. Therefore, the Seventh Claim for Relief should be dismissed with prejudice for the same reasons as the first four Claims for Relief in the Amended Complaint.

Fourth, even if a private right of action did exist under the ACA and the Connecticut statute, Hartford lacks Article III standing to bring such a claim as the assignee of Anthem's Members. An "injury in fact" that gives rise to Article III standing must be "concrete and particularized," and "actual or imminent, not conjectural or hypothetical." *Susan B. Anthony*, 134 S.Ct. at 2341; *see also Hull v. Burwell*, 66 F. Supp. 3d 278, 280 (D. Conn. 2014). Allegations of "possible future injury" are insufficient to establish "injury in fact." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013). Hartford is seeking a declaration and permanent injunction into the indefinite future that Anthem must pay Hartford directly any time it renders emergency services to an Anthem member, regardless of its out-of-network status. Hartford lacks standing to seek such relief because it is predicated on assignments of benefits from unnamed future patients that Hartford has not yet obtained—and which those patients are not legally obligated to provide to Hartford—for benefits under unspecified health plans for emergency services that Hartford has not yet rendered to the patients. Any harm under these circumstances is entirely speculative and contingent and falls far short of the "injury in fact" requirement under Article III.

Fifth, Hartford is not entitled to the extraordinarily broad and sweeping declaratory and injunctive relief it seeks in their Amended Complaint based on any assignments of benefits

Hartford may already have from certain *Anthem* Members who previously received emergency services from Hartford. Such assignments cannot grant Hartford the right to seek forward-looking relief on behalf of the Member. *Premier Health Ctr.*, 292 F.R.D. at 218-19.

Sixth, to the extent the Seventh Claim for Relief in the Amended Complaint is nothing more than a state common law breach of contract claim based on Anthem's purported breach of its contractual obligations under its Members' health plans that may be assigned to Hartford, Am. Compl. at ¶ 24, such a claim is preempted by ERISA. "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear Congressional intent to make the ERISA remedy exclusive and is therefore preempted." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Common law claims for breach of contract are preempted by ERISA. *Nicholls v. Aetna Life Ins.*, 2013 U.S. Dist. LEXIS 155467, *3 (D. Conn. Oct. 30, 2013); *Rau v. Hartford Life & Accident Ins Co.*, 2012 U.S .Dist. LEXIS 126024, at *6-7 (D. Conn. May 11, 2012) (collecting cases). In particular, Mr. Gonzalez's breach of contract claim is preempted by Section 1144(a) of ERISA, as Mr. Gonzalez alleges that his plan is governed by ERISA. (Am. Compl. at ¶ 53.) However, any of Hartford's claims are also preempted by ERISA, to the extent Hartford seeks state-law remedies for breach of a plan governed by ERISA. *Aetna Health Inc.*, 542 U.S. at 209.

VIII. Plaintiffs' Amended Complaint Fails to State a Claim for Breach of Implied-in-Fact Contract.

Plaintiffs have no express written contract with Anthem. Hartford's provider agreement with Anthem expired on September 30, 2017, and Hartford is now out-of-network. (Am. Compl. at ¶¶ 26-28.) The Eighth Claim for Relief in the Amended Complaint alleges that Hartford's provision of emergency services to Anthem's Members gives rise to an implied-in-fact contract between Anthem and Hartford and that this purported contract requires Anthem to pay Hartford

directly for emergency services they render to Anthem's Members. (*Id.* at ¶¶ 139-40.) Based on this purported contract, the Amended Complaint seeks a permanent injunction directing Anthem to pay Hartford directly for any emergency services they provide to Anthem's Members. (*Id.* at ¶ 149.) This claim for breach of implied-in-fact contract should be dismissed with prejudice for failure to state a claim. The Amended Complaint fails to allege that Anthem engaged in any conduct that establishes a meeting of the minds between Anthem and Hartford that included an agreement by Anthem to pay Hartford directly for emergency services after its contract expired and it became an out-of-network provider.

An implied-in-fact contract, like an express contract, depends on actual agreement. *Conn. Light & Power Co. v. Proctor*, 152 A.3d 470, 478 (Conn. 2016). There must be a meeting of the minds between the parties. *Id.*; *Rosario v. J.C. Penney*, 463 F. Supp. 2d 228, 231 (D. Conn. 2006); *Reynolds v. Chrysler First Commercial Corp.*, 673 A.2d 573, 577 (Conn. Ct. App. 1996). In order to establish the existence of an implied-in-fact contract, the complaint must allege that the defendant agreed, either by words or action or conduct, to undertake an actual contractual commitment to the plaintiff. *Id.* In order to support contractual liability, the defendant's representations must be sufficiently definite to manifest a present intention to undertake immediate contractual obligations to the plaintiff. *Burnham v. Karl & Gelb, P.C.*, 717 A.2d 811, 813 (Conn. Ct. App. 1998); *Lowe v. Amerigas, Inc.*, 52 F. Supp. 2d 349, 357 (D. Conn. 1999). The plaintiff's mere belief that an implied-in-fact contract exists is insufficient to bind the defendant without some words, conduct or action by defendant establishing its intent to be bound to such a contract. *Christensen v. Bic Corp.*, 558 A.2d 273, 277 (Conn. Ct. App. 1989); *Reynolds*, 673 A.2d at 577.

Plaintiffs' claim based on an implied-in-fact contract theory should be dismissed with

prejudice for failure to state a claim for the following separate and independent reasons.

First, the Amended Complaint does not identify ***any*** words, conduct or actions by Anthem that are capable of establishing an implied-in-fact contract between Anthem and Hartford in which Anthem promised to pay Hartford directly for emergency services after Hartford became an out-of-network provider. In fact, the opposite is true. The Plaintiffs here alleges that Anthem "has unequivocally announced that, starting on October 1, 2017, it will no longer pay Hartford HealthCare directly for medically necessary emergency medical services that Hartford HealthCare provides to Defendant's members and beneficiaries." (Am. Compl., ¶ 144; *see also* ¶ 32.) The Amended Complaint, itself, sets forth that there was never a meeting of the minds in which Anthem agreed to pay Hartford directly for emergency services once Hartford went out-of-network. The Amended Complaint alleges in relevant part:

> Defendant, starting October 1, 2017, ***will only pay its members and beneficiaries*** for health care services that Hartford HealthCare provided to them. It will then be the responsibility of the members and beneficiaries to deposit these funds and make separate arrangements to pay Hartford HealthCare. ***Defendant has made it clear that it will play no role in the payment of Hartford HealthCare.***

(Am. Compl. at ¶ 33 (emphasis added).) Based on these allegations, Hartford's claim based on the existence of an implied-in-fact contract requiring Anthem to make payments directly to Hartford fails as a matter of law. No such contract exists between the parties.

Second, the mere allegation that Hartford at some point in the future may provide emergency services to Members with health insurance administered or provided by Anthem does not establish an implied-in-fact contract between Hartford and Anthem. Whether Hartford provided services to a third party (the Member) is irrelevant. Hartford's theory "ignores the fundamental principle that an implied contract, like an express contract, depends on an actual agreement between the parties. Defendant must have agreed to have undertaken a contractual commitment to plaintiff." *Pecoraro v. New Haven Register*, 344 F. Supp. 2d 840, 844 (D. Conn.

2004). A decision by a Member to seek emergency services at one of Plaintiffs' hospitals simply does not constitute an action or conduct by Anthem, let alone conduct that signals Anthem's agreement to undertake a contractual obligation to pay Hartford directly. The Amended Complaint does not allege, and Hartford would have no good faith basis for alleging, that Anthem directed any of its members to seek emergency services from Hartford or that Anthem requested that Hartford provide such services.[10]

Third, Hartford's own unilateral "expectation" or belief that it should be paid directly by Anthem even though it is an out-of-network provider is insufficient as a matter of law to create an implied-in-fact contract with Anthem to that effect. *Christensen*, 558 A.2d at 277. The Amended Complaint simply does not allege any words, actions or conduct by Anthem that plausibly created such an expectation. Indeed, the Amended Complaint alleges that Hartford has no expectation that Anthem will pay it directly after it became an out-of-network provider. (Am. Compl. at ¶ 33.)

Fourth, Plaintiffs cannot bootstrap the existence of an implied-in-fact contract for direct payment from Anthem based on the mere existence of two statutes—the ACA and the Connecticut statute—that Plaintiffs contend (erroneously) require direct payment for emergency services to out-of-network providers. This Court rejected an argument based on the same logic in the employment context. In *Rosario*, this Court held that an employer's general obligation to comply with state and federal anti-discrimination laws does not give rise to a claim for breach of an implied-in-fact contract based on the employer's alleged failure to comply with these laws. 463 F. Supp. 2d at 232; *see also Pecoraro*, 344 F. Supp. 2d at 844. "To accept plaintiff's theory

[10] Anthem would have no need to make such a request. Under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), hospitals are required by law to render emergency services without regard to a patient's insurance or ability to pay. *See* 42 U.S.C. §§ 1395dd(b), (h).

would be tantamount to saying that any deviation by an employer … from the federal or state anti-discrimination laws gives rise to a claim for breach of an implied contract. That is not the law." *Rosario*, 463 F. Supp. 2d at 232. That same logic applies here to the ACA and the Connecticut statute on which Plaintiffs rely in this case. Plaintiffs cannot state a claim for an implied-in-fact contract based on nothing more than the existence of these statutes. Such a claim would be contrary to Connecticut law (it does not rely on any words, conduct or actions by Anthem) and it would create an entirely new private right of action that both Congress and the Connecticut legislature declined to create.

IX. Plaintiffs' Complaint Fails to State a Claim for Injunctive Relief Because It Does Not Allege Any Irreparable Harm.

Irreparable harm is a mandatory requirement for issuing both preliminary and permanent injunctions. *Amoco Prod. Co. v. Village of Gambell, Alaska*, 480 U.S. 531, 546 n.12 (1987); *Rodriguez v. DeBuono*, 175 F.3d 227, 235 n.9 (2d Cir. 1998). Irreparable harm is "the single most important prerequisite for the issuance of a preliminary injunction." *Jayaraj v. Scappini*, 66 F. 3d 36, 39 (2d Cir. 1995) (citation omitted). "Irreparable harm is an injury that is not remote or speculative but actual and imminent, and for which a monetary award cannot be adequate compensation." *Tom Doherty Assoc., Inc. v. Saban Entertainment, Inc.*, 60 F.3d 27, 37 (2d Cir. 1995). "The key word in this consideration is *irreparable*. Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough. The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm." *Jayaraj*, 66 F. 3d at 39, quoting *Sampson v. Murray*, 415 U.S. 61 (1974) (emphasis in original).

Plaintiffs' Amended Complaint fails to state a claim for injunctive relief because it does not allege any irreparable harm that warrants injunctive relief. Plaintiffs' Amended Complaint

alleges that Anthem's practice of sending payments for emergency services performed by out-of-network providers to the Member will impose "significant administrative burdens" *on Hartford*. (Am. Compl. at ¶ 4.) Specifically, Plaintiffs allege that sending payments to the Member increases the chances that a payment will be lost, delayed, misdirected or improperly retained by the Member. (*Id.* at ¶¶ 48-49.) Plaintiffs further allege that they will be forced to expend "time, money and effort" in follow-up efforts to determine whether Members have received payments from Anthem and to make separate payment arrangements with the Members. (*Id.* at ¶ 49.) These purported "administrative burdens" alleged by Plaintiffs—the "money, time and energy" Hartford may expend if Anthem pays its Members for out-of-network emergency services—do not constitute irreparable harm. *Jayaraj*, 66 F.3d at 39; *see also Shays v. FEC*, 337 F. Supp. 2d 28, 48 (D.D.C. 2004) (rejecting argument that "potentially wasted and diverted staff resources" constitutes irreparable harm). Instead, these alleged injuries are purely economic losses for which a monetary damages award is a more than adequate remedy.[11]

Moreover, these purely economic burdens will be borne by Hartford to some degree whether or not the Court grants Plaintiffs the relief they seek. Even if Anthem were to pay Hartford directly for services it renders to Members, Hartford will still balance bill Anthem's Members for emergency services, *i.e.*, it bills the Members for the difference between its full billed charges and the amount paid by Anthem. *See Gianetti v. Rutkin*, 70 A.3d 104, 111 (Conn. App. Ct. 2013) (out-of-network providers are not prohibited from balance billing). It is questionable, to say the least, whether Hartford will suffer any different or increased "administrative burden" when it seeks payment from a Member of the balance of its billed

[11] Notably, Plaintiffs' Amended Complaint does not seek any monetary damages. (Am. Compl. at pp. 27-29.) Plaintiffs' tactical decision not to seek such monetary damages, however, has no impact on whether the injuries alleged in the Amended Complaint constitute irreparable harm for which injunctive relief is warranted.

charge versus when it seeks the full billed charge. The vast majority of "administrative burden" alleged by Plaintiffs is ultimately a result of their out-of-network status, not the direction of payments made by Anthem.

In addition, since Hartford is entitled to seek full payment of its bill from Members, the "time, money and effort" involved in efforts to determine if Members have received payment from Anthem or to make separate payment arrangements is illusory—Hartford needs only to bill Members for the full balance of its charges and does not need to determine whether and what Anthem has already paid. Indeed, this is precisely what Hartford is doing. *See* Frequently Asked Questions, https://hartfordhealthcare.org/anthem/frequently-asked-questions ("**Step 1:** You must send full payment of billed charges to Hartford HealthCare"). .

Hartford also alleges that it is entitled to injunctive relief because Anthem sending payments to Anthem's Members rather than directly to Hartford will cause irreparable harm to Anthem's Members. (Am. Compl. at ¶¶ 42-46.) According to Hartford, Anthem's Members may be burdened by having to spend time and effort reviewing and interpreting the explanations of benefits sent by Anthem, appealing benefits determinations, and making payment arrangements with Hartford. (*Id*.) This theory of irreparable harm fails as a matter of law. Hartford cannot invoke the purported harm to third parties like Anthem's Members to support their request for injunctive relief. The parties seeking injunctive relief must establish how *they* would be irreparably harmed if no injunctive relief is granted. *NAACP v. Town of E. Haven*, 70 F.3d 219, 224 (2d Cir. 1995). Alleged harms to third parties do not provide a basis for injunctive relief. *Moore v. Consol. Edison Co. of N.Y., Inc.*, 409 F.3d 506, 511 (2d Cir. 2005). Harm to third parties "is not relevant to, and does not establish, the required showing of irreparable harm" to the party seeking injunctive relief. *Federal Ins. Co. v. Metro. Transp. Auth.*, 2017 U.S. Dist.

LEXIS 106134, *8 (S.D.N.Y. July 10, 2017).

There is also no plausible basis for Plaintiffs' claim that Anthem's Members, including Mr. Gonzalez, will be irreparably harmed by receiving a check in the mail from Anthem. All of the grounds for irreparable harm to the Member identified by Plaintiffs are baseless. A Member receives an explanation of benefits for emergency services regardless of whether the hospital is in-network or out-of-network and regardless of whether Anthem sends the payment to the Member or directly to the hospital. The same is true for appeals. Members must appeal benefits determinations regarding services performed by both in-network and out-of-network providers. Members also must pay copayments and deductibles to Hartford regardless of whether Hartford is in-network or out-of-network. Whether Anthem pays its Member or the provider directly does not change these facts. Moreover, as Hartford has now chosen to be an out-of-network provider, it will balance bill Anthem's Members for emergency services. Anthem's Members will have to make payment arrangements with Hartford regardless of whether Anthem sends the payment to its Member or directly to Hartford. Literally the only difference from the Member's perspective is that the Member will either have to endorse the check sent by Anthem over to the hospital, or, if the Member cashes Anthem's check, write a check to the hospital that includes both the amount already paid by Anthem and the Member's share balanced billed by the hospital.

Plaintiffs allege that if Anthem pays Members directly, some Members "will delay their care or seek care at other facilities." (Am. Compl. at ¶ 50.) Such purely speculative injury (regarding ER visits no less), however, does not constitute irreparable harm warranting injunctive relief. *Jayaraj*, 66 F.3d at 39; *Tom Doherty Assoc.*, 60 F.3d at 37; *Weeks Marine, Inc. v. Cargo of Scrap Metal Ladened Aboard Sunken Barge Cape Race*, 571 F. Supp. 2d 334, 337 (D. Conn. 2008). Plaintiffs do not allege any plausible scenario in which a Member needing

emergency medical care would make a conscious decision to delay care or seek care at a different facility merely because Anthem may send the payment for these services directly to the Member.

In addition to being speculative, this theory of irreparable harm fails for two additional reasons. First, any decision by an Anthem Member to delay emergency care constitutes, at best, a harm to the Member, a third party, and not to Plaintiffs, the parties seeking injunctive relief here. Second, any decision by an Anthem Member to go to a different hospital at most constitutes a purely economic injury to Plaintiffs for which an award of monetary damages is more than adequate.

Nor does Mr. Gonzalez individually allege irreparable injury when he claims he will be "tasked with following up with [Anthem] regarding any delayed or missing payments and prosecuting any appeals under his health plan." (Am. Compl. at ¶ 55.) Even if Anthem were to directly pay Mr. Gonzalez's benefits to Hartford, it would not relieve Mr. Gonzalez from his obligations under his benefit plan. Being forced to comply with those obligations is not injury, much less irreparable injury.

CONCLUSION

For the foregoing reasons, Anthem respectfully requests that this Court: 1) order expedited briefing and hearing on Anthem's Motion to Dismiss to avoid a trial on the merits of claims that have no legal basis; and 2) promptly dismiss all eight claims for relief in Plaintiffs' Amended Complaint with prejudice pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure for failure to state a claim upon which relief can be granted, and dismiss Plaintiffs' First, Third, Fifth and Seventh Claims for declaratory relief with prejudice pursuant to Rule

12(b)(1) on the separate and independent basis that this Court lacks subject matter jurisdiction over these claims.

Dated: October 23, 2017

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CERTIFICATE OF SERVICE

I, Michael G. Durham, an attorney, certify that the foregoing document was served on October 23, 2017, via USPS First Class Mail, postage prepaid, and via email upon all parties through their counsel of record in this action.

/s/ Michael G. Durham