UNITED STATES DISTRICT COURT
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, -against- ANTHEM HEALTH PLANS, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, Defendant.	CIVIL ACTION NO. 17 Civ. 1686 Hon. Janet C. Hall

MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S EMERGENCY MOTION TO DISMISS THE AMENDED COMPLAINT

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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; and Windham Community Memorial Hospital, Inc. (collectively, "Hartford HealthCare"); and Carlos David Gonzalez submit this Memorandum of Law in opposition to the Emergency Motion to Dismiss the Amended Complaint pursuant to Federal Rule of Civil Procedure 12(b)(1) and (6) filed by Defendant, Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield.

INTRODUCTION

In this action, Plaintiffs, including Hartford HealthCare and Carlos David Gonzalez, an individual who has received medical services from Hartford HealthCare in the past, and expects to receive emergency medical services from them in the future, seek declaratory and injunctive relief to remedy Defendant's continuing violation of federal and state law. The Affordable Care Act prohibits insurers and health plans from imposing greater administrative restrictions on claims for out-of-network emergency services than they do on claims for in-network emergency services, and Connecticut law specifically requires that out-of-network physicians be reimbursed directly for their emergency services. Nevertheless, beginning October 1, 2017, Defendant no longer provides reimbursement directly to Hartford HealthCare – as it has done for many years – for the emergency services provided to its members and beneficiaries. Instead, Defendant is reimbursing its members and beneficiaries for health care services that Hartford HealthCare provided to them.

Defendant's indirect payment scheme is causing, and will continue to cause, Hartford HealthCare and Carlos David Gonzalez irreparable harm.

As set forth in the Amended Complaint, Defendant's indirect payment scheme is placing one more burden on individuals and families who have suffered the tragedy of an emergency

medical condition. Before October 1, Defendant's reimbursement for emergency medical care was relatively straightforward: Hartford HealthCare provided the services and issued its bill to Defendant. Defendant then adjudicated the claim, and paid Hartford HealthCare directly at the rates and time frames set forth in the parties' agreement. Hartford HealthCare received the reimbursement promptly, along with an explanation of how Defendant adjudicated the claim, so that Hartford HealthCare could expeditiously appeal and assert its rights. If there were problems or delays, Hartford HealthCare had the ability to contact Defendant directly with status inquiries. Removed from this entire process were patients and their families, who were thereby able to focus on their health.

Since October 1, however, the process has become dramatically more complicated. Now, after Hartford HealthCare issues its bill, it is kept completely in the dark about the process. It has no idea when or how Defendant adjudicates the claim, and it has no idea when Defendant is sending its "reimbursement" check to the patient, or how much is being reimbursed. Thus, Hartford HealthCare is put in the unfortunate position of having to follow up on all of these issues with its sick patients (and their families).

These sick patients are put in the middle of the entire reimbursement process. They must field the follow-up inquiries from Hartford HealthCare. They will receive a substantial check, made payable to them, along with confusing and complex explanation of benefits forms. They will be forced to decipher these forms, deposit Defendant's check, and make arrangements to pay Hartford HealthCare. They will also have to determine whether Defendant's reimbursement amount is correct, and, if it is not, exercise their appeal rights. Hartford HealthCare has patient account personnel with years of experience handling these complex issues; Defendant is now transferring the burden to sick patients.

Defendant's actions are irreparably harming Hartford HealthCare. Hospital staff depends on the separation between treatment and financial issues to maintain positive relationships with patients that are focused on clinical issues and enabling patients to get well. By unnecessarily putting patients into the middle of reimbursement issues, Defendant is breaching this wall of separation and irreparably harming Hartford HealthCare's ability to maintain positive relationships with its patients.

If Defendant had continued its longstanding practice of paying Hartford HealthCare directly, patients inquiring about financial issues could be told that the Hospital will bill Defendant directly, and Defendant will pay the Hospital directly. Patients could also be assured that the Hospital would be tracking Defendant's payment status and handling all paperwork, problems, disputes, and appeals. Any issues regarding patient payments would be deferred until after this process played out.

Unfortunately, given Defendant's improper actions, the conversations that Hartford HealthCare emergency department personnel must have with patients are vastly different. Patients will have to be told that they will get a bill for the care from the Hospital, which they will be responsible for paying, and at some unspecified point in the future they may get a check from Defendant that will cover some unknown part of this care. They – sick patients – will have to be responsible for cashing the check, making arrangements to pay Hartford HealthCare, and handling all paperwork, problems, disputes, and appeals, regardless of their health status, age, or level of comprehension. Rather than being able to relieve patients' anxiety about financial issues, Hartford HealthCare personnel, because of Defendant's actions, will be in the unfortunate and unenviable position of increasing patients' anxiety.

This anxiety will significantly and irreparably impede Hartford HealthCare's ability to provide high quality emergency medical services to the communities it serves. More time will have to be spent with patients to alleviate their anxiety and persuade them to remain in the Emergency Department and receive needed treatment. Patients will require more extensive and intensive treatment as the anxiety exacerbates their medical conditions and impedes their recovery. All of this will lead to unnecessary backlogs and delays in the Emergency Department that impairs the effectiveness and availability of Hartford HealthCare's services.

Defendant's indirect payment scheme also imposes substantial administrative burdens on Hartford HealthCare, which will be forced to divert substantial resources – resources that can, and should, be used to maintain and improve the health and welfare of its patients and the communities in which it provides services – to unnecessary tracking of reimbursement payments, assuaging confused patients' concerns, educating patients about appeal rights, and making arrangements with sick patients to provide payments. A money damages award would simply be ineffective to regain the lost opportunities to maintain and improve the health and welfare of its patients.

Defendant's actions also will reduce and delay Hartford HealthCare's receipt of reimbursement for the emergency services that Hartford HealthCare provides its patients. This reduction and delay likely will cause Hartford HealthCare to irrevocably forego opportunities to add, enhance, or maintain health care service levels in its service area.

Defendant's actions also needlessly put significant sums of money into the hands of Emergency Department patients who, because of behavioral health, addiction, or substance abuse issues, are likely to misuse the money to place themselves or other in danger. This has a significant impact on Hartford HealthCare's ability to provide effective, high quality behavioral

health services throughout Connecticut. Substantial additional time will have to be spent in the Emergency Department ensuring that the receipt of these reimbursement funds will not place behavioral health patients in danger, leading to backlogs and delays. Also leading to backlogs and delays will be the certain increase in treatment failures and relapses as a result putting this money into patient's hands. As discussed above, backlogs and delays impair the effectiveness and availability of Hartford HealthCare's services.

Tellingly, from the inception of this action, Defendant has focused almost exclusively on perceived procedural hurdles that allegedly bar Plaintiffs from the relief that they seek. In its motion, Defendant makes only a cursory, largely unsupported argument that its indirect payment scheme – under which it provides "reimbursement" to its members and beneficiaries – comports with the Affordable Care Act and its implementing regulations and Connecticut law.

For the reasons set forth herein, the Court should deny Plaintiffs' motion to dismiss the Amended Complaint in its entirety and allow Plaintiffs to proceed to an expedited trial on the merits of their claims.

STATEMENT OF FACTS

A. Hartford HealthCare Corporation

Hartford HealthCare is a fully integrated health system that includes a tertiary-care teaching hospital, an acute-care community teaching hospital, an acute-care hospital and trauma center, two community hospitals, a behavioral health network, a multispecialty physician group, and related ancillary services. Am. Compl. (Doc. No. 42), ¶ 18.

Specifically, Hartford HealthCare includes Hartford Hospital, a 163-year old institution that is the major teaching institution affiliated with the University of Connecticut Medical School; Backus Hospital in Norwich; the Hospital of Central Connecticut in New Britain; MidState Medical Center in Meriden; and Windham Hospital. *Id.*, ¶ 19. All of these hospitals

provide medically necessary emergency medical services to the residents of their communities. Some, like Hartford Hospital, are New England regional centers for emergency medical care. *Id.*

In three of these hospitals – Hartford Hospital, the Hospital of Central Connecticut, and Backus Hospital – Hartford HealthCare bills include charges for emergency medical physician services as a part of a bundled rate negotiated by Defendant. *Id.*, ¶ 20.

In exchange for health care services – including emergency health care services – Hartford HealthCare routinely receives, and is granted, a broad assignment of benefits from its patients. *See* Am. Compl., ¶¶ 30, 78, 84, 92 & 110. Specifically, the assignments (a) authorize Hartford HealthCare and/or any attending physician or physician group to receive payment directly, (b) assign all applicable insurance benefits to Hartford HealthCare, (c) appoint Hartford HealthCare as the patient's agent to act on his or her behalf to collect hospital charges, and (d) request payment to be made to Hartford HealthCare on the patient's behalf. *See* Plaintiffs' Trial Exhibit W.

B. Defendant's Health Coverage

Defendant, Anthem Health Plans, Inc., is Connecticut's largest commercial health insurer, providing coverage to more than one million residents – including most state employees. Am. Compl., ¶ 22. For some of its health plans, Defendant serves as a traditional individual or group health insurer. *Id.*, ¶ 23. For other of its health plans, Defendant serves as claims administrator for self-insured employee benefit plans established pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* *Id.*

Defendant's members and beneficiaries receive their health care services through two categories of providers: network and out-of-network providers. *Id.*, ¶ 24. Network providers become part of Defendant's networks by entering into participating provider agreements with Defendant. Am. Compl., ¶ 24. These provider agreements specify, among other things, the

mutually agreeable rates at which the provider is to be reimbursed for health care services provided to Defendant's members and beneficiaries. *Id.* Out-of-network providers do not enter into participating provider agreements with Defendant. *Id.*, ¶ 25. They are not members of any of Defendant's networks. *Id.*

C. Hartford HealthCare Ceases to Be One of Defendant's Network Providers

For many years until September 30, 2017, Hartford HealthCare was one of Defendant's network providers. Am. Compl., ¶ 26. Defendant reimbursed Hartford HealthCare for the care that Hartford HealthCare provided to Defendant's members and beneficiaries at the rates set forth in the parties' participating provider agreement. *Id.* The most recent participating provider agreement between Defendant and Hartford HealthCare expired on September 30, 2017. *Id.*, ¶ 27. Because of Defendant's steadfast refusal to renew the participating provider agreement unless and until Hartford HealthCare agrees to unfairly – and catastrophically – low reimbursement rates, Hartford HealthCare was reluctantly forced to become an out-of-network provider for Defendant effective October 1, 2017. *Id.*, ¶ 28.

Although Defendant no longer has a participating provider agreement with Hartford HealthCare, Defendant nevertheless is obligated to provide reimbursement directly to Hartford HealthCare for emergency medical care rendered by Hartford HealthCare to Defendant's members and beneficiaries under federal and state law. Am. Compl., ¶ 29. Additionally, because patients routinely assign to Hartford HealthCare all rights they have as beneficiaries of Defendant's health plans in exchange for health care services, these assignments further obligate Defendant to reimburse Hartford HealthCare for the covered health care services it provides to these patients. *Id.*, ¶ 30.

D. Defendant's Refusal to Honor Its Direct Payment Obligations

For decades prior to October 1, 2017, Defendant directly paid Hartford HealthCare for health care services that Hartford HealthCare provided to Defendant's members and beneficiaries. *Id.*, ¶ 31. Unfortunately, Defendant announced that, starting October 1, 2017, it will not directly pay Hartford HealthCare for health care services that Hartford HealthCare provides to Defendant's members and beneficiaries. *Id.*, ¶ 32.

Instead, starting October 1, 2017, Defendant is paying its members and beneficiaries for health care services that Hartford HealthCare provides to them. Am. Compl., ¶ 33. It will then be the responsibility of the members and beneficiaries to deposit these funds and make separate arrangements to pay Hartford HealthCare. *Id.* Defendant has made it clear that it will play no role in the payment to Hartford HealthCare. Defendant also will not provide any information to Hartford HealthCare about payment status or related issues. *Id.*

Defendant has provided no legitimate justification for this dramatic change in its decades-old direct payment procedure. *Id.*, ¶ 34. Rather, it is clear from the timing of this change – and the statements made by Defendant to Hartford HealthCare – that this change is simply and blatantly in retaliation for Hartford HealthCare's refusal to agree to Defendant's unfairly low proposed reimbursement rates. Am. Compl., ¶ 34.

Defendant is stubbornly holding to this newly adopted procedure even after Hartford HealthCare pointed out to it that the federal Affordable Care Act, and its implementing regulations, require that Defendant directly pay Hartford HealthCare for medically necessary emergency medical services that Hartford HealthCare provides to Defendant's members and beneficiaries. *Id.*, ¶ 35.

Specifically, the Affordable Care Act, 42 U.S.C. § 300gg-19a(b)(1)(ii)(I), provides that, if a health plan provides coverage for medically necessary emergency medical services rendered by network providers – as Defendant's health plans do – then it must provide similar coverage for medically necessary emergency medical services rendered by out-of-network providers. *Id.*, ¶ 36. This is for the benefit of patients so that they are not forced to choose an in network provider in an emergency crisis. *Id.*

And, in covering medically necessary emergency medical services rendered by out-of-network providers, the health plan cannot impose any more restrictions or limitations on that coverage than apply to medically necessary emergency medical services rendered by network providers. 42 U.S.C. § 300gg-19a(b)(1)(ii)(I); Am. Compl., ¶ 37. Likewise, the regulations implementing the Affordable Care Act provide that, in covering medically necessary emergency medical services rendered by out-of-network providers, the health plan cannot impose "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); *see also* 29 C.F.R. § 2590.715-2719A(b)(2)(iii); 45 C.F.R. § 147.138(b)(2)(iii); Am. Compl., ¶ 38.

Additionally, Connecticut General Statutes § 38a-477aa(b)(3)(A) provides that, if "emergency services [are] 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." (Emphasis added). Am. Compl., ¶ 39. The statute defines health care provider as "an individual licensed to provide health care services." *Id.* § 38a-477aa(a)(4); Am. Compl., ¶ 39.

Finally, because patients routinely assign to Hartford HealthCare all rights they have as beneficiaries of Defendant's health plans – which includes payment rights – these assignments further obligate Defendant to reimburse Hartford HealthCare directly for covered health services it provides to these patients. Am. Compl., ¶ 30, 78 & 84.

E. Defendant's Refusal to Directly Pay Hartford HealthCare Imposes Significant Administrative Burdens and Irreparable Harm

By wrongly refusing to directly pay Hartford HealthCare for emergency medical services it provides to Defendant's members or beneficiaries – and instead only paying Defendant's members or beneficiaries – Defendant is imposing an administrative requirement on out-of-network providers and their patients that is more restrictive, limiting, and burdensome than that imposed on network providers, whom Defendant will directly pay. *Id.*, ¶ 40.

Specifically, under Defendant's new indirect payment scheme, Defendant will send "reimbursement" checks, along with explanations of benefits and other paperwork, to patients who have just recently received emergency medical services. *Id.*, ¶ 41. Before October 1, Defendant's reimbursement for emergency medical care was relatively straightforward: Hartford HealthCare provided the services and issued its bill to Defendant. Defendant then adjudicated the claim, and paid Hartford HealthCare directly at the rates and time frames set forth in the parties' agreement. Hartford HealthCare received the reimbursement promptly, along with an explanation of how Defendant adjudicated the claim, so that Hartford HealthCare could expeditiously appeal and assert its rights. If there were problems or delays, Hartford HealthCare had the ability to contact Defendant directly with status inquiries. Removed from this entire process were patients and their families, who were thereby able to focus on their health.

Since October 1, however, the process has become dramatically more complicated. Now, after Hartford HealthCare issues its bill, it is kept completely in the dark about the process. *Id.*, ¶

49. It has no idea when or how Defendant adjudicates the claim, and it has no idea when Defendant is sending its "reimbursement" check to the patient, and how much is being reimbursed. *See* Am. Compl., ¶ 49. Thus, Hartford HealthCare is put in the unfortunate position of having to follow up on all of these issues with its sick patients (and their families).

These sick patients are put in the middle of the entire reimbursement process. They must field the follow-up inquiries from Hartford HealthCare. *See id.*, ¶ 43. They will receive a substantial check, made payable to them, along with confusing and complex explanation of benefits forms. *See id.*, ¶ 41. They will be forced to decipher these forms, deposit Defendant's check, and make arrangements to pay Hartford HealthCare. *See id.*, ¶¶ 42-43. They will also have to determine whether Defendant's reimbursement amount is correct, and, if it is not, exercise their appeal rights. *See* Am. Compl., ¶ 44. Hartford HealthCare has patient account personnel with years of experience handling these complex issues; Defendant is now transferring the burden to sick patients.

Defendant's actions are irreparably harming Hartford HealthCare. Hospital staff depends on the separation between treatment and financial issues to maintain positive relationships with patients that are focused on clinical issues and enabling patients to get well. By unnecessarily putting patients into the middle of reimbursement issues, Defendant is breaching this wall of separation and irreparably harming Hartford HealthCare's ability to maintain positive relationships with its patients.

If Defendant had continued its longstanding practice of paying Hartford HealthCare directly, patients inquiring about financial issues could be told that the Hospital will bill Defendant directly, and Defendant will pay the Hospital directly. Patients could also be assured that the Hospital would be tracking Defendant's payment status and handling all paperwork,

problems, disputes, and appeals. Any issues regarding patient payments would be deferred until after this process played out.

Unfortunately, given Defendant's improper actions, the conversations that Hartford HealthCare emergency department personnel must have with patients are vastly different. Patients will have to be told that they will get a bill for the care from the Hospital, which they will be responsible for paying, and at some unspecified point in the future they may get a check from Defendant that will cover some unknown part of this care. They – sick patients – will have to be responsible for cashing the check, making arrangements to pay Hartford HealthCare, and handling all paperwork, problems, disputes, and appeals, regardless of their health status, age, or level of comprehension. Rather than being able to relieve patients' anxiety about financial issues, Hartford HealthCare personnel, because of Defendant's actions, will be in the unfortunate and unenviable position of increasing patients' anxiety.

This anxiety will significantly and irreparably impede Hartford HealthCare's ability to provide high quality emergency medical services to the communities it serves. More time will have to be spent with patients to alleviate their anxiety and persuade them to remain in the Emergency Department and receive needed treatment. Patients will require more extensive and intensive treatment as the anxiety exacerbates their medical conditions and impedes their recovery. All of this will lead to unnecessary backlogs and delays in the Emergency Department that impairs the effectiveness and availability of Hartford HealthCare's services.

Defendant's indirect payment scheme also imposes substantial administrative burdens on Hartford HealthCare, which will be forced to divert substantial resources – resources that can, and should, be used to maintain and improve the health and welfare of its patients and the communities in which it provides services – to unnecessary tracking of reimbursement payments,

assuaging confused patients' concerns, educating patients about appeal rights, and making arrangements with sick patients to provide payments. A money damages award would simply be ineffective to regain the lost opportunities to maintain and improve the health and welfare of its patients.

Defendant's actions also will reduce and delay Hartford HealthCare's receipt of reimbursement for the emergency services that Hartford HealthCare provides its patients. This reduction and delay likely will cause Hartford HealthCare to irrevocably forego opportunities to add, enhance, or maintain health care service levels in its service area.

Defendant's actions also needlessly put significant sums of money into the hands of Emergency Department patients who, because of behavioral health, addiction, or substance abuse issues, are likely to misuse the money to place themselves or other in danger. This has a significant impact on Hartford HealthCare's ability to provide effective, high quality behavioral health services throughout Connecticut. Substantial additional time will have to be spent in the Emergency Department ensuring that the receipt of these reimbursement funds will not place behavioral health patients in danger, leading to backlogs and delays. Also leading to backlogs and delays will be the certain increase in treatment failures and relapses as a result putting this money into patient's hands. As discussed above, backlogs and delays impair the effectiveness and availability of Hartford HealthCare's services.

F. Hartford HealthCare's Patients, Including Carlos David Gonzalez, Face Significant Administrative Burdens and Irreparable Harm

Plaintiff Carlos David Gonzalez and his family are members of a health plan which he receives through his employment at Aspen Square Management. Am. Compl., ¶ 52. Upon information and belief, Mr. Gonzalez's health plan is governed by ERISA. *Id.*, ¶ 53. Defendant serves as a claims administrator for the plan within the State of Connecticut, and in such capacity

has discretion to determine the procedure for reimbursing Hartford Health Care for the services it provided to plan members. *Id.*

Multiple members of the Gonzalez family have received medical services at Hartford Hospital in the past. *Id.*, ¶ 54. Given the proximity of their home to Hartford Hospital, and the status of their health, it is reasonably anticipated that they will be forced to seek emergency medical treatment from Hartford HealthCare in the near future. Am. Compl., ¶ 54.

As such, under Defendant's indirect payment scheme – which went into effect as of October 1, 2017 – Mr. Gonzalez will be forced to collect a check for "reimbursement" from Defendant, and make arrangements with Hartford HealthCare to provide payment himself. Am. Compl., ¶ 55. Mr. Gonzalez will also be tasked with following up with Defendant regarding any delayed or missing payments and prosecuting any appeals under his health plan. *Id.*

Accordingly, Mr. Gonzalez stands to suffer significant administrative burdens and irreparable harm. Indeed, as a result of the significant administrative burden that would be placed upon him, Mr. Gonzalez may choose to delay his or his family's emergency medical care, seek care at hospitals farther away from his home than Hartford HealthCare's facilities, or seek care from an outpatient urgent care center when hospital care is medically necessary.

Likewise, other Hartford HealthCare patients will suffer significant administrative burdens and irreparable harm as a result of Defendant's indirect payment scheme. Because Hartford HealthCare's interests are inextricably intertwined with those of its patients, these substantial burdens, and the irreparable harm they cause, will fall on Hartford HealthCare as well. *See id.*, ¶ 50.

G. Procedural History

Hartford HealthCare initiated this lawsuit on October 5, 2017. In its initial Complaint, Hartford HealthCare sought a judgment declaring that Defendant's actions, as of October 1,

2017, in refusing to pay Hartford HealthCare directly for medically necessary emergency medical services that Hartford HealthCare provides to Defendant's members and beneficiaries violates both the Affordable Care Act and Connecticut law. *See* Compl. (Doc. No. 1), ¶¶ 58 & 74. Hartford HealthCare also sought a permanent injunction requiring that Defendant directly pay Hartford HealthCare for medically necessary emergency medical services that Hartford HealthCare provides to Defendant's members and beneficiaries. *See id.*, ¶¶ 68 & 81.

Plaintiffs filed an Amended Complaint as of right on October 19, 2017.[1] In the Amended Complaint, Carlos David Gonzalez was joined as a plaintiff. *See* Am. Compl. (Doc. No. 42). Plaintiffs also added additional causes of action under ERISA § 502(a)(1), 29 U.S.C. § 1132(a)(1), seeking to enforce its right to benefits and to clarify its right to future benefits, and under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), seeking to enjoin Defendant's violation of the Affordable Care Act, as incorporated into ERISA. *See* Am. Compl., ¶¶ 87-132. Furthermore, Hartford HealthCare added causes of action for breach of contract and breach of implied-in-fact contract under Connecticut law. *See id.*, ¶¶ 124-49.

ARGUMENT

POINT I

PLAINTIFFS ARE ENTITLED TO DECLARATORY AND INJUNCTIVE RELIEF UNDER MULTIPLE STATUTORY AND COMMON LAW THEORIES

Recognizing Plaintiffs' likelihood of success on the merits, Defendant attempts to dismiss this action based upon the purported lack of a private right of action. However, as set forth below, Plaintiffs have multiple legal bases upon which they may challenge Defendant's indirect

[1] On October 16, 2017, Defendant filed a motion to dismiss the Complaint pursuant to Federal Rule of Civil Procedure 12(b)(1) and (6). On October 27, 2017, Plaintiffs filed a response indicating that Defendant's motion is moot in light of their amendment of the Complaint and Defendant's pending motion to dismiss the Amended Complaint.

payment scheme. Therefore, the Court should reject Plaintiffs' procedural arguments and proceed to the trial of this action on the merits.

A. Plaintiffs Have an Implied Private Right of Action under the Affordable Care Act

Plaintiffs are entitled to challenge Defendant's indirect payment scheme under the Affordable Care Act directly. The question of whether a federal statute contains an implied a private right of action is "basically a matter of statutory construction." *Transamerica Mortg. Advisors, Inc. (TAMA) v. Lewis*, 444 U.S. 11, 15 (1979). The Supreme Court has enumerated several factors that are relevant to this analysis, including: (1) whether the plaintiff is "one of the class for whose especial benefit the statute was enacted"; (2) whether there is "any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one"; (3) whether a private right of action is "consistent with the underlying purposes of the legislative scheme"; and (4) whether "the cause of action [is] 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." *Cort v. Ash*, 422 U.S. 66, 78 (1975). To imply a private right of action, a statute must grant private rights to members of an identifiable class, or prohibit certain conduct as unlawful. *See Transamerica Mortg. Advisors, Inc.*, 444 U.S. at 24; *Touche Ross & Co. v. Redington*, 442 U.S. 560, 569 (1979).

Here, Plaintiffs are able to demonstrate an implied private right of action under 42 U.S.C. § 300gg-19a. As a threshold matter, 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) expressly prohibits insurers and group health plans from imposing any requirements or limitations on coverage for out-of-network emergency services that are more restrictive than those imposed on claims for in-network services. Thus, it both prohibits certain conduct – *i.e.* placing unfair restrictions or

limitations on claims for out-of-network emergency health care services – as unlawful and confers a benefit on both patients and their health care providers.

Furthermore, the factors enumerated by the Supreme Court in *Cort* suggest that a private right of action is implied under 42 U.S.C. § 300gg-19a. *See M.F. v. State of New York Exec. Dep't Div. of Parole*, 640 F.3d 491, 495 (2d Cir. 2011) (courts in the Second Circuit continue to apply the factors set forth in *Cort* in order to discern congressional intent to provide a private right of action); *Lindsay v. Ass'n of Prof'l Flight Attendants*, 581 F.3d 47, 52 n.3 (2d Cir. 2009) (same).

First, the statute makes clear that its provisions encompass protections for patients against unfair practices by health insurers and group health plans, specifically including claims for emergency medical services. *See* 42 U.S.C. § 300gg-19a. Thus, Carlos David Gonzalez, as a former recipient of emergency medical services, who reasonably expects to require emergency medical services at Hartford Hospital in the future, falls squarely within the class of persons intended to benefit from the patient protections set forth under the statute.[2]

Likewise, Hartford HealthCare, as a health care provider, is an intended beneficiary of the statute. Although 42 U.S.C. § 300gg-19a is entitled "Patient Protections," the title of a statute cannot limit or alter the plain meaning of the text. *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 212 (1998); *Bhd. of R.R. Trainmen v. Baltimore & Ohio R. Co.*, 331 U.S. 519, 529 (1947). Contrary to Defendant's contention, the text of the statute clearly addresses the tripartite relationship between insurers, patients, and hospitals. *See* 42 U.S.C. § 300gg-19a.

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[2] In its motion, Defendant incorrectly contends that Plaintiffs do not seek relief for Mr. Gonzalez under their First and Second Claims for Relief. Rather, to the extent that 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) constitutes a legal duty independent of ERISA, Mr. Gonzalez seeks relief pursuant to the private right of action implied under the Affordable Care Act. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

Indeed, the final regulations promulgated by the Departments of the Treasury, Labor, and Health and Human Services recognize significant benefits that the Affordable Care Act intended to confer upon health care providers. The regulations establish a framework under which insurers and group health plans must provide a baseline level of reimbursement to out-of-network providers for emergency services. *See* 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, 72227 (Nov. 18, 2015). The Departments explicitly recognized that this rule may "have a direct economic benefit to providers." *Id.* at 72227-28. The Departments also "explained that it would defeat the purpose of the protections in the statute if a plan or insurer paid an unreasonably low amount to a provider, even while limiting the coinsurance of copayment associated with that amount to in-network amounts." *Id.* at 72213. Moreover, the Departments indicate that this mitigates the risk that patients will delay or avoid seeking medically necessary treatment due to the expectation of a substantial financial burden. *See id.* at 72228. This inures to the benefits of providers, as it increases patient volume and the demand for their services. In addition, in enacting the final rules, the Departments expressed a legislative and regulatory goal of strengethening the long-term relationships between patients and providers. *See id.* at 72227-28. Because these provisions, and their underlying policies, benefit both Hartford HealthCare and its patients, their interests are inextricably intertwined.

Furthermore, Hartford HealthCare routinely receives assignments of benefits in exchange for emergency medical services. Therefore, to the extent that patients, but not Hartford HealthCare, are entitled to a private right of action under the Affordable Care Act, Hartford

HealthCare would nonetheless be entitled to sue on their behalf to challenge Defendant's violation of the statute.

Second, nothing in the legislative history suggests that Congress intended either to grant or to deny a private right of action. This is not fatal to Plaintiffs' right to bring a claim under the Affordable Care Act; indeed, in *Cort*, the Supreme Court stated that "it is not necessary to show an intention to create a private cause of action" in "situations in which it is clear that federal law has granted a class of persons certain rights." 422 U.S. at 82.

Third, granting a private right of action to both patients and their providers is consistent with the statutory scheme. As stated above, Hartford HealthCare's interests are inextricably intertwined with those of its patients, and it routinely receives assignments of benefits from its patients in exchange for health care services. And, as also stated above, the text of the 42 U.S.C. § 300gg-19a, when read in conjunction with the implementing regulations, clearly confers certain benefits upon health care providers, which may not be limited simply because the title of the statute references only patient protections. Thus, it would support the statutory scheme to allow both patients and the hospitals that provide them with emergency services to sue to enforce their rights.

Fourth, a private right of action under federal law is appropriate here. Although health insurers are traditionally regulated by the states, Congress enacted sweeping reforms to the health insurance industry by passing the Affordable Care Act, which imposes numerous federal law obligations on insurers. Thus, Defendant's reliance on case law that substantially pre-dates the Affordable Care Act is unavailing.

B. Plaintiffs Have Express Private Rights of Action To Challenge Defendant's Violation of the Affordable Care Act and Its Implementing Regulations under ERISA

Even assuming, *arguendo*, that Plaintiffs do not have a private right of action directly under the Affordable Care Act, Plaintiffs are nonetheless entitled to challenge Defendant's indirect payment scheme through the private rights of action provided under ERISA. Specifically, ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) permits a plan participant or beneficiary to bring a civil action to recover plan benefits, enforce his or her rights under the plan, or clarify the right to future benefits. ERISA § 502(3), 29 U.S.C. § 1132(a)(3) further permits a plan participant or beneficiary to seek to "enjoin any act or practice which violates any provision" of ERISA or the terms of the plan, or "to obtain other appropriate equitable relief" to "redress such violations or . . . enforce any provisions" of ERISA.

Congress has expressly incorporated certain provisions of the Affordable Care Act into ERISA, including 42 U.S.C. § 300gg-19a. *See* 29 U.S.C. § 1185d (a)(1) ("[T]he provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg *et seq.*] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart . . . ."); *see New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527, 544 (S.D.N.Y. 2013), *aff'd in part, vacated in part on other grounds*, 798 F.3d 125 (2d Cir. 2015); *see also King v. Blue Cross & Blue Shield of Illinois*, 871 F.3d 730, 739 (9th Cir. 2017) (noting that certain patient protections included in the Affordable Care Act were expressly incorporated into ERISA). Indeed, 42 U.S.C. § 300gg-19a(b)(1) specifies that it applies to both a "group health plan" and a "health insurance issuer offering group or individual health insurance coverage." The Affordable Care Act defines a "group health plan" as "an

employee welfare benefit plan" as defined under ERISA "to the extent that the plan provides medical care . . . to employees or their dependents." 42 U.S.C. § 300gg-91.

Accordingly, both Carlos David Gonzalez, as a member of an ERISA-governed plan administered by Defendant in the State of Connecticut, and the Hartford HealthCare hospitals, as providers that routinely receive assignments of ERISA plan benefits from their patients in exchange for emergency health care services, are entitled to challenge the legality of Defendant's indirect payment scheme under the Affordable Care Act and its implementing regulations pursuant to ERISA § 502(a)(1)(B) and (3). In addition, Mr. Gonzalez and Hartford HealthCare may seek declaratory and injunctive relief under ERISA § 502(a)(1)(B) and (3) simply by virtue of the assignments of benefits, which obligate Defendant provide payment directly to Hartford HealthCare for the services provided to Defendant's members and beneficiaries.

1. Hartford HealthCare Has Sufficiently Alleged Its Capacity to Bring ERISA Claims as Assignee of Its Patients

In its motion, Defendant incorrectly claims that Hartford HealthCare has not sufficiently established its standing to sue under either of their ERISA claims. However, the Second Circuit has clearly held that health care providers, such as the Hartford HealthCare hospitals, have standing to bring claims under ERISA § 502(a) where their patients assign their plan rights in exchange for health care services. *See Simon v. Gen. Elec. Co.*, 263 F.3d 176, 178 (2d Cir. 2001); *see I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting Engineers Council Ins. Tr. Fund*, 136 F.3d 114, 117 (2d Cir. 1998).

Hartford HealthCare has standing because it routinely receives broad assignments of benefits from its patients in exchange for emergency health care services. As Plaintiffs seek only prospective relief, they need not identify specific patients who have assigned their right to benefits to Hartford HealthCare, or the specific plans under which those patients have assigned

their rights. Nevertheless, Plaintiffs can readily demonstrate that they have provided emergency medical treatment to the members and beneficiaries of Defendant's ERISA-governed health plans, and that they will likely do so in the future. First, Hartford HealthCare is required, under federal and state law, to provide emergency services to its patients, regardless of its network status with the patient's insurer. *See* 42 U.S.C. § 1395dd; Connecticut Agencies Regulations § 19-13-D3(j)(2). Second, as Hartford HealthCare is among the largest health systems in the State of Connecticut – with five hospitals containing Emergency Departments – and Defendant is the largest health insurer in the State, it stands to reason that Hartford HealthCare will frequently encounter patients requiring emergency medical care who are members or beneficiaries of one of the ERISA plans administered by Defendant.

For the same reasons, Defendant's claim that the Court should narrowly tailor any declaratory or injunctive relief to the specific patients who assigned their rights, and to the specific plan benefits assigned, falls flat. Hartford HealthCare stands to suffer repeated violations of the Affordable Care Act and Connecticut law as a result of Defendant's indirect payment scheme. As it is difficult, if not impossible, to predict the specific patients that Hartford HealthCare will encounter due to the nature of emergency medical services, the Court should not limit Plaintiffs' potential relief to any specific patient or plan.

Likewise, because Plaintiffs seek only declaratory and injunctive relief, there is no merit to Defendant's argument that they lack Article III standing to bring this action. *See Am. Med. Ass'n v. United HealthCare Corp.*, 2007 WL 1771498, at *19 (S.D.N.Y. June 18, 2007) ("Under the law of this circuit . . . an ERISA plaintiff is not required to 'demonstrate actual harm in order to have standing to seek injunctive relief requiring [a defendant to] satisfy its statutorily-created

disclosure or fiduciary responsibilities.'" (quoting *Cent. States Se. & Sw. Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 433 F.3d 181, 199 (2d Cir. 2005)).

The cases that Defendant cites in support of its argument are inapposite, as they involve plaintiffs who sought to enforce alleged rights separate from those assigned by their patients, *see Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253, 259 (2d Cir. 2015) (plaintiff provider sought to challenge removal from insurer's network under ERISA); *Pennsylvania Chiropractic Ass'n v. Indep. Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015) (plaintiff provider relied on network contract with insurer, rather than ERISA plan), relied upon assignments that were not received in exchange for health care services, *see Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 361 (2d Cir. 2016), or sought benefits for services already rendered to specific patients (and thus were not seeking prospective relief, as Plaintiffs here do), *NJSR Surgical Ctr., L.L.C. v. Horizon Blue Cross Blue Shield of New Jersey, Inc.*, 979 F. Supp. 2d 513, 515 (D.N.J. 2013); *Methodist Hosp. of S. California v. Blue Cross of California*, 2010 WL 11508022, at *1 (C.D. Cal. Feb. 26, 2010).

In any event, Plaintiffs have provided specific assignments of benefits forms signed by its patients to the Court, *in camera*.

Furthermore, Defendant's argument that Hartford HealthCare cannot rely upon its assignments of benefits in order to seek prospective relief must fail. The assignments that Hartford HealthCare routinely receives from its patients in exchange for health care services are sufficiently broad to include, *inter alia*, the appointment of Hartford HealthCare as the patient's agent to act on his or her behalf to collect hospital charges. The two cases on which Plaintiffs rely concern significantly more narrow assignments of benefits, and are thus they too are inapposite. *See Premier Health Ctr., P.C. v. UnitedHealth Group*, 292 F.R.D. 204, 218 (D.N.J.

2013) (defendant contended that plaintiff provider failed to clearly designate itself as the plaintiff's "authorized representative"); *Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc.*, 775 F. Supp. 2d 730, 736 (S.D.N.Y. 2011) (assignment language specifically "limit[ed] Biomed's right to sue on behalf of the Patient to actions for money damages"); *cf. Innova Hosp. San Antonio, L.P. v. Blue Cross & Blue Shield of Georgia, Inc.*, 2014 WL 10212850, at *10 (N.D. Tex. July 21, 2014) (finding that plaintiff providers sufficiently alleged standing to bring ERISA claim, which did not seek plan benefits, where their assignments included "the right to pursue all causes of action").

2. The Purported Anti-Assignment Language in Defendant's Self-Insured Plans Do Not Defeat Hartford HealthCare's Right to Seek Relied under ERISA

Defendant further erroneously challenges any assignment of benefits to Hartford HealthCare based upon anti-assignment language that is alleged contained in its ERISA plans. As a threshold matter, Defendant has stated only that "many" of the plans it administers have such provisions – and thus, conversely, some do not. *E.g.*, Defendant's Trial Memorandum (Doc. No. 44), p. 18.

Moreover, the anti-assignment language that Defendant has identified, in its Trial Exhibits, is insufficient to prohibit the assignment of benefits from the members and beneficiaries of its plans to Hartford HealthCare. Courts interpret ERISA plans "in an ordinary and popular sense as would a person of average intelligence and experience." *Critchlow v. First UNUM Life Ins. Co. of Am.*, 378 F.3d 246, 256 (2d Cir. 2004). As such, any anti-assignment provision must be unambiguous in order to prohibit the assignment of rights under an ERISA plan, and any ambiguities are construed against the insurer. *See Am. Psychiatric Assoc. v. Anthem Health Plans*, 50 F. Supp. 3d 157, 163 (D. Conn. 2014), *aff'd sub nom. Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352 (2d Cir. 2016).

Typically, to prohibit the assignment of benefits under a plan, the plan document must indicate that any assignment of rights thereunder is "void," *see Mbody Minimally Invasive Surgery, P.C. v. Empire HealthChoice HMO, Inc.*, 2016 WL 2939164, at *5 (S.D.N.Y. May 19, 2016); *Neuroaxis Neurosurgical Assocs., PC v. Costco Wholesale Co.*, 919 F. Supp. 2d 345, 352 (S.D.N.Y. 2013) (applying New York law), or must otherwise unequivocally convey an intent to prohibit an assignment of specific rights, *see Neuroaxis Neurosurgical Assocs., PC v. Costco Wholesale Co.*, 919 F. Supp. 2d 345, 354 (S.D.N.Y. 2013) (assessing individual anti-assignment provisions in accordance with their plain meanings). Where an anti-assignment clause is either narrow or is ambiguous, it will not serve to prohibit the assignment of benefits under the plan. *See, e.g.*, *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 575 (5th Cir. 1992) (finding that anti-assignment clause applied "only to unrelated, third-party assignees—other than the health care provider of assigned benefits—such as creditors who might attempt to obtain voluntary assignments to cover debts having no nexus with the Plan or its benefits"), *overruled on other grounds by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012); *see also Am. Psychiatric Assoc*, 50 F. Supp. 3d at 163 (accepting, for the purposes of defendant insurer's motion to dismiss, that anti-assignment provision does not preclude claims for breach of fiduciary duty under ERISA where the anti-assignment language merely referred to "benefits").

Here, Defendant has identified two examples of anti-assignment provisions that are purportedly contained within its ERISA plans. *See* Defendant's Trial Exhibit 3. The first provision states that Defendant "will make benefit payments directly to In-Network (Participating) Providers for Covered Services," but that "if you use an Out-of-Network (Non-Participating Provider, [it] *may* make benefit payments directly" to its members and

beneficiaries." *Id.* (emphasis added). The provision goes on to state that Defendant "reserves the right to make payments on behalf of the Employer directly to the Member at [Defendant's] discretion," but that it "may send payments and claim notifications directly to a designated representative." *Id.* Finally, the provision states that "[y]ou cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable law."

Based upon this language – which is rife with ambiguities – a person of average intelligence and experience would likely believe that he or she is permitted to assign his or her right to benefits, or to bring ERISA claims, to a health care provider. *See Critchlow*, 378 F.3d at 256. Nothing in the provision indicates that an assignment of benefits is deemed void, nor is there any plan language that unequivocally prohibits the assignment of benefits thereunder. Indeed, the provision acknowledges the possibility that benefits are paid directly to the provider, or to the patient's "authorized representative" – which providers, including Hartford HealthCare, are often appointed in exchange for the provision of health care services. Thus, this provision would not prohibit the assignment of ERISA benefits to Hartford HealthCare.

The second provision that Defendant has identified similarly states that the plan will "make benefit payments directly to Network Providers for Covered Services," but that the plan "*may* make benefit payments to you" if "you use an Out-of-Network Provider." Defendant's Trial Exhibit 3 (emphasis added). The provision goes on to state that "[y]ou cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable law." *Id.* Furthermore, the second provision states that "[o]nce a Provider performs a Covered Service, the Plan will not honor a request for us to withhold payment of the claims submitted."

Because this second alleged anti-assignment provision likewise recognizes the potential for Defendant to reimburse health care providers directly for their services, and contains equivocal language regarding Defendant's payment for out-of-network services, it too cannot void the assignments of benefits that Hartford HealthCare receives from the members and beneficiaries of Defendant's plans.

3. Plaintiffs Are Entitled to Seek a Declaratory Judgment Pursuant to ERISA §502(a)(1)(B)

Defendant also mistakenly contends that Plaintiffs are not entitled to a declaration, under ERISA § 502(a)(1)(B), that Defendant's indirect payment scheme violates the Affordable Care Act and its implementing regulations, as Plaintiffs are "not suing to secure plan benefits." The Supreme Court has stated that under ERISA § 502(a)(1)(B), a participant or beneficiary may seek "to recover accrued benefits, to obtain a declaratory judgment that she is entitled to benefits under the provisions of the plan contract, and to enjoin the plan administrator from improperly refusing to pay benefits in the future." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). As 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) has been incorporated into ERISA, Defendant must comply with this provision in providing benefits under all of its ERISA plans. Thus, Plaintiffs are entitled to seek to enforce their right to benefits paid in accordance with the requirements of the Affordable Care Act under the broad ERISA enforcement regime.

4. Plaintiffs Are Entitled to Seek a Declaratory Judgment Pursuant to ERISA §502(a)(1)(B)

Finally, Defendant speciously argues that Plaintiffs are not entitled to seek injunctive relief under ERISA § 502(a)(3) because they purportedly do not identify any particular plan under which they seek relief, or Defendant's fiduciary role under any such plan. However, as stated above, ERISA §502(a)(3) expressly authorizes a party to bring an action to enjoin a violation of ERISA itself, not just the terms of any particular plan. *See* 29 U.S.C. §1132(a)(3).

Furthermore, Plaintiffs have alleged that Defendant serves as sponsor, administrator, and/or claims administrator, and has discretion to adjudicate and pay employee health benefits claims, under numerous ERISA-governed plans. *See New York State Psychiatric Ass'n, Inc. v. UnitedHealth Group*, 798 F.3d 125, 132 (2d Cir. 2015) (holding that the claims administrator is an appropriate defendant). Plaintiffs have likewise alleged that Carlos David Gonzalez is a member of an ERISA plan for which Defendant serves as claims administrator – and, in such capacity, determines the procedure for reimbursing Hartford HealthCare for medical services it provided to plan members – for claims from health care providers within the State of Connecticut. *New York State Psychiatric*, 798 F.3d at 132.

C. Plaintiffs Have an Implied Private Right of Action Under Connecticut General Statutes § 38a-477aa(b)(3)(A)

Like the Affordable Care Act, Connecticut General Statutes § 38a-477aa(b)(3)(A) implies a private right of action.[3] Under Connecticut law, courts will look to three factors to determine whether a private statutory cause of action is implied: (1) whether the plaintiff is among the class for whom the statute was intended to benefit; (2) whether there is any indication in the legislative history that the Legislature intended to grant or deny a private cause of action; and (3) whether an implied private right of action is consistent with the legislative scheme. *Napoletano v. CIGNA Healthcare of Connecticut, Inc.*, 238 Conn. 216, 249, 680 A.2d 127, 145 (1996), *overruled on other grounds by Batte-Holmgren v. Comm'r of Pub. Health*, 281 Conn. 277, 914 A.2d 996 (2007).

[3] The Court should reject Defendant's argument that Connecticut General Statutes § 38a-477aa(b)(3)(A) is universally preempted by ERISA. Should the Court determine that Hartford HealthCare is not entitled to relief under ERISA, the statute would constitute a legal duty to provide reimbursement directly to Hartford HealthCare's emergency physicians that is "independent and distinct from its obligations" under Defendant's ERISA plans. *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 150 (2d Cir. 2017).

Here, Plaintiffs are able to meet the test for a private right of action under Connecticut General Statutes § 38A-477aa(b)(3)(A).

First, Plaintiffs are among the class of persons for whom Connecticut General Statutes § 38a-477aa(b)(3)(A) is intended to benefit. To be sure, the text of the statute specifically applies to out-of-network emergency physicians. *See* Connecticut General Statutes § 38a-477aa(b)(3) & (4). As Hartford HealthCare employs emergency physicians, and bills for their services as part of a bundled rate at three of its hospitals, Hartford HealthCare is clearly among the intended beneficiaries of the statute.

Second, there is no legislative history indicating an intent either to grant or to deny a private right of action. The *Napoletano* court found a private right of action under the same circumstances. *See* 238 Conn. at 250, 680 A.2d at 145. However, the legislative history here clearly indicates that the statute was intended to impact the tripartite relationship between patients, insurers, and providers. *See, e.g.*, 2015 Connecticut Senate Bill No. 811, Connecticut General Assembly – January Session, 2015 ("This act includes numerous provisions affecting hospitals and health systems, health care providers, and health carriers . . . ."). This weighs in favor of an implied private right of action.

To the extent that the legislative history demonstrates an intent to benefit patients, Hartford HealthCare would be entitled to enforce any rights afforded to them under the statute, as its interests are inextricably intertwined with those of its patients, and because it routinely receives assignments of benefits from its patients in exchange for emergency medical services.

Third, a private right of action is consistent with the statutory scheme. Because the Connecticut General Assembly specifically granted emergency physicians the right to receive benefits directly from health insurers, Connecticut General Statutes § 38a-477aa(b)(3)(A), it

would support the statutory scheme to allow hospitals who employ them and bill for their services to bring claims to enforce their rights.

Defendant's argument that other state law statutory provisions concerning insurance have administrative remedies or contain private rights of action is wholly unavailing. Defendant does not identify a specific administrative remedy for the enforcement of Connecticut General Statutes § 38a-477aa(b)(3)(A), but cites to statutes authorizing the Commissioner of Insurance to adopt regulations for the enforcement of *other* requirements under the same Title. Furthermore, the statutes that Defendant identifies to create an express private right of action were enacted years prior to the passage of Connecticut General Statutes § 38a-477aa(b)(3)(A) in 2015. *See* Connecticut General Statutes § 38a-470(f) (originally enacted in 1958); Connecticut General Statutes § 38a-591d(g)(2) (originally enacted in 2011). Thus, Defendant's claim that these statutes are part of the same "underlying statutory scheme" is erroneous.

Furthermore, contrary to Defendant's argument, a plaintiff seeking a private right of action under a Connecticut statute need not demonstrate that all three *Napolitano* factors are met. Rather, a plaintiff "must meet a threshold showing that none of the three factors weighs *against* recognizing a private right of action." *Asylum Hill Problem Solving Revitalization Ass'n v. King*, 277 Conn. 238, 248, 890 A.2d 522, 528 (2006) (emphasis added). "[T]he amount and persuasiveness of evidence supporting each factor may vary, and the court must consider all evidence that could bear on each factor." *Id.* Accordingly, because of the clear rights granted to emergency physicians under Connecticut General Statutes § 38a-477aa(b)(3)(A), the Court should find that Hartford HealthCare has an implied private right of action to enforce them.

D. Plaintiffs May Challenge Defendant's Violation of The Affordable Care Act and Connecticut Law through Common Law Contract Theories

Finally, to the extent that Defendant's plans are not governed by ERISA, Plaintiffs will demonstrate that they are entitled to declaratory and injunctive relief under Connecticut contract law. Under Connecticut law, an "insurance policy is to be interpreted by the same general rules that govern the construction of any written contract." *Lexington Ins. Co. v. Lexington Healthcare Grp., Inc.*, 311 Conn. 29, 37, 84 A.3d 1167, 1173 (2014).

In interpreting insurance contracts, courts have considered the underlying statutory or regulatory scheme. *See, e.g.*, *Arrowood Indem. Co. v. King*, 699 F.3d 735, 740 (2d Cir. 2012) (assessing liability insurance policy's compliance with Connecticut General Statutes § 38a–323); *Vitti v. Allstate Ins. Co.*, 245 Conn. 169, 174, 713 A.2d 1269, 1272 (1998) (assessing the validity of automobile insurance plan in light of regulation concerning exclusion for uninsured motorist benefits); *Galvan v. Metro. Prop. & Cas. Ins. Co.*, 2012 WL 4378043, at *2 (Conn. Super. Ct. Aug. 31, 2012) (same). Because Defendant's health plans must comply with all applicable federal and state statutes and regulations – including 42 U.S.C. § 300gg-19a(b)(1)(ii)(I), 26 C.F.R. § 54.9815-2719A(b)(2)(iii), and Connecticut General Statutes § 38a-477aa(b)(3)(A) – the Court must consider Defendant's compliance with those provisions in a common-law breach of contract or implied-in-fact contract claim. Accordingly, in assessing whether Defendant has breached, or will breach, an express or implied-in-fact contract, the Court must consider Defendant's compliance with 42 U.S.C. § 300gg-19a(b)(1)(ii)(I), 26 C.F.R. § 54.9815-2719A(b)(2)(iii), and Connecticut General Statutes § 38a-477aa(b)(3)(A).

1. Hartford HealthCare May Seek Relief Pursuant to the Broad Assignments of Benefits that It Receives from the Members and Beneficiaries of Defendant's Fully-Insured Plans

As alleged in the Amended Complaint, Hartford HealthCare is the assignee of numerous contracts between Defendant and its members and beneficiaries. Hartford HealthCare routinely receives assignments of benefits and other rights in exchange for the provision of health care services – including the emergency services at issue in this action – to its patients. As assignee, Hartford HealthCare "stands in the shoes" of its patients who are members or beneficiaries of Defendant's plans. *Schietinger v. S. New England Tel. Co.*, 2006 WL 2677825, at *6 (Conn. Super. Ct. Aug. 13, 2006) (quoting *Mall v. LaBow*, 33 Conn. App. 359, 362, 635 A.2d 871 (1993)). And, as stated above, these assignments of benefits that Hartford HealthCare receives are sufficiently broad to include, among other things, (a) authorization for Hartford HealthCare and/or any attending physician or physician group to receive payment directly, (b) the assignment of all applicable insurance benefits to Hartford HealthCare, (c) the appointment of Hartford HealthCare as the patient's agent to act on his or her behalf to collect hospital charges, and (d) a request that payment be made to Hartford HealthCare on the patient's behalf.

As in the context of Plaintiffs' ERISA plans, the Court should reject Defendant's attempt to invalidate the assignments of benefits that Hartford HealthCare receives from the members and beneficiaries of Defendant's fully insured plans. Given the broad assignments of rights that Hartford HealthCare receives from its patients, it is entitled to seek declaratory and injunctive relief on their behalf. In arguing that such assignments cannot afford the right to seek prospective relief, Defendant cites to two cases involving substantially narrower assignment language. *See Premier Health Ctr., P.C. v. UnitedHealth Group*, 292 F.R.D. 204, 218 (D.N.J. 2013) (defendant contended that plaintiff provider failed to clearly designate itself as the plaintiff's "authorized representative"); *Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc.*,

775 F. Supp. 2d 730, 736 (S.D.N.Y. 2011) (assignment language specifically "limit[ed] Biomed's right to sue on behalf of the Patient to actions for money damages"). As such, these cases are inapposite.

Defendant also incorrectly argues that Plaintiffs must specify individual patients who have assigned their right to benefits in exchange for emergency health care services. Because Plaintiffs seek only prospective relief, they need not do so. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (plaintiff seeking injunction must allege harm that is "actual *or imminent*" (emphasis added)); *see also Am. Med. Ass'n v. United HealthCare Corp.*, 2007 WL 1771498, at *19 (S.D.N.Y. June 18, 2007) (asserting that a plaintiff need not prove "actual harm" in order to establish standing to seek injunctive relief under ERISA). As stated above, Plaintiffs can readily demonstrate that they have provided emergency medical treatment to the members and beneficiaries of Defendant's health plans, and that they will do so in the future. First, Hartford HealthCare is required, under federal and state law, to provide emergency services to its patients, regardless of its network status with the patient's insurer. *See* 42 U.S.C. § 1395dd; Connecticut Agencies Regulations § 19-13-D3(j)(2). Second, as Hartford HealthCare is among the largest health systems in the State of Connecticut – with five hospitals containing Emergency Departments – and Defendant is the largest health insurer in the State, it stands to reason that Hartford HealthCare will frequently encounter patients requiring emergency medical care who are members or beneficiaries of one of Defendant's health plans.

For the same reasons, Defendant's claim that the Court should narrowly tailor any declaratory or injunctive relief to the specific patients who assigned their rights, and to the specific plan benefits assigned, falls flat. Hartford HealthCare stands to suffer repeated violations of the Affordable Care Act and Connecticut law as a result of Defendant's indirect

payment scheme. As it is difficult, if not impossible, to predict the specific patients that Hartford HealthCare will encounter due to the nature of emergency medical services, the Court should not limit Plaintiffs' potential relief to any specific patient or plan.

2. The Purported Anti-Assignment Language in Defendant's Fully Insured Plans Do Not Defeat Hartford HealthCare's Right to Seek Relief Thereunder

Finally, contrary to Defendant's argument, the alleged anti-assignment clauses in its plans do not destroy Plaintiffs' right to relief under a common law breach of contract claim. Under Connecticut law, "antiassignment clauses are construed narrowly whenever possible" in light of the "importance of free assignability." *Rumbin v. Utica Mut. Ins. Co.*, 254 Conn. 259, 268, 757 A.2d 526, 531 (2000). The Connecticut Supreme Court has drawn a clear distinction between the "right to assign" and the "power to do so." *Id.* at 227. Where the language of a contract limits the right to assign, a party who assigns his or her rights has breached the contract, and the other party may sue for damages resulting from the assignment. *See id.* Significantly, however, the assignment is nonetheless valid and enforceable, unless the contract contains "express language to limit the power to assign or to void the assignment itself." *Id.*

Here, Defendant fails to demonstrate that anti-assignment language contained in any of its fully insured plans will effectively void an assignment of benefits or other plan rights under Connect law. Defendant has provided two examples of anti-assignment clauses that allegedly appear in its self-insured plans. *See* Defendant's Trial Exhibit 3.

The first provision states that "[t]he Group cannot legally transfer this Booklet, without obtaining written permission" from Defendant. *Id.* The provision further states that "Members cannot legally transfer the coverage," and that "[b]enefits available under this Booklet are not assignable by any Member without obtaining written permission from [Defendant], unless in a way described in this Booklet." *Id.*

The second provision states that a "Member may not assign this Benefit Program or any of the Member's rights, benefits or obligations under this Benefit Program to any other person or entity except with the prior written consent" of Defendant. *Id.* The second provision goes on to state that "[a]ny attempted assignment by a Member in violation of this provision shall not impose any obligation upon [Defendant] to honor or give effect to such assignment and shall constitute grounds for cancellation of this Benefit Program." *Id.*

Neither of these two provisions explicitly states that an assignment of benefits is "void," and neither limits the "power" of members or beneficiaries to assign their rights to benefits under their plans. *See Rumbin*, 254 Conn. 259 at 277, 757 A.2d at 535. Indeed, the second provision – which has stronger language than the first – suggests that an assignment of benefits would constitute a breach of contract with Defendant, giving Defendant the opportunity to sue for damages or to terminate the plan. *See id.* at 277-78; 757 A.D.2d at 535-36. Thus, both provisions fail to prevent Hartford HealthCare from receiving benefits directly from Defendant, or from bringing claims to enforce the rights assigned from its patients.

3. Hartford HealthCare May Properly Challenge Defendant's Indirect Payment Scheme Under Its Claim for Breach of Implied-in-Fact Contract

Hartford HealthCare has also properly pled a cause of action for breach of implied-in-fact contract with Defendant. Under Connecticut law, a contract is implied in fact where "a plaintiff, without being requested to do so, renders services under circumstances indicating that he expects to be paid therefor, and the defendant, knowing such circumstances, avails himself of the benefit of those services." *Janusauskas v. Fichman*, 264 Conn. 796, 804-05, 826 A.2d 1066, 1073 (2003).

If the Court were to find that there are no express contracts between Hartford HealthCare, as assignee, and Defendant, Plaintiffs will nonetheless be able to demonstrate that Defendant

breached, or will soon breach, implied-in-fact contracts with Hartford HealthCare. When Hartford HealthCare renders emergency health care services to Defendant's members and beneficiaries, it does so with the expectation that it will receive reimbursement from Defendant. Defendant's members and beneficiaries likewise avail themselves of Hartford HealthCare's emergency medical services with the knowledge that Hartford HealthCare will seek reimbursement from Defendant.

As such, implied-in-fact contracts arose, and will continue to arise, between Hartford HealthCare and Defendant. Defendant has breached, or will breach, those implied-in-fact contracts by refusing to provide reimbursement directly to Hartford HealthCare for the emergency medical services rendered to its members and beneficiaries, in violation of the Affordable Care Act and its implementing regulations and Connecticut law.

Although Defendant contends, in its motion, that there was no agreement between the parties or meeting of the minds, Defendant has, at all times, been unquestionably aware that some members and beneficiaries of its plans have sought, and will likely seek, emergency health care services from Hartford HealthCare. Indeed, Defendant acknowledges that federal law requires that Hartford HealthCare provide treatment to any patient in need of emergency services. Moreover, by engaging in a dialogue with Hartford HealthCare regarding payment to its members and beneficiaries for out-of-network emergency health care services, Defendant has further acknowledged that its patients will continue to seek emergency care at Hartford HealthCare facilities.

The Court should also reject Defendant's argument that Plaintiffs are improperly attempting to "bootstrap" an implied-in-fact contract claim based upon the Affordable Care and Connecticut law. To the contrary, Plaintiffs have asserted a valid cause of action for breach of

implied-in-fact contract, and seek to enforce Defendant's compliance with those statutes thereunder. As such, *Rosario v. J.C. Penney*, upon which Defendant relies, is inapposite. 463 F. Supp. 2d 228, 232 (D. Conn. 2006) (rejecting plaintiff's contention that implied-in-fact contract may be "premised on an employer's general obligation to comply with the federal and state anti-discrimination laws").

Accordingly, Plaintiffs have articulated multiple statutory and common law bases upon which they may seek declaratory and injunctive relief. As such, the Court should also reject Defendant's claim that it lacks subject matter jurisdiction over Plaintiffs' request for declaratory judgment pursuant to 28 U.S.C. § 2201 and/or ERISA § 502(a)(1)(B).

POINT II

THE AFFORDABLE CARE ACT AND CONNECTICUT LAW REQUIRE THAT DEFENDANT REIMBURSE HARTFORD HEALTHCARE DIRECTLY FOR OUT-OF-NETWORK EMERGENCY SERVICES RENDERED TO THE MEMBERS AND BENEFICIARIES OF ITS HEALTH PLANS

As Plaintiffs have established that they are entitled to seek declaratory and injunctive relief under multiple legal theories, the Court should find, on the merits, that Defendant's indirect payment scheme violates federal law prohibiting insurers from imposing administrative burdens and limits on claims for out-of-network emergency health care services that are more restrictive than those placed on claims from network providers. The Court should further find that Defendant's indirect payment scheme violates Connecticut law requiring insurers to reimburse out-of-network physicians for emergency medical services provided to the members and beneficiaries of its plans.

The Affordable Care Act, 42 U.S.C. § 300gg-19a(b)(1)(ii)(I), provides that, if a health plan provides coverage for medically necessary emergency services rendered by network providers – as Defendant's health plans do – then it must provide similar coverage for medically

necessary emergency services rendered by out-of-network providers. In covering medically necessary emergency services rendered by out-of-network providers, insurers cannot impose any more restrictions or limitations on that coverage than apply to medically necessary emergency services rendered by network providers. 42 U.S.C. § 300gg-19a(b)(1)(ii)(I). The regulations implementing the Affordable Care Act likewise provide that, in covering medically necessary emergency services rendered by out-of-network providers, it cannot impose "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); *see also* 29 C.F.R. § 2590.715-2719A(b)(2)(iii); 45 C.F.R. § 147.138(b)(2)(iii).

In its motion, Defendant asserts an unreasonably narrow and self-serving interpretation of the Affordable Care Act and its implementing regulations. First, Defendant suggests – without any legal authority – that 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) merely prohibits insurers from requiring authorization for emergency services, or from placing other restictions or limitations on coverage *prior to* the member or beneficary's receipt of such services. Defendant then concludes that, by providing payment to its members and beneficiaries *after* they have already received Hartford HealthCare's emergency services, it complies with the statute.

Significantly, nothing in the Affordable Care Act or its implementing regulations supports Defendant's narrow interpretation. To the contrary, an ordinary person would perceive a "limitation on coverage" to include any practice that makes it more difficult for a plan member to reimburse a provider for for health care services, such as Defendant's indirect payment scheme. *See Centurion v. Sessions*, 860 F.3d 69, 75 (2d Cir. 2017) ("Statutory construction begins with the plain text and, if that text is unambiguous, it usually ends there as well."); *cf. Critchlow v. First UNUM Life Ins. Co. of Am.*, 378 F.3d 246, 256 (2d Cir. 2004) (courts interpret

ERISA plans "in an ordinary and popular sense as would a person of average intelligence and experience"). Defendant's action here is such a limitation here.

Further evidence that this broader interpretation should apply is found in the Affordable Care Act's implementing regulations. Specifically, the regulations prohbit an insurer from imposing any "administrative requirement *or* limitation on coverage" on claims for out-of-netork emergency services that are not imposed on claims from network providers. 26 C.F.R. § 54.9815-2719A(b)(2)(iii) (emphasis added). Thus, the regulations interpret 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) to prohibit not just ordinary coverage limitations, such as the need for pre-authorization, but also any other "administrative requirement" that makes it more difficult for patients to satisfy their financial obligations to their providers.

Because the interpretation of 42 U.S.C. § 300gg-19a(b)(1)(ii)(I) by the Departments of the Treasury, Labor, and Health and Human Services is reasonable, the Court should grant it deference. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2124 (2016). *Abrahams v. MTA Long Island Bus*, 644 F.3d 110 (2d Cir. 2011), which Defendant cites, is inapposite. There, the Second Circuit found that a regulation, which added an entirely new procedural requirement beyond the scope of the statute that it interpreted, did not give rise to a private right of action. *See id.* at 119-20. Here, by contrast, the Department's interpretation merely clarifies the meaning of the terms that appear within the statute.

By refusing to provide reimbursement to Hartford HealthCare directly for the emergency services of its facilities and/or staff physicians, and by forcing patients who receive out-of-network emergency services to remit payment to Hartford HealthCare, Defendant is imposing an administrative requirement on Hartford HealthCare's claims that is substantially more restrictive than it does on claims for in-network emergency services. As a result of Defendant's indirect

payment scheme, Hartford HealthCare's patients will need to collect checks from Defendant and make arrangements to provide payment to Hartford HealthCare. They will also have the responsibility to follow up with Defendant regarding unpaid or underpaid claims and to prosecute any necessary appeals. These obligations are especially onerous for a patient who recently received emergency health care services and is thus medically fragile and ill-equipped to handle them. Defendant's actions will also place a significant administrative burden on Hartford HealthCare in that it will be forced to wait a significant amount of time to receive reimbursement for services rendered, and will be required to undertake dramatically increased follow-up efforts to track down delayed, misplaced, lost, and pocketed checks, and to educate patients regarding their appeal rights.

As Defendant's indirect payment scheme makes it substantially more difficult for patients to satisfy their financial obligations to Hartford HealthCare, and for Hartford HealthCare to collect reimbursement for its emergey medical services, simply due to Hartford HealthCare's statuts as an out-of-network provider, it clearly violates the Affordable Care Act and its implementing regulations.

Contrary to Defendant's argument, the fact that the Affordable Care Act implementing regulations do not prohibit out-of-network providers from balance billing their patients does not suggest that an insurer is permitted to provide payment directly to its members and beneficiaries for emergency services. Notably, the statute and regulations do not *permit* balance billing, but rather attempt to protect patients against substantial financial liability by mandating that insurers and health plans provide a baseline level of reimbursement to providers, and impose the same cost sharing amounts – *i.e.* copayment and coinsurance – for emergency services for network and out-of-network providers. *See* 42 U.S.C. § 300gg-19a(b)(1)(ii)(II); 26 C.F.R. § 54.9815-

2719A(b)(3). In enacting the final rules, the Departments expressed an intent to mitigate the risk that patients will delay or avoid seeking medically necessary treatment due to the expectation of a substantial financial burden. *See* 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, 72228 (Nov. 18, 2015). Because Defendant's indirect payment scheme will similarly cause patients to delay or avoid seeking medically necessary treatment, due to the substantial and unjustified administrative burden that it places on Hartford HealthCare patients, it is clearly impermissible under the Affordable Care Act and its implementing regulations.

Defendant's indirect payment scheme also violates Connecticut General Statutes § 38a-477aa(b)(3)(A). Under that statute, when an out-of-network physician provides emergency services, "such health care provider may bill the health carrier directly and the health carrier **shall** reimburse such health care provider." Connecticut General Statutes § 38a-477aa(b)(3)(A) (emphasis added). Because Hartford HealthCare employs emergency physicians and, in three of its hospitals, bills for their services as a part of a bundled rate, Defendant must provide payment directly to Hartford HealthCare for the emergency services provided at those hospitals.

In its motion, Defendant makes the incredible argument that Connecticut General Statutes § 38a-477aa(b)(3)(A) does not prevent it from providing payment to its members and beneficiaries because of the General Assembly's "omission" of the word "directly." This argument must fail for two reasons: First, the statute employs mandatory language – *i.e.* "the health carrier shall reimburse such health care provider" – that unequivocally confers an obligation on insurers to provide reimbursement to the physician, rather than the patient. Second, the statute *does* use the word "directly," in stating that a physician may bill an insurer

for his or her services. Given that the statute permits a physician to submit a bill directly to an insurer for emergency services, and mandates that the insurer provide reimbursement to that physician, Defendant's contention that the statute does not prohibit it from providing payment to its members and beneficiaries must be rejected.

POINT III

PLAINTIFFS HAVE SUFFERED, AND WILL SUFFER, IRREPARABLE HARM AS A RESULT OF DEFENDANT'S ACTIONS

Finally, the Court should find that Defendant's indirect payment scheme has caused, and will cause, irreparable injury to Hartford HealthCare and Carlos David Gonzalez sufficient to sustain a claim for a permanent injunction. "Irreparable harm can be found where there is a continuing wrong which cannot be adequately redressed by final relief on the merits." *New York Pathological & X–Ray Laboratories v. Immigration and Naturalization Service*, 523 F.2d 79, 81 (2d Cir. 1975).

Defendant has expressed its intent to provide payment to the patient, rather than Hartford HealthCare, in connection with *all* claims – *i.e.*, facility and professional claims – for emergency services. Thus, Hartford HealthCare and its patients – including Carlos David Gonzalez – stand to suffer repeated violations of state and federal law, which may not be adequately remedied by monetary damages.

First, this Court and other federal courts have found that a disruption in the patient-provider relationship may cause irreparable harm, "particularly when the patient belongs to a vulnerable class." *Fairfield County Med. Ass'n v. United Healthcare of New England*, 985 F. Supp. 2d 262, 271 (D. Conn. 2013), *aff'd as modified sub nom. Fairfield County Med. Ass'n v. United Healthcare of New England, Inc.*, 557 F. App'x 53 (2d Cir. 2014); *see Barron v. Vision Serv. Plan*, 575 F. Supp. 2d 825, 835-36 (N.D. Ohio 2008); *Schisler v. Heckler*, 574 F. Supp.

1538, 1552 (W.D.N.Y. 1983); *see also New York Pathological & X-Ray Labs.*, 523 F.2d at 81 (finding that plaintiff providers established irreparable harm by demonstrating that they will "suffer substantial loss of income because they are now prevented from performing certain medical examinations").

Here, Defendant's actions will cause a repeated and substantial disruption of Hartford HealthCare's relationship with patients who are medically fragile following their receipt of emergency health care services. Specifically, Defendant's actions will breach the separation between treatment and financial issues that hospital staff needs in order to maintain positive relationships with its patients that are focused on clinical issues and enabling patients to get well. By unnecessarily putting patients into the middle of reimbursement issues, Defendant irreparably harms Hartford HealthCare's ability to maintain such positive relationships.

If Defendant had continued its longstanding practice of paying Hartford HealthCare directly, patients inquiring about financial issues could be told that the Hospital will bill Defendant directly, and Defendant will pay the Hospital directly. Patients could also be assured that the Hospital would be tracking Defendant's payment status and handling all paperwork, problems, disputes, and appeals. Any issues regarding patient payments would be deferred until after this process played out.

Unfortunately, given Defendant's improper actions, the conversations that Hartford HealthCare emergency department personnel must have with patients are vastly different. Patients will have to be told that they will get a bill for the care from the Hospital, which they will be responsible for paying, and at some unspecified point in the future they may get a check from Defendant that will cover some unknown part of this care. They – sick patients – will have to be responsible for cashing the check, making arrangements to pay Hartford HealthCare, and

handling all paperwork, problems, disputes, and appeals, regardless of their health status, age, or level of comprehension. Rather than being able to relieve patients' anxiety about financial issues, Hartford HealthCare personnel, because of Defendant's actions, will be in the unfortunate and unenviable position of increasing patients' anxiety.

This anxiety will significantly and irreparably impede Hartford HealthCare's ability to provide high quality emergency medical services to the communities it serves. More time will have to be spent with patients to alleviate their anxiety and persuade them to remain in the Emergency Department and receive needed treatment. Patients will require more extensive and intensive treatment as the anxiety exacerbates their medical conditions and impedes their recovery. All of this will lead to unnecessary backlogs and delays in the Emergency Department that impairs the effectiveness and availability of Hartford HealthCare's services.

Second, Defendant's indirect payment scheme will cause Hartford Hospital repeated and irreparable harm insofar as patients will inevitably lose or pocket checks received from Defendant, or will fail to prosecute appeals on improperly unpaid or underpaid claims, thus depriving Hartford HealthCare reimbursement for its emergency health care services. Although Defendant attempts to obfuscate this harm by stating that Hartford HealthCare will still be able to seek full payment from its patients, the reality is that Hartford HealthCare will be unable to recover against many of these patients due to insolvency or other factors. Additionally, as stated above, forcing Hartford HealthCare seek to collect payment from its patients – which may even include the necessity of bringing a lawsuit to recover an improperly pocketed reimbursement check – will cause irreparable harm, as it will impair Hartford HealthCare's ability to maintain positive relationships with its patients and to provide high quality health care services to patients.

Third, given Defendant's refusal to provide Hartford HealthCare with any information regarding the coverage of its claims for emergency services, Hartford HealthCare will be forced to divert substantial resources – resources that can, and should, be used to maintain and improve the health and welfare of its patients and the communities in which it provides services – to unnecessary tracking of reimbursement payments, assuaging confused patients' concerns, educating patients about appeal rights, and making arrangements with sick patients to provide payments. A money damages award would simply be ineffective to regain the lost opportunities to maintain and improve the health and welfare of its patients.

Fourth, similarly, Defendant's actions will delay Hartford HealthCare's receipt of reimbursement for the emergency services that Hartford HealthCare provides its patients. This delay likely will cause Hartford HealthCare to irrevocably forego opportunities to add, enhance, or maintain health care service levels in its service area.

Fifth, Defendant's actions will needlessly put significant sums of money into the hands of Emergency Department patients who, because of behavioral health, addiction, or substance abuse issues, are likely to misuse the money to place themselves or other in danger. This has a significant impact on Hartford HealthCare's ability to provide effective, high quality behavioral health services throughout Connecticut. Substantial additional time will have to be spent in the Emergency Department ensuring that the receipt of these reimbursement funds will not place behavioral health patients in danger, leading to backlogs and delays. Also leading to backlogs and delays will be the certain increase in treatment failures and relapses as a result putting this money into patient's hands. As discussed above, backlogs and delays impair the effectiveness and availability of Hartford HealthCare's services.

Sixth, Defendant's indirect payment scheme will cause repeated, irreparable harm to Hartford HealthCare's patients – including Mr. Gonzalez – whose interests are inextricably intertwined with those of Hartford HealthCare. Patients will struggle to decipher complex explanation of benefit forms, prosecute any necessary appeals, and make arrangements to pay Hartford HealthCare. If patients fail to timely follow up with Defendant regarding reimbursement or to exercise their appeal rights, then their financial burden following their receipt of emergency health care services will be increased. Elderly patients – many of them homebound – will be endangered by being forced to make needless visits to financial and other institutions to cash reimbursement checks. As a result, some patients will choose to delay their emergency medical care, seek care at hospitals farther away from their homes than Hartford HealthCare's facilities, or seek care at an outpatient urgent care center when hospital care is medically necessary. *See* 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, 72228 (Nov. 18, 2015) (expressing concern that patients will delay or avoid seeking medically necessary treatment due to the expectation of a substantial financial burden when they cannot access a network provider).

Accordingly, Plaintiffs have sufficiently alleged that they have suffered, and will continue to suffer, irreparable harm as a result of Defendant's indirect payment scheme. Thus, Plaintiffs are entitled to seek an injunction mandating that Defendant reimburse Hartford HealthCare directly for the emergency medical services rendered to its members and beneficiaries.

CONCLUSION

For all of the foregoing reasons, the Court should deny Defendant's Motion to Dismiss the Amended Complaint in its entirety, permit Plaintiffs to proceed to an expedited trial on the

merits of their claims, and afford Plaintiffs such other and further relief as it deems equitable, just, or proper.

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