IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED HEALTHCARE SERVICES, INC.; UNITEDHEALTHCARE INSURANCE COMPANY; and UMR, INC.,

Plaintiffs,

v.

HOSPITAL PHYSICIAN SERVICES SOUTHEAST, P.C.; INPHYNET PRIMARY CARE PHYSICIANS SOUTHEAST, P.C.; and REDMOND ANESTHESIA & PAIN TREATMENT, P.C.,

Defendants.

Case No. 1:23-cv-05221-JPB

DEFENDANTS' RESPONSE IN OPPOSITION TO UNITED'S MOTION FOR SUMMARY JUDGMENT

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The Georgia Medical Groups ("GMGs"),[1] by and through undersigned counsel, respectfully submit this Response in Opposition ("Response") to United's Motion for Summary Judgment ("Motion") and state as follows:

PRELIMINARY STATEMENT

This declaratory judgment action is fundamentally flawed for two reasons. One, the action fails because there is no live dispute between the parties, so declaratory relief would not serve a useful purpose. Two, the action fails because any hypothetical dispute would not be preempted by ERISA. For these reasons, the Court respectfully should deny United's Motion and in turn grant the GMG's cross-motion for summary judgment.

As a threshold matter (and as the GMGs previously have explained), there is no dispute between the GMGs and United because the GMGs have never threatened to sue United for additional reimbursement. And while other TeamHealth-affiliated entities previously have sued United in select jurisdictions for out-of-network emergency services, enactment of the federal No Surprises Act ("NSA"), effective January 1, 2022, has provided an alternative federal arbitration process for hospital-based services. Although United tries to avoid the impact of the NSA by limiting

[1] The "Georgia Medical Groups" are Defendants Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C.

this dispute to pre-NSA emergency services claims and post-NSA claims that do not qualify for federal arbitration (meaning claims for non-emergency services rendered at out-of-network hospitals), that effort fails because the GMGs already have forsaken any potential pre-NSA claims and do not staff any hospitals in Georgia that are out-of-network with United. As such, while the Court has found that it has subject-matter jurisdiction to hear this dispute based on the hypothetical possibility that a hospital staffed by the GMGs will go out-of-network at some point in the future based on an unknown set of circumstances, the actual entry of a declaratory judgment at the present time would not serve a useful purpose.

Nevertheless, even if the Court considers the supposed merits of United's claim for declaratory relief, such relief favors the GMGs. The imaginary legal claims for payment that United speculates the GMGs might bring would not be preempted by ERISA. A unanimous Supreme Court made abundantly clear in *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020), that ERISA does not preempt state regulation of medical reimbursement rates. In the years since *Rutledge*, a firm consensus has emerged in the lower federal courts that *Rutledge* means what it says: ERISA does not preempt basic rate regulation. The courts therefore routinely reject preemption defenses asserted in response to state-law statutory and common-law causes of action from medical providers challenging the rates paid on covered reimbursement claims.

United is well-aware of this state of affairs, having been on the losing end of these decisions on numerous occasions in litigation against TeamHealth affiliates. Indeed, just four months ago, in December 2025, the United States Supreme Court denied United's request for *certiorari* to review a decision from the Nevada Supreme Court confirming that ERISA does not preempt the TeamHealth affiliates' state law causes of action. *UnitedHealthcare Ins. Co. v. Fremont Emergency Servs. (Mandavia), Ltd.*, 146 S. Ct. 995 (2025). As such, United's declaratory judgment action is not intended to clear up any confusion regarding what the law is, or what defenses United may bring in response to any hypothetical claim. Rather, this action serves as part of a futile campaign to try to roll back a jurisprudential line that United considers unfavorable. The Court should reject that effort. Nothing United says in its Motion—or conceivably could say—allows it to avoid the controlling and dispositive impact of *Rutledge* on its preemption position, and United's substantive arguments therefore fail on the merits.

The Motion should be denied.

STATEMENT OF FACTS & PROCEDURAL HISTORY

For a full statement of this matter's relevant facts and procedural history, the GMGs respectfully refer the Court to their February 27, 2026, Motion for Summary Judgment ("Cross-Motion"), supporting Memorandum of Law, and Statement of Undisputed Material Facts ("SUMF"). (Dkt. 79; 79-1;79-2.) The GMGs also refer

the Court to their Response to United's Statement of Undisputed Material Facts ("Response SUMF"), submitted herewith.

LEGAL STANDARD

Federal Rule of Civil Procedure 56(a) provides that "[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." The moving party bears the initial burden of establishing the absence of a genuine dispute of material fact. *Walker v. Darby*, 911 F.2d 1573, 1576 (11th Cir. 1990). Once the moving party has satisfied that burden by presenting evidence that, if uncontradicted, would entitle it to a directed verdict at trial, the burden shifts to the non-moving party to present specific facts demonstrating a genuine dispute. *Id.* The non-moving party must present "enough of a showing that the jury could reasonably find for that party." *Id.* at 1577.

ARGUMENT

I. THE GEORGIA MEDICAL GROUPS' HYPOTHETICAL CLAIMS AGAINST UNITED WOULD NOT BE PREEMPTED

In their Cross-Motion, the GMGs explained why they are entitled to summary judgment on United's claims for declaratory relief. (Dkt. 79-1;79-2.) Specifically, this dispute is too hypothetical for the Court to render declaratory relief. Moreover, the GMGs' hypothetical state law claims against United would only seek greater reimbursement amounts on covered claims, and the Supreme Court has made clear

that ERISA does not preempt state regulation of medical reimbursement rates. (*Id.*) The GMGs respectfully adopt and incorporate herein the arguments and authorities presented in their Cross-Motion. Below, they address the arguments presented in United's Motion and further explain why United is not entitled to summary judgment.[2]

A. The Supreme Court Has Adopted a Limited Construction of ERISA's Preemption Clause

As a threshold matter, ERISA preemption is derived from § 514(a) of the ERISA statute, which directs that "this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).[3] The Supreme Court has made clear that courts applying this provision are to avoid "uncritical literalism," recognizing that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ." *N.Y. State Conf. of Blue*

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[2] The GMGs do not herein address the issue of the Court's subject-matter jurisdiction, because the Court already rejected their jurisdictional arguments in its Orders dated August 16, 2024 and January 12, 2026. (Dkt. 43; 77.) The GMGs respectfully reserve their appellate rights on that issue.

[3] ERISA is the rare federal statute giving rise to two varieties of preemption: complete preemption under § 502(a) and conflict preemption under § 514(a). These two doctrines are distinct. *See Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1343–44 (11th Cir. 2009) (explaining distinction between ERISA complete preemption and conflict preemption). This dispute addresses only conflict preemption under § 514(a).

Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655–56 (1995). Rather, courts must assume "that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress." *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

United contends that "Defendants' Threatened Claims plainly 'relate to' the ERISA-governed Plans that United administers in Georgia and are therefore preempted by ERISA…." (Motion at 10.) While that plain meaning construction may offer some surface-level appeal, it is at odds with longstanding authority construing ERISA's preemption clause more narrowly than its text would suggest. An understanding of how the Supreme Court's ERISA preemption jurisprudence has evolved over time demonstrates the error in United's core position.

The phrase "relate to," by its plain terms, has an extraordinarily expansive scope. *See Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) ("The ordinary meaning of ['relating to'] is a broad one—to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with …." (quotation marks omitted).) In its earliest ERISA cases, the Supreme Court construed § 514(a) according to the plain meaning of its text, invariably finding—given the broad scope of "relate to"—that the challenged state law was preempted. *See, e.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Metro. Life Ins. Co. v.*

Mass., 471 U.S. 724 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Beginning in the mid-1990s, the Court retreated from that approach, recognizing that the text of § 514(a) suggests an effectively unlimited preemptive reach, which the Court could not countenance. *See, e.g.*, *Travelers*, 514 U.S. at 655 ("If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course…."). Justice Scalia—joined by Justice Ginsburg—explained this shift:

> Our earlier cases sought to apply faithfully the statutory prescription that state laws are pre-empted "insofar as they . . . relate to any employee benefit plan." . . . But applying the "relate to" provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. ***The statutory text provides an illusory test***, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not.

Dillingham, 519 U.S. at 335–36 (Scalia & Ginsburg, J.J., concurring) (emphasis added).

To render the application of § 514(a) reasonable and workable in practice, the Court fashioned the test for preemption described in the Cross-Motion[4]: a state law is preempted only if it refers to, or is impermissibly connected with, ERISA plans.[5]

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[4] Dkt. 79-1 at 12–14.

[5] Laws with a "reference to" ERISA plans include laws that "act[] immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016). Laws with "an impermissible connection with' ERISA plans"

Since *Travelers*, the Court consistently has reaffirmed this more limited preemption jurisprudence. The end result is that there are many state laws (and claims asserted thereunder) which relate to ERISA plans according to the plain-English meaning of "relate to," but which are not preempted because they do not "relate to" ERISA plans according to how the Supreme Court has construed the use of that phrase in § 514(a). As such, the Court should disregard United's suggestion that the GMGs' hypothetical claims are preempted simply because, at face value, they relate to United-administered ERISA plans. The question the Court must answer is whether those claims refer to, or have an impermissible connection with, ERISA plans under the parameters of the Supreme Court's more limited ERISA jurisprudence. As explained below, they do not.

B. ERISA Does Not Preempt State Regulation of Medical Reimbursement Rates

The Supreme Court issued its *Rutledge* opinion in December of 2020. *Rutledge* addressed an Arkansas statute regulating the amounts that pharmacy benefit managers ("PBMs") must pay for prescription drugs dispensed to members of health plans (including employer-sponsored ERISA plans) whose prescription drug benefits are managed by the PBMs. 592 U.S. at 84–85. The Eighth Circuit had

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include state laws that "govern[ ] a central matter of plan administration" or "interfere[ ] with nationally uniform plan administration." *Id.*

affirmed a trial court's holding that the law was preempted because it "limited a plan administrator's ability to control the calculation of drug benefits." *Id.* at 85. A unanimous Supreme Court reversed that ruling.

Fundamentally, the Supreme Court held that state laws which merely regulate reimbursement amounts paid for covered benefits or otherwise impose costs on ERISA plans—without mandating coverage of specific benefits—are not preempted. *Id.* at 87. It explained that ERISA is "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits…." *Id.* at 86–87. However, "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so ***if a law merely affects costs.***" *Id.* at 87 (emphasis added). Thus, "***ERISA does not pre-empt state rate regulations*** that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Id.* at 88 (emphasis added). That is because "cost uniformity was almost certainly not an object of pre-emption." *Id.* at 88.[6]

[6] Indeed, the Supreme Court had long recognized that ERISA does not preempt state regulation of medical reimbursement rates. *See Travelers*, 514 U.S. at 667 n.6 ("[T]he fact that Congress envisioned state experiments with comprehensive hospital reimbursement regulation supports our conclusion that ERISA was not meant to pre-empt basic rate regulation.").

In the time since *Rutledge*, numerous federal district courts have considered preemption defenses to causes of action asserted by medical providers seeking additional reimbursement on covered claims. These courts consistently have held that *Rutledge* means what it says: ERISA does not preempt state rate regulations. *See, e.g., Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 749 F. Supp. 3d 456, 470 (S.D.N.Y. 2024) (concluding that "*Rutledge* provides the appropriate analytical framework for the defendants' [United's] preemption argument" and rejecting preemption defense because "in *Rutledge*, the Supreme Court made clear that preemption does not apply where state laws increase ERISA plan costs without requiring payment of specific benefits…."); *Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 658 F. Supp. 3d 1250, 1259 (S.D. Fla. 2023) (finding no preemption and explaining that United "misses the central holding of *Rutledge*, which is that a state law doesn't 'relate to' an ERISA plan if it merely 'establishes a floor for the cost of the benefits that plans choose to provide'"); *NEMS PLLC v. Harvard Pilgrim Health Care of Conn. Inc.*, 615 F. Supp. 3d 125, 141–42 (D. Conn. 2022) ("Every court confronted with this question has determined that ERISA does not preempt a law requiring insurers to reimburse emergency room physicians at a specific, possibly greater, rate.").

Indeed, just last year, the Nevada Supreme Court rejected United's arguments regarding ERISA preemption. *See UnitedHealthCare Ins. Co. v. Fremont*

Emergency Servs. (Mandavia), Ltd., 570 P.3d 107, 118 (Nev. 2025) (finding conflict preemption did not exist because a suit based on costs alone does not impact plan administration). United then sought *certiorari* review of this portion of the decision, which the Supreme Court summarily denied without even requesting briefing. *See UnitedHealthcare Ins. Co.*, 146 S. Ct. at 995.

Accordingly, because the GMGs' hypothetical claims would only challenge the amounts paid on covered claims, they would amount to nothing more than state regulation of reimbursement rates and would not be preempted.

C. United's Preemption Arguments Are Without Merit

United offers several meritless arguments as to why the GMGs' hypothetical claims would be preempted. Most of these are squarely foreclosed by *Rutledge*. First, United contends that the hypothetical claims would force plans to "adopt a particular scheme of substantive coverage" by "dictat[ing] benefit levels under the Plans—specifically, the portion of an out-of-network provider's billed charges that the Plans must cover for their participants." (Motion at 12–13.) But the Supreme Court considered and rejected that precise argument in *Rutledge*:

> PCMA first claims that Act 900 affects plan design by mandating a particular pricing methodology for pharmacy benefits.…But that argument is just a long way of saying that Act 900 regulates reimbursement rates. Requiring PBMs to reimburse pharmacies at or above their acquisition costs does not require plans to provide any particular benefit to any particular beneficiary in any particular way. It simply establishes a floor for the cost of the benefits that plans choose to provide.

592 U.S. at 90.

Indeed, *Rutledge* makes clear that state laws impermissibly requiring ERISA plans to "adopt a particular scheme of substantive coverage" are laws that compel plans to provide coverage for goods or services they otherwise would not cover, not laws which dictate *how much ERISA plans must pay* for goods or services they independently choose to cover. *Id.* at 87–88. For example, a hypothetical state law requiring ERISA plans to provide coverage for *in vitro* fertilization ("IVF") would be preempted. But a hypothetical state law requiring ERISA plans to pay a certain amount for IVF *if they independently choose to cover it* would not be preempted. The GMGs' hypothetical state law claims would not challenge any coverage determinations; they would merely compel United to pay more for claims that it and the plans it administers independently chose to cover. As such, those claims would not be preempted.[7]

[7] United contends that "[t]he discovery record shows that Defendants have continued to demand full billed charges from United on recent claims." (Motion at 9.) But, the only evidence of any "demand" is from claim spreadsheets that show the GMGs' billed charges for each claim. But the mere inclusion of billed charges on a claim form—which is required for all medical claims, precedes any adjudication by United of payment. United has not provided any evidence whatsoever that the GMGs have sent a subsequent "demand" to United for billed charges (or for any amount), such that United would feel threatened in any way. Further, United's contention that TeamHealth "has threatened litigation when United does not meet its demands to pay full billed charges" is also a misrepresentation of the facts. (Motion at 7–8.) Several of the lawsuits United cites did not seek recovery of full billed charges at

Next, United argues that state-specific rate regulations would disrupt "Congress's objective of facilitating nationally uniform plan administration." (Motion at 13–14 (quotation marks omitted).) But *Rutledge* addresses this as well. The Court there explained that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." 592 U.S. at 87.

Third, United maintains that the GMGs' hypothetical legal claims are preempted because—where applied to underlying reimbursement claims for services delivered to patients holding employer-sponsored health coverage—they "depend on the existence of ERISA plans, because any obligation that United may have to reimburse Defendants' patients (or anyone else) for the costs of covered medical services arises from the Plans." (Motion at 14 (citation omitted).) Once again, that position is foreclosed by *Rutledge*. In that case, the Supreme Court reaffirmed that state laws are not preempted where they affect ERISA plans and non-ERISA entities in an evenhanded manner. 592 U.S. at 88 ("Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan."). Thus, if a state were to regulate the rates paid by ERISA

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all. (Response SUMF ¶¶ 102; 104; 105.) United's framing of this dispute therefore rests on an inaccurate and unsupported premise.

plans but not regulate the rates paid by non-ERISA health insurance policies, that would be preempted. But there is no preemption where (as would be the case with the GMGs' legal claims) state law regulates reimbursement rates generally, even if the law happens to be applied to claims under ERISA plans in individual instances. In such cases, the existence of an ERISA plan is essential *to the specific claim*, but it is not essential *to the law's operation*. If it were otherwise, the statute in *Rutledge* would have been preempted. But the Supreme Court held that it was not.[8]

Finally, United attempts to distinguish *Rutledge*. (Motion at 16–18.) It maintains that:

> The state law reviewed by the *Rutledge* Court specified minimum amounts that pharmacies must be paid for their services, but the law ***did not*** regulate how payment responsibility to pharmacies was allocated among PBMs, plans, and plan participants, and ***did not*** require plans to

[8] For this argument, United relies principally upon *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 241–42 (3d Cir. 2020), wherein the Third Circuit found that a provider's unjust enrichment claim was preempted because it depended on the existence of an ERISA plan. (Motion at 14–15.) But *Plastic Surgery Center* preceded *Rutledge* and is at odds with that Supreme Court opinion. The Court should disregard it. *See Emergency Physician Servs. of N.Y.*, 749 F. Supp. 3d at 470 n.7 (stating that "[t]o the extent [United] cite[s] cases predating *Rutledge*, those cases are unpersuasive" and specifically citing *Plastic Surgery Center* as an example of an "unpersuasive" pre-*Rutledge* decision).

United further cites the Eleventh Circuit's decision in *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014). (Motion at 15.) Putting aside that *Hudgens* also predated *Rutledge*, that case is inapposite. *Hudgens* did not address rate regulation. Instead, it involved a preemption challenge to Georgia's prompt pay statute, which is a law governing claims handling procedures. *Hudgens*, 742 F.3d at 1331–32.

> pay any particular percentage or benefit amount. The law instead merely set a floor for the total cost of the covered prescriptions [*sic*] drugs—that is how much a PBM and its beneficiary owe. Nothing in the law would have prevented a plan, by its terms, from leaving its beneficiary to pay at the pharmacy counter all mandated costs above a fixed amount covered by the plan.

(Motion at 16–17 (emphasis in original and quotation marks, citations, and ellipsis omitted).)

In other words, while acknowledging that the Arkansas statute at issue in *Rutledge* regulated reimbursement rates, United contends that it is distinguishable from the GMGs' hypothetical claims because the Arkansas statute merely required an overall reimbursement amount without dictating the cost-share between the ERISA plan, the plan member, and the PBM, whereas the GMGs' claims purportedly would "dictat[e] the amounts that ***the plans themselves*** (or their administrators) alone must pay…." (Motion at 18 (emphasis in original).)

That distinction fails for several reasons. First, it mischaracterizes the *Rutledge* statute. As the Supreme Court explained, that law "require[d] ***PBMs*** to compensate pharmacies at or above their acquisition costs." 592 U.S. at 91 (emphasis added). It did so by "requir[ing] ***PBMs*** to tether reimbursement rates to pharmacies' acquisition costs," and further directing that "[i]f a pharmacy could not have acquired the drug at a lower price from its typical wholesaler, a ***PBM*** must increase its reimbursement rate to cover the pharmacy's acquisition cost." *Id.* at 84–

85 (emphasis added). In other words, the law directly regulated the amounts paid by PBMs, which—like United—are third-party administrators of ERISA plans.

Second, United's purported distinction mischaracterizes the GMGs' hypothetical claims. Where other TeamHealth-affiliated medical practices have challenged United's reimbursement amounts, they have sued *United*—not the ERISA plans—contending that *United* owes that money. (Response SUMF ¶ 100 .) In *Rutledge*, the Supreme Court recognized that "the Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract." 592 U.S. at 88–89. In other words, the Arkansas statute was not preempted in part because it regulated third-party administrators, rather than the ERISA plans themselves. The same is true of the GMGs' hypothetical claims, which would seek to compel United—not the ERISA plans—to pay greater reimbursement amounts.

Moreover, as with the PBMs in *Rutledge*, there is nothing about the GMGs' hypothetical claims against United that would compel United to pass along any added costs imposed by state law to the ERISA plans or plan members, or that would prevent it from doing so. That is an independent contractual matter between United and those parties. United's insistence that the GMGs' hypothetical claims somehow would impose costs directly on the ERISA plans or dictate the cost-share between

the plans, plan members, and plan administrator is entirely unsupported and baseless. In short, *Rutledge* is materially indistinguishable, and it is dispositive here.

II. DECLARATORY RELIEF WOULD SERVE NO PURPOSE BECAUSE THE PARTIES' RIGHTS AND OBLIGATIONS ARE ALREADY CLEAR

United contends that declaratory relief is necessary because of "confusion and disarray among certain trial courts" as to whether claims brought by healthcare providers seeking additional reimbursement under state law are preempted. (Motion at 20.) In fact, there is no such "confusion and disarray." Apart from one or two stray, outlier decisions,[9] the courts to have addressed this issue since *Rutledge* have been remarkably consistent. Those courts repeatedly have held that medical providers' claims challenging rates of reimbursement on covered claims are not preempted by ERISA § 514(a). *See, e.g., NEMS*, 615 F. Supp. 3d at 141–42 ("Every court confronted with this question has determined that ERISA does not preempt a law requiring insurers to reimburse emergency room physicians at a specific, possibly greater, rate); *Emergency Physician Servs. of N.Y.*, 749 F. Supp. 3d at 470 ("[T]he Supreme Court's analysis in *Rutledge* provides the appropriate analytical

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[9] *See, e.g., Amisub (SFH), Inc. v. Cigna Health & Life Ins. Co.*, 681 F. Supp. 3d 842, 856–57 (W.D. Tenn. July 11, 2023).

framework for defendants' preemption argument").[10] In light of this judicial consensus, declaratory relief is not needed because the law is already clear.

Next, United offers an extended discussion of the entirely distinct "complete preemption" doctrine under § 502(a) of ERISA. (Motion at 20–24.) As United observes, courts deciding whether federal question jurisdiction exists over a

[10] *See also Vanguard*, 658 F. Supp. 3d at 1259 (finding no preemption and explaining that the defendant-payer "misses the central holding of *Rutledge*, which is that a state law doesn't 'relate to' an ERISA plan if it merely 'establishes a floor for the cost of the benefits that plans choose to provide'"); *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, at *8–9 (S.D.N.Y. Sep. 28, 2021) (no preemption where payer's "asserted liability does not derive from the particular rights and obligations established by any plan … [n]or do Plaintiffs allege a violation of any plan provision"); *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc.*, 2021 WL 4651504, at *3 (S.D. Fla. Sept. 21, 2021) (no preemption where "Plaintiff's claims are based on its interactions with Defendants independent of the Plan, and Plaintiff brings those claims in its own right and on its own behalf"); *Emergency Servs. of Okla., PC v. Aetna Health, Inc.*, 556 F. Supp. 3d 1259, 1263–65 (W.D. Okla. 2021) (no preemption because "the plans are not the factual basis for Plaintiffs' claims as Plaintiffs are not seeking payment under the plans and have not asserted their claims based upon any terms of any ERISA plan"); *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1297–99 (S.D. Fla. 2021) (no preemption because "the common law causes of action under which Plaintiffs bring their claims all have force and operate independently of the existence of any ERISA plans" and "the Supreme Court has stated that law which increase[s] the costs plans incur in one state versus another does not necessarily have an impermissible connection with an ERISA plan"); *ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514 F. Supp. 3d 927, 939–42 (S.D. Tex. 2021) (finding "emergency care statutes equate to cost regulation that does not bear an impermissible connection with or reference to ERISA, and are therefore not preempted"), *rev'd on other grounds*, 60 F.4th 899 (5th Cir. 2023); *United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in and for Cnty. of Clark*, 2021 WL 2769032, at *1 (Nev. July 1, 2021) (same).

plaintiff's state law claims challenging ERISA reimbursement decisions—and hence whether those claims are removable to federal court—often have applied a "right-to-payment" versus "rate-of-payment" distinction. *See, e.g., Conn. State Dental*, 591 F.3d at 1349–50; *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018). But United's suggestion that post-*Rutledge* courts to have found that medical providers' state law claims are not defensively preempted under ERISA § 514(a) did so only because they erroneously conflated complete preemption under § 502(a) with defensive preemption under § 514(a) (Motion at 22–23) is incorrect for two reasons.

First, on their face, those decisions specifically cite ERISA § 514(a)[11] and decisional law construing that provision. *See, e.g., Emergency Physician Servs. of N.Y.*, 749 F. Supp. 3d at 467–71. Second, given the core holding in *Rutledge*—that state regulation of medical reimbursement rates *is not* preempted, but state law dictating which medical services ERISA plans must cover *is* preempted—a right-to-payment versus rate-of-payment dichotomy applies equally in the defensive preemption context. Indeed, at least one federal court has explicitly noted as much:

> The Supreme Court's ruling in *Rutledge* is strikingly similar to the Fifth Circuit's complete preemption rule….In the context of complete preemption, the Fifth Circuit held that when a claim implicates the *rate* of payment in a contract, rather than the *right* to payment under the terms of a plan, it is not completely preempted. It would not be

[11] Codified at 29 U.S.C. § 1144(a).

> surprising if the Fifth Circuit interpreted *Rutledge* as requiring application of its rule distinguishing a rate of payment from a right to payment to apply with equal force to complete preemption (ERISA § 502) and conflict preemption (ERISA § 514).

ACS, 514 F. Supp. 3d at 940 n.12 (citations omitted and emphasis in original).

Finally, United argues that "[a] declaratory judgment would resolve past claims totaling millions of dollars." (Motion at 25.) That is wrong, because the GMGs already have committed in writing to never suing United for additional reimbursement on past medical claims, as the Court has recognized. (Dkt. 77 at 9; Cross-Motion at 5.) And as the Court further acknowledged, no disputed claims have arisen in the last couple years—nor could any arise under present conditions—because there are no hospitals in Georgia that are staffed by the GMGs and out-of-network with United. (Dkt. 77 at 10; Cross-Motion at 6.) In short, not only are there not "millions of dollars" at stake in this dispute, there are *no* dollars at stake.

CONCLUSION

For all the foregoing reasons, the Court should deny United's Motion.

Respectfully submitted, this 13th day of April, 2026.

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CERTIFICATE OF COMPLIANCE

Pursuant to L.R. 7.1(d), I hereby certify that the foregoing document complies with the font and point selections approved by L.R. 5.1(C). The foregoing document was prepared using Times New Roman font in 14 point.

This 13th day of April, 2026.

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CERTIFICATE OF SERVICE

I hereby certify that I have caused a true and correct copy of the foregoing to be filed with the Clerk of Court using the CM/ECF system, which will send a notification of such filing to all counsel of record.

This 13th day of April, 2026.

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