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' REPLY MEMORANDUM OF LAW
IN FURTHER SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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Pursuant to Federal Rule of Civil Procedure 56(a), the GMGs[1] by and through undersigned counsel, respectfully submit this Reply Memorandum of Law in Further Support of their Motion for Summary Judgment ("Motion")[2] and state as follows:

PRELIMINARY STATEMENT

The Supreme Court held in *Rutledge* that "ERISA does not pre-empt state rate regulations…." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 88 (2020). That pronouncement is clear and unambiguous, and it renders the Court's task in this action exceedingly straightforward. Should the Court deem it appropriate even to address the merits of United's preemption challenge to the GMGs' hypothetical state-law claims, it can and must resolve that challenge simply by applying *Rutledge* and concluding that those imaginary claims would not be preempted because they would amount to nothing more than basic rate regulation. Many federal district courts adjudicating analogous payor/provider reimbursement disputes in the years since *Rutledge* have reached this conclusion when presented with similar preemption defenses, aptly recognizing that *Rutledge* means what it says: ERISA does not preempt state rate regulations. And most recently, the U.S. Supreme Court denied *certiorari* review of the Nevada Supreme Court decision, against United, finding

[1] Unless otherwise specified, capitalized terms shall have the meanings assigned to them in the GMGs' February 27, 2026, Memorandum of Law.

[2] The GMGs' Motion is Dkt. 79.

that state-law claims for out-of-network emergency services were not preempted by ERISA.

Try as it might, United cannot evade *Rutledge*. It offers a series of misguided arguments on the purpose of the ERISA statute, the need for uniformity in plan administration, how benefits determinations are a central matter of plan governance, etc. Yet, as explained previously and reinforced below, all of those arguments were specifically considered and rejected in *Rutledge*. United also tries to differentiate *Rutledge* on the basis that the law at issue in that case regulated pharmacy benefit managers ("PBMs"), rather than ERISA plans themselves. But that effort falls flat. PBMs are third-party administrators of pharmacy benefits for ERISA plans, just like United is a third-party administrator of health benefits for the same plans. United serves the same role in the health benefits process that PBMs serve in the pharmacy benefits process, and the laws hypothetically at issue here would function in exactly the same manner as the law in *Rutledge*: they would indirectly affect the costs imposed on ERISA plans for covered benefits by regulating the rates paid by the plan administrators. As such, *Rutledge* is materially indistinguishable and dispositive.

Ultimately, the only question presented here is not as to the correct merits outcome, but as to why United thought that outcome was sufficiently in doubt to warrant a declaratory judgment action. The answer to that question—as the GMGs

have observed—is that United is not seeking clarity as to the status of the law; it is trying to change law. United is well aware that there is not—and has never been—any actual dispute between itself and the GMGs, because the GMGs have never even contemplated suing United in Georgia (and have given no indication otherwise). United is also aware that the federal No Surprises Act ("NSA") has significantly impacted the out-of-network reimbursement litigation between itself and TeamHealth-affiliated entities by providing a federal arbitral forum for the reimbursement disputes. United's hope in bringing this action is that it can convince this Court—and, ultimately, the Eleventh Circuit—to render a decision at odds with *Rutledge* and at odds with the U.S. Supreme Court's recent decision not to accept *certiorari* to review this very issue, thereby begin rolling back a jurisprudential line it considers unfavorable but nevertheless correct. The Court should recognize this action for what it is, and should respectfully grant the GMGs' motion for summary judgment.

ARGUMENT

I. DECLARATORY RELIEF IS UNAVAILABLE BECAUSE THIS DISPUTE IS PURELY HYPOTHETICAL

As the GMGs explained previously, the uncertain, hypothetical nature of this "dispute" renders declaratory relief untenable. While the Court has held that it enjoys subject-matter jurisdiction, it would be impossible to tailor an actual declaratory judgment to the "established facts" of this case because there are no

established facts. (Dkt. 79-1 at 6–10 (citing *Ashcroft v. Mattis*, 431 U.S. 171, 172 (1977)).) In response, United contends that the "established facts" necessary for the Court to enter a declaration are merely those necessary to establish the Court's subject-matter jurisdiction. Thus, because the Court has found that it enjoys subject-matter jurisdiction, there necessarily are established facts upon which to issue a declaration. (United Response Br. at 6–7.) That position misses the mark.

While United is correct that the Court already has found that the record presented satisfies the minimum threshold to establish an actual controversy, it conflates that jurisdictional question with the separate question of whether the facts here are sufficiently definite to render declaratory relief feasible. As shown in the GMGs' Motion, they are not. Because there are no disputed claims at issue (and no conceivable prospect that any will arise), the essential facts underlying this "dispute"—with respect to, *inter alia*, the ERISA plans at issue, the types of medical services at issue, the contents of the plan terms governing reimbursement for those medical services, the legal theories under which the GMGs would pursue relief, etc.—are matters of pure speculation. Under these circumstances, there is no practical way for the Court to fashion declaratory relief.[3]

[3] Consider a hypothetical dispute between two contracting parties over whether a specific threatened action would be permitted under their contract. Such a dispute likely would lend itself to declaratory relief, because the critical facts—the terms of the contract and the nature of the threatened action—are definite and established. But consider an alternative hypothetical where the parties have not finalized their

United's only response is to contend that these missing facts are "irrelevant for purposes of the preemption analysis." (United Response Br. at 10.) They are not. While preemption does not apply here in any capacity because ERISA does not preempt state rate regulation (Part II, *infra*), even if it could apply, the extent of that application would depend on the facts presented. For instance, the majority of the non-NSA-eligible claims that United identified in discovery as illustrative of the types of disputed claims that could arise in the future were small-dollar claims for smoking-cessation treatment. (*See, e.g.*, Dkt. 55-8 (Ex. 31 to Decl. of Joao dos Santos) at 459, rows 3, 4, 9, 12.) Putting aside the absurdity of assuming the GMGs would ever sue United to recover, at most, several thousand dollars on underpaid smoking-cessation claims, whether those hypothetical legal claims could be preempted would depend on the facts and circumstances at issue. Many—if not all—of the United-administered ERISA plans produced in this matter do not contain specific terms addressing how much United or the plan will pay for smoking-cessation treatment. (*See generally* Dkt. 79-13, SPD for Delta (providing no specific reimbursement for smoking-cessation treatment), Dkt. 79-14, COC for Insperity

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contract, and one party threatens to take an action without specifying what that action would be. In that instance, the terms of the contract and nature of the threatened action would not be settled. As such, any declaratory judgment would require the Court to assume hypothetical facts, rendering declaratory relief untenable. The present dispute mirrors this latter hypothetical.

Holdings (same), Dkt. 79-15, SPD for Love's Travel Stops and Country Stores (same), Dkt. 79-16, SPD for Caterpillar Inc. (same), Dkt. 79-17, SPD for Sotera Health Holdings, LLC (same), Dkt. 79-18, SPD for Southwest Airlines Co. (same).) As such, even under United's misguided view of this case, a provider's legal claim seeking additional reimbursement would not create any factual conflict with the plan terms.

The legal theories of relief that would be asserted also are critical but unknown. As the GMGs have explained, even the precedents that United relies on for its preemption argument held that some legal causes of action were preempted and others were not. (Opening Br. at 9–10 (citing *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 242 (3d Cir. 2020); *Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 387 (5th Cir. 2011)).) United's only response is to contend that "none of the Threatened Claims is analogous to the contract or misrepresentation-based causes of action found not preempted in [*Plastic Surgery Center* and *Access Mediquip*], which all arose from promises the plans made independent of the plan terms." (United Response Br. at 12.) But there is no conceivable way for United to know what the "Threatened Claims" would be, because the GMGs have never threatened to bring any claims against United. And to the extent United is looking to previous litigation between itself and TeamHealth-affiliates in other jurisdictions as precedent, all of those cases involved emergency

medical services and anesthesia services delivered at in-network facilities (and hence are different in kind from the non-NSA-eligible claims purportedly at issue here). Given the different nature of the hypothetical reimbursement claims here, it stands to reason the GMGs would bring different legal causes of action.[4] Moreover, even in those non-analogous prior disputes, the TeamHealth-affiliated plaintiffs have asserted statutory claims and claims for breach of implied-in-fact contract (the sorts of claims *Plastic Surgery Center* and *Access Mediquip* found not to be preempted).

Accordingly, the pervasive uncertainty about the facts at issue in this "dispute" render declaratory relief untenable.

II. ERISA DOES NOT PREEMPT STATE REGULATION OF MEDICAL REIMBURSEMENT RATES

Even if the Court is determined to resolve United's request for declaratory relief on the merits, it must deny that request and enter summary judgment for the GMGs. That is because, as the GMGs have explained in their prior briefing, the

[4] For instance, many of the prior TeamHealth/United reimbursement cases have involved claims for unjust enrichment. Those claims were predicated on law creating a right to recover in restitution the reasonable value of *emergency* services rendered. (*E.g.*, *UnitedHealthCare Ins. Co. v. Fremont Emergency Servs. (Mandavia), Ltd*, 141 Nev. Adv. Op. 29, 570 P.3d 107, 121–22 (2025), *cert. denied sub nom. UnitedHealthcare Ins. Co. v. Fremont Emergency Servs. (Mandavia), Ltd.*, 146 S. Ct. 995 (2025) (citing RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 22).) That legal claim—recovery for the reasonable value of *emergency* services—would not apply here, where NSA-eligible emergency services are not at issue.

hypothetical state law legal claims here would merely challenge the rates paid on covered claims for reimbursement, and "ERISA does not pre-empt state rate regulations…." *Rutledge*, 592 U.S. at 88; *see also N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 667 n.6 (1995) ("[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."). United offers several contrary arguments, none of which have merit.

First, United contends that "the Threatened Claims seek to override the plan's payment terms by allowing a state court to determine de novo what reimbursement rate is required under state law," and thus the "effect of the Threatened Claims is…to force the plans to adopt a certain scheme of substantive coverage…." (United Response Br. at 14–15 (quotation marks omitted).) But the Supreme Court considered and rejected that same 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 any 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.

Next, United contends that "reference to" preemption applies because "[t]he Threatened Claims are also premised on the existence of an ERISA plan, because a relationship created by a plan is the only means by which United could ever be named as a defendant…." (United Response Br. at 15–16 (citations, quotation marks, and brackets omitted).) United misunderstands "reference to" preemption. As the Supreme Court has explained, this type of preemption applies "[w]here a State's law acts immediately and exclusively upon ERISA plans…or where the existence of ERISA plans is essential to ***the law's*** operation…." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (emphasis added). In other words, the test is not whether the existence of a specific ERISA plan is essential to a specific claim. The dispositive question is whether the existence of ERISA plans generally is essential to the general operation of the state law in all instances.

The following hypothetical illustrates this distinction. Assume a statute criminalizes robbery committed with a firearm. The presence of firearms would be

essential to the law's operation, because the law would apply only when the defendant possessed a firearm. The law accordingly would "refer to" firearms. Alternatively, consider a statute criminalizing armed robbery. The existence of firearms would *not* be essential to the law's operation, because a defendant could violate the law with use of a weapon that is *not* a firearm. This latter law would *not* "refer to" firearms. Critically, that would remain the case even where a particular defendant happened to commit armed robbery with a firearm. In such instance, the existence of a firearm would be essential *to the specific criminal case against the specific defendant*, but it would not be essential to *the law's operation*.

The conceivable state statutory or common law legal theories under which the GMGs could challenge United's reimbursement amounts would function like the second hypothetical penal statute. Because those state laws would apply to both ERISA and non-ERISA health plans/policies in an evenhanded manner, the existence of ERISA plans would not be essential to the laws' operation. Critically, that would remain the case even in individual instances where the law is applied to claims arising under ERISA plans. As such, these laws would not "refer to" ERISA. *See Rutledge*, 592 U.S. at 89 (explaining that "ERISA plans are likewise not essential to Act 900's operation [because]…Act 900 regulates PBMs whether or not the plans

they service fall within ERISA's coverage," and finding no "reference to" preemption for this reason).[5]

Third, United attempts to distinguish *Rutledge*. It observes that the Arkansas statute at issue in *Rutledge* regulated PBMs by setting a minimum price that pharmacies must be paid for prescription drugs. This had the effect of increasing the cost for prescription drugs, but "did not require any plan to depart from plan terms that set benefit levels or allocated responsibility for the total bill between the plan and the beneficiary." (United Response Br. at 20.) United contends that the GMGs' imagined claims would be different, because they would be asserted "directly against a plan administrator" and would require the administrator to "pay certain providers not the amount prescribed by the plan, but whatever amount a jury decides is the appropriate rate under state law—and without regard to the plan's chosen allocation of financial responsibility between the plan and the beneficiary." (United Response Br. at 20–21.)

[5] United contends that "every federal appellate court to address the question" has agreed with its flawed analysis of "reference to" preemption. (United Response Br. at 16.) But the only post-*Rutledge* decision it cites is an unpublished Second Circuit opinion that does not even mention *Rutledge* and gives no indication the Court ever considered this issue in depth. (United Response Br. at 17 (citing *Park Ave. Podiatric Care, P.L.L.C. v. Cigna Health & Life Ins. Co.*, 2024 WL 2813721, at *2 (2d Cir. June 3, 2024).) To the extent other federal courts have issued opinions which support United's argument, those opinions are at odds with Supreme Court jurisprudence and were wrongly decided.

United's attempted distinction fails for several reasons. First, United plays the same role in the health claims process that PBMs play in the prescription drug claims process. United is a third-party administrator of health benefits. (Dkt. 81-1, GMGs' Response SUMF, ¶ 1.) PBMs are third-party administrators of pharmacy benefits. *See Trone Health Servs., Inc. v. Express Scripts Holding Co.*, 974 F.3d 845, 848 (8th Cir. 2020) ("Pharmacy Benefit Managers (PBM) serve as third-party administrators of prescription drug programs sponsored by employers…."). Where a member of a United-administered ERISA plan seeks medical care, the medical provider submits a claim to United (not the plan). (Dkt. 81-1, GMGs' Response SUMF, ¶¶ 66, 70–74.) United then adjudicates the claim. Where the claim is covered, United determines the amount payable and pays the claim on behalf of the plan. (Dkt. 81-1, GMGs' Response SUMF, ¶ 5.) How much of the payment amount United is reimbursed, the calculation of its administrative fee, etc. are contractual matters between United and the plan. (Dkt. 81-1, GMGs' Response SUMF, ¶¶ 7, 12.)

Similarly, where a member of an ERISA plan seeks prescription drugs at a pharmacy, the pharmacy dispenses the drugs and submits a claim to the PBM. The PBM then adjudicates the claim. If the claim is covered, the PBM determines the amount payable and pays the claim on behalf of the plan. *Rutledge*, 592 U.S. at 83–84. Once again, the amount of the reimbursement from the plan to the PBM and the

fee charged by the PBM are contractual matters between itself and the plan. *Id.* at 84 ("[T]he amount that prescription-drug plans reimburse PBMs is a matter of contract between a given plan and a PBM."). In other words, United and PBMs serve identical roles in the claims processes.

Second, the statute at issue in *Rutledge* and the laws under which the GMGs would assert their hypothetical state-law claims would function identically. The law in *Rutledge* regulated the amounts that PBMs must pay to pharmacies for prescription drugs. *Rutledge*, 592 U.S. at 84–85. But that law had no effect on the relationship between the PBMs and ERISA plans, nor did it directly regulate the plans. *Id.* at 88–89 ("[T]he 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."). The law's only impact on ERISA plans was indirect, because the PBMs presumably would seek reimbursement for the higher costs imposed by the law from the ERISA plans. *Id.* As the Supreme Court explained, "PBMs may well pass those increased costs on to plans, meaning that ERISA plans may pay more for prescription-drug benefits in Arkansas than in, say, Arizona. But cost uniformity was almost certainly not an object of pre-emption." *Id.* at 88 (quotation marks omitted).

Similarly, the GMGs' hypothetical state-law claims would impose costs on United—not the ERISA plans—by forcing United to pay more for health claims. As

in *Rutledge*, United may pass those added costs on to the plans it administers, but "cost uniformity was almost certainly not an object of pre-emption." As such, the state laws providing the GMGs' causes of action would not regulate the plans directly, nor would they affect the relationship between United and the plans. How much reimbursement United would receive, how any added costs would affect United's administrative fees etc. would remain contractual matters between United and the plans.

Finally, United contends that the GMGs' hypothetical claims would dictate the cost-share between United, the ERISA plans, and the plan beneficiaries. (United Response Br. at 20–21.) That is false, and United provides no support for its assertion. In reality, the GMGs' hypothetical claims would compel *United* to pay greater amounts. As in *Rutledge*, those claims (and the laws under which they are asserted) would have no bearing on what portion of the added costs (if any) United would pass onto the plans and plan members.[6]

[6] United cites several decisions that purportedly support its position on preemption. (United Response Br. at 21–22.) Many of these are distinguishable. For instance, *Long Island Plastic Surgical Group, P.C. v. Unitedhealthcare Insurance Company of New York*, 2026 WL 161152 (E.D.N.Y. Jan. 21, 2026), dealt with benefit *denials*, rather than challenges to the rates paid on covered claims. *See Long Island Plastic Surgical Grp., P.C. v. Unitedhealthcare Ins. Co. of N.Y.*, 2025 WL 3461046, at *2 (E.D.N.Y. Aug. 29, 2025) ("Plaintiffs then billed Defendants for these procedures which Defendants denied….Defendants allegedly affirmed these claim denials, leading Plaintiff to pursue relief through this Court."). And *America's Health*

Ultimately, *Rutledge* is indistinguishable, and it commands a holding that the GMGs' hypothetical claims would not be preempted.

CONCLUSION

For all the foregoing reasons, the Court should grant the Motion and enter summary judgment for the GMGs and against United.

Insurance Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014) dealt with a statute regulating claims handling procedures, rather than a law regulating rates.

Several of the cases United has identified are erroneous outlier decisions which the Court should disregard. *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). In any event, United's authority is overwhelmed by the decisions correctly resolving analogous preemption defenses. (*See* GMGs' Memorandum of Law in Support of MSJ at 17–18 (collecting cases); GMGs' Response to United MSJ at 17–18 (collecting cases).)

Respectfully submitted, this 4th day of May, 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 4th day of May, 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 4th day of May, 2026.

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