**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF GEORGIA**

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.

Civil Action No. 1:23-cv-05221-JPB

**UNITED'S RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS THE AMENDED COMPLAINT**

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## PRELIMINARY STATEMENT

Through this declaratory judgment action, Plaintiffs (collectively, "United") seek to resolve an ongoing dispute with Defendants over the law governing United's payments on certain claims Defendants have submitted for services to members of health plans United administers (the "Plans"). The dispute concerns whether United may continue to fulfill its obligation under ERISA to pay reimbursements according to the varying terms of the Plans or whether United must instead submit to Defendants' demands for reimbursement of their full, unilaterally-set billed charges pursuant to Georgia common law.

Defendants are controlled by the largest for-profit, private-equity backed healthcare provider staffing company, TeamHealth Holdings, Inc. ("TeamHealth"). Defendants' TeamHealth affiliates have brought numerous suits across the country to recover their full billed charges under state law, regardless of the terms of the Plans—and TeamHealth officials have threatened additional litigation in Georgia and other states. Meanwhile, United continues to process hundreds of thousands of dollars of Defendants' claims and must make decisions about the proper amount to pay under the law under constant threat that Defendants could file suit in Georgia at any time of their choosing.

With each and every claim, United faces an impossible choice. If United adheres to its duties under ERISA by adjudicating benefit amounts in accordance

with Plan terms—as it historically has done and continues to do—it thereby incurs potential liability under state law if Defendants' strident assertion that ERISA permits state law to override Plan payment terms proves correct. But if United were instead to give in to Defendants' demands by paying their full billed charges, and thus overpay the claims under Plan terms, United could instead be accused of violating ERISA's requirement to administer the Plans according to their terms. To avoid this threat and to ensure it is in compliance with the law, United seeks to clarify its legal obligation to reimburse Defendants' claims according to the terms of the Plans and without regard to Georgia common law—which is expressly preempted by Section 514 of ERISA, 29 U.S.C. § 1114.

Defendants seek dismissal on two grounds. They first contend that—despite their affiliates commencing reams of cases in other states, some as recently as a few months ago—"there is no actual controversy" between United and the Georgia TeamHealth affiliates. Not so. Defendants have consistently billed United at their full, inflated billed charges for services to Plan members in Georgia. TeamHealth's Chief Executive has threatened action wherever network contracts with United have been terminated—and, making good on this threat, TeamHealth affiliates that were previously covered under the very same network contracts to which Defendants were parties have already filed suit. Under the relevant cases, TeamHealth's threats ***alone*** establish a live case or controversy, even setting aside

the numerous lawsuits making good on those threats. Against this backdrop, the self-serving declaration of TeamHealth's Senior Vice President—stating that TeamHealth "presently" lacks an intent to litigate in Georgia—is insufficient to negate jurisdiction. Indeed, that same SVP made clear in a January 29, 2024 letter that TeamHealth has not withdrawn and will not withdraw its threats, reaffirming that TeamHealth reserves the right to file a lawsuit in Georgia at any time based on various unspecified "conditions" or "factors."

Second, Defendants suggest that this Court should decline to adjudicate this dispute because (i) the issue of express ERISA preemption is settled in Defendants' favor and (ii) Defendants no longer submit any disputed claims to the Plans. On the first point, while Defendants are correct that some trial courts have applied the incorrect ERISA preemption standard to allow similar state-law claims to proceed, the confusion among trial courts over the scope of ERISA's express preemption clause, and Defendants' emphatic position that it does not apply, cuts strongly in favor of United's request for declaratory relief. And Defendants' second point is factually wrong: There plainly are ongoing claims in dispute.

## STATEMENT OF FACTS

### A. United Administers Claims in Georgia Pursuant to Employee Benefits Plans Subject to ERISA

United is a health insurer and a third-party claims administrator for certain ERISA-governed employee health benefit plans in Georgia. Am. Compl. ¶¶ 1, 5,

13–16. United determines benefit payments when a participant in a Plan obtains covered healthcare treatments (a "Covered Service"). *Id.* ¶¶ 27, 32.

Defendants Hospital Physician Services Southeast, P.C., InPhyNet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. are for-profit private-equity backed staffing companies owned by TeamHealth, the largest physician staffing, billing, and collections company in the United States. *Id.* ¶ 2. The Defendants have provided emergency and non-emergency services in Georgia to Plan participants. *Id.* ¶ 3.

Two of the Defendants and United were previously parties to a network participation agreement setting rates for services; the third was not. *Id.* ¶ 44. On October 15, 2019, United terminated the participation agreement. *Id.* Since that termination, Defendants affiliated providers rendered "out-of-network" services to the Plans' members, and United's sole obligation as claims administrator under ERISA is to pay the benefit amount prescribed by Plan terms. *Id.* ¶¶ 4–6. Plan B, for example, states that an out-of-network provider will be paid "based on the reasonable and customary rate and not the amount charged by the provider." *Id.* ¶ 39. Under all Plans, once Plan-allowable amounts have been paid, the participant remains responsible for any balances. *Id.* ¶ 37.[1]

[1] Under the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. 1, 134 Stat. 1182, 2758–2890 (2020) (the "No Surprises Act"), claims for

### B. TeamHealth Disputes United's Payment Determinations as Part of a Global Strategy to Compel Higher Reimbursements and Profits

Over the last five years, Defendants have submitted millions of dollars in claims for Covered Services provided to participants in and beneficiaries of the Plans on an out-of-network basis in Georgia. *Id.* ¶ 48. The Defendants have declared United's determinations on these claims "disputed" and insist that they will remain so unless and until United reimburses the Defendants 100% of the providers' full-billed charges—far in excess of rates calculated in accordance with the Plans' rate calculation methodologies and applicable Summary Plan Descriptions ("SPDs") or Certificates of Coverage ("COCs"). *Id.* ¶ 53.

TeamHealth officials have repeatedly testified they consider any claim reimbursed at less than 100% of billed charges to be subject to potential litigation, regardless of the nature of the services or the network status of the facility at which the services were provided. *Id.* ¶¶ 56–57. In fact, during negotiations, TeamHealth's CEO, Leif Murphy, told United that TeamHealth will file suit anytime a network contract between United and a TeamHealth affiliate is terminated and noted that "[w]e've gotten really good at the litigation route and have a template to file [a complaint] in every state for every contract." *Id.* ¶¶ 59–60 ("For every UHG termination, we'll file a TeamHealth lawsuit.").

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emergency services and claims for services provided at network facilities delivered on or after January 1, 2022 are subject to special dispute-resolution provisions.

Making good on this threat, TeamHealth affiliates have already sued United in nine states across the country claiming that provisions or doctrines of state law other than contract principles—such as unjust enrichment and quantum meruit—require United to pay claims at the providers' full billed charges (the "Non-Contractual State Law Claims"), regardless of the Plans' benefit language. *Id.* ¶¶ 9–10. Indeed, TeamHealth sued United in four of the five other states covered by the terminated network contract that included two of the Defendants here. *Id.* ¶ 59.

## LEGAL STANDARD

The Declaratory Judgment Act ("DJA") permits a federal court, "[i]n a case of actual controversy," to "declare the rights ... of any interested party seeking such declaration." 28 U.S.C. § 2201(a). Because DJA actions often involve "a somewhat hypothetical set of facts," the threshold question is whether a justiciable controversy exists. *GTE Directories Publishing Corp. v. Trimen America, Inc.*, 67 F.3d 1563, 1568–69 (11th Cir. 1995) (declaratory relief can be "'proper even though there are future contingencies that will determine whether a controversy ever actually becomes real.'" (quoting 10A C. Wright, A. Miller M. Kane, FEDERAL PRACTICE AND PROCEDURE, Section(s) 2757, at 586 (2d ed. 1983))). A mere threat of litigation is typically sufficient to establish jurisdiction. *Nike, Inc. v.*

*Already, LLC*, 663 F.3d 89, 95–96 (2d Cir. 2011) ("the threat of future litigation remains relevant in determining whether an actual controversy exists").[2]

Rule 12(b)(1) motions challenge whether a justiciable controversy exists through a facial or factual attack. *Williamson v. Tucker*, 645 F.2d 404, 412–14 (5th Cir. 1981). "Unless the relevant averments in plaintiff's complaint are controverted by the undisputed facts in the case, they will be accepted as true in resolving the jurisdictional questions at hand." *Helton v. United States,* 532 F. Supp. 813, 818 (S.D. Ga. 1982); *accord Kason Indus., Inc. v. Dent Design Hardware, Ltd.*, 952 F. Supp. 2d 1334, 1339 (N.D. Ga. 2013).

## ARGUMENT

### I. The Court Has Subject Matter Jurisdiction Because There Is an Actual Case or Controversy

Defendants claim that there is no actual case or controversy between the Parties and that the Court therefore lacks jurisdiction to provide relief. The factual record confirms otherwise. Defendants have consistently disputed the reimbursement rates United has paid for their services to Plan members in Georgia;

[2] If jurisdictional facts are in dispute in a DJA case, the DJA plaintiffs "are entitled to a reasonable opportunity for discovery and, where necessary, a hearing[.]" *Brannen v. McGlamery*, 2021 WL 6072558, at *2 (S.D. Ga. 2021). The proper course in such instances is to deny dismissal without prejudice and permit the plaintiff to conduct targeted discovery of any such disputed jurisdictional facts. *See Majd-Pour v. Georgiana Cmty. Hosp., Inc.*, 724 F.2d 901, 903 (11th Cir. 1984); *Eaton v. Dorchester Dev., Inc.*, 692 F.2d 727, 729–31 (11th Cir. 1982).

Defendants' parent company has threatened to sue United over all such claims; and the parent company has made good on this threat in numerous other jurisdictions. These actions are more than sufficient to establish subject matter jurisdiction for DJA relief—as many courts have held—and Defendants' attempt to evade this reality by submitting a transparently self-serving declaration suggesting that they have no "present intent" to sue United is unavailing.

### A. Defendants' Threats of Litigation Over United's Reimbursement of Claims in Georgia Underscore a Live Dispute Between the Parties

There is a live dispute between Defendants and United over the proper rate of reimbursement from the Plans for Defendants' services to Plan members in Georgia. As the Amended Complaint avers, Defendants have submitted thousands of claims for services provided to Plan members in Georgia, demanding their full billed charges in each case, but United has consistently followed its obligation under ERISA to pay the claims according to the Plans' reimbursement terms. Am. Compl. ¶¶ 48–51. On behalf of Defendants and a host of affiliated entities across the country, TeamHealth has declared those reimbursements insufficient, insisting providers are entitled to their full billed charges under state law, regardless of Plan terms. *Id.* ¶¶ 48, 52–53, 56–57. Even in the absence of threats to take the demands to court, such disputed claim submissions to insurers and claims administrators like United are alone sufficient to establish a live controversy. *See State Farm Mut. Auto. Ins. Co. v. Bates*, 542 F. Supp. 807, 817 (N.D. Ga. 1982) ("Federal courts

long have held that an insurance company seeking determination of its liabilities under an insurance contract could utilize the [DJA] for such a purpose."). After all, it is the job of entities like United to pay claims correctly and in accordance with law. They frequently need authoritative determinations of their legal responsibilities so they can comply with them.

Here, Defendants have done more than merely submit thousands of formal claims to United demanding their full billed charges. Through their common parent company (with full control over Defendants' actions),[3] they have repeatedly threatened litigation over these demands and followed through on those threats across the country. Am. Compl. ¶¶ 9–10, 54–56 (TeamHealth filed suits in nine states). Indeed, TeamHealth's CEO has promised to file a lawsuit against United in ***precisely*** the circumstances present in Georgia: following termination of a network contract with a TeamHealth subsidiary. *Id.* ¶¶ 57–61.[4] Since United terminated a network agreement encompassing two Defendants (along with other TeamHealth

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[3] As Bristow affirms in his declaration, he alone has "the authority to determine what reimbursement rates are acceptable to TeamHealth and its affiliates, including [Defendants], and whether to take legal action against health insurers and/or third-party administrators, such as United." Declaration of Kent Bristow, Dkt. 29-1 at ¶ 7 ("Bristow Decl.").

[4] TeamHealth's CEO has publicly declared that "if we are not paid the amount that we bill . . . by an insurance company, like United, we seek the balance payment from United." TeamHealth, Taking On UnitedHealthcare (2022) (beginning at 6:58 mark), available at https://www.youtube.com/watch?v=R0qu-R4oU1o.

subsidiaries) on October 15, 2019, TeamHealth affiliates have sued United in four of the five other jurisdictions covered by the letter. *Id.* ¶ 59.

That is enough to establish a dispute, but TeamHealth's SVP, Kent Bristow, recently cemented the threat by expressly refusing to renounce pursuit of litigation in Georgia. In January 2024, United sought Mr. Bristow's signature on a declaration confirming TeamHealth's retraction of its prior litigation threats. Ex. A to the Declaration of G. Jacob. Bristow refused, making clear that TeamHealth might direct Defendants to file suit in Georgia at any time based on its evaluation of unspecified "factors" and "conditions." Ex. B to the Declaration of G. Jacob.

As numerous courts have recognized, even outside the context of formal insurance claims, such threats of litigation are more than sufficient to establish subject matter jurisdiction for DJA relief. *See GTE Directories Publ'g Corp.*, 67 F.3d at 1569; *Gordon v. Auto-Owners Ins. Co.,* 2020 WL 2770169 at *3 (S.D. Ga. May 28, 2020); *see also Nike*, 663 F.3d at 95–96. And, as the Eleventh Circuit has pointedly observed, a controversy is all the more concrete when, as here, the DJA defendant has already sued on related claims. *GTE*, 67 F.3d at 1568–69.

Defendants' principal rejoinder is that the threats do not reference Defendants by name and are "nearly five years old." Defendants' Motion to Dismiss ("Mot") at 15, n.12. As explained, however, TeamHealth's CEO has promised litigation in the exact context present in Georgia—where a United

contract was terminated. Moreover, the threat is far from stale: TeamHealth has commenced case after case against United (its last filing was less than four months ago),[5] without signaling ahead of time where its next litigation target would be. Case law offers no support for Defendants' contention that United must wait until it is sued to obtain clarity on its obligations, and in the meantime incur additional potential liability each time it pays a claim. To the contrary, "the [very] purpose of declaratory judgment actions . . . is to resolve outstanding controversies without forcing a putative defendant to wait to see if it will be subjected to suit." *Am. Ins., Co. v. Evercare Co*., 699 F. Supp. 2d 1355, 1359 (N.D. Ga. 2010) (quoting *Sherwin–Williams Co. v. Holmes County*, 343 F.3d 383, 398 n. 8 (5th Cir. 2003)).[6]

The sole case relied on by TeamHealth to challenge subject matter jurisdiction, in fact, confirms that a justiciable controversy exists here. Mot. 12–14 (citing *Atlanta Gas Light Co. v. Aetna Cas. & Sur. Co.*, 68 F.3d 409, 414 (11th Cir.

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[5] *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, Case No. 2023-CA-016780 (Fla. 13th Judicial Cir., Hillsborough Cnty).

[6] *See also GTE*, 67 F.3d at 1569 ("This is the type of Damoclean threat that the Declaratory Judgment Act is designed to avoid."); *State Farm*, 542 F. Supp. at 817 ("In this posture, [the insurer] need not wait for [the insured] to file his complaint") (citing *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 244 (1937)); *Am. Heritage Life Ins. Co v. Johnson*, 2022 WL 30175 at *3 n.3 (11th Cir. Jan. 4, 2022) ("[t]here is no requirement that a declaratory judgment defendant formally pursue an action or assert a claim before the plaintiff may obtain relief."); *Gordon*, 2020 WL 2770169, at *3 (citing *GTE*, 67 F.3d at 1569) ("the threat of litigation may provide justification for a declaratory judgment action in the insurance context."); *Am. Ins. Co.,* 699 F. Supp. 2d at 1359 (same).

1995)). In *Atlanta Gas*, the plaintiff sought a declaratory judgment that its insurers were liable to cover environmental cleanup costs at its manufactured gas plants. 68 F.3d at 411–12. But the *Atlanta Gas* plaintiff jumped the gun—it initiated the DJA action ***before*** its insurance companies had even "taken [a] position [] with regard to their duties under [plaintiff's] policies." *Id.* at 412, 414–15. "Not only had the insurers not yet received notice, no one knew exactly what had to be cleaned up, who was to undertake the cleanup, or how much the cleanup would cost." *Id.* at 415. Under these circumstances, the Eleventh Circuit held that the plaintiff could not claim either "actual or threatened injury [] from [the insurers] conduct." *Id.* at 414. A host of courts have distinguished *Atlanta Gas* in finding that subject matter jurisdiction exists in circumstances like those here, where the DJA defendants have submitted claims to an insurer and the insurer has responded. *See Am. Ins. Co.*, 699 F. Supp. 2d at 1359 (noting existence of coverage decision that defendant "refused to accept"); *see also CSX Transp., Inc. v. Admiral Ins. Co.*, 1996 WL 33569825, at *4 (M.D. Fla. 1996) (similarly distinguishing *Atlanta Gas*).

### B. The Self-Serving Declaration of TeamHealth's SVP That He Does Not Have a "Present Intent" to Sue United in Georgia Does Not Negate the Live Controversy That United Seeks to Resolve

Defendants also offer up a self-serving declaration of TeamHealth's SVP in an attempt to establish that TeamHealth's previously tendered threats of litigation are no longer operative. *See* Bristow Decl., Dkt. 29-1, ¶ 8 (declaring that

TeamHealth presently has no intent to sue United in Georgia). The effort is ineffective. First, Bristow's declaration must be read in conjunction with his subsequent refusal ***just last month*** to withdraw TeamHealth's CEO's threat, which United afforded him the opportunity to do in a letter. Exs. A & B to Decl. of G. Jacob. Second, courts consistently reject self-serving declarations regarding intentions to litigate as devices for defeating subject matter jurisdiction over DJA claims. When a potential litigant "'has engaged in a course of conduct that shows a preparedness and willingness' [to sue],' it may not later deny its intent to sue merely to defeat jurisdiction over a declaratory action." *YKK Corp. of Am., Inc. v. Silver Line Bldg. Prod. Corp.*, 2007 WL 9711195 at *4 (S.D. Ga. 2007) (quoting *SanDisk Corp. v. STMicroelectronics, Inc.*, 480 F.3d 1372, 1383 (Fed. Cir. 2007)).

For example, in *C.R. Bard, Inc. v. Schwartz*, the court rejected a DJA defendant's attempt to defeat subject matter jurisdiction with a self-serving affidavit because:

> An examination of the affidavit shows that its words were carefully chosen and did not negate the possibility of an infringement action. That affidavit said [Defendant] had and has no intention of terminating the license agreement or suing for infringement. Intentions, however, may change over time. [Defendant] did not say that he would not terminate the agreement and would not bring an infringement suit. . . . He would only say that on the facts presently known to him he would not sue.

716 F.2d 874 (Fed. Cir. 1983). Bristow presents the identical fact pattern. His carefully chosen words disclaim only a ***present*** intent to litigate and deliberately

avoid renouncing the possibility of later litigation. As in *C.R. Bard*, such artful language cannot negate a live controversy because "intentions, however, may change over time," 716 F.2d at 881–82, especially when they are not memorialized "into a binding, judicially enforceable agreement" not to sue (which Bristow has refused here). *Kidder, Peabody & Co. v. Maxus Energy Corp.,* 925 F.2d 556, 563 (2d Cir. 1991) (holding that defendant could not defeat subject matter jurisdiction by representing that he would not an action because his representation was not enforceable and that DJA action was the appropriate way to settle the controversy).

In any event, because the DJA "was designed to fix the problem that arises when the other side does not sue," Bristow's professed "present intent" concerning Defendants' litigation plans are "not the measure of Article III standing in a declaratory judgment case." *Ucp Int'l Co. v. Balsam Brands Inc.*, 252 F. Supp. 3d 828, 832–33 (N.D. Cal. 2017) (holding DJA defendant's statement that it "is not interested in suing" did not defeat subject matter jurisdiction); *Brooks v. Flagg Bros., Inc.*, 63 F.R.D. 409, 413 (S.D.N.Y. 1974). Bristow's declaration is exactly the type of fleeting, non-binding representation that courts have recognized does not eliminate a party's "well-grounded fear that, should it continue its course of action, a suit may result." *United Merchants & Mfrs., Inc. v. Henderson*, 495 F. Supp. 444, 446 (N.D. Ga. 1980) ("statement that [defendant] had no intention of filing or threatening a lawsuit . . . does not negate the existence of a controversy"

where prior threats had put plaintiff in "a position of reasonable apprehension"); *Nike*, 663 F.3d at 95–96 (decision to hold "litigation in abeyance" and even "forestall litigation indefinitely . . . does not eliminate the case or controversy" (citing *MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 128 (2007)).

## II. THE COURT SHOULD EXERCISE ITS DISCRETION TO GRANT DECLARATORY RELIEF

Defendants also urge dismissal in the Court's discretion because, they say, the ERISA preemption issue has already been definitively resolved by other courts against United and because there are no ongoing claim submissions for which a declaration would be useful. Neither suggestion is persuasive.

### A. The ERISA Preemption Issue Is Far From Resolved in Defendants' Favor, and the Disarray Among Trial Courts Only Reinforces United's Need for Relief

Defendants argue that there is no need for a declaration because the "issue has been adjudicated again and again" in other states "with courts consistently recognizing" that state-law claims like the ones Defendants threaten "are not preempted." Mot. 20. True enough, a number of state trial courts have misapplied ERISA's express preemption clause—defending their home states' parochial interest in expanding the reach of state law. But the courts are, in fact, divided, and the particular set of state court decisions on which Defendants rely are demonstrably incorrect because they ignore that ERISA's "expansive pre-emption provisions" are expressly aimed at allowing uniform administration of ERISA

benefit plans nationwide, *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004), and plainly disable healthcare staffing companies like Defendants from relying on state laws to dictate plan benefit amounts. *See Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1193, 1198 (10th Cir. 2023) ("ERISA's promise of uniformity is vitally important for employers, who 'have large leeway to design . . . plans as they see fit.'") (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003)). It is precisely this confusion, as between itself and Defendants, that United properly seeks to resolve.

While there is no need for the Court to definitively resolve the core preemption question framed by United's Amended Complaint in order to deny Defendants' Motion to Dismiss, the declaration United seeks is supported by the text of ERISA's express preemption clause, which states that its provisions "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) (emphasis added). The Supreme Court has repeatedly declared that this clause, which must be given "common-sense meaning," is of "conspicuous [] breadth." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138–39 (1990). Its preclusive force is "not limited to 'state laws specifically designed to affect employee benefit plans,'" *Pilot Life v. Dedaux*, 481 U.S. 41, 47–48 (1987), but rather extends to any state law having "a connection with or reference to" an ERISA plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147

(2001) (quotation omitted); *see also New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 653 (1995). And the clause supersedes not only state statutes and regulations but also state common law doctrines that litigants may seek to invoke to override or supplement the terms of a plan. *See Pilot Life*, 481 U.S. at 47–48, 57; *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *AMISUB (SFH), Inc. v. Cigna Life & Health Ins. Co.*, 2023 WL 8232887 at *8–9 (W.D. Tenn. 2023). Particularly suspect are laws that "interfere[] with nationally uniform plan administration," or that "force an ERISA plan to adopt a certain scheme of substantive coverage." *Rutledge v. Pharma. Care Mgmt. Assoc.*, 592 U.S. 80, 87 (2020); *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016) (quoting *Egelhoff*, 532 U.S. at 148, and *Travelers*, 514 U.S. at 668). For instance, the Supreme Court has held that ERISA preempts state laws regulating a plan's "method of calculating . . . benefits." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814–15 (1997).

The Non-Contractual State Law Claims that Defendants threaten here plainly "relate to" the ERISA-governed Plans that United administers in Georgia. As United has no independent contractual relationship with Defendants, the reimbursement remitted from anyone other than the patients who received the services exist ***only*** because United administers benefit claims for the Plans in Georgia. This was the logic the Eleventh Circuit applied in upholding an

injunction against enforcement of a Georgia prompt payment law against self-funded ERISA plans. *See Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324, 1331–32, n.18 (11th Cir. 2014); *see also Michael M. v. Nexsen Pruet Grp. Med. & Dental Plan*, 2021 WL 1026383, at *8 (D.S.C. 2021) ("While a comprehensive Group Health Plan must fulfil its obligations under the Plan, it is not required to pay for every medical treatment a participant . . . might receive."); *Catholic Diocese v. Blue Cross, Blue Shield*, 960 F. Supp. 1145, 1151 (S.D. Miss. 1997) (same). When Non-Contractual State Law Claims are used to compel reimbursement at full billed charges (rather than, to take the terms of one Georgia Plan as an example, "based on the reasonable and customary rate and ***not the amount charged by the provider***," Am. Compl. ¶ 39 (quoting Plan B)), state law effectively compels a "scheme of substantive coverage" different than the one adopted by the Plan. And as many of the Plans at issue have members receiving medical care outside of Georgia, *see id*. ¶ 16, such Non-Contractual State Law Claims would—if allowed despite ERISA—threaten United's ability to ensure "nationally uniform plan administration." *Egelhoff*, 532 U.S. at 148.

Courts have regularly found that state law claims are expressly preempted when, as here, a claimant is using state law to obtain additional reimbursement from a party based solely on the party's connection to an ERISA plan. For example, in *Advanced Orthopedics and Sports Medicine Institute, P.C. v. Oxford*

*Health Insurance, Inc.*, the court held promissory estoppel and unjust enrichment claims expressly preempted because the claims inescapably "flow[ed] from the insured's plan which provides coverage for services provided by out-of-network providers" but at a "lower level of benefits" than the claimant demanded. 2022 WL 1718052, at *3–8 (D.N.J. 2022). Likewise, in *Nathaniel L. Tindel, M.D., LLC v. Excellus Blue Cross Blue Shield*, the court held an unjust enrichment claim expressly preempted because the "benefit conferred, if any, [on the insurer] was the discharge of the obligation the insurer owes to the insured" and, thus, the court would need to "find that 'an ERISA Plan exists' in order to demonstrate that Defendant 'received a benefit.'" 2023 WL 3318489, at *4–7 (N.D.N.Y. 2023) (citing *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 240–42 (3d Cir. 2020)); *see also Nat'l Renal All., LLC v. Blue Cross & Blue Shield of Georgia, Inc.,* 598 F. Supp. 2d 1344, 1361 (N.D. Ga. 2009) (state law claims preempted because they allege "wrongful denial of benefits promised under an ERISA" plan).

Defendants emphasize that many trial courts have—largely in interlocutory decisions—allowed Non-Contractual State Law Claims like those threatened by Defendants to proceed to discovery or even trial. *E.g.*, Mot. 20, n. 15. By and large, however, these decisions erroneously apply principles drawn from ERISA's distinct and more narrow "complete preemption" doctrine in interpreting the reach

of ERISA's express preemption clause.[7] ERISA's separate "complete preemption" doctrine allows state-court complaints to be recharacterized as federal in nature and thus removed to federal court, *Davila*, 542 U.S. at 209; *Pilot Life*, 481 U.S. at 52, if (and only if) the plaintiff could have brought a claim for benefits under ERISA, and no other independent legal duty is implicated. *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1344–45 (11th Cir. 2009).

Two important limitations cabin ERISA's complete preemption doctrine that have no place in ERISA's express preemption analysis. First, courts have held complete preemption inapplicable unless the provider has been legally assigned the patient's claims for plan benefits—and thus is in a position to press an ERISA claim. *N.J. Plastic Surgery Ctr., LLC v. 1199 SEUI Nat'l Benefit Fund*, 2023 WL 5956142, at *4 (S.D.N.Y. 2023). Second, where a provider claims to have an agreement with the claims administrator dictating payment amounts for specific

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[7] *See, e.g., Surgery Ctr. Of Viera, LLC v. Cigna Health and Life Ins. Co.*, 2023 WL 375556, at *5 (M.D. Fla. 2023) (finding state law claims expressly preempted by ERISA and decrying confusion among other courts caused by providers' "bait-and-switch" tactics that conflate complete and express preemption analyses); *see also Ervast v. Flexible Products Co.*, 346 F.3d 1007, 1013–14 & n.7 (11th Cir. 2003) (similar); *Cotton v. Mass. Mut. Life Ins. Co.*, 402 F.3d 1267 (11th Cir. 2005) (similar). Needless to say, Defendants' assertion (Mot. n.16) that only one "outlier" court has found ERISA to expressly preempt Non-Contractual State Law Claims like those at issue here is plainly wrong. *See* pp. 17–19, *supra*; *see also Sarasota Cnty. Pub. Hosp. Bd. v. Blue Cross & Blue Shield of Fla., Inc.*, 2020 WL 5898978, at *6 n.8 (M.D. Fla. 2020) (since *Travelers* was decided, "no decision . . . holds that ERISA *per se* never defensively preempts a provider's breach of contract claim or another state-law claim against an ERISA plan administrator.").

services and merely seeks to enforce the contracted payment amounts, courts have held that disputes over the contracted payment rates (denoted "rate of payment" disputes, to be contrasted with "right to payment" disputes) are governed by state contract principles, not by ERISA. *See id.* at *20; *Plastic Surgery Ctr.*, 967 F.3d at 229–33; *Marin General Hospital v. Modesto & Empire Traction, Co.*, 581 F.3d 941 (9th Cir. 2009). As the court explained in *Surgery Center of Viera, LLC v. Cigna Health*, however, "recent case law has established the rate/right distinction, ***but only in complete preemption cases***," and thus any suggestion that this applies to express preemption is "a bait-and-switch" that "invites the Court into error by intentionally conflating the jurisdictional analysis necessary in removal cases with the 'related to' analysis appropriately applied to defensive preemption claims." 2020 WL 4227428, at *2–3 (M.D. Fla. 2020) (emphasis added); *Evans v. Infirmary Health Servs., Inc.*, 634 F. Supp. 2d 1276, 1289–90 (S.D. Ala. 2009) ("Defendant's arguments conflates these distinct analyses."); *York v. Ramsay Youth Servs. of Dothan*, 313 F. Supp. 2d 1275, 1280–81 (M.D. Ala. 2004) ("existing case law contributes to the morass that is ERISA law by confusing defensive preemption . . . with complete preemption"); *Wilson v. Coman*, 284 F. Supp. 2d 1319, 1331–32 n.6 (M.D. Ala. 2003) ("a court must take pains not to apply the [wrong] test").

Some trial courts have misinterpreted *Rutledge*, the Supreme Court's latest pronouncement on the scope of ERISA's express preemption clause, to hold that

state laws that specify the ***amounts*** that plans must pay for covered services (but that do not dictate which services are covered) are insulated from ERISA preemption. *See, e.g.*, *Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 2023 WL 2257961, at *5 (S.D. Fla. Feb. 28, 2023). Defendants offer that view. *See* Mot. 3 & n.6, 20 & n.15. But *Rutledge* does nothing of the sort. *Rutledge* addressed a state law prescribing the minimum total amount that pharmacy benefit managers were required to pay pharmacists to ensure that their costs were covered—but that did not "adopt a certain scheme of coverage," impose any direct obligation on any ERISA plan, or "require the plans to provide any particular benefit to any particular beneficiary in any particular way." 592 U.S. at 83–84, 88–90; *Griffin v. AT&T Servs., Inc.*, 2023 WL 3213550, at *6 (N.D. Ga. 2023) ("*Rutledge*, if anything, reinforces the notion that state laws cannot dictate ERISA-governed plan terms.").

Defendants' threatened Non-Contractual State Law Claims go beyond the limits *Rutledge* expressly drew. While *Rutledge* might allow a state to enforce a law requiring ***patients*** to pay Defendants' full billed charges for their services, what Defendants seek through their Non-Contractual State Law Claims is to compel ***ERISA plans***, alone, to cover the entirety of those billed charges as plan benefits. Georgia law cannot regulate the amount a plan must pay. *See Am.'s Health Ins.*, 742 F.3d at 1331–34 (preempting Georgia law that directly regulated

"the amount paid" by third-party administrators on behalf of the benefit plans they administered (emphasis omitted)).

If the Amended Complaint proceeds as United requests, United will provide a full airing of its express preemption arguments in an early motion for summary judgment. For now, it suffices to note that the confusion among trial courts that has led to Defendants' expressed conviction that they are lawfully entitled to millions of dollars of additional reimbursement is a compelling reason for the Court to provide the requested declaratory relief. *See, e.g., C.R. v. Noggle*, 559 F. Supp. 3d 1323, 1342 (N.D. Ga. 2021) (DJA action should proceed when "'the judgment will serve a useful purpose in clarifying and settling the legal relations in issue,' and . . . a declaratory judgment 'will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding.'"). United and other similarly-situated health insurers need to know they may, as ERISA instructs, continue to administer benefit plans according to their terms.

### B. Declaratory Relief Would Be Valuable in Resolving Disputes Over Ongoing Health Benefit Claims Adjudication

Defendants also wrongly suggest that their dispute with United is limited to the types of claims that United has excluded from its Am. Complaint. Mot. 18–19. Specifically, they claim that when their affiliates have sued United, they have limited the scope of their actions to "emergency medical services or non-emergent

anesthesia services delivered at in-network hospitals." Mot. 18–19. That argument is unavailing for two independent reasons.

First, United ***is*** seeking declaratory relief as to reimbursement for emergency services and non-emergent services delivered at in-network hospitals—the exact claims for which Defendants concede their affiliates have brought litigation against United in other states. The Amended Complaint expressly includes claims for such services that were rendered prior to January 1, 2022, and Defendants do not deny the pleadings put at issue millions of dollars in such claims. Mot. 19 n. 14; *see* Am. Compl. ¶¶ 46–49. Because litigation by Defendants on these claims would be timely under applicable Georgia statutes of limitations,[8] a declaration would clarify United's (and the Plans') obligations regarding the further reimbursement Defendants have demanded. *See Am. Ins. Co.*, 699 F. Supp. 2d at 1359 (holding that dispute over "determination of coverage issues" related to historical claims "sufficed as a justiciable controversy"); *State Farm*, 542 F. Supp. at 817 (similar).

Second, while United seeks no relief as to claims that are subject to the No Surprises Act's dispute resolution provisions, United does seek to clarify its responsibilities with respect to other ongoing claims from Defendants—that is,

[8] For example, the statute of limitations for claims for unjust enrichment and quantum meruit in Georgia is four years. *See* O.C.G.A. § 9-3-26, § 9-3-26.

claims for ***non-emergency*** services at ***non-network*** facilities.[9] The Amended Complaint alleges that Defendants continue to demand reimbursement at full billed charges for such claims too, Am. Compl. ¶¶ 9, 48, 52, 56, 62, and Defendants conspicuously do not dispute these allegations. In the face of Defendants' continuing demands, United faces the same impossible choice with respect to these ongoing claims, because the state law principles underpinning Defendants' theories are not by any means confined to services rendered at in-network facilities. *See, e.g.*, *Nat'l Alliance, LLC v. Blue Cross and Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1347, 1361 (N.D. Ga. 2009) (state law claims for out-of-network dialysis center services); *S. Broward Hosp. Dist. v. ELAP Servs*., LLP, 2023 WL 6547748 (S.D. Fla. 2023) (state law claims for out-of-network hospital services). And reinforcing United's continuing dilemma, the reimbursement provisions applicable to out-of-network services under many of the Plans are the same for emergency and non-emergency services alike. *See* Am. Compl. ¶¶ 39–41. Declaratory relief is accordingly necessary and warranted for these ongoing claims.

## **CONCLUSION**

Defendants' Motion to Dismiss the Amended Complaint should be denied.

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[9] The federal No Suprises Act provides an alternative dispute resolution mechanism for claims provided on or after January 1, 2022. *See* 42 U.S.C. § 300gg-111; *see also* Requirements Related to Surprise Billing, 87 F.R. 52618, 52619 (Aug. 26, 2022) (codified at 26 C.F.R. § 54, 149, 2590). United seeks no declaration concerning such claims. Am. Compl. ¶ 47.

Respectfully submitted,

Dated: February 22, 2024

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**LOCAL RULE 7.1(D) CERTIFICATION**

In accordance with L.R. 7.1(D), the undersigned counsel hereby certifies that, consistent with L.R. 5.1C, the foregoing document was prepared in Times New Roman font, 14 point.

*/s/ Greg Jacob*
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**CERTIFICATE OF SERVICE**

I hereby certify that I have this day 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 22nd day of February, 2024.

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