UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
GREENEVILLE DIVISION

BALLAD HEALTH, et al., Plaintiffs, v. UNITEDHEALTH GROUP INCORPORTATED, et al., Defendants.	No. 2:25-CV-176-DCLC-CRW

REPLY SUPPORTING THE MOTION TO COMPEL ARBITRATION, OR ALTERNATIVELY, TO DISMISS THE COMPLAINT FOR LACK OF PERSONAL JURISDICTION AND FAILURE TO STATE A CLAIM

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INTRODUCTION

This is not a creative-writing class. This is federal court. You wouldn't know that from Ballad Health's brief. Faced with the reality that it ignored binding arbitration clauses to pursue a PR stunt in this Court, Ballad Health now argues that its lawsuit is in service of the public good.

There is, of course, a reason for Ballad Health's retreat to vague arguments about the public good. Ballad Health has no answer—not even a bad one—for the facts in front of it: Ballad Health and its affiliated hospitals agreed to arbitrate "[redacted]" claims with United. That includes claims relating to United's Medicare Advantage membership. Inasmuch as Ballad Health suggests that arbitration agreements are against public policy when they reach Medicare-related claims, no case supports that contention.[1] And literally dozens of cases say the opposite.

The rest of Ballad Health's arguments are cut from the same cloth. This Court should dismiss the Complaint and compel arbitration.

ARGUMENT

I. BALLAD HEALTH'S CLAIMS ARE SUBJECT TO BINDING ARBITRATION.

A. Ballad Health concedes that the arbitration agreements govern its claims.

Courts compel arbitration when parties have agreed to arbitrate. *See AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 339 (2011). The parties' contracts mandate arbitration of "[redacted]" claims. Opp. at 7–8; *see*, *e.g.*, *Jernigan v. RSS/Manchester Operations, LLC*, 2023 WL 6053059, at *2–4 (E.D. Tenn. Sep. 15, 2023) (Corker, J.) (compelling arbitration where agreement applied to "[a]ny and all claims"). Ballad Health does not dispute that point.

[1] Ballad Health cites a handful of off-topic, forty-year-old cases and one Northern District of California case about litigation between a local prosecutor and a criminal suspect.

B. Ballad Health's public policy arguments are frivolous.

Undeterred, Ballad Health argues that (i) arbitration violates public policy because their Medicare Advantage-related claims require "transparency" and (ii) its material breach allegations excuse noncompliance with the arbitration clause. Both arguments are frivolous.[2]

1. Public policy favors arbitration.

Ballad Health argues that the arbitration provisions are against public policy because they undermine "transparency" in the Medicare Advantage program. Opp. 9. But Ballad Health does not cite a single case supporting that contention. There isn't one.[3] And on the other side of the ledger, there are dozens upon dozens of judicial decisions compelling arbitration in cases relating to Medicare claims. *See, e.g.*, *Shy v. Navistar Int'l Corp.*, 781 F.3d 820 (6th Cir. 2015) (reversing district court order and compelling arbitration of dispute involving classification of Medicare Part D subsidies); *Houston Cnty. Health Care Auth. v. UnitedHealthcare Ins. Co.*, 2025 WL 3657195, at *2–5 (M.D. Ala. Dec. 17, 2025) (compelling arbitration of dispute between UnitedHealthcare and a hospital over reimbursement rates for Medicare Advantage enrollees); *JPMorgan Chase Bank, N.A. v. Okla. Oncology & Hematology, P.C.*, 2007 WL 646372, at *5 (S.D. Tex. Feb. 26,

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[2] Ballad Health agrees that the party opposing arbitration "must show a genuine issue of material fact as to the validity of the agreement to arbitrate." Opp. at 6 (citing *Great Earth Cos. v. Simons*, 288 F.3d 878, 889 (6th Cir. 2002) (citation omitted)). A party "may not rely solely on the pleadings and must adduce more than a mere scintilla of evidence" to show a genuine issue of material fact. *See Thompson v. Ashe*, 250 F.3d 399, 405 (6th Cir. 2001). But in opposing arbitration, Ballad Health has presented only policy arguments—not evidence.

Ballad Health has also abandoned its argument that the arbitration agreements "constitute unlawful contracts of adhesion." Compl. ¶ 99. That argument was also baseless. *See Seawright v. Am. Gen. Fin., Inc.*, 507 F.3d 967, 976 (6th Cir. 2007).

[3] The *Elevance Health, Inc. v. Becerra*, 736 F.Supp.3d 1, 5–6 (D.D.C. 2024), and *In re Blackburne*, 87 N.Y.2d 660, 664 (1996), cases that Ballad Health cites don't support its argument. *Elevance Health* has nothing to do with arbitration; it mentions "transparency" only to say that "CMS decided to . . . improve transparency within the [Stars Ratings] program." *Id.* at 6. And *Blackburne* was about the Hatch Act; it had nothing to do with Medicare. *See* 87 N.Y.2d at 664–66.

2007) (compelling arbitration and rejecting argument that arbitration of dispute implicating Medicare contravenes public policy because "disputes involving healthcare and Medicare/Medicaid statutes are routinely submitted to arbitration").[4]

The few cases that Ballad Health cites don't hold otherwise. Ballad Health cites *Board of Education, Hunter-Tannersville Center School District v. McGinnis*, 475 N.Y.S.2d. 512, 515–17 (NY. App. Div. 1984), but that court refused to stop an arbitration and explained that any public-policy exception "has been sparingly applied to stay arbitration or vacate awards . . . because of the countervailing policy in favor of arbitration as an expeditious and economical alternative method of resolving legal disputes." *McGinnis*, 475 N.Y.S.2d at 515. The court explained that "judicial interference *in advance of the arbitration process* may only be justified if 'the arbitrators could not grant any relief without violating public policy.'" *Id.* (emphasis added). And "the public policy at issue must be a strong one, amounting to gross illegality or its equivalent, generally to be found in a readily identifiable source in the statutes or common-law principles." *Id*. (cleaned up).

There is nothing like that here. Although Ballad Health argues that Tennessee Law applies, it offers no Tennessee law supporting its argument that the arbitration provisions violate public policy. For good reason: Tennessee law, like federal law, favors arbitration. *See, e.g.*, Br. at 8–9.

[4] *See also, e.g.*, *Osterhaus Pharm., Inc. v. UnitedHealth Grp. Inc.*, 2025 WL 3280347 (W.D. Wash. Nov. 25, 2025); *Nitta v. Haw. Med. Serv. Ass'n*, 575 P.3d 547 (Haw. 2025); *Caremark, LLC v. N.Y. Cancer & Blood Specialists*, 740 F.Supp.3d 340 (S.D.N.Y. 2024); *Bd. of Trs. of the Univ. of Ala. v. Humana, Inc.*, 2024 WL 1748434 (N.D. Ala. Apr. 23, 2024); *Mansour v. Freedom Health, Inc.*, 2024 WL 551950 (M.D. Fla. Feb. 12, 2024); *Salerno Med. Assocs., LLP v. Riverside Med. Mgmt., LLC*, 542 F. Supp. 3d 268 (D.N.J. 2021); *Spanos v. Kaiser Found. Health Plan*, 2019 WL 7945608 (C.D. Cal. Sep. 25. 2019); *Enivision Ins. Co. v. Khan*, 2014 WL 12868890 (M.D. Fla. Feb. 25, 2014); *Pacificare of Nev., Inc. v. Rogers*, 266 P.3d 596 (Nev. 2011); *Drissi v. Kaiser Found. Hosps., Inc.*, 543 F. Supp. 2d 1076 (N.D. Cal. 2008); *Clay v. Permanente Med. Grp. Inc.*, 540 F. Supp. 2d 1101 (N.D. Cal. 2007); *Health Ins. Corp. of Ala. v. Smith*, 869 So.2d 1100 (Ala. 2003); *THI of N.M., LLC v. Spradlin*, 893 F. Supp. 2d 1172, 1184 (D.N.M. 2012) (collecting cases compelling arbitration *because* receipt of Medicare payments constitutes interstate commerce).

Ballad Health also cites *Breazeale v. Victim Services, Inc.*, 198 F. Supp. 3d 1070 (N.D. Cal. 2016). But that case addressed an arbitration agreement between criminal suspects and a prosecutor related to criminal diversion. *Id.* at 1073–75. The court struck that agreement because it prevented public access to "abuses of the policy power" and limited judicial review of law enforcement power. *Id.* at 1080–81. That case has nothing to do with the agreements here [5]

The bottom line: Ballad Health invented a public-policy rationale for disregarding arbitration agreements because it wanted to publicize its lawsuit against United. There is no precedent, no statute, no authority supporting Ballad Health's argument that the arbitration agreements are void because this litigation involves Medicare.

2. Ballad Health's "material breach" argument makes no sense.

Ballad Health's argument that the arbitration provisions are unenforceable because United allegedly breached the agreements is nonsensical. If mere allegations of breach of contract were enough to avoid arbitration, there would be no arbitration. Courts often compel arbitration in cases in which the plaintiff alleges that the defendant breached a contract.[6] Indeed, most arbitrations involve that kind of claim. And in any case, [redacted]

[5] Ballad Health's other cases are no better. *Board of Education v. Areman*, 362 N.E.2d 943, 946–48 (N.Y. 1977), and *Beynon v. Garden Grove Medical Group*, 100 Cal.App.3d 698, 712 (Ct. App. 1980), also had nothing to do with Medicare.

[6] *See, e.g.*, *Mallory v. Consumer Safety Tech. LLC*, 2024 WL 3897144 (E.D. Tenn. Aug. 21, 2024); *J&J Global Invs., L.P. v. Zip-Flyer, LLC*, 2022 WL 19714588 (E.D. Tenn. Nov. 28, 2022); *Swift Enters., LLC v. Trunorth Warranty Plans of N. Am., LLC*, 2022 WL 19396072 (E.D. Tenn. Sep. 30, 2022); *Green v. U.S. Xpress Enters., Inc.*, 434 F. Supp. 3d 633 (E.D. Tenn. 2020); *Capitalplus Equity v. Tutor Perini Corp.*, 2019 WL 3779529 (E.D. Tenn. Feb. 15, 2019).

None of Ballad Health's three cited cases involved an arbitration agreement—let alone held that an arbitration agreement could be invalidated based on allegations of material breach. *See Jackson v. State Farm Fire & Cas. Co.*, 461 F. App'x 422, 425–27 (6th Cir. 2012); *Costello v. Lungaro*, 1995 WL 290249, at *2–3 (6th Cir. May 11, 1995); *A & P Excavating & Materials, LLC v. Geiger*, 622 S.W.3d 237, 253 (Tenn. Ct. App. 2020). Because UHIC and Ballad Health agreed to binding arbitration clauses, it is the arbitrator's duty to determine if any party breached the contracts.

II. THIS COURT LACKS PERSONAL JURISDICTION OVER UHG.

Ballad Health does not dispute that this Court lacks general jurisdiction over UHG. But it argues that this Court can exercise specific jurisdiction over UHG because UHIC entered the arbitration agreements both for itself and for other United affiliates. Opp. at 11. Thus, Ballad Health reasons that UHG was obligated to pay for covered medical services rendered. *Id.*

But UHG is not a party to either agreement. Only UHIC contracted with Wellmont Health System and Mountain States Health Alliance. *See* Ex. 1 at 1; Ex 2 at 1. That the agreements mention UHG does not establish that UHG has suit-related contacts creating a substantial connection with Tennessee. *See Walden v. Fiore*, 571 U.S. 277, 284 (2014) ("[The substantial relationship must arise out of contacts the defendant *himself* creates with the forum State.").

Ballad Health does not allege that UHG had substantial, suit-related contact with Tennessee. The only allegations about UHG focus on its status as UHIC's corporate parent. Compl. ¶¶ 1, 9, 17–18. Ballad Health does not identify *any* contractual obligations binding UHG or suit-related actions connecting it to Tennessee. And Ballad Health's novel argument (which appears for the first time in its response) that UHG was required to pay Ballad Health for medical services has no basis in the Complaint or in the parties' agreements (which this Court can consider

as part of the Complaint). *See Luis v. Zang*, 833 F.3d 619, 626 (6th Cir. 2016) ("In evaluating a motion to dismiss, we 'may consider the complaint and any exhibits attached thereto . . . so long as they are referred to in the complaint and are central to the claims contained therein.'"). Ballad Health lumped UHIC and UHG together in its Complaint (Compl. ¶ 19) and then leveled all its allegations at "United." That approach violates basic corporate law (*see, e.g.*, *United States v. Bestfoods*, 524 U.S. 51 (1998)), and offers no nexus between UHG, Tennessee, and Ballad Health's claims. The Court lacks personal jurisdiction over UHG and should dismiss claims against it.

III. THE MEDICARE ACT PREEMPTS BALLAD HEALTH'S CLAIMS.

The Medicare Act and its regulations govern the medical-necessity, appeals-timing, and payment issues that Ballad Health raises. Ballad Health's claims are "directly governed by federal standards."[7] *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1158 (9th Cir. 2010), so the Medicare Act preempts them. Ballad Health resists that conclusion, arguing that United "ignores the relevant case law." Opp. at 13 (citing, among other cases, *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004)). But *RenCare* was about federal jurisdiction and exhaustion of administrative remedies, not about preemption under the Medicare Act's express preemption provision. *See* 42 U.S.C. § 1395w-26(b)(3); *see also* 42 C.F.R. § 422.402 (similar). The *RenCare* court never addressed that preemption provision. *Houston Methodist Hospital v. Humana Insurance Co.* is instructive on *RenCare*'s limits. 266 F. Supp. 3d 939, 951 (S.D. Tex. 2017)

[7] Ballad Health accuses United of "misstat[ing] the relevant statute" governing coverage exclusions because 42 U.S.C. § 1395y(a)(1)(A) references only Part A and B services, not Part C. But the regulations cited with that statute (42 C.F.R. § 422.100(a); 422.100(c)(1)) subject Part C plans to the same coverage standards as Part A and B. *See, e.g.*, *Fournier v. Sebelius*, 718 F.3d 1110, 1114 (9th Cir. 2013); *Williams v. Aetna Better Health of Ohio*, 2024 WL 3925879, at *2–3 (S.D. Ohio Aug. 22, 2024); *McCue v. Sec'y of Health & Human Servs.*, 2019 WL 150540, at *4 (D. Me. Jan. 4, 2019). And it's undisputed that the Medicare Act's preemption provision applies to disputes under Medicare Part C. *See, e.g., Hou. Methodist*, 266 F. Supp. 3d at 946–47; *Williams*, 2024 WL 3925879, at *2–3.

(explaining that "*RenCare* did not address express preemption under 42 U.S.C. § 1395w-26(b)(3), but instead addressed the question of whether the claims at issue there were 'claims arising under' the Medicare Act . . . and whether the Medicare Act's exhaustion of administrative remedies requirements gave rise to federal question jurisdiction, subjects that are not at issue in this case."); *see also Gen. Surgical Assocs., P.A. v. Humana Health Plan of Tex., Inc.*, 2015 WL 1880276, at *8 (W.D. Tex. Mar. 17, 2015) ("*RenCare* does not address the express preemption provision at issue here."), *R&R adopted*, 2015 WL 1880298 (W.D. Tex. Apr. 23, 2015).

Ballad Heath also argues that *RenCare* limits the Medicare Act's broad preemption provision to disputes brought by enrollees. Opp. at 13. That is wrong. Courts often hold that the Medicare Act preempts claims by providers. *See, e.g.*, *Hou. Methodist*, 266 F. Supp. 3d at 951–52; *Gen. Surgical Assocs.*, 2015 WL 1880276, at *8; *Cent. Orthopedic Grp., LLP v. Aetna Life Ins. Co.*, 2025 WL 2614971, at *2 (E.D.N.Y. Sep. 9, 2025); *S. Tex. Health Sys. v. Care Improvement Plus of Tex. Ins. Co.*, 2015 WL 9257021, at *6 (S.D. Tex. Sept. 28, 2015).

IV. THE COMPLAINT ALSO FAILS THE APPLICABLE PLEADING STANDARDS.

Ballad Health has not pleaded sufficient facts supporting its claims.[8]

A. The breach-of-contract claims (Counts II, III, & IV) fail on their face.

Starting with Count II, Ballad Health argues that it adequately alleged that UHIC breached its contractual obligations through "excessive medical necessity denials." Compl. ¶¶ 112–18. Ballad Health offers that, sometime in June 2025, UHIC determined that emergency room admissions for three unnamed patients were unnecessary. Compl. ¶ 100. Ballad Health does not say what claims were denied or why or whether those patients were Medicare Advantage members.

In Count III, Ballad Health offers no factual allegations at all, alleging only that UHIC

[8] Of course, the Court doesn't need to assess the Complaint's pleading deficiencies if it compels arbitration because the arbitration agreements leave weighing the claims' merits for the arbitrator.

breached the agreements by not timely responding to appeals. Compl. ¶¶ 119–25. But it does not allege facts about a single instance in which United supposedly took too long to respond.

Count IV is more of the same. Ballad Health alleges that UHIC breached the agreements by not making bed-day payments. Compl. ¶¶ 126–30. It argues that it has done enough to plead the claim because the contracts "require United to pay a per diem rate . . . yet United failed to remit the full amounts due." Opp. at 22. But the Complaint does not include factual allegations about a single missed or deficient payment, nor does it identify how many payments are at issue. Labels and conclusory allegations are not enough to sustain the breach-of-contract claims.

B. Ballad Health's response confirms that Count VI fails.

In Count VI, Ballad Health asserts a claim for breach of the duty of good faith and fair dealing. Compl. ¶¶ 131–36. Ballad Health argues that United's objection to Count VI is with its "labelling" and not the actual merits of the claim. Opp. at 24. That is wrong. The *Cadence Bank, N.A. v. Alpha Trust* case that Ballad Health cites explains that "a claim based on the implied covenant of good faith and fair dealing is not a stand[-]alone claim; rather, it is part of an overall breach of contract claim." 473 S.W.3d 756, 759, 773 (Tenn. Ct. App. 2015). In *Haley v. Bank of America, N.A.*, the district court dismissed a stand-alone claim based on the implied covenant of good faith and fair dealing at the motion to dismiss stage in reliance on *Cadence*. 2019 WL 13159817 at *8 (E.D. Tenn. July 10, 2019). This Court should do the same.

C. Count V fails because Ballad Health has not pleaded fraud with 9(b) particularity.

Ballad Health likewise fails to plead its fraud claims consistent with Rule 9(b) particularity. It claims to have met the requirement to "specify the 'who, what, when, where, and how' of the alleged fraud." *Greer v. Strange Honey Farm, LLC*, 114 F.4th 605, 614 (6th Cir. 2024) (quoting *Sanderson v. HCA*, 447 F.3d 873, 877 (6th Cir. 2006)). But Ballad Health's response confirms that

the Complaint lacks those details.

Ballad Health's claim that the "what" is "false representations concerning lawful administration of Medicare Advantage benefits and claims handling" fails to "specify the statements that the plaintiff contends were fraudulent." *New London Tobacco Mkt., Inc. v. Ky. Fuel Corp.*, 44 F.4th 393, 411 (6th Cir. 2022) (quoting *Frank v. Dana Corp.*, 547 F.3d 564, 570 (6th Cir. 2008)). That Ballad Health purports to "identif[y] a timeline" for alleged statements does not state with particularity "where and when the statements were made." *Id.* at 411. Nor has Ballad Health identified the "who"—asserting "the 'who'" is "UnitedHealthcare and UnitedHealth Group" but "never identif[ying] the person who made the allegedly fraudulent misrepresentation . . . is not enough." *Id.* at 411 (citing *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003)); *see also Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012) (affirming dismissal of fraud-based claim for lack of particularized pleading because the allegations referred only to "defendants" en masse).

CONCLUSION

Ballad Health's response confirms it has no basis for pursuing this lawsuit. This Court should dismiss the Complaint in favor of arbitration.

Dated: January 16, 2026

Respectfully submitted,

s/ John E. Winters
John E. Winters (BPR # 016345)
KRAMER RAYSON, LLP
PO Box 629
Knoxville, TN 37901-0629
(865) 524-5134
jwinters@kramer-rayson.com

Brian D. Boone (pro hac vice)
ALSTON & BIRD LLP
Vantage South End
1120 South Tryon Street, Suite 300
Charlotte, NC 28203
(704) 444-1000
brian.boone@alston.com

Esmat Hanano (pro hac vice)
ALSTON & BIRD LLP
One Atlantic Center
1201 W Peachtree St NW, Suite 4900
Atlanta, GA 30309
(404) 881-7000
esmat.hanano@alston.com

Counsel for Defendants UnitedHealth Group Incorporated & UnitedHealthcare Insurance Company

CERTIFICATE OF SERVICE

On this 16th day of January, 2026, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which serves a true and correct copy of the same to all attorneys.

s/ John E. Winters
John E. Winters