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

APOLLO MD BUSINESS SERVICES, L.L.C.; et al.,	:	
Plaintiffs,	:	
	:	CIVIL ACTION NO.
v.	:	1:16-CV-4814-RWS
AMERIGROUP CORPORATION (DELAWARE); et al.,	:	
Defendants.	:	

ORDER

This case comes before the Court on the following motions: Defendants Blue Cross Blue Shield and Amerigroup's Motion to Dismiss [21] and Plaintiff's Motion for Leave to File a Response to that Motion [41]; Plaintiff's Motion for Leave to File a Second Amended Complaint [48] and Peach State's Motion to Dismiss Plaintiff's Second Amended Complaint [62]; and three motions to compel arbitration filed by Defendants United Healthcare [33], Peach State Health Plan [35], and Humana [37]. After reviewing the record, the Court enters the following Order.

Background[1]

This case is about how insurers pay medical providers for the emergency services that federal law requires them to provide. Plaintiff Apollo MD and its affiliates staff emergency departments in hospitals throughout the United States and the state of Georgia. Defendants are various health insurance providers and Care Management Organizations.[2] Plaintiff brings this suit alleging that Defendants are liable for systematic underpayment and non-payment of claims submitted to them for treatment administered to covered patients with emergency medical conditions. The Court will begin with a brief overview of the federal statutes at play, then discuss the facts of this case.

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[1] As the case is before the Court on a Motion for Leave to Amend and a Motion to Dismiss, the Court accepts as true the facts alleged in the complaint. Cooper v. Pate, 378 U.S. 546, 546 (1964).

[2] There are ten Defendants named in this action. For the sake of clarity, the Court will refer to them as follows:

- Amerigroup Corporation ("Amerigroup")
- Blue Cross Blue Shield Healthcare Plan of Georgia and Blue Cross and Blue Shield of Georgia (collectively, "Blue Cross Blue Shield")
- Health Value Management, d/b/a ChoiceCare Network ("ChoiceCare")
- Humana Employers Health Plan of Georgia, Humana Health Plan, and Humana Insurance Company (collectively, "Humana")
- Peach State Health Plan ("Peach State")
- UnitedHealthcare of Georgia and UnitedHealthcare Community Plan of Georgia (collectively, "UnitedHealthcare")

I. Statutory Overview

This case involves several, complex federal statutes. First, the Emergency Medical Treatment and Labor Act ("EMTALA"), which was designed to ensure patients receive prompt emergency medical services regardless of their ability to pay. It requires hospitals with emergency departments to "provide for an appropriate medical screening examination" for individuals who present to the emergency room if "a request is made on the individual's behalf for an examination or treatment for a medical condition." 42 U.S.C. § 1395dd(a). If the hospital determines that the individual has an emergency medical condition, the hospital must, within its means, provide necessary treatment to stabilize the medical condition or transfer the individual to another medical facility. Id. § 1395dd(b).

Of course, in the midst of an emergency, individuals are often unable to select a hospital or doctor on the basis of insurance coverage and often end up receiving treatment from healthcare providers outside of their insurer's network. In that instance, the Patient Protection and Affordable Care Act ("ACA") provides that individuals who receive emergency medical treatment from an out-of-network provider cannot be charged higher copayment or

coinsurance rates simply because they were treated by a provider that was not in their insurer's network. 42 U.S.C. § 300gg-19a(b).

In 2010, the Departments of Labor, Health and Human Services, and the Treasury collectively recognized that patients who received out-of-network emergency treatment were still at a financial risk despite the ACA's protections because providers could "balance bill patients for the difference between the providers' charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount." 75 Fed. Reg. 37,188, 37,194. In other words, "if a plan or issuer paid an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts," the patient would likely be charged an unreasonably high amount in the form of "balance billing." Id. This would defeat the purpose of the emergency services provision of the ACA. Id. The departments, therefore, deemed it "necessary [for] a reasonable amount [to] be paid before a patient becomes responsible for a balance billing amount." Id. To ensure that a "reasonable amount [is] paid for services by some objective standard," they published an Interim Final Rule establishing, among other things, what has become known as the "Greatest of Three" regulation. Id.

According to that regulation,

> a plan or issuer satisfies the copayment and coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of three possible amounts—
>
> > (1) The amount negotiated with in-network providers for the emergency service furnished;
> > (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or
> > (3) The amount that would be paid under Medicare for the emergency service.

Id. It is Defendants' implementation of this reimbursement procedure that forms, by and large, the basis of Plaintiff's lawsuit.

II. Factual Background

Plaintiff's contracted physicians provide medical services for patients with emergency medical conditions regardless of insurance coverage or their ability to pay. (Second Am. Compl., Dkt. [59] ¶¶ 23–25.) Afterwards, Plaintiff submits bills and collects payments on behalf of its hospital providers. (Id. ¶¶ 26–27.) If Defendants provide coverage for the patient, Plaintiff will submit a bill to them, seeking reimbursement for the cost of treatment. (Id.)

In the case of in-network providers, there are contracts that set forth the reimbursement amount that providers receive for their services. But out-of-network providers do not have contracts containing negotiated reimbursement rates. Instead, the physician will be reimbursed at an unnegotiated rate that is "subject to the whim of Defendants." (Id. ¶ 87.)

A. The Agreements

Plaintiff entered into written agreements with all Defendants. (Id. ¶ 128.) The terms of those agreements require Defendants "to make reasonable and appropriate payments to Plaintiff for medical services provided to covered patients . . . ." (Id.) Many of the agreements also contain arbitration provisions.

1. Humana and ChoiceCare

Plaintiff contracted with Humana and ChoiceCare–a Humana subsidiary–on January 1, 2016. (Id. ¶¶ 147, 156.) Those agreements set forth "the rights, responsibilities and conditions governing" Plaintiff and its contracted physicians' providing of health care services to Humana and ChoiceCare members. (Ex. A, Def. Humana's Mot. to Stay Proceedings & Compel Arbitration ("Humana's Mot. to Compel Arbitration"), Dkt. [37-3] at

4; Ex. B, Humana's Mot. to Compel Arbitration, Dkt [37-4] at 4.) The agreements also contain arbitration provisions which provide, in relevant part, "The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration . . . including disputes concerning the scope, validity or applicability of the agreement to arbitrate . . . ." (Ex. A, Humana's Mot. to Compel Arbitration, Dkt. [37-3] at 8; Ex. B, Humana's Mot. to Compel Arbitration, Dkt [37-4] at 8.)

2. UnitedHealthcare

On September 1, 2014, Plaintiff entered into a contract with United Healthcare and all of its affiliates regarding the payment of claims for covered medical services provided by Plaintiff and its contracted physicians. (Second Am. Compl., Dkt. [59] ¶ 173.) The contract's arbitration provision states:

> The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.
>
> If the parties are unable to resolve any such Dispute within 60 days . . . and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration . . . .

(Decl. of Adam A. Carroll in Supp. of Mot. to Compel Arbitration & Dismiss All Claims Against UnitedHealthcare with Prejudice ("Carroll Decl."), Dkt. [33-3] at 6.)

3. Peach State

Plaintiff contracted with Peach State on February 1, 2015, and Peach State agreed to reimburse Plaintiff for "Covered Services provided to Covered Persons in accordance with" a negotiated compensation schedule. (Decl. of Clyde White, Ex. A, Def. Peach State's Mot. & Mem. of Law in Support of Mot. to Stay All Proceedings Against It & to Compel into Arbitration all Claims Asserted Against It ("White Decl."), Dkt. [35-1] at 12; see also Second Am. Compl., Dkt. [59] ¶ 165.) The contract also contains a dispute resolution section, which provides that if "[a]ny disputes between the parties arising with respect to the performance or interpretation of this Agreement ("Dispute") . . . [are] not resolved in accordance with [an informal process] . . ., either party wishing to pursue the Dispute shall submit it to binding arbitration . . . ." (White Decl., Dkt. [35-1] at 15.)

B. Defendants' Reimbursement Practices

According to Plaintiff, Defendants never reimburse Plaintiff for the

actual amount billed. (Second Am. Compl., Dkt. [59] ¶ 30.) That is because Defendants employ two types of improper reimbursement practices. First, Defendants retroactively classify Plaintiff's claims for emergency services as "non-emergent," resulting in underpayment of the claims at a reduced triage rate or their outright denial. (Id. ¶¶ 44–53, 70–82.) Second, in instances where medical providers are outside of Defendants' networks, Defendants underpay by manipulating their calculations in determining the Greatest of Three as required by the Interim Final Rule described above. (Id. ¶¶ 54, 65–69, 84–112.) According to Plaintiff, the greatest of three should typically be the second–that is, the amount calculated using a method generally used to determine payments for out-of-network services (such as the usual customary, and reasonable amount). However, Defendants use private, non-verifiable data to manipulate their calculations so as to "downwardly adjust reimbursement rates." (Id. ¶ 100.) As a result, Defendants pay Plaintiff (if at all) the lowest possible rate–usually the Medicare rate. (Id. ¶ 108.) Now, Plaintiff brings suit alleging that these practices violate state and federal law.

Discussion

I. Motions to Compel Arbitration [33], [35], [37]

Defendants United Healthcare, Peach State, Humana, and ChoiceCare move to enforce the arbitration provisions of their contracts with Plaintiff pursuant to the Federal Arbitration Act ("FAA"), 9 U.S.C. § 1, *et seq.*, which "embodies a 'liberal federal policy favoring arbitration agreements.'" Hill v. Rent-A-Center, Inc., 398 F.3d 1286, 1288 (11th Cir. 2005) (quoting Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24 (1983)). .

The FAA governs the agreements at issue because each involves interstate commerce as that term is contemplated under the FAA. 9 U.S.C. § 1 (defining "interstate commerce" as "commerce among the several states"); see also Citizens Bank v. Alafabco, Inc., 539 U.S. 52, 56 (2003) (defining the term as follows: "the functional equivalent of the more familiar term 'affecting commerce'-words of art ordinarily signal the broadest permissible exercise of Congress' Commerce Clause power"). In fact, in the agreements with Humana and UnitedHealthcare, the parties stipulated that the contracts affect interstate commerce and that the FAA applies. (See Carroll Decl., Dkt. [33-3] at 7; Ex. A, Humana's Mot. to Compel Arbitration, Dkt. [37-3] at 8; Ex. B, Humana's

Mot. to Compel Arbitration, Dkt [37-4] at 8.) No party disputes the appropriateness of those terms nor the applicability of the FAA. And, as Peach State rightfully points out, the agreements necessarily involve commerce because "the national healthcare system in which [the parties] operate implicates interstate activities." (Def. Peach State Health Plan, Inc.'s Mot. & Mem. in Supp. of Mot. to Stay all Proceedings Against It & to Compel Into Arbitration All Claims Asserted Against It, Dkt. [35] at 5.)

Under Section 2 of the FAA, arbitration agreements are "valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of the contract." 9 U.S.C. § 2. Further, Section 4 of the FAA permits one party to seek the assistance of the district court when the other party refuses to proceed with arbitration. 9 U.S.C. § 4. The court, in that instance, must "either stay or dismiss a lawsuit and . . . compel arbitration upon a showing that (a) the plaintiff entered into a written arbitration agreement that is enforceable under ordinary state-law contract principles and (b) the claims before the court [] fall within the scope of that agreement." Lambert v. Austin Ind., 544 F.3d 1192, 1195 (11th Cir. 2008) (quotation marks omitted).

No parties contend that the arbitration agreements are invalid under basic

contract formation principles–in other words, that they lack mutual assent, consideration, parties able to contract, or subject matter upon which the contracts can operate. See O.C.G.A. § 13-3-1. Instead, Plaintiff argues that the arbitration agreements are not enforceable under Georgia contract law because (1) Plaintiff was fraudulently induced to enter into the underlying agreements and (2) the arbitration provisions are unconscionable. See Parnell v. CashCall, Inc., 804 F.3d 1142, 1146 (11th Cir. 2015) ("Arbitration provisions will be upheld as valid unless defeated by fraud, duress, unconscionability, or another 'generally applicable contract defense.'" (quoting Rent-A-Center v. Jackson, 561 U.S. 63, 67–68 (2010))).

Where, as here, the making of the agreement for arbitration is at issue, courts distinguish between "claims that challenge the contract generally and claims that challenge the arbitration provision itself." Jenkins v. First Am. Cash Advance of Ga., LLC, 400 F.3d 868, 876 (11th Cir.2005) (citing Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 398 (1967)). If a claim challenges the contract in general–and not the arbitration agreement in particular–that claim must be decided by an arbitrator.

The Supreme Court articulated this principle in Prima Paint. There, the

plaintiff sought to rescind a contract–and thereby avoid arbitration–based on fraudulent inducement where the defendant represented that it was solvent when in fact it was not. Prima Paint, 388 U.S. at 398. The Supreme Court "concluded that because the fraudulent inducement claim related to the underlying contract generally, and not to the arbitration clause specifically, it was a matter to be resolved by the arbitrator, not the federal court." Jenkins, 400 F.3d at 877 (citing Prima Paint, 388 U.S. at 403–04.); see also Rent-A-Center, 561 U.S. at 71 ("[W]here the alleged fraud that induced the whole contract equally induced the agreement to arbitrate which was part of that contract . . . we nonetheless require the basis of challenge to be directed specifically to the agreement to arbitrate before the court will intervene.").

Here, Plaintiff articulates no arguments that differentiate between alleged fraud in the formation of the contracts and fraud specifically in the inclusion of the arbitration provisions. It is clear, then, that Plaintiff's challenge is to the entirety of the contracts and not the arbitration provisions in particular. Therefore, without deciding the merits of Plaintiff's fraudulent inducement arguments, under the holding of Prima Paint and its progeny, the Court must treat the provisions "as valid under § 2 [of the FAA], and must enforce [them]

under §§ 3 and 4, leaving any challenge to the validity of the Agreement[s] as a whole for the arbitrator." Rent-A-Center, 561 U.S. at 72. .

On the other hand, Plaintiff's second argument–unconscionability–challenges the arbitration provisions specifically. Importantly, however, the agreements with UnitedHealthcare, ChoiceCare, and Humana contain so-called "delegation provisions," requiring the parties to submit threshold issues of "scope, validity, or applicability of" the arbitration agreements to arbitration. (Ex. A, Humana's Mot. to Compel Arbitration, Dkt. [37-3] at 8; Ex. B, Humana's Mot. to Compel Arbitration, Dkt [37-4] at 8 (same); see also Carroll Decl., Dkt. [33-3] at 6 (defining the term "Disputes" to include "all questions of arbitrability, the existence, validity, scope of termination of the Agreement or any term thereof," and agreeing to submit all Disputes to binding arbitration).) "When an arbitration agreement contains a delegation provision . . . the plaintiff must 'challenge the delegation provision *specifically*." Parnell, 804 F.3d at 1146 (quoting Rent-A-Center, 561 U.S. at 72); accord Given v. M & T Bank Corp. (In re Checking Account Overdraft Litig.), 674 F.3d 1252, 1255 (11th Cir. 2012). Plaintiff, however, calls the entire arbitration provisions unconscionable. Accordingly, as to the

UnitedHealthcare, ChoiceCare, and Humana agreements, the issue of unconscionability is one that must be raised in arbitration.

Plaintiff's contract with Peach State is different, however. It does not contain a delegation provision; so even though the Eleventh Circuit has extended the Prima Paint rule to claims of contractual unconscionability, see Benoay v. Prudential-Bache Secs., Inc., 805 F.2d 1437, 1441 (11th Cir.1986), it is the Court, not the arbitrator that must decide this issue. Rent-A-Center, 561 U.S. at 71 ("If a party challenges the validity under § 2 [of the FAA] of the precise agreement to arbitrate at issue, the federal court must consider the challenge before ordering compliance with that agreement under § 4.").

In such an instance, "state law generally governs whether an enforceable contract or agreement to arbitrate exists." Caley v. Gulfstream Aerospace Corp., 428 F.3d 1359, 1368 (11th Cir. 2005) (citing Perry v. Thomas, 482 U.S. 483, 492 n. 9 (1987)). And Georgia law–which controls the agreement with Peach State–sets a high bar for finding unconscionability. In particular, Georgia law typically requires both procedural and substantive unconscionability to be present. See, e.g., NEC Techs., Inc. v. Nelson, 478 S.E.2d 769, 773 n.6 (Ga. 1996) ("[T]o tip the scales in favor of

unconscionability, most courts seem to require a certain quantum of procedural plus a certain quantum of substantive unconscionability.") (citation omitted); Gordon v. Crown Cent. Petroleum Corp., 423 F. Supp. 58, 61 (N.D. Ga. 1976) (holding that "unconscionability has generally been recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party." (quoting Williams v. Walker-Thomas Furniture Co., 350 F.2d. 445, 449 (D.C. Cir. 1965))). "Procedural unconscionability concerns the process of making a contract (largely focusing on the parties and their relative bargaining power), whereas the inquiry into substantive unconscionability focuses on the contractual terms themselves." Kaspers v. Comcast Corp., 631 F. App'x 779, 782 (11th Cir. 2015) (citing Dale v. Comcast Corp., 498 F.3d 1216, 1219 (11th Cir.2007)). To determine substantive unconscionability, "courts have focused on matters such as the commercial reasonableness of the contract terms, the purpose and effect fo the contract terms, the allocation of risks between the parties and similar public policy concerns." NEC Techs., 478 S.E.2d at 772 (citations omitted).

As an initial matter, Plaintiff articulates no arguments that the arbitration

provision is procedurally unconscionable. Instead, Plaintiff argues that the arbitration provision is substantively unconscionable because–taken in conjunction with the other agreements at issue–it requires Plaintiff to arbitrate its claims against each Defendant individually, meaning, in this instance, that Plaintiff must participate in and pay the associated costs for six separate arbitrations. However, unconscionability is to be determined "under the circumstances existing at the time of the making of the contract," NEC Techs, 478 S.E.2d at 771, not when the terms of the contract are sought to be enforced. Moreover, to be unconscionable under Georgia law, a contract must be "so one-sided" that "no sane man not acting under a delusion would make and that no honest man would" participate in the transaction. Id. at 771 & n.2 (quoting R.L. Kimsey Cotton Co. v. Ferguson, 214 S.E.2d 360, 363 (Ga. 1975)). The arbitration clause here falls well short of this standard.

Indeed, it is well settled that through arbitration agreements "parties may agree to limit the issues subject to arbitration, to arbitrate according to specific rules, and to limit with whom a party will arbitrate its dispute." AT & T Mobility LLC v. Concepcion, 563 U.S. 333, 344 (2011) (citations omitted). Accordingly, parties may agree to resolve matters through arbitration on an

individual basis rather than consolidate them with related disputes involving third parties. See id. at 344–45. This is what the parties here have done. And Plaintiff fails to cite to any case law that would require a party in such an instance to ameliorate the costs of its adversary.[3] "The party seeking to avoid arbitration . . . has the burden of establishing that enforcement of the agreement would 'preclude' [it] from 'effectively vindicating [its] federal statutory right in the arbitral forum.'" Musnick, 325 F.3d at 1259 (quoting Green Tree Fin. Corp.-Alabama v. Randolph, 531 U.S. 79, 91 (2000)). Plaintiff has failed to carry that burden.

All pending Motions to Compel Arbitration [33], [35], and [37] are, therefore, **GRANTED**. Plaintiff's claims against the following Defendants are hereby **ORDERED** to be submitted to arbitration in accordance with the terms of the underlying agreements: (1) Health Value Management, Inc. d/b/a ChoiceCare Network; (2) Humana Employers Health Plan of Georgia, Inc.; (3)

[3] The Court further notes that the arbitration agreement with Peach State mitigates the individual costs of arbitration by providing, "Each party shall bear its own costs related to the arbitration except that the costs imposed by the [American Arbitration Association] shall be shared equally." (White Decl., Dkt. [35-1] at 15); see also Musnick v. King Motor Co. of Fort Lauderdale, 325 F.3d 1255, 1259 (11th Cir. 2003) (admonishing that even if an arbitration agreement "involve[s] some 'fee-shifting,'" it is not necessarily unenforceable).

Humana Health Plan, Inc.; (4) Humana Insurance Company; (5) United Healthcare of Georgia, Inc.; (6) United Healthcare Community Plan of Georgia, Inc.; and (7) Peach State Health Plan, Inc.

Having so held, the Court must now either stay the claims pending against those parties until they have been arbitrated, or dismiss them from this lawsuit. All of the parties, including Plaintiff, request that the Court order a stay, with the exception of UnitedHealthcare, which seeks dismissal. The Court has discretion to either stay or dismiss the action. Anderson v. Am. Gen. Ins., 688 F. App'x 667, 669 (11th Cir. 2017). The Court declines to stay the case pending arbitration or appeal. In the event court action is necessary to resolve issues arising out of the arbitrations, the parties may file a separate civil action with the Court. The Clerk is **DIRECTED** to terminate the seven Defendants listed above from this action.

In light of the foregoing, the only Defendants remaining in this case are Amerigroup and Blue Cross Blue Shield.[4] Moving forward, the Court will only consider the filings of those parties, and, of course, Plaintiff.

[4] Hereinafter, use of the term "Defendants" shall refer only to the remaining defendants–that is, Blue Cross Blue Shield and Amerigroup, collectively.

II. Plaintiff's Motion for Leave to File Amended Complaint [48]

A. Legal Standard

Under Rule 15(a)(1) of the Federal Rules of Civil Procedure, a party may amend a pleading once as a matter of right within twenty-one days after service of the pleading, or, if the pleading requires a response, within twenty-one days after service of a responsive pleading or motion filed under Rule 12(b), (e), or (f). Otherwise, under Rule 15(a)(2), the party must seek leave of court or the written consent of the opposing parties to amend. Rule 15(a)(2) directs the Court, however, to "freely give leave when justice so requires." Yet, despite this instruction, leave to amend is "by no means automatic." Layfield v. Bill Heard Chevrolet Co., 607 F.2d 1097, 1099 (5th Cir. 1979).[5] The trial court has "extensive discretion" in deciding whether to grant leave to amend. Campbell v. Emory Clinic, 166 F.3d 1157, 1162 (11th Cir.1999). A trial court may choose not to allow a party to amend "when the amendment would prejudice the defendant, follows undue delays, or is futile." Id. A claim is futile if it cannot withstand a motion to dismiss. Fla. Power & Light Co. v. Allis

[5] In Bonner v. City of Prichard, the Eleventh Circuit Court of Appeals adopted as binding precedent all decisions of the former Fifth Circuit decided before October 1, 1981. 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc).

Chalmers Corp., 85 F.3d 1514, 1520 (11th Cir.1996); see Burger King Corp. v. Weaver, 169 F.3d 1310, 1315 (11th Cir.1999) (futility is another way of saying "inadequacy as a matter of law"). That is, leave to amend will be denied "if a proposed amendment fails to correct the deficiencies in the original complaint or otherwise fails to state a claim." Mizzaro v. Home Depot, Inc., 544 F.3d 1230, 1255 (11th Cir. 2008).

B. Analysis

Plaintiff moves to amend the First Amended Complaint, predominately to include additional details about the underlying agreements between Plaintiff and each of the named Defendants. Defendants oppose Plaintiff's Motion because of procedural defects and further argue that the proposed amendments have been unduly delayed and would be futile. Plaintiff has not filed a reply.

1. Plaintiff's Improper Filing of the Second Amended Complaint

First, the Court must address a procedural aberration. As Defendants point out, Plaintiff first filed its motion requesting leave to amend, and then, after Defendants responded, Plaintiff filed the Second Amended Complaint,

itself, without obtaining leave from the Court.[6] According to Defendants, as a consequence of this, the Court should refuse to consider the proposed Second Amended Complaint when deliberating whether to allow Plaintiff to amend. This is significant because Plaintiff's motion does not include the details of any proposed alterations, meaning that the Court would be unable to fully assess whether the amendments would correct any deficiencies in the existing complaint. The Court is unwilling to impose such a constraint and will consider the allegations of the proposed Second Amended Complaint in this deliberation.[7]

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[6] Plaintiff is required to obtain leave of court because it has already amended the complaint once as of right (see First Am. Compl., Dkt. [10]) and because it is well outside the 21-day limitation period described in Rule 15(a) of the Federal Rules of Civil Procedure.

[7] The Court reaches this conclusion cautiously, however, given that this is not the first instance of Plaintiff ignoring procedural requirements. Specifically, Plaintiff also filed a Motion for Leave to File a Response to Blue Cross Blue Shield and Amerigroup's Motion to Dismiss [41] after missing the response deadline, but then proceeded to file the Response [50] without an Order from the Court. Moving forward, Plaintiff is strongly encouraged to review and abide by the Federal Rules of Civil Procedure, as well as the Local Rules applicable to all filings made in this Court.

2. Changes in the Proposed Second Amended Complaint[8]

Plaintiff does not attempt to add parties to this action or assert additional claims against the named parties. In fact, Plaintiff only seeks to amend the factual allegations contained in its breach of contract claim (Count V) and its fraudulent inducement claim (Count VI).[9] As to the former, Plaintiff provides details about the underlying agreements, including the dates upon which they were executed and citations to and excerpts from the provisions at issue. As to the fraudulent inducement claim, Plaintiff alleges that between April and June of 2012, while deciding whether to renew its existing contracts, Plaintiff engaged in negotiations with certain representatives of Blue Cross Blue Shield,

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[8] The allegations described in this section and assessed under the legal standard described above are limited to those affecting the claims against Blue Cross Blue Shield and Amerigroup as they are the only Defendants remaining in this action. See Part I, supra. Similar allegations against Peach State, UnitedHealthcare, Humana, and ChoiceCare do not influence the Court's analysis and will not be discussed at length. Rather, Plaintiff's Motion is hereby **DENIED** as to all allegations in the proposed Second Amended Complaint against the parties dismissed from this action in Part I, supra.

[9] Plaintiff titles Count VI "Fraudulent Misrepresentation, Fraudulent Inducement." As discussed more fully below, Plaintiff is essentially alleging that during negotiations Blue Cross Blue Shield "made promises as to future events with the present intention not to perform or with the knowledge that the future event would not occur." Higginbottom v. Thiele Kaolin Co., 304 S.E.2d 365, 368 (Ga. 1983) Under Georgia law, this is commonly referred to as fraudulent inducement or fraud in the inducement, an element of which includes misrepresentation. See id.

attempting to agree upon reimbursement rates for medical services provided by Plaintiff. According to Plaintiff, during that time, Blue Cross Blue Shield misrepresented to Plaintiff that the negotiated rates would be paid, while in reality, they never intended to do so. Then, relying on those misrepresentations, Plaintiff entered into contracts that, ultimately, were not honored by Blue Cross Blue Shield.

3. Whether to Grant Plaintiff Leave to Amend

As an initial matter, the Court holds–and Defendants do not dispute–that granting Plaintiff leave to file the proposed Second Amended Complaint would not be unduly prejudicial. Defendants do argue, however, that Plaintiff's motion should be denied because Plaintiff has unduly delayed in filing it and because the proposed amendments are futile.

a. Undue Delay

Defendants argue that Plaintiff's motion should be denied because the proposed amendments are based on facts Plaintiff knew before the earlier pleadings were filed and Plaintiff has not explained why it failed to include these facts until now. Admittedly, Defendants are correct; however, the Court declines to deny Plaintiff's motion on this basis. As evidenced by the motions

currently before the Court, this case is still in its initial stages. And although Plaintiff sought leave to amend one month after Defendants filed their motion to dismiss, the majority of arguments set forth in Defendants' motion to dismiss are still applicable to the proposed Second Amended Complaint; thus, allowing Plaintiff to amend will not require additional or duplicative filings by Defendants and will not result in further delay of the proceedings. Therefore, in light of the timing and relatively limited amendments in the proposed Second Amended Complaint, the Court will not deny Plaintiff's motion simply because of undue delay.

b. Futility

"Futility justifies the denial of leave to amend where the complaint, as amended, would still be subject to dismissal." Patel v. Ga. Dep't. BHDD, 485 F. App'x 982, 982 (11th Cir. 2012) (citing Burger King Corp. v. Weaver, 169 F.3d 1310, 1320 (11th Cir. 1999)). "In order to survive a motion to dismiss, a plaintiff must plead 'enough facts to state a claim to relief that is plausible on its face,' rather than merely conceivable." Id. at 983 (quoting Bell Atl. Corp. v. Twombly, 550 U.S.. 544, 570 (2007)). To analyze futility, the Court will take up Plaintiff's proposed amendments to its breach of contract and

fraudulent inducement claims in turn.

i. Breach of Contract

The Court finds that Plaintiff's proposed Second Amended Complaint contains sufficient facts to support a plausible claim for breach of contract against Blue Cross Blue Shield. Under Georgia law, the requirements for a breach of contract claim "are the breach and the resultant damages to the party who has the right to complain about the contract being broken." Budget Rent-A-Car of Atlanta, Inc. v. Webb, 469 S.E.2d 712, 713 (Ga. Ct. App. 1996). "[A] plaintiff asserting a breach of contract claim must allege a particular contract provision that the defendants violated to survive a motion to dismiss." Anderson v. Deutsche Bank Nat. Trust Co., No. 1:11-cv-4091-TWT-ECS, 2012 WL 3756512, at *12 (N.D. Ga. Aug. 6, 2012) (citing Am. Casual Dining, L.P. v. Moe's Sw. Grill, LLC, 426 F. Supp. 2d 1356, 1370 (N.D. Ga. 2006)).

In addition to alleging the contracts' existence, Plaintiff alleges that Blue Cross Blue Shield "failed and/or refused to pay . . . the contractual reimbursement rates set forth in the Agreement[s] . . ." (Second Am. Compl. ¶¶ 138, 145); and "failed and/or refused to maintain its claims payment administrative system in a manner necessary to meet its payment obligations

under the Agreement[s] . . . ." (Id. ¶¶ 139, 146.) In furtherance of these assertions, Plaintiff includes the relevant section numbers from two contracts that it entered into with Blue Cross Blue Shield, as well as the language from those sections alleged to have been violated. These allegations, taken as true and resolved in the light most favorable to Plaintiff, are sufficient for the Court to conclude that Plaintiff's breach of contract theory of recovery is not futile.[10]

ii. Fraudulent Inducement

In Georgia, rather than attacking the terms of an underlying contract, a claim for fraud in the inducement attacks the circumstances surrounding the transaction or making of the contract. Picken v. Minuteman Press Int'l, Inc., 854 F. Supp. 909, 911 (N.D. Ga. 1993). A claim based upon fraud in the inducement requires five elements: "(1) a false representation or concealment

[10] The Court notes that Blue Cross Blue Shield takes issue with Plaintiff's failure to identify the details of the claims that were not paid for in accordance with the terms of the agreements, including "the date of any claim, the services allegedly rendered, [and] the amount allegedly owed[.]" (Defs. Amerigroup & Blue Cross Blue Shield's Notice Concerning Pl.'s Improper Filing of Second Am. Compl. Without Leave of Court, Dkt. [60] at 3.) This is particularly concerning in the context of an ongoing business relationship during which–according to Blue Cross Blue Shield–Plaintiff has submitted thousands of claims. Nevertheless, Plaintiff alleges repeatedly that Defendants *never* reimburse Plaintiff appropriately, and that is an allegation that the Court must take as true at this stage of the proceedings. As such, Plaintiff's breach of contract claim is sufficiently alleged.

of a material fact; (2) that the defendant knew the representations or concealment were false; (3) an intent to induce the allegedly defrauded party to act or refrain from acting; (4) justifiable reliance by the plaintiff; and (5) damages as a result of the false representations or concealment."[11] Earthcam, Inc. v. Oxblue Corp., No. 1:11-CV-2278-WSD, 2014 WL 793522, at *2 (N.D. Ga. Feb. 26, 2014) (citing Pacheco v. Charles Crews Custom Homes, 658 S.E.2d 396, 398 (Ga. Ct. App. 2008)). Hence, "a promise made without the present intention to perform can create a cause of action for fraud in the inducement." J'Carpc, LLC v. Wilkins, 545 F. Supp. 2d 1330, 1340 (N.D. Ga. 2008) (citing Buckley v. Turner Heritage Homes, Inc., 547 S.E.2d 373, 375 (2001)).

Defendants argue that Plaintiff's allegations are insufficient because (1) Plaintiff failed to plead fraud with particularity as required by Federal Rule of

[11] Under Georgia law, a party alleging fraudulent inducement "has two options: (1) affirm the contract and sue for damages from the fraud or breach; or (2) promptly rescind the contract and sue in tort for fraud." Megel v. Donaldson, 654 S.E.2d 656, 661 (Ga. Ct. App. 2007). "[A] claim for damages unaccompanied by a claim for rescission operates as an election to affirm the underlying contract." Weinstock v. Novare Group, Inc., 710 S.E.2d 150, 154 (Ga. Ct. App. 2011). Here, Plaintiff has not sought recission of the Blue Cross Blue Shield agreements; therefore, the Court presumes Plaintiff is seeking damages resulting from the purported misrepresentations.

Civil Procedure 9(b); and (2) "plaintiff cannot claim that it was fraudulently induced into entering into a contract based on a promise that was included in the contract." (Defs. Amerigroup & Blue Cross Blue Shield's Notice Concerning Pl.'s Improper Filing of Second Am. Compl. Without Leave of Court, Dkt. [60] at 4–5.; see also Consolidated Resp. in Opposition to Pl.'s Mot. for Leave to File Am. Compl. & Reply Brief in Support of Mot. to Dismiss Filed by Defs. Amerigroup & Blue Cross Blue Shield, Dkt. [55] at 15–17.)[12]

Rule 9(b) requires that the circumstances constituting fraud be stated with particularity. "A complaint satisfies Rule 9(b) if it sets forth precisely what statements or omissions were made in what documents or oral

[12] Defendants also argued, before the proposed Second Amended Complaint was filed, that Plaintiff "cannot plausibly allege reliance on any alleged misrepresentations" in administering emergency care because Plaintiff is required to do so under federal law. (Br. in Supp. of Mot. to Dismiss Am. Compl. by Defs. Amerigroup & Blue Cross Blue Shield, Dkt. [21-1] at 24–25; see also id. at 20–21.) However, as the proposed Second Amended Complaint has clarified, Plaintiff is not alleging that it relied on Blue Cross Blue Shield's misrepresentations in administering emergency care, but rather that Plaintiff relied on those misrepresentations when deciding to enter into the underlying agreements in the first place. See Kent v. White, 520 S.E.2d 481, 483 (Ga. Ct. App. 1999) ("[M]aking a promise without a present intent to perform is a misrepresentation of a material fact and will support a cause of action for fraud."). The Court, therefore, need not consider this argument further.

representations, who made the statements, the time and place of the statements, the content of the statements and manner in which they misled the plaintiff, and what benefit the defendant gained as a consequence of the fraud." In re Theragenics Corp. Sec. Litig., 105 F. Supp. 2d 1342, 1347 (N.D. Ga.2000) (citing Brooks v. Blue Cross and Blue Shield of Fla., Inc., 116 F.3d 1364, 1371 (11th Cir.1997)). Plaintiff alleges that between April and June of 2012 Alexandra Leopold and other agents of Blue Cross Blue Shield promised that Plaintiff would be reimbursed at certain rates for services provided under the contracts, did not intend to pay Plaintiff at those rates, and made this false representation for the purpose of convincing Plaintiff to enter into contracts through which Plaintiff agreed to provide medical services. Plaintiff claims that its reliance on these representations were reasonable, and that Plaintiff was damaged by these false representations. These allegations are adequate to meet the heightened-pleading requirement of Rule 9(b). And the fact that they are based on purportedly false promises that became memorialized in the underlying agreements does not render Plaintiff's claim legally deficient.

It is true that an action for fraud typically does not "result from a mere failure to perform promises made. Otherwise any breach of a contract would

amount to fraud." Gibson Tech. Servs, Inc. v. JPay, Inc., 755 S.E.2d 377, 379 (Ga. Ct. App. 2014) . However, "[t]he well recognized exceptions to this rule are promises made without present intent to perform, which is a misrepresentation of a present state of mind and promises made as an inducement to enter a contract." Goodlett v. Ray Label Corp., 319 S.E.2d 533, 535 (Ga. Ct. App. 1984). Here, Plaintiff alleges that at the time the agreements were executed Blue Cross Blue Shield had no intent to comply with the provisions setting the rates at which Plaintiff was to be reimbursed. Plaintiff's fraud claim, then, is not barred by the general rule that fraud may not be based on a promise to perform in the future. And because "the question of intent to deceive or not to perform is in all cases the dominion of the factfinder," Sims v. Nat. Prod. of Ga., LLC, 785 S.E.2d 659, 662 (Ga. Ct. App. 2016), at this stage in the litigation, Plaintiff's allegations are sufficiently plead.

Accordingly, Plaintiff's Plaintiff's Motion for Leave to File Amended Complaint [48] is hereby **GRANTED, in part** and **DENIED, in part**. It is granted as to all allegations in Count V and Count VI against Blue Cross Blue Shield. The motion is denied as to any other allegations in Count V and Count VI. Peach State's Motion to Dismiss the Second Amended Complaint [62] is

hereby **DENIED as moot**.

In addition, as mentioned in Part II.B.2, supra, Plaintiff has not amended all counts in the Complaint. As such, many of the arguments set forth in the Defendants Amerigroup and Blue Cross Blue Shield's Motion to Dismiss [Dkt. 21-1] are still applicable and will be evaluated. Additionally, after Plaintiff filed its Second Amended Complaint without leave of court, Defendants' submitted a Notice of Improper Filing [Dkt. 60], and the arguments set forth therein will also be considered in deciding whether to grant the Motion to Dismiss.

III. Defendants Amerigroup and Blue Cross Blue Shield's Motion to Dismiss [21][13]

A. Legal Standard

Federal Rule of Civil Procedure 8(a)(2) requires that a pleading contain a "short and plain statement of the claim showing that the pleader is entitled to relief." While this pleading standard does not require "detailed factual allegations," "labels and conclusions" or "a formulaic recitation of the elements

[13] The Court will consider Plaintiff's Response [50] when deliberating whether to grant this motion. Therefore, Plaintiff's Motion for Leave to File a Response [41] is **DENIED as moot**.

of a cause of action will not do." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007)). In order to withstand a motion to dismiss, "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" Id. (quoting Twombly, 550 U.S. at 570). A complaint is plausible on its face when the plaintiff pleads factual content necessary for the court to draw the reasonable inference that the defendant is liable for the conduct alleged. Id.

At the motion to dismiss stage, "all well-pleaded facts are accepted as true, and the reasonable inferences therefrom are construed in the light most favorable to the plaintiff." Bryant v. Avado Brands, Inc., 187 F.3d 1271, 1273 n.1 (11th Cir. 1999). However, the same does not apply to legal conclusions set forth in the complaint. Sinaltrainal v. Coca-Cola Co., 578 F.3d 1252, 1260 (11th Cir. 2009) (citing Iqbal, 556 U.S. at 678). "Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." Iqbal, 556 U.S. at 678. Furthermore, the court does not "accept as true a legal conclusion couched as a factual allegation." Twombly, 550 U.S. at 555.

B. Plaintiff's Federal Law Claims

In Counts I, II, and III of the Second Amended Complaint, Plaintiff alleges violations of the ACA, EMTALA, and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Defendants argue that these claims should be dismissed because Plaintiff has not and cannot state a viable cause of action under the statutes.

1. ACA

Defendants argue that no private right of action exists under the ACA. Plaintiff argues in response that its ACA claims are, in fact, derived from ERISA–specifically, 29 U.S.C. § 1132(a)(3), which allows "a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (b) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." According to Plaintiff, because the statute, in a subsequent section, "incorporate[s] by reference the ACA provisions on which Counts I and III of Plaintiff's Complaint are based," Plaintiff has a viable cause of action for alleged ACA violations. (Pl.'s Br. in Supp. of Opposition to Defs. Amerigroup & Blue Cross Blue Shield's Mot. to

Dismiss ("Pl.'s Resp. to Mot. to Dismiss"), Dkt. [50-1] at 5.); see also 29 U.S.C. § 1185d(a)(1) ("[T]he provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.").

The Court finds, however, that Plaintiff has failed to plead sufficient factual allegations to show that it has standing to bring a cause of action pursuant to ERISA. ERISA claims may only be brought "by a participant or beneficiary." 29 U.S.C. § 1132(a)(1)). "Healthcare providers generally are not considered 'beneficiaries' or 'participants' under ERISA and thus lack standing to sue under the statute." Borrero v. United Healthcare of New York, Inc., 610 F.3d 1296, 1301–02 (11th Cir.2010); see also Nat'l Med. Care, Inc. v. United Health Care of Fla., Inc., No. 00-8160, 2001 WL 268205, at *2 (S.D. Fla. Jan.26, 2001) (holding that a provider of medical services is not a "beneficiary" even if a plan participant authorizes the plan to make payments directly to that provider or assigns that provider the right to recover payments for the medical services). As such, "[h]ealthcare providers may have standing under ERISA

only when they derivatively assert rights of their patients as beneficiaries of an ERISA plan," which requires the provider to "have obtained a written assignment of claims from a patient with standing to sue under ERISA." Borrero, 610 F.3d at 1302.

Plaintiff is a provider of health care services, not a beneficiary or participant. (See Second Am. Compl., Dkt. [59] ¶ 113.) Accordingly, Plaintiff can only have standing to bring its claims through ERISA if Plaintiff received assignments from its patients broad enough to cover those claims. With respect to assignments, Plaintiff's complaint includes only the following assertion: "Plaintiff brings this Complaint as an assignee of its patients' rights to sue under ERISA as participants or beneficiaries." (Id. ¶ 113.)

Plaintiff has not identified any patients by whom these assignments were executed, nor has Plaintiff described the terms or the scope of those assignments. "To sufficiently plead its standing as an ERISA beneficiary to assert the claims in the [Second] Amended Complaint, Plaintiff[] must also provide the language of the actual assignments . . . [because] '[l]ike any other contract, the scope of the assignment depends foremost upon the language of the agreement itself.'" Sanctuary Surgical Ctr., Inc. v. UnitedHealthcare, Inc.,

No. 10-81589-CV, 2011 WL 6935289, at *4 (S.D. Fla. Dec. 30, 2011) (quoting Via Christi Reg'l Med. Ctr., Inc. v. Blue Cross & Blue Shield of Kan., Inc., Nos. 04-1253-WEB, 04-1339-WEB, 2006 WL 3469544, at *7 (D. Kan. Nov.30, 2006)). Plaintiff has failed to do so. And as a result, the Court cannot determine, as a matter of law, whether the alleged assignments actually conferred upon Plaintiff standing to bring these claims. Thus, the Court holds that Plaintiff has failed to state a claim under the ACA through ERISA.

2. EMTALA

Defendants argue that Plaintiff cannot state a claim under EMTALA because only hospitals are amenable to suit under that statue. Defendants are correct. "Congress enacted EMTALA . . . to remedy the narrow problem of emergency rooms turning away indigent patients." Kizzire v. Baptist Health Sys., Inc., 441 F.3d 1306, 1310 (11th Cir. 2006) (citing Harry v. Marchant, 291 F.3d 767, 770 (11th Cir.2002)). There is no evidence that Congress intended for EMTALA to apply to issues arising from insurers' reimbursement for care administered pursuant to the statue's requirements. Nor is there any indication–in the text of the statute or otherwise–that an entity like Plaintiff has standing to bring a claim under EMTALA. To the contrary, EMTALA's

remedial mechanisms are quite plainly restricted to *persons* requiring emergency medical treatment and *medical facilities* that suffer financial loss as a result of a participating hospital's violation of EMTALA. See 42 U.S.C. § 1395dd(d)(2) (creating a civil cause of action for "any individual" and "any medical facility"). Accordingly, Plaintiff–a company that staffs emergency departments and hospitals–cannot bring a claim under EMTALA against Defendants as a matter of law.

3. COBRA

Defendants argue that Plaintiff has failed state a claim under COBRA by failing to identify any specific COBRA provision that Defendants violated. Plaintiff admits that COBRA is not mentioned or cited throughout Counts I and III of the Second Amended Complaint, but that it nevertheless states a claim by describing "Defendants' systematic, wrongful underpayment or non-payment of reimbursements due [to] the Plaintiff under the ACA and COBRA." (Pl.'s Resp. to Mot. to Dismiss, Dkt. [50-1] at 8.) Plaintiff goes on to suggest that the repeated use of "*et al*" when citing statutes is sufficient to link this conduct to COBRA. The Court disagrees, and declines Plaintiff's invitation to engage in a fishing expedition to identify a COBRA provision that might fit Plaintiff's

factual allegations.[14] It is Plaintiff's burden to provide fair notice to Defendants as to the basis of its claims. Insofar as those claims are premised upon COBRA, Plaintiff has failed to do so. "Factual allegations must be enough to raise a right to relief above the speculative level." Twombly, 550 U.S. at 555. And while Plaintiff supplies ample factual detail describing Defendants' purportedly unlawful conduct, Plaintiff fails to adequately explain how those actions actually violate COBRA and entitle Plaintiff to relief. This amounts to nothing "more than an unadorned, the-defendant-unlawfully-harmed-me accusation" insufficient to survive a motion to dismiss. Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Twombly, 550 U.S. at 555).

In sum, the Court holds that Plaintiff has failed to state any cognizable claim under the ACA, EMTALA, or COBRA. Defendants' Motion to Dismiss is, therefore, **GRANTED** as to Plaintiff's federal law claims, and Counts I, II, and III of Plaintiff's Second Amended Complaint are hereby **DISMISSED**.

C. Plaintiff's State Law Claims

1. Breach of Contract and Fraudulent Inducement

[14] COBRA is a vast statutory scheme spanning across twenty titles of the United States Code.

For the reasons set forth in Part II.B.3.b, supra, the Court concludes that the allegations against Blue Cross Blue Shield for breach of contract and fraudulent inducement–Counts V and VI, respectively–are sufficient to survive Defendants' Motion to Dismiss. It is a different story as to Amerigroup, however. Amerigroup is not mentioned once in Counts V and VI of the Second Amended Complaint. Consequently, there are no allegations defining the terms of any contract between Plaintiff and Amerigroup or explaining how those terms were breached; nor are there facts evidencing that Amerigroup made any misrepresentations to Plaintiff that would rise to the level of fraud. As a result, Plaintiff has failed to plead facts sufficient to state claims against Amerigroup for breach of contract and fraudulent inducement. Count V and Count VI are, therefore, **DISMISSED** except as to allegations against Blue Cross Blue Shield.

2. Fair Business Practices Act

Count IV of the Second Amended Complaint alleges that Defendants violated the Georgia Fair Business Practices Act (FBPA). The Georgia FBPA "protect[s] consumers and legitimate business enterprises from unfair or deceptive practices in the conduct of any trade or commerce in part or wholly

in the state." O.C.G.A. § 10-1-391(a). However, this statute does not apply to "[a]ctions or transactions specifically authorized under laws administered by or rules and regulations promulgated by any regulatory agency of [Georgia] or the United States." O.C.G.A. § 10-1-396(1). "[T]he legislature 'intended that the Georgia FBPA have a restricted application only to the unregulated consumer marketplace and that the FBPA not apply in regulated areas of activity, because regulatory agencies provide protection or the ability to protect against the known evils in the area of the agency's expertise.'" Brogdon v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1336 (N.D. Ga. 2000) (citing Chancellor v. Gateway Lincoln-Mercury, Inc., 502 S.E.2d 799 (Ga. Ct. App. 1998)).

Here, the conduct at issue–reimbursement for emergency care–is heavily regulated by federal law. In particular, EMTALA requires hospitals with emergency departments to screen and, when necessary, provide certain treatment for individuals with emergency medical conditions. 42 U.S.C. § 1395dd. Furthermore, the ACA requires that insured individuals who need emergency medical treatment not be charged higher copayment or coinsurance rates if treated by a provider outside the insurer's network. 42 U.S.C. § 300gg-

19a. And ultimately, how insurers pay physicians for required emergency services is regulated by the Departments of Health and Human Services, Labor, and the Treasury, which have promulgated rules dealing with the emergency services provision of the ACA described above. See 75 Fed. Reg. 37,188. Plaintiff surely recognizes this given that a considerable amount of space in the Second Amended Complaint has been dedicated to describing the numerous statutes and regulations at play.

Accordingly, because the conduct serving as the basis for Plaintiff's claim is heavily regulated by federal law, the FBPA cannot apply to the facts alleged in this case. The Court, therefore, **GRANTS** Defendants' Motion to Dismiss with respect to Count IV of the Second Amended Complaint.

Conclusion

For the foregoing reasons, UnitedHealthcare's Motion to Compel Arbitration and Dismiss with Prejudice [33], Peach State's Motion to Stay Proceedings and Compel Arbitration [35], and Humana and ChoiceCare's Motion to Stay Proceedings and Compel Arbitration [37] are **GRANTED, in part** and **DENIED, in part**. Plaintiff and the foregoing Defendants are hereby **ORDERED** to undergo arbitration in accordance with the terms of the

underlying agreements, and all claims against those Defendants are hereby **DISMISSED without prejudice**.

Plaintiff's Motion for Leave to File a Second Amended Complaint [48] is **GRANTED, in part** and **DENIED, in part**. It is granted as to all allegations against Blue Cross Blue Shield in Count V and Count VI. The motion is denied as to any other allegations. Peach State's Motion to Dismiss Plaintiff's Second Amended Complaint [62] is **DENIED as moot**.

Blue Cross Blue Shield and Amerigroup's Motion to Dismiss [21] is **GRANTED, in part** and **DENIED, in part**. It is granted as to Plaintiff's federal law claims (Counts I, II, and III), Plaintiff's FBPA claim (Count IV), and all claims against Amerigroup. It is denied as to Plaintiff's breach of contract claim against Blue Cross Blue Shield (Count V) and Plaintiff's fraudulent inducement claim against Blue Cross Blue Shield (Count VI). Plaintiff's Motion for Leave to File a Response to the Motion to Dismiss [41] is hereby **DENIED as moot**.

The Clerk is **DIRECTED** to terminate all Defendants from this action except for (1) Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and (2) Blue Cross and Blue Shield of Georgia, Inc. Within 14 days of the entry of this

Order, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Blue Cross and Blue Shield of Georgia, Inc. shall file their responsive pleading to Counts V and VI of the Second Amended Complaint. Thereafter, counsel for the Parties remaining in the case shall confer and submit a proposed discovery schedule to the Court.

SO ORDERED, this 27th day of November, 2017.

RICHARD W. STORY
United States District Judge