CASE NO. 15-10210

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

AETNA LIFE INSURANCE COMPANY,

Plaintiff-Appellant,

v.

METHODIST HOSPITALS OF DALLAS, doing business as METHODIST MEDICAL CENTER, doing business as CHARLTON MEDICAL CENTER; TEXAS HEALTH RESOURCES; MEDICAL CENTER EAR, NOSE & THROAT ASSOCIATES OF HOUSTON, P.A.,

Defendants-Appellee.

On Appeal From the United States District Court
For the Northern District of Texas
No. 3:14-cv-347

AMICUS BRIEF OF AMERICA'S HEALTH INSURANCE PLANS SUPPORTING APPELLANT

Robert I. Howell
Texas Bar No. 10107300
Evan A. Young
Texas Bar No. 24058192
BAKER BOTTS L.L.P.
98 San Jacinto Blvd., Suite 1500
Austin, TX 78701
Telephone: (512) 322-2500
Facsimile: (512) 322-2501
Counsel for Amicus
America's Health Insurance Plans

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INTEREST OF AMICUS

This brief is filed by America's Health Insurance Plans (AHIP)[1] as *amicus curiae* in support of the position of Aetna Life Insurance Company (Aetna) that:

- The Prompt Pay Provisions (Texas Insurance Code, Chapter 1301, subchapters C and C-1, and related sections) cannot be construed to encompass self-funded plans governed by ERISA and companies that administer ERISA plans;[2]
- Even if the Prompt Pay Provisions could be so construed, they would be expressly preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a);[3] and
- The Prompt Pay Provisions would also be preempted because they duplicate, supplement, or supplant the exclusive civil enforcement remedy set out in Section 502(a) of ERISA, 29 U.S.C. § 1132(a), and because they conflict with the claims processing regulations promulgated pursuant to Section 503, 29 U.S.C. § 1133.[4]

AHIP is a national trade association whose members administer or provide health coverage to more than 200 million Americans. The association's goals are to provide a unified voice for the healthcare financing industry, expand access to high quality, cost-effective healthcare to all Americans, and ensure Americans' fi-

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[1] AHIP confirms that all parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a). AHIP further confirms that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparing or submitting the brief; and no person, other than AHIP, its members or its counsel, contributed money intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(c)(5).

[2] Brief of Appellant at 18-29.

[3] *Id.* at 34-52.

[4] *Id.* at 53-58.

nancial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

Most people with health coverage insured or administered by AHIP members are participants in, or beneficiaries of, employee benefit plans governed by ERISA. AHIP and its members therefore have a significant interest in ensuring that courts correctly interpret and apply ERISA. The Eleventh Circuit recently recognized AHIP's interest in this issue by affirming its associational standing to sue to enjoin enforcement of a Georgia prompt-pay statute against self-funded ERISA plans. *America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331-32 (11th Cir. 2014). Addressing the exact preemption issue present in this case, the Eleventh Circuit held that ERISA Section 514(a) preempts the Georgia statute. *Id.* at 1334.

The judgment below will substantially affect AHIP's members and those whom they serve. AHIP is concerned that the District Court has misread the state statutory provisions in issue and, on top of that misreading, has misapplied ERISA preemption principles. Among other things, the judgment below undermines one of ERISA's principal features, a nationally uniform administrative scheme to guide the processing of claims and disbursement of benefits. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001). Without such uniformity, plans will be more complicated and costly to administer, *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), ultimate-

ly to the detriment of plan members and their dependents.

As will be explained, the law requires none of these adverse consequences. AHIP accordingly urges this Court to reverse the judgment below.

ARGUMENT

I. How employer-provided healthcare works.

An appreciation of some aspects of employer-provided healthcare coverage can facilitate the Court's review of the issues presented in this case.

Of the population with health coverage, 54% receive coverage through the workplace.[5] Most employment-based coverage is provided through plans governed by ERISA.[6] To encourage employers to establish benefit plans, ERISA provides a nationally uniform regulatory regime that makes health coverage easier—and far less costly—to administer. *Egelhoff*, 532 U.S. at 147.

ERISA plans provide coverage in either or both of two ways. "Insured" plans purchase insurance for plan members and their dependents. The insurer agrees to pay for necessary healthcare, and accordingly bears the risk that costs

[5] Jessica C. Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013*, United States Census Bureau (Sept. 2014), https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.

[6] *Health Benefits, Retirement Standards, and Workers' Compensation: Employee Benefit Plans*, United States Department of Labor (Sept. 2009), http://www.dol.gov/elaws/elg/erisa.htm#who.

will exceed the premiums it is paid.[7] "Self-funded" plans retain the obligation to pay for member healthcare costs. Under this approach, the plan sponsor (the employer) bears the risk of paying member healthcare costs.[8]

Many employers lack the experience and infrastructure necessary to administer a self-funded plan. Such plans, therefore, typically enter into an "Administrative Services Only" arrangement[9] with a third-party administrator, or TPA.[10] Such administrative services can include assessment for medical necessity, claim preauthorization, claim review for coverage and completeness, and claim payment. A TPA may also make its network of physicians, hospitals, and other providers available to plan members. Most such companies have assembled a network of providers that have agreed to provide care to plan members and their dependents at contractually-agreed rates. Network providers benefit not only from the compensation they receive for the care they provide, but also from the increased business directed

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[7] Thomas Perez, Secretary of Labor, *Annual Report to Congress on Self-Insured Group Health Plans*, at iv (March 2015), http://www.dol.gov/ebsa/pdf/acareporttocongress2015.pdf.

[8] *Id*.

[9] "Administrative Services Only" refers to "[a]n arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims." *Definitions of Health Insurance Terms*, Federal Interdepartmental Committee on Employment-based Health Insurance Surveys (Federal Bureau of Labor Statistics 2002), http://www.bls.gov/ncs/ebs/sp/healthterms.pdf.

[10] A third party administrator (TPA) is "an individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer." *Id*.

their way.

TPAs often are also licensed insurers or affiliates of a licensed insurer. But the capacity in which a TPA acts in processing a given claim will depend on whether the plan covering the claim is insured or self-funded. In the case of self-funded plans, the claims are paid not by insurance, but by the plan directly, and agreements between TPAs and providers typically recognize that the plan sponsor, and not the TPA, is liable on self-funded claims.[11] *See NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993) (recognizing that administrators of self-funded plans do not bear risk.) The insured versus self-funded distinction is well-known in the healthcare industry.[12]

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[11] Aetna's contract with Methodist is a good example. It provides—

> 3.4 Company Obligation to Pay. *While Company [Aetna] may pay claims on behalf of Payors, … Company has no legal responsibility for the payment of such claims.* … Company represents that its agreements with Payors require that such Payor make funds available to allow company to reimburse participating providers for Covered Services provided to Members *enrolled in the applicable self-fund plan*. …Where there is a Payor, Company shall have no obligation to pay Hospital in the event the Payor or member fails to pay Hospital.[11] (Emphasis added.)

"Payor" is defined as—

> *An employer*, insurer, health maintenance organization, labor union, organization or other person or entity *which has agreed to be responsible for funding benefit payments* for Covered Services provided to members under the terms of a Plan.[11] (Emphasis added.)

[12] *See, e.g.*, discussion at *Fast Facts*, Employee Benefit Research Institute, (Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf.

II. The Prompt Pay Provisions do not apply to claims covered by self-funded ERISA plans.

AHIP agrees with Aetna that the analysis begins and should end with the unambiguous language of the Prompt Pay Provisions.[13]

A. The Prompt Pay Provisions, construed in accordance with their unambiguous language, do not apply to self-funded plans.

The most fundamental statutory construction principle under Texas law is that "when a statute's words are unambiguous and yield a single inescapable interpretation, the judge's inquiry is at an end." *Alex Sheshunoff Mgmt. Servs., L.P. v. Johnson***,** 209 S.W.3d 644, 651-52 (Tex. 2006). A close corollary is that "if a statute defines a term, a court is bound to construe that term by its statutory definition only." *Tex. Dep't of Transp. v. Needham*, 82 S.W.3d 314, 318 (Tex. 2002). Another corollary is that a statutory provision must be interpreted in light of the larger statute of which it is a part. *Bridgestone/Firestone v. Glyn-Jones*, 878 S.W.2d 132, 133 (Tex. 1994). This is because "[o]nly in the context of the remainder of the statute can the true meaning of a single provision be made clear." *Id.*

The Prompt Pay Provisions are unambiguous. When read, as Texas law requires, in conjunction with Section 1301.0041(a), Chapter 1301's scope provision,

[13] The court below used the term "Texas Prompt Pay Act," or TPPA, to refer to the subject prompt pay provisions. AHIP does not use that term because it implies the subject provisions are stand-alone statutes to be construed separately from the Insurance Code chapter of which they are a part. The Prompt Pay Provisions are not stand-alone statutes; they are sections of an integral code chapter, Texas Insurance Code chapter 1301, which has a chapter-wide scope provision and definitions that apply to the Prompt Pay Provisions.

and the pertinent statutory definitions from Section 1301, those provisions yield but one meaning—that they apply only to "insurers" (as defined at Section 1301(5)), not to self-funded ERISA plans. Neither do the Prompt Pay Provisions apply to TPAs serving self-funded plans, since TPAs do not contract with an "insurer" when they contract with a self-funded plan. *See* §§ 1301.138, 1301.109 (extending claims processing subchapters to "entities contracting with insurer.")

The Appellees argued in the District Court that the Prompt Pay Provisions are not restricted by the Section 1301.0041(a) scope provision because they fall within the "[e]xcept as otherwise specifically provided" exception. This is not so. The Legislature knows how to "otherwise specifically provide," and did not do so in the Prompt Pay Provisions. It did, however, "otherwise specifically provide" in other provisions from Chapter 1301. For example, Section 1301.1591, concerning the provider information that an insurer must place on its website, reads:

> *Notwithstanding any other provision of this chapter,* this section applies to an entity subject to Chapter 941 or 942 and to a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

§ 1301.1591(d) (emphasis added). The introductory "notwithstanding" phrase specifically expands the application of Section 1301.1591 beyond the scope set out in Section 1301.041(a), so that it also encompasses Lloyd's Plans (Chapter 941), subscribers to reciprocal or inter-insurance exchanges (Chapter 942), and multiple employer welfare arrangements authorized under Chapter 846. Without the "not-

withstanding" phrase—which in the language of Section 1301.0041(a), "otherwise specifically provides"—Section 1301.1591 would not reach those additional plans and arrangements. None of the Prompt Pay Provisions contains comparable language. Their reach, therefore, is restricted to the scope set out in Section 1301.0041(a).

B. The prompt pay penalty provision, Section 1301.137, must be strictly construed in a "limited, narrow" manner.

The above conclusion is all the more compelling given that Section 1301.137, the Prompt Pay Provision that provides for late-payment penalties, is just that, a penalty provision, and as such must be "strictly" construed. *In re Hecht*, 213 S.W.3d 547, 572 (Tex. 2006). *See also, Tenneco Oil Co. v. Padre Drilling Co.*, 453 S.W.2d 814, 818 (Tex. 1970) (holding that a statute penal in nature must be strictly construed). This means it must be given "a limited, narrow, or inflexible reading and application." *Id.*[14]

C. Judge Boyle's reasoning and conclusion in *Healthcare Serv. Corp.* are correct and should be adopted here.

Judge Jane Boyle was recently presented with the identical statutory-construction issue raised here and concluded that the Prompt Pay Provisions did

[14] For some penalty provisions contained in the Insurance Code, the Legislature provided for liberal construction (*see*, *e.g.,* §§ 541.008, 542.054, 562.005, 885.155, 888.02, 1103.052); tellingly, the Legislature did not so provide for Section 1301.137. Courts are to presume that words the Legislature did not include in a statutory "*were purposefully omitted*." *In re M.N.*, 262 S.W.3d 799, 802 (Tex. 2008) (emphasis added).

not apply to self-funded plans. *See Healthcare Serv. Corp. v. Methodist Hosps. of Dallas*, No. 3:13-CV-4946B (N.D. Tex. Jan. 28, 2015),[15] appeal docketed, No. 15-10154 (5th Cir. March 3, 2015). Judge Boyle's analysis is firmly grounded in the unambiguous statutory language and her conclusion is correct. It should be adopted in this case.

D. This Court must itself decide the statutory-construction issue by applying Texas statutory-construction principles.

Whether or not Aetna agreed for Judge Lynn to rely on the Tarrant County state trial court's view on the statutory construction issue[16] does not affect this Court's own interpretation of the Prompt Pay Provisions. Judge Lynn herself recognized that the issue, whichever way she ruled, would be "subject to appeal on the merits." *Aetna Life Ins. Co. v. Methodist Hosps. of Dallas,* __ F. Supp. 3d __, 2015 WL 918586, *2 n.3 (N.D. Tex. 2015).

The standard for interpreting a state statute is straight-forward. The meaning of a state statute is controlled by state law. *See Keenan v. Donaldson, Lufkin & Jenrette, Inc*, 529 F.3d 569, 572-73 (5th Cir. 2008) (applying Louisiana statutory construction law in construing Louisiana credit agreement statute). And under Texas law, "statutory construction is a legal question [an appellate court] review[s] *de novo*"—in other words, without deference to the trial court's construction. *City*

[15] Record on Appeal at 7910-7939.

[16] AHIP, an observer of the proceedings below, believes Aetna did *not* so agree.

of Rockwall v. Hughes, 246 S.W.3d 621, 625 (Tex. 2008). Federal law is in accord. *See NCDR, L.L.C. v. Mauze & Bagby, P.L.L.C.*, 745 F.3d 742, 753 (5th Cir. 2014) ("This Court reviews a district court's interpretation of a state statute *de novo*, interpreting the state statute the way the state supreme court would ….").

The Court therefore should determine for itself the meaning of the Prompt Pay Provisions, doing so by applying the already-discussed statutory construction principles laid down by the Texas Supreme Court.

III. Even if the Prompt Pay Provisions encompassed self-funded ERISA plans and administrators for such plans, they would nonetheless be preempted by ERISA Section 514(a).

Because the statutory-construction issue should dispose of the case, the Court need not reach ERISA preemption.[17] Indeed, reading the unambiguous statutory text as argued above and by Aetna has the virtue of avoiding a conflict between ERISA and the Texas statutory scheme. For if the Prompt Pay Provisions reached as far as the District Court thought, they would *for that reason* be preempted by ERISA. Because the integrity of the ERISA regime is important to AHIP, its members, and the Americans who are served by AHIP's members, AHIP addresses ERISA preemption in some detail.

[17] *See Citizens Nat'l Bank v. Taylor*, 812 F.2d 931, 933-34 (5th Cir. 1987) ("Our disposition of the case on state law grounds makes it unnecessary to consider the alternative argument of the trustee and the creditors' committee that the Texas law is preempted by ERISA.").

A. ERISA establishes and protects a nationally uniform administrative scheme.

ERISA was enacted in 1974 to "promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 90 (1983). The Act accomplishes this by establishing "'a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff,* 532 U.S. 148 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

The nationwide uniformity of this scheme is central and indispensable to ERISA's mission. Uniformity "minimize[s] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133, 142 (1990). "[A] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation." *Fort Halifax*, 482 U.S. at 10. "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." *FMC Corp.*, 498 U.S. at 60.

B. If interpreted to cover self-funded plans, the Prompt Pay Provisions would be preempted by Section 514(a).

"[To] ensure that benefit plans will be governed by only a single set of regu-

lations," *Id.*, Congress included within ERISA an express preemption clause providing that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a) (29 U.S.C. § 1144(a)). This Preemption Clause is both "conspicuous for its breadth," *FMC Corp*., 498 U.S. at 58, and "clearly expansive." *Egelhoff*, 532 U.S. at 146. It "establish[es] as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp*., 498 U.S. at 58. Differing state regulations for '"processing claims and paying benefits' [would] impose 'precisely the burden that ERISA pre-emption was intended to avoid." *Egelhoff*, 532 U.S. at 142 (quoting *Fort Halifax, supra*). That is why the Supreme Court "[has] not hesitated to apply ERISA's preemption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *FMC Corp.,* 498 U.S. at 59.

For purposes of Section 514(a) preemption, a state law "relate[s] to" an ERISA plan if it "has 'a connection with or reference to such a plan.'" *Id.* at 58 (quoting *Shaw*, 463 U.S. at 96-97). A law that interferes with nationally uniform plan administration has a connection with ERISA plans and is therefore preempted. *See Egelhoff*, 132 U.S. at 148 (holding that a Washington state statute had a prohibited connection with ERISA because it "interfere[d] with nationally uniform plan administration."). This Court has held in three different cases that Section

514(a) preempts prompt-pay provisions.[18]

The Fifth Circuit applies a two-prong test to determine when a state law "relates to" ERISA plans. This test asks whether the law (1) addresses an area of exclusive federal concern, and (2) directly affects the relationship among traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Bank of La. v. Aetna U.S. Healthcare Inc*., 468 F.3d 237, 242 (5th Cir. 2006). Aetna has explained why the Prompt Pay Provisions meet both prongs of the test and are therefore preempted.[19] AHIP writes to provide additional context.

Self-funded plans are of the utmost importance in the funding of healthcare in this country. As of 2012, 49% of all employer plans were either completely or partially self-insured.[20] That 49% of plans, however, covered 84% of plan enrollees—a population of 58.6 million employees and employee dependents.[21] Many

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[18] *See N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare*, 781 F.3d 182, 197 (5th Cir. 2015) (Section 514(a) preempts Texas HMO prompt-pay provisions); *Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 274-76 (5th Cir. 2004) (Section 514(a) preempts Texas Insurance Code Section 21.55, a prompt-pay provision applicable to a wide variety of claims); *NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993) (Section 514(a) preempted Texas Insurance Code art. 21.07-6, which, among other things, required TPAs to adjudicate claims within 60 days of receipt).

[19] Brief of Appellant at 38-55.

[20] Constantin W. A. Panis, PhD and Michael J. Brien, PhD, *Self-Insured Health Benefit Plans 2015* at 1, (Sept. 16, 2014) http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport2015.pdf (Deloitte Financial Advisory Services LLP, under contract with the U.S. Department of Labor).

[21] *Id.* The 58.6 million population figure was derived by applying 84%—the percentage

of these plans are regional or national, which means they—or TPAs on their behalf—must process claims from multiple—or even all—states. To contain costs and make claims administration easier (two of ERISA's fundamental goals[22]), many plans and TPAs process claims from multiple states at one or more central locations. For this to work, however, nationwide uniformity is essential. The Supreme Court has recognized that subjecting self-funded plans to differing state claim processing regulations would produce inefficiencies and adversely affect plans and plan members. *Fort Halifax*, 482 U.S. at 10-11; *FMC Corp.*, 498 U.S. at 60.

Therefore, the issue is not just claim administration in Texas, but claim administration nationwide. If the judgment below is affirmed, courts could construe prompt-pay laws in other states as applying to self-funded plans, or state legislatures could be emboldened to amend their state prompt-pay laws to include such plans. Administrators of self-funded plans would then have to conform to widely disparate claim-processing rules and guidelines. The result would be significantly greater administrative expense for plans and possibly reduced benefits for plan members.

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of employee benefit plans in 2012 that were wholly or partially self-funded, as the cited report states on page 1—to the total 2012 population of 69.8 million covered by employee benefit plans of all types, as it states on page 5.

[22] *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

This is not an academic or theoretical issue. So that the Court may appreciate the complexity and confusion that patchwork state regulation would cause, here is a sample of state processing deadlines. While the below-listed statutes do not apply to self-funded plans, they illustrate the widely-divergent regulation that such plans could become subject to in the absence of ERISA preemption. In the following states, electronic claims (the most common kind) must be paid, rejected, or deemed incomplete (with missing information requested) within—

- **15 days**
  - Hawaii (Haw. Rev. Stat. § 431:13-108)
  - New Hampshire (N.H. Rev. Stat. Ann. §§ 415:6-h, 415:18-k, 420-A:17-d, and 420-J:8-a)
  - North Dakota (N.D. Cent. Code § 26.1-36-37.1)
- **20 days**
  - Florida (for 95% of claims) (Fla. Stat. § 627.613)
  - South Carolina (20 business days) (S.C. Code Ann. § 38-59-230, et seq.)
- **21 days**
  - Tennessee (for 90% of claims) (Tenn. Code Ann. § 56-7-109)
- **25 days**
  - Louisiana (La. Rev. Stat. § 22:250.31, et seq.)
  - Mississippi (Miss. Code Ann. § 83-9-5(1)(h))
- **40 days**
  - Virginia (but 30 days to request additional information) (Va. Code

Ann. § 38.2-3407.15)

- **45 days**
    - Oklahoma (but 30 days to request additional information) (Okla. Stat. tit. 36, § 1219(A)).

Congress enacted Section 514(a) precisely to avoid the burden such inconsistent state regulation would impose. ERISA preempts state claim-processing regulations, including prompt-pay laws, in order to preserve the Act's nationally uniform claims-administration scheme and the efficiency and cost-savings that that scheme makes possible. The District Court's holding that the Texas Prompt Pay Provisions are not preempted destroys uniformity and the benefits that flow from it. It also ignores ERISA's language and spirit.

C. Section 514(a) also preempts the Prompt Pay Provisions to the extent they are applied to TPAs acting for self-funded plans.

Appellees' argument in the court below that ERISA does not preempt prompt pay statutes as applied to TPAs is contrary to Fifth Circuit case law. In *NGS American*, this Court held that Section 514(a) preempts a prompt-pay provision to the extent it is "applied to third-party administrators of ERISA-governed insurance plans in their capacity as third party-administrators of ERISA-governed insurance plans." 998 F.2d at 300.[23] *NGS* dealt with a different prompt pay provi-

[23] Although this quote references "insurance plans," the opinion makes clear that the plan in question was self-funded. "Masco established a Self-Funded Employee Benefit Plan … to provide medical and other benefits to its employees." *NGS Am.*, 998 F.2d at 297.

sion, Texas Insurance Code art. 21.07-6, which, among other things, required TPAs to adjudicate claims within 60 days of receipt.[24] *NGS* nonetheless controls here, given the Court's reasoning that "art. 21.07-6 imposes significant burdens on administrators of ERISA-governed employee benefit plans. It is these burdens of complying with conflicting state regulations that Congress sought to eliminate by enacting ERISA." *Id*. at 300. The Prompt Pay Provisions at issue are even more burdensome than art. 21.07-6 was.

Moreover, AHIP agrees with Aetna's explanation of (1) why the Savings Clause, Section 1144(b)(2)(A), does not save the Prompt Pay Provisions from preemption; and (2) why, even if the Savings Clause could apply to the Prompt Pay Provisions, the Deemer Clause, Section 1144(b(2)(B), would except those provisions from the Savings Clause to the extent they apply to self-funded plans. *See* Brief of Appellant at 50-53; *see also Hudgens*, 742 F.3d at 1333 n.18 ("Whether direct or indirect, state insurance regulation of self-insured ERISA is not allowed by operation of the Deemer Clause."). In short, the Prompt Pay Provisions would be preempted whether or not the Savings Clause applies.

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[24] Texas Insurance Code art. 21.07-6, Section 18 (re-codified at Tex. Ins. Code § 4151.111) provided:

> The administrator shall adjudicate the claims not later than the 60th day after the date on which valid proof of loss is received by the administrator. The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement.

IV. Section 514(a) preempts the Prompt Pay Provisions for another reason: the penalties they impose are so excessive as to interfere with nationally uniform claims administration and affect the ERISA relationship.

As discussed above and in Aetna's brief, Section 514(a) preempts *all* prompt pay provisions that apply, or are construed to apply, to self-funded plans. Without detracting from that fundamental principle, AHIP does, though, want to point out an additional factual basis for § 514(a) preemption—namely, the penalties imposed by the Prompt Pay Provisions are so excessive that they meet both prongs of the *Bank of Louisiana* "relates to" test.

A. "Billed charges" greatly exceed contracted-for rates, the market value of the provider's services, and any compensatory damages the provider may incur because of late-payment.

Texas Insurance Code Section 1301.103 generally provides that an "insurer" (as statutorily defined) must, within 30 days of receiving a claim electronically (the most common way a claim is transmitted), either pay the claim or notify the provider that the claim is rejected and state why. Section 1301.103 provides for the following tiered late penalties, which apply even if a claim is later determined not to be covered:

- For claims not completely paid or rejected on or before the 30-day pay-or-reject deadline, the insurer owes a penalty of 50% of the difference between *billed charges* and the amount of any underpayment, up to a cap of $100,000;[25] or
- For claims paid or rejected on or after the 46th day but before

[25] Tex. Ins. Code § 1301.137(a).

the 91st day after the 30-day deadline, the insurer owes a penalty of 100% of the difference between *billed charges* and the amount of any underpayment, up to a cap of $200,000;[26] or

- For claims not paid or rejected before the 91st day after the 30-day deadline, the insurer owes the penalty specified immediately above and, in addition, 18% annual interest calculated from the 30-day pay-or-reject deadline.[27]

To fully appreciate just how excessive and arbitrary these penalties are, one must understand the meaning of "billed charges," a principal variable in the penalty formula. Simply put, "billed charges" are non-negotiated, non-market-based rates that a provider unilaterally sets solely for billing purposes, even though it has contracted for payment at different rates and on different fee arrangements. The use of *pro forma* "billed charges" is an odd artifact left over from the days before managed care, when providers really did expect to collect the charges they billed.

Every hospital has what is called a "chargemaster," a comprehensive list of all procedures and goods offered by the hospital, with a price assigned to each.[28] "Billed charges" are based on chargemaster rates. The provider bills everyone at chargemaster rates, regardless of whether it has agreed to other rates or fee structures for the services—which is virtually always the case.

Chargemaster rates do not represent an agreement between a hypothetical

[26] Tex. Ins. Code § 1301.137(b).

[27] Tex. Ins. Code § 1301.137(c).

[28] Christopher Weaver, *Want to Know What a Hospital Charges? Good Luck*, Kaiser Health News (June 29, 2010). http://khn.org/news/hospital-prices/.

willing provider and willing payor. Indeed, they are not even what a willing provider *expects* to receive, much less what it requires as a condition for providing services. Negotiated rates and arrangements are typically less than half of charge-master rates—often significantly less. "In 2004, the overall ratio of gross to net revenues was 2.57, which means that for every $100 the hospital actually collected from all sources, it initially charged $257."[29] "[T]he totals reflected on a hospital's itemized bill bear neither a specific relationship to the actual value of the goods and services received nor to the amounts actually paid on behalf of patients by the various insurers that the hospital deals with."[30] "[Hospitals] can set them at any level they want. There are no market constraints."[31] With no grounding in the market, billed charges "vary wildly."[32]

Thus, billed charges have no relation to contracted-for rates, the market value of the provider's services, or the compensatory damages (i.e., lost interest) the provider incurs because of late-payment. To impose such costs on an ERISA plan

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[29] Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, Health Affairs (May 2007), http://content.healthaffairs.org/content/26/3/780.full.

[30] George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care ACT, Governmental Insurers, Private Insurers and Uninsured Patients*, 65 Baylor Law Review 426, 470-71 (2013).

[31] Elizabeth Rosenthal, *As Hospital Prices Soar, A Single Stitch Tops $500*, N.Y. Times, Dec. 2, 2012, http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?hp (quoting health economist Glenn Melnick).

[32] Erin Brown, *Irrational Hospital Pricing* (Houston Journal of Health Law & Policy (2014), https://www.law.uh.edu/hjhlp/Issues/Vol_14/Brown.pdf.

or the administrator of an ERISA plan would not only be unfair, but would invariably alter claims handling in a way that would undermine the goal of nationally-uniform claim processing and affect the ERISA relationship.

B. The penalties specified by the Prompt Payment Provisions would interfere with nationally uniform claim processing standards.

Late payment penalties based on billed charges are so excessive that they could well interfere with nationally uniform claim-processing standards. For Texas claims, a TPA—to avoid incurring such large penalties for itself or its customer—could facilitate a quick coverage determination by erring on the side of determining that coverage exists.[33] In other words, because of the excessiveness of the Texas penalties, the plan could bear the added expense of paying claims that a more deliberate determination would have revealed were not covered.

The plan and all its members accordingly have a real interest, grounded in ERISA, in preserving a consistent and uniform incentive structure across all 50 states. Inconsistent incentive structures among the states could cause inconsistent claim processing procedures, the very antithesis of national uniformity. Every dollar that a self-funded plan spends paying a non-covered claim is a dollar less that it has available for covered claims and administrative expenses. This could ultimately affect plan members. *See FMC*, 498 U.S. at 60 ("[D]iffering state regulations

[33] A TPA would more likely err on the side of determining that coverage exists than that it does not exist. Incorrect "no coverage" determinations would spawn disputes with plan members and providers, which the TPA would be motivated to avoid.

would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.).

C. The Prompt Payment Provisions' penalties would create tension between the plan and the plan administrator, adversely affecting the ERISA relationship.

Unsurprisingly, the second prong of the "relates to" test is also met. These arbitrary and excessive penalties would invariably create tension between the plan and the plan administrator, which could significantly affect the ERISA relationship. As noted, for Texas claims, the TPA could be motivated to make a quick and possibly less thorough coverage determination; the plan, on the other hand, would want a more deliberate analysis that would assure non-covered claims would not be paid. The ERISA relationship could well be weakened.

V. The Prompt Pay Provisions are otherwise preempted.

AHIP supports Aetna's thorough and proper analysis of why the Prompt Pay Provisions would also be preempted by ERISA Sections 502(a) and 503 (29 U.S.C. §§ 1132(a) and 1133). The Prompt Pay Provisions duplicate, supplement, or supplant the exclusive civil enforcement remedy set out in ERISA Section 502(a) and conflict with the claims-processing regulations promulgated pursuant to ERISA Section 503. *See* Brief of Appellant at 53-58.

CONCLUSION

Accordingly, the Court should reverse the District Court's judgment because

the Prompt Pay Provisions, by their clear language, do not apply to self-funded ERISA plans, and, even if they did, they would be preempted by ERISA.

Respectfully submitted,

BAKER BOTTS L.L.P.

By: /s/ *Robert I. Howell*

Robert I. Howell
Texas Bar No. 10107300
robert.howell@bakerbotts.com
Evan A. Young
Texas Bar No. 24058192
evan.young@bakerbotts.com
98 San Jacinto Blvd., Suite 1500
Austin, Texas 78701
(512) 322-2500 (Telephone)
(512) 322-2501 (Facsimile)

ATTORNEYS FOR AMICUS
AMERICA'S HEALTH
INSURANCE PLAN

CERTIFICATE OF SERVICE

I hereby certify that on June 8, 2015, an electronic copy of the foregoing Amicus Brief of America's Health Insurance Plans was filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service on all parties will be accomplished by the appellate CM/ECF system.

/s/ *Robert I. Howell*
Robert I. Howell
Texas Bar No. 10107300
Baker Botts, L.L.P.
98 San Jacinto Blvd., Suite 1500
Austin, Texas 78701

CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 29(C)(5)

No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparing or submitting the brief; and no person, other than AHIP, its members or its counsel, contributed money intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(c)(5).

/s/ *Robert I. Howell*
Robert I. Howell
Texas Bar No. 10107300
Baker Botts, L.L.P.
98 San Jacinto Blvd., Suite 1500
Austin, Texas 78701

CERTIFICATE OF COMPLIANCE WITH

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/s/ *Robert I. Howell*
Robert I. Howell
Texas Bar No. 10107300
Baker Botts, L.L.P.
98 San Jacinto Blvd., Suite 1500
Austin, Texas 78701

United States Court of Appeals

FIFTH CIRCUIT
OFFICE OF THE CLERK

LYLE W. CAYCE
CLERK

TEL. 504-310-7700
600 S. MAESTRI PLACE
NEW ORLEANS, LA 70130

June 10, 2015

Mr. Robert Ivah Howell
Baker Botts, L.L.P.
98 San Jacinto Boulevard
San Jacinto Center
Suite 1500
Austin, TX 78701-4078

No. 15-10210 Aetna Life Insurance Company v. Methodist Hospitals of Dallas, et al
USDC No. 3:14-CV-347

Dear Mr. Howell,

The following pertains to your brief electronically filed on June 8, 2015.

You must submit the seven (7) paper copies of your brief required by 5TH CIR. R. 31.1 within five (5) days of the date of this notice pursuant to 5th Cir. ECF Filing Standard E.1.

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Sincerely,

LYLE W. CAYCE, Clerk

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504-310-7668

cc:
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Mr. Mikal Watts