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-Appellees*

On Appeal from the United States District Court
for the Northern District of Texas, No. 3:14-CV-347

# APPELLEE METHODIST'S CORRECTED PETITION FOR PANEL REHEARING

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# CERTIFICATE OF INTERESTED PERSONS

No. 15-10210

AETNA LIFE INSURANCE COMPANY,
*Plaintiff-Appellant,*

V.

METHODIST HOSPITALS OF DALLAS and TEXAS HEALTH RESOURCES,
*Defendants-Appellees*

The undersigned counsel of record for Appellees certifies that the following listed persons and entities as described in Rule 28.2.1 have an interest in the outcome of this case. The following representations are made so that the judges of this Court may evaluate possible disqualification or recusal. The Certificate of Interested Persons set out in Appellant Aetna Life Insurance Company's original Appellant's Brief on file with this Court remains correct except that –

- Defendant-Appellee Medical Center Ear, Nose & Throat Associates of Houston, P.A. is not a party to this appeal, having been dismissed from the case on January 17, 2014, while it was still in the District Court. See ROA 2719-20; and

- Defendant-Appellee Texas Health Resources has elected not to participate in this Petition for Panel Rehearing. The only petitioner for rehearing here is Defendant-Appellee Methodist.

**1. Plaintiff-Appellant**: Aetna Life Insurance Company ("Aetna"), licensed to do business in Texas but having its principal place of business at 151 Farmington

Avenue, Rt21, Hartford, Connecticut 06156. **Affiliates**: An Aetna affiliate, Aetna Health, Inc. ("AHI"), has an interest in the outcome of this case because it is a party in related litigation. AHI is owned by Aetna Health Holdings, LLC ("AHH"). Aetna and AHH are owned by Aetna, Inc.

**2. Attorneys for Plaintiff-Appellant:** (i) John Bruce Sheely of Andrews & Kurth, LLP, 600 Travis street, Suite 4200, Houston, Texas 77002, tel. 713.220.4105, and (ii) Miguel A. Estrada, Geoffrey M. Sigler, and Matthew Scott Rozen of Gibson, Dunn & Crutcher, LLP, 1050 Connecticut Avenue, N.W., Washington, D.C. 20036-5306, tel. 202.955.8500.

**3. Defendants-Appellees:** Methodist Hospitals of Dallas ("Methodist") and Texas Health Resources ("THR"), both Texas non-profit corporations. Neither Methodist nor THR has any parent corporation, nor does any publicly held corporation own more than 10% of the stock or other ownership interests of either.

**4. Attorneys for Plaintiff-Appellant:** (i) Blair G. Francis and Bobby D. Amick of Francis & Totusek, LLP, 500 N. Akard Street, Suite 1830, Dallas, Texas 75201, tel. 214.740.4250, and (ii) Mikal C. Watts of Watts Guerra, LLP, 4 Dominion Drive, Bldg. 3, Suite 100, San Antonio, Texas, tel. 210.447.0500.

/s/ Blair G. Francis
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## PRELIMINARY STATEMENT

In the companion case to this one,[1] the Court held that Texas's Prompt-Pay Statute, Chapter 1301 of the Texas Insurance Code, applies to preferred provider benefit plans only episodically, when the insurers which organize and operate them provide the members' underlying coverage but not when they administer such coverage. Applying that holding here, the Court reversed with instructions the judgment of the District Court, which, relying on an interlocutory judgment of a Texas state trial court holding that Chapter 1301 does apply, as well when the insurer administers as when it provides the coverage, had gone on to hold that ERISA does not preempt the application. This Court held that the District Court erred by failing to make an *Erie* guess about how the Texas Supreme Court would have decided the applicability question and rule as this Court has now done in the companion case. Had the District Court done so and ruled as this Court did in the companion case, whether ERISA preempted would have been rendered moot. Hence the remand with instructions.

The Court erred here, however, just as it did in the companion case, and for the same reasons stated by Methodist in its Petition for Rehearing filed there: Every

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[1] *Health Care Service Corporation v. Methodist Hospitals of Dallas*, cause no. 15-10154, decided February 10, 2016; Petition for Panel Rehearing pending.

insurer organizer/operator of every preferred provider benefit plan, whether Aetna here or BCBSTX in the companion case, "provides . . . for"[2] the payment of a different level of coverage depending on whether the member uses a preferred provider. It does so by means of a series of contracts. The dispute is whether that series constitutes "the insurer's health insurance policy."[3] It does, as well when the insurer administers as when it provides the coverage, because in either case it fits precisely the definition of "health insurance policy" set out in § 1301.001(2): it constitutes one, composite "insurance . . . contract providing benefits for medical or surgical expenses . . ." By holding otherwise, this Court contradicted the carefully expressed will of the Texas Legislature and wrongly decided this case.

## STATEMENT OF ISSUES PRESENTED

Does Chapter 1301 apply to Aetna's preferred provider benefit plan as much when Aetna administers as when it provides its members' coverage? Methodist[4] contends that it does.

Does ERISA preempt § 1301.137's imposition of prompt pay penalties upon

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[2] *See* §1301.0041(a).

[3] *See* §1301.0041(a).

[4] Appellee THR has elected not to petition for rehearing.

Aetna (if it is the recipient of claim submissions[5]) when Aetna contracts with self-funded plans to administer them? Methodist contend ERISA does not preempt, as the District Court held.

## STANDARD OF REVIEW

A court should grant a motion for rehearing if the court rendered an erroneous judgment. *See* Rule 40(a)(2), FED. R. APP. PROCEDURE. This Court's judgment is erroneous. The Court should therefore grant this motion, withdraw its prior judgment and opinion, and render new ones affirming the judgment below.

## SUMMARY OF THE ARGUMENT

Section 1301.061(c) requires each preferred provider benefit ***plan*** offered in Texas to comply with all of Chapter 1301 of the Texas Insurance Code. This Court has held, however, that the insurers which receive the claim submissions of the preferred providers, need comply with § 1301.137 only occasionally, when they pay claims as *providers, but not w*hen they perform the same function as *administrators,* of their members' coverage. The Court thus misapplied Chapter 1301 and therefore erred.

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[5] *See* § 1301.137. *See also* ¶ 3.5 of Aetna's preferred provider agreement with Methodist ("[Methodist] shall bill [Aetna] or the applicable [self-funded plan] . . ."), ROA 4648, and ¶ 4.1.1 of Aetna's preferred provider agreement with THR ("[THR] agrees to submit Clean Claims to [Aetna] or the applicable Plan Sponsor . . ."), ROA 4691.

The District Court correctly held that ERISA does not preempt. Chapter 1301 applies only to preferred provider benefit plans – i.e., to the administrative and preferred provider *contracts* that comprise them[6] – and its penalty provisions only to the insurers which receive clam submissions.[7] Therefore, as the District Court held, correctly applying 10 years of this Circuit's preemption analysis, Chapter 1301 does not "relate to" any self-funded plan. Accordingly, ERISA does not preempt Chapter 1301's applicability to Aetna's preferred provider benefit plan here in issue.

## ARGUMENT

### 1. The One Contract Consisting of (i) Aetna's Contract with a self-funded plan to Administer It, and (ii) Aetna's Contract with the Preferred Provider, constitutes Aetna's "Health Insurance Policy."

Section 1301.0041(a) applies Chapter 1301 to "each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage that is different depending on whether the insured uses a preferred provider . . ." Methodist – the Appellant in the companion case and an Appellee here – set out in detail in its Petition for Panel Rehearing there why that section applies to preferred provider benefit plans – and thus why their insurer organizer/operators are liable under § 1301.137 for late-pay penalties – both when the

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[6] *See* note 22, *infra.*

[7] *See* § 1301.137.

insurers provide and when they administer, the underlying healthcare coverage of their preferred provider benefit plan members. Methodist adopts that reasoning here and incorporates it by reference.[8] The record citations that follow will show why the argument for applicability applies here just as it did there.

The *mechanism* by which Aetna *"provides . . . for"* the *payment* of a different level of coverage is a *contract* consisting of the combination of Aetna's preferred provider and administrative services agreements. Those two contracts form one.[9]

That one contract *provides . . . for the payment* of a level of coverage, as Aetna's preferred provider agreements with Methodist and THR demonstrate.[10] In its agreement with Methodist, Aetna defined "Plan" as "[a]ny health benefit product or plan issued, *administered*, or serviced by [Aetna] . . .[emphasis added]," ROA 4658. A "Member" of Aetna's preferred provider benefit plan is any "individual covered by or enrolled in a Plan." ROA 4658. It is thus that Aetna, by contracting with self-funded plans to administer them, causes their participants to become "Members" of Aetna's preferred provider benefit plan. Methodist agrees to render

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[8] With the retraction notified to the Court in Methodist's letter dated February 29, 2016.

[9] *See Baylor Univ. Med. Ctr. v. Epoch Group, L.C.*, 340 F. Supp. 2d 749 (N.D. Tex. 2004).

[10] *See* ROA 4646ff. for Aetna's preferred provider contract with Methodist and ROA 4681ff. for its preffered provider contract with THR.

healthcare services to Members, ROA 4646 at ¶ 1.1. Aetna agrees to pay for the services at the rates set out in the Aetna/Methodist contract or notify the self-funded plans to do so, ROA 4647 at ¶ 3.1, and Methodist agrees to accept payment at such rates as payment in full and not to make any additional charge to Members. *Id.*

Aetna contracts with THR in the same way it does with Methodist. *See* ROA 4863ff. A "Member" is "[a]n individual covered by or enrolled in a Plan." ROA 4865. A "Plan" is "[a] Member's health care benefits as set forth in the Member's Summary Plan Description [provided as required in ERISA by a self-funded ERISA plan] . . ." Id. A "Plan Sponsor" is "[a]n employer . . . which has contracted with [Aetna] to . . . administer a Plan . . ." Id. THR promises that it will provide its services to Members[11] and treat them equitably with non-members.[12] Aetna promises to facilitate payment to THR at preferred provider rates,[13] and THR promises not to balance-bill Members as a general rule.[14]

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[11] *See* § 2.1 of Aetna/THR preferred provider agreement, ROA 4867.

[12] *See* § 2.2.1 of Aetna/THR preferred provider agreement, ROA 4867.

[13] *See* § 4.1.1 of Aetna/THR preferred provider agreement ROA 4873, "[Aetna] agrees to . . . notify Plan Sponsors to forward payment to [Aetna] for payment to Hospital . . ."

[14] The Aetna/THR preferred provider agreement permits THR to bill Members in limited circumstances, when the Plan Sponsor becomes insolvent or "otherwise breaches the terms and conditions of its agreemen to pay Hospital . . ." See § 4.3.1 of Aetna/THR preferred provider agreement, ROA 4878.

*The level of coverage* for the payment of which the one contract provides *is different.* The basic level of coverage is provided by the self-funded plan. The different, or preferred provider level, is provided for in the preferred provider agreement, and made effective to the Members by the administrative services agreement, all as shown above.

The one contract is *the insurer's*. Both components of the one contract are issued by the insurer, Aetna here. The two components are thus the insurer's/Aetna's. The one contract they comprise is thus also the insurer's/Aetna's.

The one contract also qualifies as the insurer/Aetna's *health insurance policy.* Section 1301.001(2) defines that term as an "insurance . . . contract providing benefits for medical or surgical expenses . . ." Aetna's composite contract is an *insurance* contract because the self-funded plan, which is a party to it, bears risk. It is an insurance contract *providing benefits* because when the participants in self-funded plans become Members of Aetna's preferred provider benefit plan by means of their employers contracting with Aetna to administer the self-funded plans, the newly constituted Members gain "benefits for medical or surgical expenses" that they did not previously have. First, they gain the preferred providers' express promise to

provide them with healthcare services.[15] They had no such promise when covered only by their self-funded plan. Second, they gain Aetna's promise to pay for such services or notify the self-funded plan to do so.[16] They did not previously have that promise. And third, and very significantly, they gain the preferred providers' promise to accept payment from Aetna at the rates set out in the preferred provider agreement as payment in full and not to make any additional charge to the Members.[17] That immunity from balance billing is the principal "*benefit*[] for medical or surgical *expenses* [emphasis added]"[18] that Members gain from membership in a preferred provider plan. That is the *benefit* that principally incentivizes Members to use preferred providers, and that incentive, which steers patients to preferred providers, is the principal reason for any provider to join any preferred provider network. Without such steerage, no provider would participate, or have any reason to participate, in any preferred provider plan. Without providers, no such plan could exist. That preeminent benefit to Members, the exculpation from liability for balance billing, is thus the benefit for medical or surgical expenses which makes the existence

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[15] *See* § 1.1 of the Aetna/Methodist preferred provider agreement, ROA 4646.

[16] *See* § 3.1 of the Aetna/Methodist preferred provider agreement, ROA 4647.

[17] *Id.*

[18] *See* § 1301.001(2).

of any preferred provider benefit plan possible. And because the contract that provides that benefit is Aetna's composite contract, it qualifies that contract as Aetna's "health insurance policy" as defined in § 1301.001(2): The composite contract is an "insurance [because the self-funded plan is a party to it] . . . contract [two documents, one contract] providing benefits [as detailed above] for medical or surgical expenses . . ."

*All requirements for § 1301.0041(a) applicability are thus met.* Aetna's plan here is a "preferred provider benefit plan in which an insurer [Aetna] provides, through Aetna's health insurance policy [the Aetna-issued composite contract, to which the self-funded plan becomes a party by signing the administrative services component] for the payment [Aetna promises in the preferred provider agreement component to pay the provider or notify the self-funded plan to do so] of a level of coverage that is different [it is a preferred provider level, and thus different from the basic level] . . ."[19] By holding otherwise the Court erred.

Further proof of the Court's error is shown by how the Court's ruling violates conventions of statutory construction that the Court itself cited. The Court correctly

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[19] That is not to say that "insurer's health insurance policy" and "preferred provider benefit plan" are co-extensive or identical terms. Aetna's one preferred provider benefit plan is made up of many Aetna health insurance policies.

noted that it is to consider a statutory provision in the context of the broader statute, because it is only in that context that "'the true meaning of a single provision [can] be made clear.'"[20] However, Court's holding nullifies many other sections of Chapter 1301, whereas Methodist's position would effectuate them:

Section 1301.061(c) requires each preferred provider benefit plan issued in Texas to comply with Chapter 1301. But this Court has amended that section to add, "but when the insurer that organized and operates the plan receives claim submissions on coverage it administers rather than provides, the insurer need not comply."

Sections 1301.151-.154 impose continuity of care provisions on all insurers. The effect of that requirement is to give all provider benefit plan members a right to continuity of care. But according to this Court, only some of the members in any given plan have such a right, only those whose coverage is insurer-*provided*. The rest, whose coverage is insurer-*administered*, have no such right. Thus did the Court override the Legislature and, by so doing, err.

Similarly, §§ 1301.067-.068 protect patients against insurer interference with their physician-patient relationship. But under the Court's holding, this protection extends only to patients whose coverage the insurer provides. It does not extend to

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[20] *See* opinion in the companion case, § II.B.1, at 8.

patient/members of the same plan whose coverage the insurer administers.

Sections 1301.133 and 1301.135 provide certain protections to preferred providers during the verification and pre-authorization process. But under the Court's holding, a preferred provider to the same preferred provider benefit plan enjoys these protections only sometimes, when the insurer provides the coverage of the patient being inquired about, but not the rest of the time, when it administers the coverage.

As the foregoing examples show, by construing § 1301.0041(a) as it did, the Court thwarted the Legislature's clear intention. That was error.

**2. ERISA does not Preempt Chapter 1301's Applicability.**

This Court has already held that ERISA does not preempt prompt-pay penalty claims against insurer-administrators of self-funded plans if the party bringing the claim is not a beneficiary (or one standing in his/her shoes).[21] The same reasoning should apply here. Methodist did not sue as a beneficiary of any ERISA plan. It has grounded its penalty claims exclusively on its status as a party which *contracted* with Aetna and on its resultant statutory rights under Chapter 1301.

In *Baylor University Medical Center v. Arkansas Blue Cross Blue Shield*, 331

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[21] *See Lone Star OB/Gyn Associates v. Aetna Health, Inc.*, 579 F.3d 525 (5th Cir. 2009).

F.Supp.2d 502 (N.D. Tex. 2004), the federal district court held Baylor's prompt-pay penalty claims against BCBS were not preempted by ERISA because the state law on which they were predicated did not relate to an ERISA plan. Neither does Methodist's penalty claims against Aetna here "relate to" any such plan.

In *Baylor*, the ERISA plan was held to be peripheral to the statutory prompt-pay obligation Baylor sought to enforce. The ERISA plans here are likewise peripheral to the same statutory obligations Methodist seeks to enforce against Aetna.

In *Baylor*, Judge Fish held that "ERISA does not preempt generally applicable state laws that impact ERISA plans only tenuously . . ." *Baylor, supra*, at 511. Chapter 1301 is a generally applicable state law. By deliberate, careful discrimination, the Legislature limited its regulating reach to the insurer-issued contracts – i.e., the administrative services and preferred provider agreements – on purpose that self-funded plans would not be affected or that any effect on them would be too tenuous and thus, in either event, that preemption by ERISA would be avoided.[22] Because Chapter 1301's impact on ERISA plans is tenuous, ERISA does

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[22] *See* Mattax testimony (emphasis added in all cases): "But I would suggest that there shouldn't be [a] fundamental difference between the payment of a self-funded ERISA plan or an insured ERISA plan." ROA 4196. "There are cases that talk about regulating the *contract* between the provider and the plan. That is [,] the state law that regulates those *contracts*, do[es] not regulate the ERISA plans. * * * . . . ERISA doesn't preempt it regardless of whether it's insured or self-funded." ROA 4199 ". . . if you view this as regulating the contract between the provider and the plan, you don't have an ERISA preemption problem . . ." ROA 4200 " . . .

not preempt.

In *Baylor*, Judge Fish rested his no-preemption holding on the fact that Baylor's claims against BCBS arose out of its preferred provider *contract* with BCBS and the legal conclusion that ERISA did not restrict the ability of two entities wholly outside ERISA to contract. Here, Methodist's penalty claims arise out of its essentially identical preferred provider *contract* with Aetna. ERISA no more restricts Methodist, which is wholly outside ERISA, to contract with Aetna than it did Baylor to contract with BCBS. "ERISA does not go so far as to eliminate the ability of parties on the periphery of ERISA to contract with one another, nor the right of state legislatures to pass laws that impact those contracts."[23]

Moreover, Aetna has not provided any evidence that the contract between itself and Methodist implicates any exclusive federal concern or impacts any of the traditional ERISA entities. *Memorial Hospital System v. Northbrook Life Insurance*

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we're regulating the insurance company. And, therefore, because it's an insurance situation, ERISA allows me to regulate the insurance company because of the savings clause." ROA 4201-02. ". . . what you're saying is, you know, even if you're in an ERISA plan, because you're using an insurance company, we can regulate that." ROA 4203. ". . . it has nothing to do with the plan relationship with the beneficiary." ROA 4204. "If the court views your law as saying no, we're regulating that [contractual] relationship between the provider and the payer and the provider has a contract . . . with the payer [including a payor that is an insurer-administrator], then you're going to be on very safe ERISA grounds." ROA 4207.

[23] *See* Lynn opinion at 20, citing *Baylor*, 331 F.Supp. 2d at 511 ("Congress's wide preemptive scope was not intended to 'insulate an insurer from liability against a third-party health care provider seeking to enforce its rights under a contract.")

*Co.*, 904 F.2d 236 (5th Cir. 1990)(two unifying characteristics of preemption of state law claim: it (1) addresses areas of exclusive federal concern, and (2) directly affects relationship between the traditional ERISA entities – the plan and its fiduciaries, and participants and beneficiaries). Nothing in this record shows that compliance by Aetna with § 1301.137's penalty provisions will influence claim outcomes. Nor can Aetna demonstrate that complying with that section's time deadlines will create any additional burden or cost. Aetna can achieve multistate compliance by complying with the most restrictive of the state deadlines. Nor can Aetna show that § 1301.137 impacts any traditional entity. That section affects Aetna, but Aetna is not among the traditional ERISA entities named by *Memorial Hermann*. "[T]he courts are more likely to find that a state law relates to a benefit plan if its affects relations among the principal ERISA entities . . . than if it affects relations between one of those entities and [as here] an outside party [Aetna] . . ." Therefore, just as ERISA did not preempt in *Baylor*, neither does it preempt here.

## CONCLUSION

Accordingly, the Court should set aside its prior opinion and judgment and render new ones affirming the judgment of the district court.

Respectfully submitted,

By: /s/ Blair G. Francis

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*Counsel for Appellee Methodist*

Dated: March 3, 2016

**CERTIFICATE OF SERVICE**

I hereby certify that on March 3, 2016, an electronic copy of the foregoing instrument was filed with the Clerk of the Court using the appellate CM/ECF system and that service will be accomplished by the appellate CM/ECF system.

/s/ Blair G. Francis
*Counsel for Appellee Methodist*

**CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATIONS, AND WITH TYPEFACE AND TYPE STYLE REQUIREMENTS**

This Motion for Rehearing complies with the type-volume limitations of Federal Rule of Appellate Procedure 40(b) because it 15 pages or less.

This motion complies with the typeface requirements of Federal Rule of

Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using WordPerfect X6 in 14-point Times New Roman font.

Dated: March 3, 2016

/s/ Blair G. Francis
*Counsel for Appellee Methodist*

**CERTIFICATE OF ELECTRONIC COMPLIANCE**

I hereby certify that on March 3, 2016, this Motion for Rehearing was transmitted to the Clerk of this Court through the Court's CM/ECF document filing system, https://ecf.ca5.uscourts.gov. I further certify that: (1) required privacy redactions have been made pursuant to this Court's Rule 25.2.13, (2) the electronic submission is an exact copy of the paper document pursuant to this Court's Rule 25.2.1, and (3) the document has been scanned with the most recent version of Webroot and was fond to have no viruses.

/s/ Blair G. Francis
*Counsel for Appellee Methodist*

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# IN THE UNITED STATES COURT OF APPEALS
# FOR THE FIFTH CIRCUIT

United States Court of Appeals
Fifth Circuit
**FILED**
February 18, 2016
Lyle W. Cayce
Clerk

No. 15-10210

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 - Appellees

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 3:14-CV-347

Before SMITH, WIENER, and GRAVES, Circuit Judges.

PER CURIAM:*

Plaintiff-Appellant Aetna Life Insurance Company ("Aetna Life"), a subsidiary of Aetna Inc., appeals the district court's judgment, which held that (1) Texas Insurance Code, Chapter 1301 applies to Aetna Life as the administrator of self-funded employer plans, and (2) the Employee Retirement

* Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, does not preempt such application. We reverse, vacate, and remand for entry of judgment as directed.

## I.

Aetna Inc. is a national managed-healthcare company. Its subsidiaries that operate in Texas, including Aetna Life and Aetna Health Inc. ("Aetna Health"), offer fully insured plans as well as administrative services for self-funded plans. Aetna Health administers health maintenance organization ("HMO") plans, and Aetna Life administers preferred provider plans.

Defendant-Appellees Methodist Hospitals of Dallas and Texas Health Resources (collectively, the "Providers") are hospitals that provide health care in Texas to the beneficiaries of plans insured or administered by, *inter alia*, Aetna Inc.'s subsidiaries. Aetna Health contracted on behalf of itself and its affiliates—including Aetna Life—with the Providers to furnish services at reduced rates. This appeal relates specifically to allegedly late payments arising out of Aetna Life's administration of self-funded preferred provider ERISA benefit plans for which it contracted with the Providers as preferred providers.

Texas Insurance Code Chapters 843 and 1301 comprise the Texas Prompt Pay Act ("TPPA"). Only Chapter 1301 is relevant to this appeal because Aetna Life administers only preferred provider plans. Chapter 1301 applies to "each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy," payment to preferred providers at discounted rates.[1] Chapter 1301 also applies to entities with which insurers contract to perform particular administrative functions.[2] The statute requires

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[1] TEX. INS. CODE § 1301.0041(a).
[2] *Id.* § 1301.109.

an insurer that receives a "clean claim"[3] from a preferred provider to "make a determination of whether the claim is payable" and to pay or deny the claim.[4] It must do so within 45 days for nonelectronically-filed claims and 30 days for electronically-filed claims.[5] The subject chapter imposes a range of penalties for late payments.[6]

In September 2013, the Providers sent a "Pre-Arbitration Demand" letter to Aetna Health, stating that it had paid particular clean claims late, and claiming that the Providers were owed late-payment penalties in excess of ten million dollars. The Providers cited the Texas Health Maintenance Organization Act[7] (applicable to HMOs) and the Texas Insurance Code, Chapter 1301[8] (applicable to preferred-provider plans) as the source of the obligations for timely payment and for late payment penalties.

Aetna Life responded by filing the instant federal action for a declaratory judgment holding that it is not liable for statutory penalties for claims under the self-funded ERISA plans that it administers. Aetna Life contended that (1) Chapter 1301 does not apply to self-funded ERISA plans or to third party administrators of such plans, or (2) in the alternative, ERISA preempts application of the statute to such plans.

After Aetna Life filed its federal declaratory judgment action, the Providers filed two lawsuits against Aetna Health in Texas state court—one in Tarrant County and the other in Dallas County—seeking penalties for late

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[3] Section 1301.131 defines the elements of a "clean claim."

[4] TEX. INS. CODE § 1301.103.

[5] *Id.*

[6] *See id.* § 1301.137 (outlining penalties); *id.* § 1301.108 ("A preferred provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.").

[7] TEX. INS. CODE § 843.

[8] *Id.* § 1301.

payments.[9] The Providers then filed a motion in the federal case asking the court to abstain from exercising jurisdiction over Aetna Life's declaratory judgment action on the basis of the related state-court proceedings. Aetna Life opposed the Providers' motion. The parties then filed cross-motions for summary judgment.

During the pendency of those motions, Aetna Health filed a motion for summary judgment in the Tarrant County action, contending that the TPPA does not apply to administrators of self-funded plans. At that point, the federal district court opted to "defer" to the Tarrant County court's determination of the TPPA's applicability. The Tarrant County court subsequently denied Aetna Health's motion for summary judgment, holding, without explanation, that the TPPA "applies to Aetna with respect to claims administered by Aetna for self-funded plans."[10]

In March 2015, the federal district court exercised jurisdiction over the action and granted the Providers' motion for summary judgment. It (1) deferred to the Texas state trial court's "non-final interpretation of state law" on the issue of the TPPA's applicability to administrators of self-funded plans and (2) held that ERISA does not preempt such application. Aetna Life timely filed a notice of appeal.

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[9] *Tex. Health Res. v. Aetna Health Inc.*, No. 17-269305-13 (Tex. Tarrant Cty. Dist.) ("Tarrant County action"); *Methodist Hosps. of Dall. v. Aetna Health, Inc.*, No. 13-13865 (Tex. Dallas Cty. Dist.) ("Dallas County action").

[10] Because the order contained no explanation, it is unclear whether the state trial court's holding applies specifically to the applicability of Chapter 1301 to Aetna Life, the relevant issue in this case. For example, the state trial court's reference to the "TPPA" could also refer to Chapter 843 of the Texas Insurance Code, and its reference to "Aetna" could refer to "Aetna Health," the defendant in that action.

## II.

On appeal, Aetna Life contends that the district court erred in deferring to the Texas state court's determination that Chapter 1301 applies to third-party administrators of self-funded plans. Aetna Life also contends that, under the plain language of the statute, Chapter 1301 does not apply to its administration of self-funded ERISA plans, or , in the alternative, that ERISA does preempt such application.

### A.

The district court erred when it deferred to the Texas court's non-final interpretation of law on the question of the TPPA's applicability. The abstention doctrine announced by the Supreme Court in *Brillhart v. Excess Insurance Co. of America*[11] gives district courts discretion to stay a declaratory judgment action or to abstain from exercising jurisdiction over a declaratory judgment action when a parallel case is pending in state court.[12] Here, the district court categorized its decision as one to "abstain." But that court did not

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[11] 316 U.S. 491 (1942).

[12] The Fifth Circuit has identified the following factors to be considered in making this determination:

> (1) whether there is a pending state action in which all of the matters in controversy may be fully litigated;
> (2) whether the plaintiff filed suit in anticipation of a lawsuit filed by the defendant;
> (3) whether the plaintiff engaged in forum shopping in bringing the suit;
> (4) whether possible inequities in allowing the declaratory plaintiff to gain precedence in time or to change forums exist;
> (5) whether the federal court is a convenient forum for the parties and witnesses;
> (6) whether retaining the lawsuit would serve the purposes of judicial economy; and
> (7) whether the federal court is being called on to construe a state judicial decree involving the same parties and entered by the court before whom the parallel state suit between the same parties is pending.

*Sherwin-Williams Co. v. Holmes Cty.*, 343 F.3d 383, 388 (5th Cir. 2003) (quoting *St. Paul Ins. Co. v. Trejo*, 39 F.3d 585, 590–91 (5th Cir. 1994)).

in fact abstain. Rather, it expressly exercised jurisdiction over Aetna Life's declaratory judgment. Without abstaining from exercising jurisdiction and without a basis to give preclusive effect to the non-final holding of the Texas state trial court,[13] the district court accepted an interlocutory decision of a state trial court on a point of law, which provided a basis for its judgment.[14] This constituted error. Because the district court did in fact exercise jurisdiction over the action, it should have made an *Erie* guess as to how the Texas Supreme Court would decide whether Chapter 1301 applies to Aetna Life's activities in this case.[15]

**B.**

That brings us to the question whether Chapter 1301 applies to Aetna Life's administration of the self-funded ERISA plans.[16] Our recent opinion in *Health Care Service Corp. v. Methodist Hospitals of Dallas*[17] holds that Chapter 1301 does not apply to a third-party administrator of self-funded employer plans. Specifically, we held that neither Chapter 1301's express

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[13] Under Texas law, "[a] prior adjudication of an issue will be given estoppel effect only if it was adequately deliberated and firm." *Mower v. Boyer*, 811 S.W.2d 560, 562 (Tex. 1991). Texas courts consider "(1) whether the parties were fully heard, (2) that the court supported its decision with a reasoned opinion, and (3) that the decision was subject to appeal or was in fact reviewed on appeal." *Id.* Here, the state trial court did not support its denial of summary judgment with a reasoned opinion and the interlocutory order was not subject to appeal. Accordingly, issue preclusion does not provide a basis for the district court's deferral to the state trial court's decision.

[14] The district court only reached the issue of ERISA preemption because it deferred to the Texas state trial court's holding that the TPPA applies in the first place.

[15] The Providers themselves justify the district court's deference to the Texas trial court's determination of law only on the basis that "the Texas Supreme Court would likewise have held the TPPA applicable."

[16] We decline Methodist's invitation to remand this issue to the district court because we review determinations of state law de novo. Moreover, we recently decided this precise issue in the related case, *Health Care Serv. Corp. v. Methodist Hosps. of Dall.*, ___ F.3d ___, 2016 WL 530680 (5th Cir. Feb. 10, 2016).

[17] *Id.*

applicability provision[18] nor its extension of the statute to administrators[19] applies to administrators of self-funded plans. That is why we now hold that Chapter 1301 does not apply to Aetna Life's administration of the self-funded ERISA plans at issue here.[20] Aetna Life's activities are not covered by the statute's express applicability section because Aetna Life does not provide payments of covered expenditures through its "health insurance policy."[21] Neither is Aetna Life an administrator with whom an "insurer" contracts under the provision of the statute that extends its applicability to administrators. This is because the self-funded ERISA plans are not "insurers" under Chapter 1301.[22]

## III.

In light of our holding that Chapter 1301 of the Texas Insurance Code does not apply to Aetna Life's administration of the self-funded ERISA plans, the district court's denial of Aetna Life's motion for summary judgment and its grant of the Providers' motion for summary judgment are reversed, the judgment of that court is vacated, and the case is remanded for entry of judgment in favor of Aetna Life.

REVERSED, VACATED, and REMANDED for entry of judgment.

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[18] TEX. INS. CODE § 1301.0041(a).

[19] *Id.* § 1301.109.

[20] Because we hold that Chapter 1301 does not apply, we decline to decide whether ERISA would preempt such application.

[21] *See* TEX. INS. CODE § 1301.0041(a).

[22] *See id.* § 1301.109; *id.* 1301.001(5). *See also See Tex. Dep't of Ins. v. Am. Nat'l Ins. Co.*, 410 S.W.3d 843, 848–49 (Tex. 2012) ("Without question, self-funded employee health-benefit plans operate much like insurers. Their activities not surprisingly then fit the definitions of 'insurer' and 'business of insurance' found in the chapter designed to prohibit the unauthorized business of insurance. But that chapter's purpose is to extend the state's regulatory authority to those conducting the business of insurance in the state without authorization. That purpose does not include self-funded employee health-benefit plans because they are not regulated like insurance companies.").

Print Form

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

# BILL OF COSTS

**NOTE: The Bill of Costs is due in this office *within 14 days from the date of the opinion, See* FED. R. APP. P. & 5TH CIR. R. 39. Untimely bills of costs must be accompanied by a separate motion to file out of time, which the court may deny.**

_____ v. _____ No. _____

The Clerk is requested to tax the following costs against: _____

| COSTS TAXABLE UNDER Fed. R. App. P. & 5th Cir. R. 39 | REQUESTED | | | | ALLOWED (If different from amount requested) | | | |
|---|---|---|---|---|---|---|---|---|
| | No. of Copies | Pages Per Copy | Cost per Page* | Total Cost | No. of Documents | Pages per Document | Cost per Page* | Total Cost |
| Docket Fee ($500.00) | | | | | | | | |
| Appendix or Record Excerpts | | | | | | | | |
| Appellant's Brief | | | | | | | | |
| Appellee's Brief | | | | | | | | |
| Appellant's Reply Brief | | | | | | | | |
| Other: | | | | | | | | |
| | | | Total $ | | | | Costs are taxed in the amount of $ | |

Costs are hereby taxed in the amount of $ _____ this _____ day of _____, _____.

LYLE W. CAYCE, CLERK

State of
County of _____

By _____
Deputy Clerk

I _____, do hereby swear under penalty of perjury that the services for which fees have been charged were incurred in this action and that the services for which fees have been charged were actually and necessarily performed. A copy of this Bill of Costs was this day mailed to opposing counsel, with postage fully prepaid thereon. This _____ day of _____, _____.

_____
(Signature)

*SEE REVERSE SIDE FOR RULES GOVERNING TAXATION OF COSTS

Attorney for _____

*FIFTH CIRCUIT RULE 39*

***39.1 Taxable Rates.*** *The cost of reproducing necessary copies of the brief, appendices, or record excerpts shall be taxed at a rate not higher than $0.15 per page, including cover, index, and internal pages, for any for of reproduction costs. The cost of the binding required by 5TH CIR. R. 32.2.3that mandates that briefs must lie reasonably flat when open shall be a taxable cost but not limited to the foregoing rate. This rate is intended to approximate the current cost of the most economical acceptable method of reproduction generally available; and the clerk shall, at reasonable intervals, examine and review it to reflect current rates. Taxable costs will be authorized for up to 15 copies for a brief and 10 copies of an appendix or record excerpts, unless the clerk gives advance approval for additional copies.*

***39.2 Nonrecovery of Mailing and Commercial Delivery Service Costs.*** *Mailing and commercial delivery fees incurred in transmitting briefs are not recoverable as taxable costs.*

***39.3 Time for Filing Bills of Costs.*** *The clerk must receive bills of costs and any objections within the times set forth in FED. R. APP. P. 39(D). See 5TH CIR. R. 26.1.*

**FED. R. APP. P. 39. COSTS**

**(a)** ***Against Whom Assessed.*** The following rules apply unless the law provides or the court orders otherwise;

(1) if an appeal is dismissed, costs are taxed against the appellant, unless the parties agree otherwise;

(2) if a judgment is affirmed, costs are taxed against the appellant;

(3) if a judgment is reversed, costs are taxed against the appellee;

(4) if a judgment is affirmed in part, reversed in part, modified, or vacated, costs are taxed only as the court orders.

**(b)** ***Costs For and Against the United States.*** Costs for or against the United States, its agency or officer will be assessed under Rule 39(a) only if authorized by law.

**©)** ***Costs of Copies*** Each court of appeals must, by local rule, fix the maximum rate for taxing the cost of producing necessary copies of a brief or appendix, or copies of records authorized by rule 30(f). The rate must not exceed that generally charged for such work in the area where the clerk's office is located and should encourage economical methods of copying.

**(d)** ***Bill of costs: Objections; Insertion in Mandate.***

(1) A party who wants costs taxed must – within 14 days after entry of judgment – file with the circuit clerk, with proof of service, an itemized and verified bill of costs.

(2) Objections must be filed within 14 days after service of the bill of costs, unless the court extends the time.

(3) The clerk must prepare and certify an itemized statement of costs for insertion in the mandate, but issuance of the mandate must not be delayed for taxing costs. If the mandate issues before costs are finally determined, the district clerk must – upon the circuit clerk's request – add the statement of costs, or any amendment of it, to the mandate.

**(e)** ***Costs of Appeal Taxable in the District Court.*** The following costs on appeal are taxable in the district court for the benefit of the party entitled to costs under this rule:

(1) the preparation and transmission of the record;

(2) the reporter's transcript, if needed to determine the appeal;

(3) premiums paid for a supersedeas bond or other bond to preserve rights pending appeal; and

(4) the fee for filing the notice of appeal.

# *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

February 18, 2016

MEMORANDUM TO COUNSEL OR PARTIES LISTED BELOW

Regarding: Fifth Circuit Statement on Petitions for Rehearing or Rehearing En Banc

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

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Enclosed is a copy of the court's decision. The court has entered judgment under FED R. APP. P. 36. (However, the opinion may yet contain typographical or printing errors which are subject to correction.)

FED R. APP. P. 39 through 41, and 5TH CIR. R.s 35, 39, and 41 govern costs, rehearings, and mandates. **5TH CIR. R.s 35 and 40 require you to attach to your petition for panel rehearing or rehearing en banc an unmarked copy of the court's opinion or order.** Please read carefully the Internal Operating Procedures (IOP's) following FED R. APP. P. 40 and 5TH CIR. R. 35 for a discussion of when a rehearing may be appropriate, the legal standards applied and sanctions which may be imposed if you make a nonmeritorious petition for rehearing en banc.

Direct Criminal Appeals. 5TH CIR. R. 41 provides that a motion for a stay of mandate under FED R. APP. P. 41 will not be granted simply upon request. The petition must set forth good cause for a stay or clearly demonstrate that a substantial question will be presented to the Supreme Court. Otherwise, this court may deny the motion and issue the mandate immediately.

Pro Se Cases. If you were unsuccessful in the district court and/or on appeal, and are considering filing a petition for certiorari in the United States Supreme Court, you do not need to file a motion for stay of mandate under FED R. APP. P. 41. The issuance of the mandate does not affect the time, or your right, to file with the Supreme Court.

The judgment entered provides that defendants-appellees pay to plaintiff-appellant the costs on appeal.

Sincerely,

LYLE W. CAYCE, Clerk

By:_____
Jamei R. Schaeffer, Deputy Clerk

Enclosure(s)

Mr. Martin J. Bishop
Mr. Miguel Angel Estrada
Mr. Robert Ivah Howell
Mr. Michael Branch Kimberly
Mr. Brian David Netter
Mr. Matthew Scott Rozen
Mr. John Bruce Shely
Ms. Meredith Shippee
Mr. Geoffrey M. Sigler
Mr. Micah Ethan Skidmore
Ms. Kathryn Comerford Todd
Mr. Mikal Watts