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

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CERTIFICATE OF INTERESTED PERSONS

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Defendants–Appellees.

The undersigned counsel of record certifies that the following interested persons and entities described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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C. Affiliates of Plaintiff–Appellant

Aetna Life Insurance Company's affiliate, Aetna Health Inc., has an interest in the outcome of this case, as it is a party in related litigation. Aetna Health Inc. is owned by Aetna Health Holdings, LLC. Aetna Life Insurance Company and Aetna Health Holdings, LLC are owned by Aetna Inc.

D. Defendants–Appellees

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* Medical Center Ear, Nose & Throat Associates of Houston, P.A. is no longer a party to this action because Aetna Life's claims against it have been dismissed. In the interest of completeness, however, its prior involvement has been noted here exclusively for purposes of evaluating possible disqualification or recusal.

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STATEMENT REGARDING ORAL ARGUMENT

Under Fifth Circuit Rule 28.2.3, appellant Aetna Life Insurance Company ("Aetna Life") respectfully submits that oral argument will assist this Court in resolving the important, central issue in this appeal: whether self-funded ERISA plans—*i.e.*, plans through which employers provide and fund health benefits for their employees—can be subjected to claim-processing requirements and penalties under a Texas "prompt pay" statute. That issue is important given its impact on numerous self-funded plans and their administrators operating in Texas and nationwide. Under the district court's decision, those plans face burdensome state-specific claims-processing rules requiring them to process claims in Texas more quickly than they process claims in other states, or else pay providers in Texas at higher rates than providers in other states. Plans and their administrators also face a wave of lawsuits by healthcare providers based on the Texas prompt-pay statute. Appellees' counsel, for example, claim to represent "over 500 different medical entities across . . . Texas" accounting for "10,600 medical providers," and boast that prompt-pay litigation has "exploded" in Texas. ROA.3502-3503 (letter to Aetna's counsel). This suit alone, which involves two hospitals, resulted from the hospitals' demands for more than $73 million in statutory penalties.

Many of the prompt-pay lawsuits pending in Texas—including most of the hospitals' demands of Aetna Life, and all of the claims at is-

sue in this declaratory-judgment action—rest on administrators' alleged violations of the Texas statute in connection with benefits claims under *self-funded* ERISA plans. Oral argument will assist this Court in determining whether such litigation may proceed against Aetna Life and other administrators of self-funded plans.

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INTRODUCTION

This appeal arises from an attempt by two Texas hospitals to expand the scope of the Texas prompt-pay statute, Tex. Ins. Code §§ 1301.101 *et seq.*, and related provisions to claims paid under "self-funded" health benefits plans, through which many employers provide health benefits for their employees. The hospitals have advanced this position by suing these plans' administrators for millions of dollars in penalties, based on purported application of the Texas statute to claims that were paid under these self-funded plans.

The hospitals' position is squarely refuted by the Texas statute itself, which by its terms does not apply to self-funded health plans or their administrators. The hospitals' attempted expansion of the statute's scope is also barred by the federal statutory scheme that governs health benefits plans, the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*. In fact, federal preemption caselaw uniformly holds that self-funded plans cannot be subjected to state regulation. The district court nevertheless denied Aetna Life Insurance Company's ("Aetna Life") request for a declaratory judgment, ruling that the Texas prompt-pay statute could be applied to self-funded plans and is not preempted.

This Court should reverse the district court's order.

First, the Texas statute by its terms applies its prompt-pay requirements—requiring that benefits claims be processed and paid in a

set number of days, on pain of significant financial penalties—only to payments by an "insurer" through the "insurer's health insurance policy." Tex. Ins. Code § 1301.0041 ("Applicability"). The statute thus applies only to claims paid by *insurers* under *insured* plans—plans that have complied with the Texas statute for years and are not at issue in this case. This case concerns a separate type of plan: *self-funded* plans, through which employers assume the financial obligation to directly fund claim payments and other plan expenses, rather than transferring the financial risk of such obligations to an insurer. Quite simply, claims under self-funded plans are not paid under "health insurance polic[ies]"—they are instead funded out of the employer's own assets. And in processing claims under self-funded plans, Aetna Life functions as an administrator, not as an "insurer." Under its straightforward text, therefore, the statute does not apply to benefits claims under self-funded plans. Indeed, the Texas agency charged with enforcing the statute has repeatedly concluded that it does *not* apply to such plans.

The district court did not directly address this threshold question whether the Texas statute applies to self-funded plans. Instead, the court "defer[red]" to a state trial court's non-final order in another proceeding, without any supporting reasoning or analysis, that the prompt-pay statute applies to such plans. That was error. The district court had no basis for deferring to the state trial court's interlocutory decision, and instead was required to determine how the Texas Supreme

Court would interpret the prompt-pay statute. Under the Texas Supreme Court's decisions and well-established principles of statutory interpretation, the Texas statute does not apply to claims under self-funded ERISA plans. The district court's ruling should be reversed. In the alternative, this state-law issue should be certified to the Texas Supreme Court.

Second, even if the prompt-pay statute did apply to self-funded plans, it would be preempted. ERISA § 514(a) expressly preempts "any and all State laws" that "relate to" this type of plan. 29 U.S.C. § 1144(a). This express-preemption provision blocks States from forcing plans "to design their programs in an environment of differing state regulations." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990). Congress enacted that bar because allowing such a patchwork approach would "complicate the administration of nationwide plans" and produce "inefficiencies that employers might offset with decreased benefits." *Ibid*. Applying the prompt-pay statute to self-funded plans would frustrate Congress's aims by requiring administrators to process claims more quickly—and pay higher amounts—in Texas than in other states, where other beneficiaries of the same plans reside. The statute is also preempted because it interferes with ERISA's claim-processing regulation and impermissibly supplements ERISA's "comprehensive civil enforcement scheme." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987).

The district court rejected preemption, on the ground that the statute merely affects the contractual relationship between administrators and healthcare providers, with no direct effect on ERISA plans other than the cost of paying penalties. These rulings should be reversed because the statute significantly affects how claims are processed—and therefore how plan eligibility and benefits are determined—under these plans. The statute also interferes with ERISA's claim-processing regulation and remedial provisions. As numerous courts have held in ruling that similar prompt-pay claims by providers are preempted, such claims strike at ERISA's core design and undermine its uniform federal standards and exclusive remedies.

JURISDICTIONAL STATEMENT

The district court had jurisdiction over this diversity action under 28 U.S.C. § 1332. Order 4 (ROA.7946). The district court also had jurisdiction under 29 U.S.C. §§ 1132(a)(3)(B)(ii) and 1132(e)(1) because Aetna Life seeks declaratory relief enforcing ERISA's preemption provision, and under 28 U.S.C. §§ 1331 and 2201 because the hospitals' prompt-pay claims are "so completely pre-empt[ed]" by ERISA that they necessarily arise under federal law. *Met. Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 63-64 (1987); *see also Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 209 (2004).

This Court has appellate jurisdiction under 28 U.S.C. § 1291. The district court entered final judgment for the hospitals on March 13,

2015. ROA.7965. Aetna Life filed a notice of appeal that day. ROA.7966.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Texas's prompt-pay statute is codified in Chapter 1301 of the Texas Insurance Code, which "applies" only to payments by an "insurer" through the "insurer's health insurance policy." Tex. Ins. Code § 1301.0041(a). Self-funded ERISA benefits plans are established and funded by employers, which pay claims from their own assets, rather than through an insurance policy from an insurer. Does the prompt-pay statute apply to claims under self-funded plans?

2. ERISA bars States from regulating self-funded ERISA plans and preempts state laws that directly affect ERISA plan administration or conflict with any ERISA provision. As construed by the district court, Texas's prompt-pay statute imposes claim-processing requirements that directly affect administration of self-funded ERISA plans and conflict with ERISA's claims procedures and enforcement scheme. If the prompt-pay statute is construed to apply to claims under self-funded plans, does ERISA preempt it?

STATEMENT OF THE CASE

I. Employer Health Benefit Plans Under ERISA

The primary means for obtaining health coverage in the United States is through employer-provided benefits plans. Employers typical-

ly pay for or subsidize health coverage through plans governed by ERISA.

ERISA plans generally address the financial and administrative burdens of providing health coverage by taking either of two approaches. First, a plan can buy an insurance policy issued by an insurer, thereby transferring both financial risk and administrative duties (such as claim processing) to the insurer. Plans that take this approach are called "insured." Second, a plan can fund itself. In doing so, the plan sponsor (the employer) retains the financial risk of liability for healthcare costs and pays benefits claims out of its own assets. These "self-funded" plans often hire insurance companies or other third parties as "administrators" to apply the terms set by the plan and pay claims from the plan's assets. *Am.'s Health Ins. Plans* v. *Hudgens* 742 F.3d 1319, 1324 (11th Cir. 2014).

Under ERISA, States may in some circumstances regulate indirectly the first type of plan—insured plans—by regulating those plans' insurers. States may not "dee[m]" self-funded plans—the type of plan at issue in this case—to be "insurer[s]," however, 29 U.S.C. § 1144(b)(2)(B), and thus "may not regulate" those plans. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 64 (1990). That distinction reflects "Congress' presumed desire to reserve to the States the regulation of the business of insurance" while sparing employers from "conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* at 64-65 (quo-

tation marks omitted). This protection from state-specific plan-administration requirements enables employers to provide a uniform program of benefits to employees located in multiple states.

Health benefits plans, including self-funded plans, frequently enlist healthcare providers as "preferred providers" to provide care at contracted rates. Plans encourage their beneficiaries to choose preferred providers, lowering overall plan costs while generating business for these providers. *N. Cypress Med. Ctr. Operating Co.* v. *CIGNA Healthcare*, 781 F.3d 182, 187 (5th Cir. 2015).

II. The Texas Prompt-Pay Statute

For nearly twenty years, the Texas Insurance Code has required insurers that issue insurance policies in Texas to pay claims submitted by their preferred providers within specified "prompt pay" periods or incur steep financial penalties. *See*, *e.g.*, Tex. Ins. Code Art. 3.70-3C (1998). Throughout this period, the Code's terms have made clear that these and other requirements apply only to insured plans—not to self-funded plans.

The earliest of these Texas prompt-pay laws were part of a larger enactment governing payments to preferred providers through an "insurer['s]" own "health insurance policy." Tex. Ins. Code Art. 3.70-3C § 2 (1998) ("Application"). Those laws were thus—as the hospitals have conceded—"confined to fully-funded insurance products [*i.e.*, insured

plans]." Defendants' Brief in Support of Their Cross-Motion for Summary Judgment, at 6 (ROA.3948) ("Hospitals' Cross-Mot.").

In 2003, Texas enacted the Texas Prompt Pay Act ("TPPA"), which augmented insurers' prompt-pay duties and imposed harsher penalties for late payments. Tex. Acts 2003, 78th Leg., ch. 214, § 1. The prompt-pay provisions were later recodified in Chapter 1301 of the Texas Insurance Code. Tex. Acts 2003, 78th Leg., ch. 1274; Tex. Ins. Code §§ 1301.101 *et seq*.

The TPPA did not modify the provisions limiting the prompt-pay statute to insured plans. Chapter 1301, like its predecessor, thus "applies"—subject to exceptions not relevant here—to "preferred provider benefit plan[s] in which *an insurer provides*, *through the insurer's health insurance policy*," payment to preferred providers at discounted rates. Tex. Ins. Code § 1301.0041(a) ("Applicability") (emphasis added). When it applies, Chapter 1301 requires an insurer that receives a "clean" (that is, properly submitted) claim from a preferred provider to "make a determination of whether the claim is payable"—and to pay or deny the claim—within 30 days for electronically submitted claims, or 45 days otherwise. *Id.* § 1301.103. That deadline cannot be extended even if more time is needed for "[t]he investigation and determination of payment." *Id*. § 1301.1053.

An insurer that does not pay within this statutory deadline faces stiff penalties. "[I]f a clean claim submitted to an insurer is payable

and the insurer does not determine" and "pay" it within the deadline, the insurer must pay at least 50%—and in some circumstances up to 100%—of the amount by which the full "billed" rate set by the provider exceeds "the contracted rate" that the provider agreed to accept for the services. Tex. Ins. Code § 1301.137(a), (b). After 90 days, the insurer also accrues penalties of "18 percent annual interest." *Id*. § 1301.137(c). And the statute awards attorney fees to providers that prevail on prompt-pay claims. *Id.* § 1301.108. These penalties are triggered when (1) the insurer does not timely "determine" whether "the claim is payable," (2) the insurer timely determines that the claim is payable but does not timely "pay," or (3) the insurer does not timely "pay" because it incorrectly determines, even in good faith, that the claim is not payable. *Id*. § 1301.137(a)-(c).

III. Aetna's Contracts With The Hospitals

Aetna Life is a subsidiary of Aetna Inc. ("Aetna"), a national managed-healthcare company that provides services to employee welfare benefit plans governed by ERISA. Aetna's affiliates offer both insured plans and administrative services for self-funded plans. "[A]pproximately 75% of the plans administered by Aetna affiliates in Texas are 'self-funded.'" ROA.784-785 ¶ 4 (Solomon Declaration). Aetna operates in Texas through several affiliates, including Aetna Health Inc. ("Aetna Health") and Aetna Life. Aetna Health administers health

maintenance organization ("HMO") plans, while Aetna Life administers preferred-provider plans. ROA.7822 (Roberts Deposition).

Methodist Hospitals of Dallas ("Methodist") and Texas Health Resources ("THR") are hospitals that provide healthcare to beneficiaries of plans insured or administered by Aetna's affiliates. Aetna's affiliates contracted with Methodist and THR as preferred providers to provide services at reduced rates. ROA.197-225, *as amended* ROA.227-231 ("Methodist Contract"); ROA.233-269 ("THR Contract"). Aetna Health entered into the contracts "on behalf of itself and its Affiliates" (Methodist Contract 1 (ROA.197)) or "applicable Affiliates" (THR Contract 1 (ROA.235)), including Aetna Life. *See* Order 6 (ROA.7948). Both contracts establish deadlines for Aetna's affiliates to process payments to these two hospitals, but those deadlines are not as stringent (and the penalties not as severe) as under the statute involved in this case.[1]

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[1] Under the Methodist contract, claims not paid within 45 days accrue 1.5% interest per month. Methodist Contract § 3.1 (ROA.228). Under the THR contract, claims under "Plan Sponsor [*i.e.*, self-funded] Plans" must be paid within 30 days, with no penalty until 30 more days after THR notifies the plan sponsor of its failure to pay. THR Contract § 4.1.2.2 (ROA.245). Late payments are subject to penalties of 50% to 100% of the amount by which the "billed" rate exceeds the "contracted" rate. *Ibid.* Under these provisions, any prompt-pay penalties relating to self-funded plans are to be paid by the "[p]lan [s]ponsors," not Aetna Life. *Ibid.*; *see also* Methodist Contract § 3.1 (ROA.228) (imposing penalties on "Payors," defined as "employer[s]" "responsible for funding benefit payments," *id.* § 12.13 (ROA.209)).

IV. This Litigation

In September 2013, Methodist and THR sent demand letters to Aetna Health alleging that "certain clean claims submitted to Aetna were paid late." ROA.311, ROA.340. The hospitals' multi-million dollar demand rested *entirely* on the purported application of the Texas prompt-pay "statut[e]," *ibid*.; comparable relief was unavailable under the contractual deadlines and penalties described above. Many of the claims to which the hospitals sought to apply those statutory requirements and penalties were paid under *self-funded* health benefits plans. ROA.864-1424 (listing such claims).

Aetna Life, which administers self-funded plans, then brought this federal action against Methodist and THR.[2] Aetna Life sought a declaration that it is not liable for statutory penalties for claims under self-funded plans because (1) the Texas prompt-pay statute does not apply to self-funded plans or their administrators, or (2) if it does apply, ERISA preempts it. Complaint (ROA.194).

The hospitals then filed two lawsuits in Texas state court against Aetna Health—the separate Aetna entity that is a licensed HMO, and that does not administer self-funded plans. *Tex. Health Res.* v. *Aetna*

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[2] The action originally was filed in the Southern District of Texas, and was transferred to the Northern District of Texas under 28 U.S.C. § 1404(a). ROA.3522. Aetna Life also sued Medical Center Ear, Nose & Throat Associates of Houston, but those claims were dismissed and are no longer at issue. ROA.2719.

Health Inc., No. 17-269305-13 (Tex. Tarrant Cty. Dist.) ("Tarrant County action"); *Methodist Hosps. of Dallas* v. *Aetna Health*, *Inc.*, No. 13-13865 (Tex. Dallas Cty. Dist.) ("Dallas County action"). The hospitals sought prompt-pay penalties for claims under both insured and self-funded plans. The Tarrant County action and this action proceeded; the Dallas County action remains in its preliminary stages.

In December 2013, the hospitals moved the federal district court to abstain from deciding Aetna Life's declaratory-judgment claims under *Brillhart* v. *Excess Ins. Co. of Am.*, 316 U.S. 491 (1942), which recognizes a district court's "discretion" to stay or dismiss a declaratory-judgment claim while "parallel state court proceedings" are "pend[ing]," *Wilton* v. *Seven Falls Co.*, 515 U.S. 277, 279-82 (1995). *See* ROA.476. Aetna Life opposed that motion, ROA.1737-1747, and the parties cross-moved for summary judgment on Aetna Life's state-law and preemption defenses. ROA.754-780; ROA.3935-3937.

In August 2014, while those motions were pending, Aetna Health moved for summary judgment in the Tarrant County action on its state-law defense. *See* Sept. 9, 2014 Tr. 21:20-23 (ROA.7989). The district court decided to abstain from further proceedings pending resolution of that motion. ROA.4601-4602. In October 2014, the Tarrant County court denied Aetna Health's summary-judgment motion in a one-paragraph order, stating that "the Texas Prompt Pay Act applies to

Aetna with respect to claims administered by Aetna for self-funded plans." Doc. 00513062509 ("Tarrant County Order").[3]

Approximately four months after the Tarrant County court's order, while Aetna Life's motions were still pending in the district court below, another district judge in a separate action—in which Methodist sought similar prompt-pay claims against a different administrator—ruled that "the prompt payment provisions of Texas Insurance Code § 1301.101 *et seq*. do not apply" to "self-insured plans." *Health Care Serv. Corp.* v. *Methodist Hosps. of Dallas*, No. 13-cv-4946, slip op. 29 (N.D. Tex. Jan. 28, 2015) (Boyle, J.) (ROA.7910-7939) ("*HCSC* Order"). The ruling was supported by a lengthy opinion analyzing the Texas prompt-pay statute's text and rejecting many of the arguments made by the hospitals in this case. *Id*. Aetna Life promptly notified the district court of that decision. ROA.7906-7908.

In March 2015, the district court granted summary judgment to the hospitals. After determining that it "ha[d] the authority to grant declaratory relief" and "should allow [Aetna Life's] action to proceed," Order 7-10 (ROA.7949-7952), the district court "defer[red]" to the Tarrant County court's "non-final," one-paragraph ruling that the Texas

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[3] Although a copy of that order was not entered on the district court's docket, counsel provided it to the district court and the district court's ruling refers to it. Aetna Life has accordingly moved this Court to take judicial notice of the order's contents and entry. Doc. 00513062508.

prompt-pay statute "'applies to Aetna with respect to claims administered by Aetna for self-funded plans.'" *Id*. at 3-4 (ROA.7945-7946). The district court did not address the *HCSC* court's contrary ruling or its reasoning.

The district court then ruled that ERISA does not preempt the prompt-pay statute. The court held that the hospitals' claims were not expressly preempted because they did not "'addres[s] an area of exclusive federal concern'" or "'directly affec[t] the relationship among traditional ERISA entities.'" Order 12 (ROA.7954). It reasoned that the statute's "only impact on ERISA plans" is "the increased cost" resulting from "prompt payment penalties," which it found "insufficient to serve as a basis for preemption." *Id.* at 19-21 (ROA.7961-7963).

The court also concluded that awarding the hospitals prompt-pay penalties would not "'directly affec[t] the relationship among traditional ERISA entities'" because the hospitals are not such entities. Order 19 (ROA.7961). It reasoned that the hospitals seek relief because of "their contractual privity with [Aetna Life]," rather than "because any ERISA plan beneficiaries have assigned [the hospitals] their rights." *Id*. at 19-20 (ROA.7961-7962). The court stated that ERISA does not "eliminate the ability of parties on the periphery of ERISA plans to contract with one another, nor the right of state legislatures to pass laws that impact those contracts." *Id.* at 21 (ROA.7963).

The court similarly held that the prompt-pay deadlines and penalties do not conflict with ERISA. It reasoned that ERISA's claim-processing regulation (29 C.F.R. § 2560.503-1) merely establishes "'procedures pertaining to claims for benefits by participants and beneficiaries,'" and thus "does not apply to the [hospitals'] claims." Order 21 (ROA.7963). And it found no conflict with ERISA's remedial scheme because the hospitals were not "standing in [beneficiaries'] shoes by virtue of assignment." *Id.* at 21-22 (ROA.7963-7964).

This timely appeal followed.

SUMMARY OF ARGUMENT

I. The district court erred by deferring to a state trial court's non-final ruling that the Texas prompt-pay statute applies to self-funded plans.

A. By its terms, the Texas prompt-pay statute does not apply to claims under self-funded plans. Rather, it applies only to payments made by an "insurer" through the "insurer's health insurance policy." The self-funded plans at issue here (and the employers that use them) are not "insurer[s]." And claims under these plans are not paid through "health insurance polic[ies]." That textual conclusion is confirmed by prior codifications of the prompt-pay statute and by guidance from the Texas Department of Insurance, which—as the agency charged with enforcing the prompt-pay statute—has stated for years that the statute's requirements do not apply to self-funded ERISA plans.

B. The district court erred in deferring to the state trial court's contrary interpretation. The Tarrant County court's non-final, one-paragraph ruling was not binding in this case, no abstention doctrine warranted deference to that ruling, and that ruling carried no preclusive effect in the district court. The district court was required to determine how the Texas Supreme Court would have interpreted the statute. That court would conclude that the prompt-pay statute does not apply to self-funded plans.

C. This Court should reverse the district court and hold that the prompt-pay statute does not apply to Aetna Life in its capacity as an administrator for self-funded plans. If this Court has any doubt on that issue, it should certify the question to the Texas Supreme Court.

II. If the prompt-pay statute were construed to apply to self-funded plans, ERISA would preempt it.

A. ERISA § 514(a) preempts any state law that "relates to" an ERISA plan. That standard is met if a statute regulates an area of exclusive federal concern and directly affects the relationship among traditional ERISA entities. As interpreted by the hospitals, the Texas prompt-pay statute meets that standard because (1) it directly regulates how plan administrators, acting as fiduciaries for ERISA plans, make plan eligibility and benefits determinations on claims submitted on behalf of plan beneficiaries, and (2) it also directly regulates the amounts paid on these claims. The statute thus encroaches on ERISA's guaran-

tee that plans are subject to uniform national standards for plan administration—without interference from state-specific claim-processing rules. Indeed, other circuits have held that ERISA § 514(a) preempts similar prompt-pay laws. The statute's application here is not saved as a law regulating insurance because the issue here concerns its application only to self-funded plans.

B. The prompt-pay statute is also preempted because it conflicts with two ERISA provisions regulating plan administration: ERISA's claims-processing regulation, which allows a longer time period for determining coverage than the prompt-pay statute does; and ERISA's civil-enforcement provision, which provides the exclusive remedy for all benefits disputes, including claims that benefits were not processed within the time period prescribed under the claim-processing regulation.

STANDARD OF REVIEW

A federal court interpreting state law is "bound to answer the question the way the state's highest court would resolve the issue." *Occidental Chem. Corp.* v. *Elliott Turbomachinery Corp.*, 84 F.3d 172, 175 (5th Cir. 1996). This Court therefore "review[s] a district court's interpretation of a state statute *de novo*." *Ibid*. The legal determination that ERISA preempts a state law is also reviewed *de novo*. *Bank of La.* v. *Aetna U.S. Healthcare Inc.*, 468 F.3d 237, 241 (5th Cir. 2006).

ARGUMENT

I. The District Court Erred In Adopting The Hospitals' Position That The Texas Prompt-Pay Statute Applies To Self-Funded Plans.

The district court deferred to the Tarrant County court's order stating that the Texas prompt-pay statute applies to self-funded plans. But the state trial court's conclusory ruling was wrong and was entitled to no deference. This Court should hold that the statute does not apply to benefits claims under self-funded plans.

A. The Statute Does Not Apply To Self-Funded Plans.

There is no basis for the hospitals' attempted expansion of the Texas prompt-pay act's requirements and penalties to claims under self-funded health plans. The statute is expressly limited to payments by "an insurer" through "the insurer's health insurance policy." Self-funded plans, like those administered by Aetna Life, do not involve an insurer or its health insurance policy. So the statute's text alone requires dismissal of the hospitals' claims. And there is more: The current prompt-pay statute is materially similar to its predecessor statutes, which the hospitals *concede* did not apply to self-funded plans. Finally, the Texas Department of Insurance—the agency charged with enforcing the prompt-pay statute—has consistently and authoritatively interpreted the statute to apply only to insured plans. The hospitals' attempt to extend the statute to self-funded plans should be rejected, and the district court's order should be reversed.

1. The Statute's Plain Text Shows That It Does Not Apply To Self-Funded Plans.

The threshold question whether the Texas prompt-pay statute applies to self-funded plans is governed by the statute's "Applicability" provision, Tex. Ins. Code § 1301.0041. *See Lake Charles Diesel, Inc.* v. *Gen. Motors Corp.*, 328 F.3d 192, 198-99 (5th Cir. 2003) (An "Applicability" provision's "functio[n]" is to "describ[e] the kind of [transactions] to which [a statute] applies."). Section 1301.0041 provides:

> Except as otherwise specifically provided by this chapter, this chapter *applies 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 an insured uses a preferred provider or a nonpreferred provider.

Tex. Ins. Code. § 1301.0041(a) (emphasis added).

Chapter 1301—including the prompt-pay provisions—thus "applies" only to "preferred provider benefit plan[s]" in which an "insurer" provides payment "through the insurer's health insurance policy." Tex. Ins. Code § 1301.0041(a). "[T]he purposeful inclusion" of those plans "implies the purposeful exclusion" of other plans. *Steering Comms. for Cities Served by TXU Elec.* v. *Pub. Util. Comm'n*, 42 S.W.3d 296, 302 (Tex. App. 2001). Courts have thus consistently recognized that such applicability provisions are "finite rather than illustrative." *Lake Charles*, 328 F.3d at 198-99 ("Applicability" provision defining contracts to which Act "shall apply" contained an "unambiguous catalog of every

feature that a contract must have if the [statute] is to apply"); *see also Panhandle E. Pipe Line Co.* v. *Pub. Serv. Comm'n of Ind.*, 332 U.S. 507, 516 (1947) (where applicability provision listed three transactions to which statute "shall apply," statute applied to those "three only"); *Anderson* v. *Wood*, 152 S.W.2d 1084, 1086-87 (Tex. 1941) (provision imposing obligations on "each county" applied only to counties within scope of separate provision identifying counties to which the act "shall apply").

Other features of Chapter 1301 confirm this limitation. The chapter is titled "Preferred provider benefit plans"—a term defined as "benefit plan[s] in which an insurer" provides for payment to preferred providers "through its health insurance policy." Tex. Ins. Code § 1301.001(9). And several provisions of Chapter 1301—including key provisions of the prompt-pay statute—apply only to "preferred provider[s]," a term that is defined as providers who provide care to "insureds covered by a health insurance policy," *id.* § 1301.001(8). *See*, *e.g.*, *id.* §§ 1301.103 (setting deadline for paying "a clean claim from a preferred provider"), 1301.137 (requiring insurer to pay penalties to "the preferred provider making the claim").

Because the prompt-pay provisions apply only to plans in which an "insurer" provides payment through "the insurer's health insurance policy," those provisions do not apply to claims under self-funded plans. To begin, employers who offer self-funded plans are not "insurer[s]" as contemplated by Chapter 1301. An "insurer" is an "insurance company,

or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in [Texas] health insurance policies." Tex. Ins. Code § 1301.001(5). Self-funded plans are not insurance companies, do not operate under those chapters, and are not authorized to issue health-insurance policies. "Although an employee health-benefit plan may in some respects act like an insurer with respect to the plan's participants, the [Texas] Insurance Code does not regulate it as one." *Tex. Dep't of Ins.* v. *Am. Nat'l Ins. Co.*, 410 S.W.3d 843, 854-55 (Tex. 2012).

In administering self-funded plans, moreover, Aetna Life does not function as an insurer. Those plans are offered and funded by employers without insurance. ROA.784-785 ¶ 4 (Solomon Declaration). Thus when, as here, Aetna Life processes claims under a self-funded plan, the *employer's* plan provides payment out of its own assets, rather than through an "insurer's health insurance policy." The prompt-pay statute thus does not apply to claims under self-funded plans. *See St. Luke's Episcopal Hosp.* v. *Principal Life Ins. Co.*, No. 05-cv-3825, 2007 WL 189375, at *3 (S.D. Tex. Jan. 22, 2007) (self-funded plans are not "insurance polic[ies]" subject to Texas prompt-pay statute's applicability provision).

The surrounding legal context supports this interpretation. Under longstanding ERISA caselaw predating the Texas prompt-pay statute, States may regulate insured plans indirectly through their insur-

ers, but "may not regulate" self-funded plans. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 64 (1990). The prompt-pay statute therefore limits its application to plans that the State permissibly may regulate. The statute should be construed in keeping with that design because doing otherwise would render the statute unconstitutional as preempted by ERISA. *See infra* Part II; Tex. Gov't Code § 311.021(1) (establishing "presum[ption] that" Texas legislature intended "compliance with the [United States] constitutio[n].").

The hospitals have nonetheless attempted to extend the Texas prompt-pay statute to self-funded plans. Their arguments lack merit.

First, citing the Texas Code Construction Act, the hospitals have argued that "the specific prompt pay provisions" should "trump" the "Applicability" provision's "general language." Defendants' Response to Motion for Summary Judgment, at 3-4 (ROA.2218-2219) ("Hospitals' Resp."). Under that Act, a "special" (*i.e.*, specific) provision usually trumps a "general" provision if those provisions "irreconcilabl[y]" "conflict." Tex. Gov't Code § 311.026(b). The hospitals' argument is unavailing because here there is no conflict—let alone an irreconcilable conflict. "[T]he Applicability Section is not merely a 'general' section, but is rather the section that defines the scope of the entire Chapter 1301." *HCSC* Order 17 (ROA.7926). Because self-funded plans do not meet the "Applicability" requirements, the purportedly "specific" prompt-pay provisions do not apply to them at all, and thus create no conflict. And

even independent of the "Applicability" requirements, the prompt-pay provisions do not apply to self-funded plans because they regulate only payments by "insurer[s]" to "preferred provider[s]" who render care to "insureds covered by a health insurance policy," Tex. Ins. Code §§ 1301.001(8), 1301.103. *See supra*, at 20.

Second, the hospitals have argued that Section 1301.0041(a)'s opening clause ("Except as otherwise specifically provided by this chapter") requires courts "to follow the specific language" in Chapter 1301's substantive provisions even if the "Applicability" requirements are not met. Hospitals' Resp. 4-5 (ROA.2219-2220). But the opening clause *limits*, rather than expands, the statute's applicability: it clarifies that individual provisions *do not apply* to all plans regulated by Chapter 1301 if the specific provisions state that they apply only to a narrower subset of plans. Several provisions added in 2011, for example, apply only to "exclusive provider benefit plans." *See* Tex. Acts 2011, 82nd Leg., ch. 288. The opening clause, which was added in the same Act, *ibid*., simply ensures that those provisions do not apply to other types of preferred-provider plans.

Third, the hospitals have argued that "Aetna's interpretation would improperly graft onto the statute an 'exclusion' that the Legislature did not include." Hospitals' Resp. 5-6 (ROA.2220-2221). But that gets things backwards. "Nothing in . . . the statute indicates that all plans not specifically excluded are included within its reach." *HCSC*

Order 19 (ROA.7928). The Legislature did not need to "exclu[de]" self-funded plans from Chapter 1301 because those plans do not fall within the "Applicability" provision, and thus were never included in the first place.

Fourth, the hospitals have tried to force their claims within the statute by characterizing their preferred-provider agreements as insurance policies. Hospitals' Resp. 6-8 (ROA.2221-2223). But the Texas Insurance Code defines a "[h]ealth insurance policy" as "a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness." Tex. Ins. Code § 1301.001(2). Aetna Life's agreements with providers are not "insurance contract[s]" and do not "provid[e] benefits."

Against that textual barrier, the hospitals have offered the tortured contention that the word "insurance" modifies only the word "policy," so the preferred-provider "contract[s]" somehow qualify as "[h]ealth insurance polic[ies]." Hospitals' Resp. 6-7 (ROA.2221-2223). But under settled interpretive principles, a preceding adjective "typically modifies all the words in a string that follow it." *Evanston Ins. Co.* v. *Legacy of Life, Inc.*, 370 S.W.3d 377, 381 (Tex. 2012). The word "insurance" thus modifies "policy," "certificate," and "contract." There is no reason to deviate from that rule here: As the *HCSC* court explained, the hospitals' contrary reading leads to the "absurd result" that "any certificate or contract issued by an insurer would qualify as a 'health insurance poli-

cy,' even if it is unrelated to insurance services." *HCSC* Order 14 (ROA.7923). Texas courts would not embrace that "'absurd conclusio[n].'" *Owens & Minor, Inc.* v. *Ansell Healthcare Prods., Inc.*, 251 S.W.3d 481, 486 (Tex. 2008).

The hospitals' attempt to extend Chapter 1301 beyond its Applicability provision would nullify that provision and sweep within the statute health plans to which it was never intended to apply. By the hospitals' reading, self-funded plans involving no insurer's health insurance policy would face not only prompt-pay requirements, but also a host of other requirements involving healthcare coverage, disclosure, and tort liability. *See*, *e.g.*, Tex. Ins. Code § 1301.006(a) (preferred-provider agreements must "ensur[e] availability of and accessibility to adequate personnel, specialty care, and facilities" for beneficiaries); *id.* § 1301.009 (annual reporting requirements); *id.* § 1301.0515(a) (insurers "may not refuse to provide reimbursement for the performance of a covered acupuncture service solely because the service is provided by an acupuncturist"); *id.* § 1301.065 (preferred-provider contract may not "shift the insurer's tort liability resulting from the insurer's acts or omissions to the preferred provider"). Nothing in the TPPA's text or history suggests that Texas's legislature intended to subject self-funded plans to these requirements—a move that would, after all, directly contravene the Supreme Court's categorical holding that States "may not regulate" such plans. *FMC Corp.*, 498 U.S. at 64.

2. Prior Codifications And Authoritative Agency Interpretations Confirm That The Statute Does Not Apply To Self-Funded Plans.

Texas courts consider prior codifications of a statute when construing the statute, *see*, *e.g.*, *City of Round Rock* v. *Rodriguez*, 399 S.W.3d 130, 137 (Tex. 2013), and give later codifications the same meaning if the "change in the language of the two [provisions] makes [no] material difference." *Mann* v. *Cook*, 11 S.W.2d 572, 574 (Tex. Civ. App. 1928). As the hospitals concede, the earliest prompt-pay provisions "were confined to fully-funded insurance products [*i.e.*, insured plans] provided by insurers and HMOs" and thus did not apply to self-funded plans. Hospitals' Cross-Mot. 6 (ROA.3948). The present statute is in relevant respects identical to its predecessors: Both require an "insurer" to pay claims within a fixed deadline. *Compare*, *e.g.*, Tex. Ins. Code, Art. 3.70-3C § 3A(c) (2000), *with* Tex. Ins. Code § 1301.103. Both define "insurer" in substantially identical terms. *Compare*, *e.g.*, Tex. Ins. Code, Art. 3.70-3C § 1(6) (2000), *with* Tex. Ins. Code § 1301.001(5). And both appear in a section of the Insurance Code that applies only to a "preferred provider benefit plan" in which an "insurer" provides for payment "through its health insurance policy." *Compare*, *e.g.*, Tex. Ins. Code, Art. 3.70-3C § 2 (2000), *with* Tex. Ins. Code § 1301.0041(a). Indeed, the hospitals have not identified any material change distinguishing the statute's current codification from its predecessors, which the hospitals concede did not apply to self-funded plans.

The hospitals argued below that legislative materials concerning the TPPA's enactment in 2003 evince an intent by some supporters to extend the statute to self-funded plans. Hospitals' Resp. 8-9 (ROA.2223-2224). Because the statute's text is "unambiguous," the Court has no basis for consulting such "extrinsic" materials. *See Round Rock*, 399 S.W.3d at 137. Wishful statements by legislators that "did not pass through the law-making processes, were not enacted, and are not published as law" cannot trump "the language actually enacted." *Molinet* v. *Kimbrell*, 356 S.W.3d 407, 414 (Tex. 2011). None of the bill analyses cited by the hospitals below mentions self-funded plans, much less supports any argument that the enacted statute applies to such plans despite its applicability provision. ROA.2445-2269. To the contrary, then-Assistant Attorney General David Mattax—a *proponent* of regulating self-funded plans, *see* ROA.2432-2435 (November 2001 testimony)—testified that the bill that ultimately passed as the TPPA "does not apply to self-funded plans." ROA.5840 (March 2003 testimony). In any event, ambiguous legislative history cannot infuse a "clear and unambiguous" statute with ambiguity. *Round Rock*, 399 S.W.3d at 137; *cf. Milner* v. *Dep't of Navy*, 131 S. Ct. 1259, 1266 (2011) ("[A]mbiguous legislative history" cannot "muddy clear statutory language.").

The hospitals also have no response to the Texas Department of Insurance's ("TDI") longstanding interpretation of the prompt-pay pro-

visions. Texas courts "generally uphold an agency's interpretation of a statute it is charged by the Legislature with enforcing," if "the construction is reasonable and does not contradict the [statute's] plain language." *R.R. Comm'n of Tex.* v. *Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 625 (Tex. 2011) (quotation marks omitted). Even "[i]nformal interpretations" "may merit some deference." *Ibid*. (citing *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 139-40 (1944)). An agency's "interpretation of its own regulations" is similarly "entitled to deference." *Pub. Util. Comm'n of Tex.* v. *Gulf States Utils. Co.*, 809 S.W.2d 201, 207 (Tex. 1991).

TDI is charged by statute with interpreting Chapter 1301. Tex. Ins. Code § 1301.007 ("The [TDI] commissioner shall adopt rules" to "implement this chapter."). TDI's regulations reflect its "long-standing position" that prompt-pay rules "do not apply to self-funded ERISA plans." 28 Tex. Reg. 8647, 8651 (Oct. 3, 2003); *see also* ROA.1623 (2004 TDI report) (prompt-pay rules "have not reached self-funded plans"). Those regulations thus interpret Chapter 1301—including the prompt-pay provisions—as limited to "[a]n insurer that issues a preferred provider benefit plan." 28 Tex. Admin. Code §§ 21.2801, 21.2802(27). Administrators like Aetna Life merely administer—and do not issue—*self-funded* plans, so they fall outside of Chapter 1301 as interpreted by TDI. TDI also has interpreted its own quarterly and annual reporting

regulations (*id.* § 21.2821)—enacted under Chapter 1301—to exempt self-funded plans. ROA.1668.

TDI's other guidance is in accord. *See* Helping You with Your Insurance Complaint (ROA.1635-1636) ("Prompt-payment laws do not apply" to "self-funded health plans."); Prompt Pay FAQs (ROA.1647) ("The prompt pay statutes and rules do not apply to self-funded ERISA plans."); Physician/Provider FAQs (ROA.1658) ("The prompt payment laws . . . do not apply to valid self-funded plans.").[4]

Despite repeatedly amending Chapter 1301, the Legislature has not disapproved of TDI's interpretation. This further fortifies the conclusion that TDI's interpretation is correct. *Sharp* v. *House of Lloyd, Inc.*, 815 S.W.2d 245, 248 (Tex. 1991) (Statutes that "'ha[ve] been construed by the proper administrative officers, when re-enacted without any substantial change in verbiage, will ordinarily receive the same construction.'"). This Court should reach the same conclusion.

B. The Tarrant County Court's Non-Final Ruling Is Not Entitled To Deference.

The district court did not address any of the arguments set out above; instead, it stated only that it would "defer" to the Tarrant Coun-

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[4] As of June 1, 2015, TDI's website provides materially identical guidance to the versions contained in the record. *See*, respectively, www.tdi.texas.gov/pubs/consumer/cb003.html, www.tdi.texas.gov/hprovider/ppsb418faq.html, and www.tdi.texas.gov/hprovider/doctors4.html.

ty court's "non-final interpretation" of the statute. Order 3-4 (ROA.7945-7946). The district court erred in doing so.

1. Aetna Life Did Not Agree To Be Bound By The Tarrant County Court's Order.

The district court "defer[red]" to the state trial court because it believed that the parties had "agreed at the motion hearing on September 9, 2014, that the state court's Order binds both Aetna entities." Order 4 n.3 (ROA.7946). As support for that conclusion, the district court cited seven pages of a September 2014 transcript on the hospitals' abstention motion. *Ibid*. (citing Sept. 9, 2014 Tr. 30-36 (ROA.7998-8004)).

Nowhere in those pages—or anywhere else in the record—did Aetna Life make the agreement that the district court claimed. The district court *asked* both parties to agree that a state decision on "whether the statute covers self-funded plans" would be "binding," but only the hospitals agreed to that request. Sept. 9, 2014 Tr. 30:11-16, 31:1-2 (ROA.7998-7999). Aetna Life did not agree, and instead objected to the district court's statement that it would "wait and see" how the state trial court resolved the statutory-interpretation question. *Id.* at 28:17-22 (ROA.7996). Aetna Life's attorney repeatedly encouraged the court to "get to the construction issue," *id*. at 51:4-6 (ROA.8019), and lamented that he "c[ould] not convince [the district court] to decide" it. *Id*. at 35:12-14 (ROA.8003).

At no point did Aetna Life withdraw either its claim seeking a declaratory judgment on this issue or its motion for summary judgment on that claim. Instead, when *HCSC* was decided, Aetna Life promptly notified the district court of that ruling, "[o]n precisely the same grounds asserted by [Aetna Life]," that the prompt-pay statute does not apply to self-funded plans. ROA.7906-7908. Aetna Life thus urged the district court to reject the Tarrant County court's ruling and interpret the prompt-pay statute *de novo*. Nothing supports the district court's contrary view, and its decision to defer should be rejected.

2. The District Court Lacked Any Other Basis For Deferring To The Tarrant County Court's Non-Final Ruling.

The district court had no other ground for deferring to the state trial court's non-final ruling.

First, principles of abstention do not support deference. The district court briefly granted the hospitals' motion to abstain pending the state trial court's interpretation of the prompt-pay statute. ROA.4601-4602 (abstention order). *Wilton-Brillhart* abstention—which the hospitals invoked, ROA.476—recognizes a district court's "discretion in determining whether and when to *entertain an action* under the Declaratory Judgment Act" during "the pendency of parallel state court proceedings." *Wilton* v. *Seven Falls Co.*, 515 U.S. 277, 279, 282 (1995) (emphasis added). It thus allows the district court to "stay or dismiss" a

declaratory-judgment action, *id.* at 283—not to defer on the merits to a non-final state court order in an action it has agreed to hear. But the district court ultimately agreed to hear the action after the state court ruled. Order 10 (ROA.7952). Once the district court "exercise[d] its discretion [to] hear [Aetna Life's] suit," *ibid.*, *Wilton-Brillhart* had no further role to play.

Second, the Tarrant County order does not have any preclusive effect that could bar the district court from ruling on Aetna Life's state-law defense. Under Texas law, "[a] prior adjudication of an issue will be given estoppel effect only if it was adequately deliberated and firm" based on three factors: "(1) whether the parties were fully heard, (2) [whether] the court supported its decision with a reasoned opinion, and (3) [whether] the decision was subject to appeal or was in fact reviewed on appeal." *Mower* v. *Boyer*, 811 S.W.2d 560, 562 (Tex. 1991).[5] Under those factors, the Tarrant County court's ruling on Aetna Life's state law defense is not entitled to preclusive effect. That court did not "suppor[t] its decision with a reasoned opinion," *ibid.*; it issued a one-paragraph order denying Aetna Life's motion for partial summary judgment and simply stating its conclusion that the TPPA "applies to

[5] State law establishes the preclusive effect of a state judgment in federal court. *See* 28 U.S.C. § 1738 (state proceedings "shall have the same full faith and credit in [federal] court" as "they have by law or usage in the courts of such State").

Aetna with respect to claims administered by Aetna for self-funded plans." Tarrant County Order 1. Nor is that interlocutory order "subject to appeal": no judgment was issued on any claim, and none of the statutory grounds for interlocutory appeal applied, *see* Tex. Civ. Proc. & Rem. Code § 51.014(a). Thus, the "third factor reveals that [the district court's order on] summary judgment in this case was interlocutory" and therefore not preclusive. *Green* v. *Gemini Exploration Co.*, No. 03-02-00334-cv, 2003 WL 1986859, at *6 (Tex. App. May 1, 2003). Preclusion is also inapt because the Tarrant County court "ha[s] the authority to modify the summary judgment order" at any point, *ibid.*, and because the decision could be rendered permanently unappealable by an order dismissing THR's claims under self-funded plans on other grounds, such as preemption or THR's failure to prove liability.

Third, the district court could not have relied on the state trial court's non-final order for determining how the Texas Supreme Court would rule on Aetna Life's state-law defense.

Because the threshold issue requires interpretation of a Texas statute, the district court was required to "make an '*Erie* guess' and 'determine as best it can' what the [Texas] Supreme Court would decide." *Howe ex rel. Howe* v. *Scottsdale Ins. Co.*, 204 F.3d 624, 627 (5th Cir. 2000) (emphasis added). "In making an *Erie* guess," a federal court must consider "'decisions of the [state] Supreme court,'" the "general rule on the question," and "other available sources, such as treatises

and legal commentaries." *Gulf & Miss. River Transp. Co.* v. *BP Oil Pipeline Co.*, 730 F.3d 484, 488-89 (5th Cir. 2013). Although decisions by "[i]ntermediate appellate courts" are "'a datum for ascertaining state law,'" *Howe*, 204 F.3d at 627, "this court does not consider" (for example) "unpublished opinions when making an *Erie* guess." *Amerisure Ins. Co.* v. *Navigators Ins. Co.*, 611 F.3d 299, 311 (5th Cir. 2010). Published appellate decisions, too, must be "disregarded" if "'other persuasive data'" shows "that the highest court of the state would decide otherwise.'" *Howe*, 204 F.3d at 627. Even the "*dicta* of the [state] Supreme Court weigh move heavily" than "appellate cour[t]" holdings. *Am. Int'l Specialty Lines Ins. Co.* v. *Rentech Steel, L.L.C.*, 620 F.3d 558, 566 (5th Cir. 2010) (emphasis added).

The district court did not comply with these authorities when it based its interpretation of state law on an unpublished, non-final, summary decision by a state trial court. Neither the decision below nor the Tarrant County decision on which it relied addresses the merits of Aetna Life's statutory arguments. Neither identifies any basis for disregarding the prompt-pay statute's "Applicability" provision or explains how that provision includes self-funded plans. Neither explains how the TPPA could have altered the pre-2003 status quo, during which self-funded plans were concededly not subject to the Texas prompt-pay laws. And none addresses Texas Supreme Court precedent counseling deference to state agencies. Based on the statutory text and Texas Supreme

Court precedent, the district court should have held that Texas's prompt-pay statute does not apply to self-funded plans.

C. This Court Should Hold That The Statute Does Not Apply To Self-Funded Plans, Or Certify That Issue To The Texas Supreme Court.

Because the district court's ruling on the scope of the prompt-pay statute is a logical predicate to its decision on Aetna Life's preemption claims, this Court should review that ruling or certify the issue to the Texas Supreme Court. *See* Tex. R. App. P. 58.1 ("The Supreme Court of Texas may answer questions of law certified to it by any federal appellate court if the certifying court is presented with determinative questions of Texas law having no controlling Supreme Court precedent.").

Certification is unnecessary here because the answer to the state-law question is "sufficiently clear." *Patterson* v. *Mobil Oil Corp.*, 335 F.3d 476, 487 (5th Cir. 2003). The Texas prompt-pay statute "unambiguous[ly]" does not apply to self-funded plans. *HCSC* Order 22 (ROA.7931); *see supra* Part I.A.1. And the Texas Supreme Court would resolve any ambiguity by deferring to TDI's longstanding interpretation that the statute does not apply to self-funded plans. *See supra* Part I.A.2.

If this Court believes that the statute's scope is ambiguous, however, it should certify to the Texas Supreme Court the question whether the prompt-pay statute applies to self-funded plans. There is no "con-

trolling Supreme Court precedent" on that question. That question is also "determinative" of this appeal because a "ruling to the effect that the [challenged statute] does not apply to [Aetna Life] would moot" Aetna Life's challenge to the statute on preemption grounds. *Word of Faith World Outreach Ctr. Church, Inc.* v. *Morales*, 986 F.2d 962, 968 (5th Cir. 1993). The requirements for certification are therefore met.

II. If The Texas Prompt-Pay Statute Applies To Self-Funded Plans, It Is Preempted By ERISA.

If this Court (or the Texas Supreme Court) were to hold that the prompt-pay statute applies to self-funded plans, the Court should hold that ERISA preempts the statute on two independent grounds. First, the prompt-pay statute is expressly preempted by ERISA § 514(a): the statute directly regulates the processing and payment of benefits claims, and therefore impermissibly "relate[s] to" ERISA plans. 29 U.S.C. § 1144(a). And if it applies to self-funded plans (as the hospitals contend), it is not saved from preemption as a law regulating insurance. Second, the prompt-pay statute is also invalid under principles of conflict preemption because (1) it imposes timeliness standards shorter than those contemplated by ERISA's claim-processing regulations, and (2) it provides civil-enforcement remedies unavailable under ERISA's comprehensive and exclusive civil-enforcement scheme.

A. The Prompt-Pay Statute Is Expressly Preempted Because It "Relate[s] To" Employee Benefits Plans.

Section 514(a) of ERISA preempts "any and all State laws" that "relate to" an ERISA plan. 29 U.S.C. § 1144(a). The Supreme Court has "observed repeatedly that this broadly worded provision is 'clearly expansive.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001). Under Section 514(a), "[a] state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Id.* at 147. Application of that rule is guided by ERISA's "objectives" and "the effect of the state law on ERISA plans." *Ibid.* (quotation marks omitted).

Applying those considerations, this Court has held that a state law has an impermissible "connection with" ERISA plans if it: (1) "'addresses an area of exclusive federal concern'" under ERISA; 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, 241-42 (5th Cir. 2006). Both requirements are satisfied here.

1. The Prompt-Pay Statute Addresses An Area Of Exclusive Federal Concern Because It Directly Regulates Plan Administration.

A state law invades "'an area of exclusive federal concern'" (*Bank of La.*, 468 F.3d at 242) if it "governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 148. Other courts have conclud-

ed that state prompt-pay claims undermine uniform administration of ERISA plans and are therefore preempted. *See*, *e.g.*, *Am.'s Health Ins. Plans* v. *Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014). The Texas prompt-pay statute, too, invades an area of exclusive federal concern under ERISA, and is preempted, because it directly regulates claim processing and payments—two central aspects of plan administration—at the expense of national uniformity.

a. The Statute Directly Regulates Claim Processing.

The prompt-pay statute directly regulates claim processing by dictating strict timelines for paying claims—therefore requiring plans to make benefit and eligibility determinations faster in Texas than in other states. The statute requires administrators to process claims in as few as 30 days. Tex. Ins. Code § 1301.103. That is substantially shorter than is required under federal law, which allows up to 45 days including extensions. *See* 29 C.F.R. § 2560.503-1(f)(2)(iii)(B). And it directly overrides the terms of ERISA plans that incorporate those federal deadlines. *See*, *e.g.*, ROA.1912 (summary plan description allowing up to 45 days including extensions).

The district court apparently believed that "the statute does not hasten the determination of coverage." Oct. 16, 2014 Tr. 38:2-5 (ROA.8072). It concluded that the prompt-pay statute's strict timeline does not affect claim *processing*, but instead affects only "when [admin-

istrators are] obligated to *pay*." Order 20 (ROA.7962) (emphasis added). It thus held that the prompt-pay statute's "only impact on ERISA plans" is "the increased cost" resulting from "prompt payment penalties." *Id.* at 19, 21 (ROA.7961, ROA.7963). That is wrong: the statute unambiguously governs how quickly Aetna Life must "make a *determination* of *whether* the claim is payable." Tex. Ins. Code § 1301.103 (emphases added). That determination requires Aetna Life to decide, among other things, whether the patient listed on the claim was eligible for coverage (which may depend on the employer's records) and whether the services performed were "[c]overed" under the beneficiary's plan (including whether those services were medically necessary). Methodist Contract § 1.1 (ROA.197); THR Contract § 1.15 (ROA.236). Under the statute, the clock runs from "the date an insurer receives a clean claim," not the date it determines that the claim is payable. Tex. Ins. Code § 1301.103. That deadline cannot be "extend[ed]" even if necessary for "investigation and determination of payment." *Id.* § 1301.1053. So the prompt-pay statute compels insurers to make all necessary claim-related determinations more quickly in Texas than in other states—and thus directly affects multiple aspects of claim processing.

ERISA makes clear that claim processing is a central aspect of plan administration and thus an area of exclusive federal concern. ERISA § 503 (29 U.S.C. § 1133) regulates "[c]laims procedure" and authorizes the Department of Labor's (DOL's) corresponding "[c]laims pro-

cedure" regulation (29 C.F.R. § 2560.503-1), which establish uniform deadlines for claim determinations and uniform remedies for delay. *See infra* Part II.B. Those provisions "ensure" a "uniform body of benefits law" that "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. *McClendon*, 498 U.S. 133, 142 (1990). ERISA thus enables employers to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits" so that plans are not required to "process claims in a certain way in some States but not in others." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987).

"[T]imeliness requirements," including prompt-pay laws, "fly in the face" of that goal and thus "impermissibl[y] encroac[h] upon federal law." *Hudgens*, 742 F.3d at 1331, 1334. Authorizing each State to impose its own claim-processing requirements invites a burdensome patchwork of varying state rules governing timeliness and interest payments that would complicate administration of self-funded plans covering beneficiaries in multiple states. Those laws would require administrators of these plans to "familiarize themselves with state statutes," "'tailor'" their "'conduct to the peculiarities of the law of each jurisdiction,'" and grapple with "choice-of-law problems" when processing claims under self-funded plans. *Egelhoff*, 532 U.S. at 148-49, 151. Con-

gress enacted ERISA to protect plans and their administrators from precisely such a morass. *See id.* at 148-49

Claim processing is also central to ERISA because it affects how plans make eligibility and coverage determinations. Cutting short the time to investigate could force administrators to make these decisions more quickly, even though with more time and information the plan might have reached a different determination. In addition, steep penalties may be imposed if an insurer is found to have incorrectly denied a claim, even if the insurer did so in good faith based on available information. Tex. Ins. Code § 1301.137(a)-(c).

ERISA's central concern for claim processing is confirmed by numerous decisions holding claim-processing regulations preempted. As the Supreme Court has held, ERISA § 514(a) preempts state-law remedies for "improper *processing* of a claim for benefits"—including claims based on delayed payments. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987) (emphasis added). This Court has twice held that claims under Texas prompt-pay statutes are preempted on that basis. *See N. Cypress Med. Ctr. Operating Co.* v. *CIGNA Healthcare*, 781 F.3d 182, 198-201 (5th Cir. 2015) (healthcare providers' claims against insurer under prompt-pay deadlines for HMOs); *Ellis* v. *Liberty Life Assur. Co.*, 394 F.3d 262, 274-78 & n.53 (5th Cir. 2004) (insured's claims against insurer under statutory deadlines for paying insureds). And in *Bank of Louisiana*, this Court held that ERISA § 514(a) preempted a self-funded

ERISA plan's claims that its administrator "improperly delayed processing and paying" claims to reduce the administrator's liability on a "stop-loss" insurance policy. 468 F.3d at 242. These cases confirm this Court's repeated recognition that claims alleging delayed processing and payment "require inquiry into an area of exclusive federal concern." *Ibid*.

Indeed, every circuit to address the issue has held that ERISA § 514(a) preempts prompt-pay claims based on an alleged failure to timely determine and pay ERISA claims. *See Hudgens*, 742 F.3d at 1331 (Georgia's prompt-pay statute, which "require[d] self-funded ERISA plans to process and pay provider claims, or notify claimants of claim denials, within fifteen or thirty days"); *Schoedinger* v. *United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875 (8th Cir. 2009) (healthcare providers' claims against administrator of self-funded plans under Missouri's prompt-pay law, which imposed statutory and interest penalties if a "health carrier" "'fail[ed] to pay, deny or suspend' a claim within forty days"); *Cicio* v. *Does*, 321 F.3d 83, 95 (2d Cir. 2003) (insured's claim against an HMO under New York law that required ERISA plans to reply within 24 hours to requests for certain treatments).[6] Other circuits have similarly ruled that Section 514(a)

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[6] *Cicio* was vacated on other grounds, *Vytra Healthcare* v. *Cicio*, 542 U.S. 933 (2004), but the Second Circuit reaffirmed the district court's

[Footnote continued on next page]

preempts state-law claims for untimely claim processing. *See*, *e.g.*, *Hotz* v. *Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 58 (1st Cir. 2002) (claim that "delay" in "approving payment" for treatment "caused [patient's] condition to worsen"); *Kanne* v. *Conn. Gen. Life Ins. Co.*, 867 F.2d 489, 491 (9th Cir. 1988) (per curiam) (claims for "emotional distress" caused by "delay in payments" for medical bills).

The hospitals have sought to avoid preemption by arguing that their suit is limited to "claims that the insurer has already decided to pay." Hospitals' Resp. 21-22 (ROA.2236-2237). They thus attempted below to distinguish cases involving "denial[s] of coverage." *See*, *e.g.*, *id.* at 16-18 (ROA.2231-2233). But the effect on plan administration and claim processing is the same regardless of the ultimate coverage determination. Prompt-pay statutes tell administrators how quickly they must determine whether a claim is payable, and this determination obviously cannot be made without also making all of the underlying coverage and eligibility determinations. This Court and other circuits have thus repeatedly held delayed-payment claims preempted even where the insurer had decided to pay or did pay the benefits claims at issue. *See*, *e.g.*, *N. Cypress*, 781 F.3d at 189 (claims reimbursed at reduced rates); *Bank of La.*, 468 F.3d at 240 (payments delayed to subsequent

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dismissal, on preemption grounds, of the insured's timeliness claims. *Cicio* v. *Does*, 385 F.3d 156, 158 (2d Cir. 2004) (per curiam).

periods); *Hudgens*, 742 F.3d at 1330-34 (upholding injunction against enforcing Georgia's prompt-pay statute without distinguishing between paid and unpaid claims); *Hotz*, 292 F.3d at 58 (payments approved after delay); *Kanne*, 867 F.2d at 494 (appeal from *Kanne* v. *Conn. Gen. Life Ins. Co.*, 607 F. Supp. 899, 904 (C.D. Cal. 1985) (indicating that claims were eventually paid)).

In making this argument, the hospitals have relied on *Lone Star OB/GYN Assocs.* v. *Aetna Health Inc.*, 579 F.3d 525 (5th Cir. 2009). *Lone Star*, however, did not involve express preemption under ERISA § 514(a), but instead the more stringent "complet[e] preempt[ion]" doctrine, *id.* at 528, which governs only whether a state law claim can be removed to federal court. *See Copling* v. *Container Store, Inc.,* 174 F.3d 590, 594-95 (5th Cir. 1999) (explaining that claim "preempted by [ERISA] § 514(a)" nonetheless may not be "removable under the complete-preemption principles"). *Lone Star* held only that certain state-law claims—alleging that the insurer "failed to pay the correct contractual rate for services" and seeking additional penalties based on that alleged underpayment—did not satisfy the requirements for federal removal under the complete preemption doctrine. 579 F.3d at 529. This Court found removal inappropriate because the underpayment claims were based solely on a contractually created duty that did not "implicat[e]" "benefit determinations" or affect the timing of those determinations. *Id.* at 532; *accord N. Cypress*, 781 F.3d at 201 ("*Lone Star* was

based on" an "'independent legal duty'" that was "created" by "contract."). The claims in *Lone Star* thus did not affect plan administration in the way that the *statutorily* created prompt-pay deadlines do here.

b. The Statute Directly Regulates The Amount Of Claim Payments.

The prompt-pay statute also regulates the amount of claim payments. When beneficiaries of self-funded ERISA plans obtain healthcare services through preferred providers, plans reimburse a portion of their expense at the contract rate negotiated with providers. *See*, *e.g.*, ROA.1869 (summary plan description for plan administered by Aetna Life, defining "network reimbursement level" as a percentage of the "negotiated rate"). The Texas prompt-pay statute, however, dictates that plans must pay different amounts, up to the "billed" rate, plus "18 percent annual interest" after 90 days and attorneys' fees. Tex. Ins. Code §§ 1301.137(a)-(c), 1301.108. As illustrated by the hospitals' multi-million dollar claims in this case—for statutory penalties in excess of the contracted rates already paid—these are potentially massive mark-ups of the amounts to be paid under self-funded plans.

The amount of claims payments is an area of exclusive federal concern under ERISA. Congress passed ERISA in part to enable plan administrators "to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60. ERISA § 514 thus preempts state statutes regulating a plan's "method for calculating pension benefits." *Alessi* v.

Raybestos-Manhattan, Inc., 451 U.S. 504, 524-25 (1981). Prompt-pay laws that "impact the *amount* paid" for services to beneficiaries are therefore preempted. *Hudgens*, 742 F.3d at 1331.

Relying on *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), the district court deemed this "increase in cost" "insufficient to serve as a basis for preemption." Order 20-21 (ROA.7962-7963). But *De Buono* held only that ERISA does not preempt "every state law" that "increases the cost of providing benefits" solely because increased expenses "will have some effect on the administration of" benefits. 520 U.S. at 814-16. The Court thus held that New York could tax hospitals owned by ERISA plans even though the tax would indirectly affect "the cost of providing benefits." *Ibid*. Unlike the tax in *De Buono*, the Texas prompt-pay penalties directly interfere with ERISA's goal of uniformity by increasing the amount of payments due on claims submitted to a plan. ERISA § 514(a) forbids that interference.

2. The Prompt-Pay Statute Directly Affects The Relationship Among Traditional ERISA Entities.

The prompt-pay statute also "'directly affects the relationship among traditional ERISA entities.'" *Bank of La.*, 468 F.3d at 242. "The critical distinction" for purposes of this requirement, "is not whether the parties to a [state-law] claim are traditional ERISA entities, but whether the claims *affect* an aspect of a relationship that is

comprehensively regulated by ERISA." *Access Mediquip L.L.C.* v. *UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011), *reinstated*, 698 F.3d 229 (5th Cir. 2012) (en banc) (emphasis altered).

As an initial matter, plan administrators are ERISA "fiduciaries," and thus—like "plans" and "beneficiaries"—are "'traditional ERISA entities.'" *Bank of La.*, 468 F.3d at 242. As this Court has held, an "administrator" with "authority to grant, deny, or review denied claims" is an ERISA fiduciary. *Reich* v. *Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *see also LifeCare Mgmt. Servs. LLC* v. *Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 846 n.10 (5th Cir. 2013) (administrator "responsible for interpreting plans" to determine eligibility had "fiduciary relationship with the plan"); *Blue Cross & Blue Shield of Ala.* v. *Sanders*, 138 F.3d 1347, 1352-53 & n.4 (11th Cir. 1998) ("Claims administrators are fiduciaries if they have the authority to make ultimate decisions regarding benefits eligibility."). As plan "fiduciaries," third-party administrators are "'traditional ERISA entities.'" *Bank of La.*, 468 F.3d at 242. States thus cannot avoid preemption by targeting administrators rather than plans. *See Light* v. *Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1248-49 (5th Cir. 1986) (rejecting argument that ERISA § 514 does not preempt claims against a plan administrator).

The prompt-pay statute regulates the relationships among administrators, plans, and beneficiaries because it directs administrators how to process claims. The statute tells administrators, acting as fiduciaries

for self-funded plans, when and how to "determin[e]" "whether [a] claim is payable," Tex. Ins. Code § 1301.103, and thus when and how to determine whether a provider's services were covered under a beneficiary's plan. *See supra*, at 39. It thus directly regulates administrators' performance of their duties to plans, and it directly regulates plans' performance (through administrators) of their duties to beneficiaries. *See supra* Part I.A.1.

The district court held that the prompt-pay statute was not preempted because "the parties in this case are not all traditional ERISA entities." Order 19 (ROA.7961). The hospitals are not such entities, in the court's view, because their "demands arise by virtue of their contractual privity with [Aetna Life]," rather than "because any ERISA plan beneficiaries have assigned their rights to the" hospitals. *Id.* at 19-20 (ROA.7961-7962).

The district court's analysis is wrong for two reasons.

First, it disregards the dispositive fact that the state law claims here "affect an aspect of a relationship that is comprehensively regulated by ERISA." *Access Mediquip*, 662 F.3d at 385 (emphasis omitted). It is "irrelevan[t]" whether the parties themselves are "'ERISA entit[ies]'" if, as here, the claims "would 'affect relations among [such] entities.'" *Hudgens*, 742 F.3d at 1331; *see also id.* at 1328 (ERISA preempted Georgia's prompt-pay statute even though statute's "primary purpose [wa]s to regulate the timeliness and manner of pay-

ment to health care providers."). Indeed, in *Mayeaux* v. *Louisiana Health Service & Indemnity Co.*, this Court rejected a provider's argument that his claim against an insurer was not preempted because, as a provider, he was not a traditional ERISA entity; the provider's claim was preempted, this Court ruled, because it concerned "'handling, review, and disposition of a request for coverage,'" which "go to the very heart of the ERISA administration process," and thus necessarily affects ERISA fiduciaries and beneficiaries. 376 F.3d 420, 432-33 (5th Cir. 2004). So too here. ERISA preempts the Texas prompt-pay statute *even if* the hospitals never took any assignments, because it regulates administrators' "handling, review, and disposition" of requests for coverage and thus necessarily affects the relationship between administrators, plans, and beneficiaries.

The district court nonetheless apparently believed that the hospitals' claims could affect traditional entities only if the hospitals "'stand in the shoes' of ERISA plan beneficiaries." Order 19-20 (ROA.7961-7962). The court based that conclusion on this Court's decision in *Memorial Hospital System* v. *Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990), and on a district court decision in *Baylor Univ. Med. Ctr.* v. *Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502 (N.D. Tex. 2004).

Neither of those cases can bear the weight the district court attributed to them. *Memorial Hospital* held only that ERISA did not

preempt a provider's state-law claim against an insurer for negligently misrepresenting that it would cover the provider's services. 904 F.2d at 249. The claim did not involve "processing of [benefits] claim[s]," a "right to policy benefits," or "derivative standing as an assignee," and thus did not in any way "depen[d] on" or affect a beneficiary's rights. *Id*. at 244, 249 n.20 Unlike the claims in *Memorial Hospital*—but like the claim in *Mayeaux*—the hospitals' prompt-pay claims here directly affect the "'handling, review, and disposition of a request for coverage,'" and thus affect relationships among ERISA fiduciaries, the plans they administer, and those plans' beneficiaries. 376 F.3d at 432-33.

The district court's reliance on *Baylor* is similarly unavailing. *Baylor* did not consider or address the question here—whether a provider's prompt-pay claims *affect* traditional ERISA entities under ERISA § 514(a). Instead, it ruled that a provider lacked standing to sue under ERISA "absent status as an assignee" and therefore the provider's case could not be removed to federal court under the separate "complete preemption" standard—which concerns the *jurisdiction* of federal courts, not whether ERISA displaces a particular state law. 331 F. Supp. 2d at 508. By relying on *Baylor*, the district court conflated the ERISA § 514(a) standard with the standard for complete preemption. That error alone justifies reversal.

Second, even if the district court were correct that assignments are required for preemption under ERISA § 514(a), that requirement

would be satisfied here because the hospitals' claims *are* "dependent on, and derived from" assignments of beneficiaries' rights. *Mem'l Hosp.*, 904 F.2d at 249-50 n.20. The hospitals' contracts with Aetna Life expressly require them to obtain assignments. Methodist Contract § 4.5 (ROA.202); THR Contract § 4.1.1 (ROA.243). And the hospitals do not dispute that they obtained such assignments and "submitted" their claims to Aetna Life "under [those] assignment[s]." ROA.3091-3092 ¶ 14, ROA.3475 ¶ 14 (Tidwell Declarations). Without those assignments, the hospitals' claims would not have been "payable" at all, and they would not be entitled to seek prompt-pay penalties. Tex. Ins. Code § 1301.137. Their prompt-pay claims thus directly depend on and derive from those assignments.

The district court apparently accepted the hospitals' disclaimer of any prompt-pay claims "based on an assignment." Dec. 11, 2014 Tr. 8:14-16 (ROA.8115). But the hospitals' attempt to avoid preemption through that disclaimer does not change the fact that the hospitals *are* assignees and plainly *were* assignees (and presented themselves as such) when their claims were processed and paid. Even under *Memorial Hospital*, therefore, the hospitals qualify as traditional ERISA entities. 904 F.2d at 249 n.20.

Noting that the hospitals are in "contractual privity" with Aetna Life, the district court also suggested that finding preemption here would interfere with "the ability of parties on the periphery of ERISA

plans to contract with one another." Order 19-21 (ROA.7961-7963). That concern was misplaced: The hospitals are not seeking to enforce the terms of their contracts; they are seeking to rewrite them. The hospitals seek only "statutory" damages and have not alleged any contractual breaches or sought any contractual remedies under their preferred-provider agreements. Dallas County Petition ¶ 17 (ROA.3979); Tarrant County Petition ¶ 17 (ROA.3986). This case therefore does not involve the enforcement of "an independent legal duty" that was "created" by "contract," and thus preemption would not restrict peripheral parties from entering into enforceable contracts. Order 16 (ROA.7958).

Texas's *statutory* deadline for paying claims operates *irrespective* of the terms of the provider contract. The statute requires payment of claims in as few as 30 days, *see* Tex. Ins. Code § 1301.103, even though the Methodist contract allows up to 45 days. Methodist Contract § 3.1 (ROA.228). And unlike the THR contract, which gives plan sponsors 30 "additional days" to pay after THR notifies them of a late payment, THR Contract § 4.1.2.2 (ROA.245), the prompt-pay statute imposes penalties immediately if the deadline is missed. The statute also provides steeper penalties than either contract: The Methodist contract provides only for interest penalties, to be paid by "Payors,"—*i.e.*, the "employer[s]" "responsible for funding benefits payments" (Methodist Contract §§ 3.1, 12.13 (ROA.228, ROA.209))—and the THR contract requires "Plan Sponsors" to pay a portion of the "billed" rate (THR Con-

tract § 4.1.2.2 (ROA.245)). The prompt-pay statute imposes both types of penalties, and under the hospital's interpretation, allows providers to seek those penalties from administrators. Tex. Ins. Code § 1301.137. And the prompt-pay deadlines and penalties "may not be waived, voided, or nullified by contract." Tex. Ins. Code § 1301.107.

The statute thus unlawfully "'dictat[es] the choice[s] facing ERISA plans'" by forcing plans to choose between two equally unlawful restrictions on plan administration: either abandon the preferred-provider contracting model that is vital to controlling costs in the modern insurance market or submit to state-specific rules for processing claims. *Egelhoff*, 532 U.S. at 150 (statute requiring choice between paying benefits and amending plan was preempted by ERISA). That outcome flouts the Supreme Court's directive that "the State may not regulate" self-funded plans. *FMC Corp.*, 498 U.S. at 64.

3. The Statute Is Not "Saved" By The Saving Clause.

Because the prompt-pay statute "relates to" an ERISA plan, it is preempted as applied to self-funded plans unless ERISA's saving clause, Section 514(b)(2)(A), saves it from preemption. *See FMC Corp.*, 498 U.S. at 58. That clause provides an exception to ERISA's preemption provision for state laws that "regulate insurance." 29 U.S.C. § 1144(b)(2)(A). It thus "returns to the States the power to enforce [such] laws." *FMC Corp.*, 498 U.S. at 58. But when the saving clause otherwise would apply, ERISA's "deemer clause" (Section 514(b)(2)(B))

provides an exception to the saving clause exception: no self-funded plan may be "deemed" to be "engaged in the business of insurance" for purposes of any state law "purporting to regulate insurance." 29 U.S.C. § 1144(b)(2)(B). The Supreme Court "read[s] the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance.'" *FMC Corp.* 498 U.S. at 61.

The hospitals did not argue below that the saving clause applies. They have therefore waived any argument under the clause. *Celanese Corp.* v. *Martin K. Eby Constr. Co.*, 620 F.3d 529, 531 (5th Cir. 2010) ("[A]rguments not raised before the district court are waived.").

In any event, the saving clause does not save the prompt-pay statute because that statute does not regulate insurance. A statute regulates insurance only if it "substantially affect[s] the risk pooling arrangement between the insurer and the insured" by affecting either the "benefits an insured has access to" or "the population covered." *N. Cypress*, 781 F.3d at 198, 200. Prompt-pay laws do not affect those things. *Id.* at 200. Prompt-pay *penalties*, in particular, "cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio*" because they are merely "remedial" in nature. *Ellis*, 394 F.3d at 277. This Court thus twice has held that the saving clause does not save prompt-pay laws from preemption. *Ibid*. (insured's prompt-pay claims against insurer); *N. Cypress,* 781 F.3d at 200 (providers' prompt-pay claims

against insurer). The hospitals' prompt-pay claims in this case are no exception.

Even if the saving clause could save from preemption prompt-pay claims under insured plans, it would not save the hospitals' claims under self-funded plans. As applied to such plans, the prompt-pay statute does not regulate "insurers . . . '*with respect to their insurance practices*,'" *Ky. Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329, 334 (2003) (emphasis added); it regulates administrators with respect to their administrative practices. Administrators do not act as insurers because the plans—not the administrators—bear all risk. ROA.784-785 ¶¶ 4-5 (Solomon Declaration).

Under the deemer clause, the hospitals cannot bootstrap their way around that problem by "deeming" self-fund plans to be insurance and thus characterizing administration of those plans as an insurance practice. Instead, as the Supreme Court has declared, States "may not regulate" "uninsured" [*i.e.*, self-funded] plans, even "indirectly." *FMC Corp.*, 498 U.S. at 64. Because self-funded plans cannot be deemed insurers, and their administrators do not act as insurers for those plans, the hospitals' claims against self-funded funded plans cannot be saved as based on laws regulating insurance. Those claims are thus preempted.

B. The Prompt-Pay Deadlines And Penalties Are Preempted Because They Conflict With ERISA.

Under conflict-preemption principles, a state law is preempted if it "stands as an obstacle to the accomplishment and execution of [a federal law's] full purposes." *Hines* v. *Davidowitz*, 312 U.S. 52, 67 (1941). Those principles invalidate state laws that "conflic[t] with" ERISA's provisions or "frustrate" its goals. *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997); *see also Ingersoll-Rand*, 498 U.S. at 143 (state law preempted because it conflicted with ERISA § 510).

Besides the Section 514 express-preemption grounds set forth above, the prompt-pay deadlines and penalties are also invalid because they conflict with two distinct ERISA provisions regulating plan administration. First, the prompt-pay deadlines conflict with the claim-processing regulation adopted under ERISA § 503. Second, the prompt-pay penalties conflict with ERISA's comprehensive, exclusive remedies for ERISA violations.

1. The Prompt-Pay Deadlines Are Preempted Because They Conflict With The Claim-Processing Regulation Adopted Under ERISA § 503.

ERISA § 503 authorizes the Department of Labor, as the federal regulator of employee benefits plans, to develop claim-processing regulations to ensure that ERISA plan members receive a "full and fair review" of their claims. 29 U.S.C. § 1133(2). DOL has in turn promulgated a regulation setting uniform federal time periods for processing

health benefits claims. *See* 29 C.F.R. § 2560.503-1. DOL's regulation requires that plans provide notice of a denial within 30 days of receiving a claim, a period that can be extended by 15 days in specified circumstances. *See id.* § 2560.503-1(f)(2)(iii)(B).

The prompt-pay statute unlawfully shortens this deadline by scrapping the 15-day extension. *See* Tex. Ins. Code § 1301.1053 (prompt-pay deadline cannot be "extend[ed]" for "investigation and determination of payment"). Electronically submitted claims must therefore be determined within 30 days, *id.* § 1301.103, even if additional time is "necessary" and permitted by regulation "due to matters beyond the control of the plan." 29 C.F.R. § 2560.503-1(f)(2)(iii)(B). As the Second Circuit has held, a state law that imposes a shorter time period to process claims than the ERISA regulation "conflicts with" ERISA because it "establishes a different rule from ERISA's" for how claims under ERISA plans should be processed. *Cicio*, 321 F.3d at 95.

Indeed, an object of DOL's regulation was to "help streamline and make more uniform and predictable claims and appeals procedures." 65 Fed. Reg. 70,246, 70,259 (Nov. 21, 2000). The Texas prompt-pay deadlines frustrate that uniformity and predictability.

The district court found no conflict, reasoning that the DOL regulation merely establishes "'procedures pertaining to claims for benefits *by participants and beneficiaries*,'" and thus "does not apply to the [hospitals'] claims." Order 21 (ROA.7963) (emphasis added) (quoting 29

C.F.R § 2560.503-1(a)). But the hospitals' claims here are derived entirely from beneficiaries' claims because the hospitals took and relied on assignments in seeking payment from Aetna. *See supra,* at 50-51. And regardless of whether the hospitals are themselves beneficiaries, their prompt-pay claims interfere directly with federal procedures, because Aetna Life cannot meet its statutory obligations to determine whether providers' claims are "payable," Tex. Ins. Code § 1301.103, without first ascertaining whether those claim are for services covered under a beneficiary's plan. *See supra*, at 39. The prompt-pay deadlines thus require Aetna Life to determine a beneficiary's coverage within a shorter period than federal law provides. Those deadlines are therefore preempted.

2. The Prompt-Pay Penalties Are Preempted Because They Conflict With ERISA's Remedial Scheme.

The prompt-pay penalties also conflict with ERISA § 502(a), ERISA's "carefully integrated civil enforcement provisio[n]" that sets forth the remedies for "improper or untimely processing of benefit claims." *Mass. Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 146, 148 (1985). "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions" based on "improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. "[A]ny state-law cause of action that duplicates, supplements, or

supplants the ERISA civil enforcement remedy" is "therefore pre-empted." *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 209 (2004).

The hospitals' prompt-pay claims meet this standard because the hospitals "could have brought [their] claim[s] under ERISA § 502(a)(1)(B)." *Davila*, 542 U.S. at 210. ERISA § 502(a) and its implementing regulations authorize "suit in federal court to dispute a plan's failure to respond to a claim" "within [the] time limit proscribed by regulation." *Ponsetti* v. *GE Pension Plan*, 614 F.3d 684, 691 (7th Cir. 2010). Under Section 502(a)(1)(B), a plan beneficiary may sue "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). A plan that fails to "follow claims procedures"—such as the deadline for determining coverage under 29 C.F.R. § 2560.503-1(f)(2)(iii)(B)—waives the requirement that beneficiaries must "exhaust [the plan's] administrative remedies" before filing suit to recover benefits. 29 C.F.R. § 2560.503-1(*l*). In that circumstance, the claimant is immediately "entitled to pursue any available remedies under section 502(a) of the Act." *Ibid*. Administrators that do not meet DOL's deadlines are thus subject to suit, and must defend that suit without the benefit of an exhaustion defense, or in some cases an administrative decision on eligibility for benefits that would be entitled to judicial deference and reviewed "only for abuse of discretion." *Heimeshoff* v. *Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 614 (2013). ERISA § 502 thus grants beneficiaries a remedy for undue delay.

Providers, too, may pursue that remedy with valid assignments from plan beneficiaries. *See*, *e.g.*, *Baptist Mem'l Hosp.–DeSoto Inc.* v. *Crain Auto. Inc.*, 392 F. App'x 288, 293-94 (5th Cir. 2010) (per curiam) (applying 29 C.F.R. § 2560.503-1(*l*) to excuse hospital suing as assignee from exhausting administrative remedies). Although ERISA § 502(a) grants standing only to plan "participant[s]" and "beneficiar[ies]," a provider may "sue derivatively to enforce an ERISA beneficiary's claim" if it "obtain[s] a valid assignment" from the beneficiary. *Harris Methodist Ft. Worth* v. *Sales Support Servs. Inc. Emp. Health Care Plan*, 426 F.3d 330, 333-34 (5th Cir. 2005). A provider that obtains an assignment "takes all of the rights of the assignor," *Quality Infusion Care, Inc.* v. *Health Care Serv. Corp.*, 628 F.3d 725, 729 (5th Cir. 2010) (quotation marks omitted), including the beneficiary's right, under 29 C.F.R. § 2560.503-1(*l*), to sue without exhausting administrative remedies if the regulatory deadline has passed. The hospitals do not dispute that they obtained assignments, as their contracts with Aetna Life required. *See supra*, at 51. So they have a remedy under Section 502(a) if Aetna Life does not make a benefits determination within the DOL deadline.

The prompt-pay statute impermissibly "supplement[s]" the ERISA remedy for untimely processing of claims by imposing monetary penalties for "late" claims—a remedy that neither ERISA § 502(a) nor 29 C.F.R. § 2560.503-1(*l*) provides. The prompt-pay statute thus upsets ERISA's "comprehensive civil enforcement scheme" that already

"represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54. It also undermines DOL's considered judgment about "the consequences that [should] ensue when a plan fails to provide procedures" that comply with DOL regulations. 65 Fed. Reg. at 70,255. "The policy choices reflected in" ERISA § 502 and 29 C.F.R. § 2560.503-1(*l*) "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies"—or the benefit of remedies—"under state law that Congress rejected in ERISA." *Pilot Life*, 481 U.S. at 54. The Eighth Circuit recognized this conflict in holding that Missouri's prompt-pay rules imposing statutory interest penalties were preempted because they would supplement the remedies available under ERISA § 502(a). *Schoedinger*, 557 F.3d at 876 ("'*Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive.'").

The district court found no conflict because the providers disclaimed any prompt-pay claims "based on an assignment," Dec. 11, 2014 Tr. 8:14-16 (ROA.8115), and thus, the court ruled, were not "standing in [beneficiaries'] shoes by virtue of assignment." Order 21-22 (ROA.7963-7964). But the decisive question is not what position the hospitals have elected to take in this litigation; it is whether the hospitals "at some point in time, *could have* brought [their] claim[s] under ERISA

§ 502(a)(1)(B)." *Davila*, 542 U.S. at 210 (emphasis added). In *Lone Star*, for example, this Court found no conflict preemption because "an assignment of benefits from [beneficiaries] [would] not confer standing" to redress the injury alleged in that case—"underpayment under [a] [p]rovider [a]greement" to which beneficiaries were not parties. 579 F.3d at 529 n.3, 533. This Court thus allowed the providers to pursue statutory remedies relating to those alleged contractual underpayments. *Id.* at 532. Here, by contrast, the hospitals are not pursuing claims that they were underpaid under a contractual fee schedule; rather, they claim they were not paid quickly enough—a claim for which they could have sought relief in federal court when DOL's claim-processing deadline expired. Because the hospitals' "timeliness claims are 'an alternative mechanism'" for "'enforcing the rights protected by ERISA,'" ERISA preempts them. *Cicio*, 321 F.3d at 95.

CONCLUSION

This Court should reverse the district court's holding that the Texas prompt-pay statute applies to self-funded plans or certify that issue to the Texas Supreme Court. If the statute is held to apply to self-funded plans, the district court's preemption holding should be reversed, based on express preemption under ERISA § 514, as well as conflict preemption under ERISA's claim-processing regulation and its exclusive civil-remedies provision, Section 502.

June 1, 2015

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on June 1, 2015, an electronic copy of the foregoing Brief for Appellant 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 will be accomplished by the appellate CM/ECF system.

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

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CERTIFICATE OF ELECTRONIC COMPLIANCE

I hereby certify that, on June 1, 2015, this Brief for Appellant was transmitted to the Clerk of the United States Court of Appeals for the Fifth Circuit 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 Microsoft Forefront Endpoint Protection and is free of viruses.

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

Dear Mr. Estrada,

The following pertains to your brief electronically filed on June 1, 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.

Failure to timely provide the appropriate number of copies may result in the dismissal of your appeal pursuant to 5TH CIR. R. 42.3.

Sincerely,

LYLE W. CAYCE, Clerk

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cc:
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