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

BRIEF FOR APPELLEES

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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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STATEMENT REGARDING ORAL ARGUMENT

Under Fifth Circuit Rule 28.2.3, Appellees Methodist Hospitals of Dallas and Texas Health Resources (collectively, the "Hospitals") respectfully submit that oral argument will assist this Court in resolving the two issues in this appeal: (1) whether the Texas Prompt Pay Act ('TPPA") applies to self-funded health care plans; and, if it does, (2) whether ERISA preempts that applicability to third-party administrators of self-funded health insurance plans. These issues are critical because of the large number of individuals in Texas covered by self-funded health insurance plans and health care providers—such as the Hospitals in this case—that provide health care services to them.

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JURISDICTIONAL STATEMENT

The District Court correctly determined that it had diversity jurisdiction over this action pursuant to 28 U.S.C. § 1332. (ROA.7946, 7964). Because the District Court entered final judgment for the hospitals on March 13, 2015, (ROA.7965), this Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Does the Texas Prompt Pay Act ("TPPA") apply to self-funded ERISA health benefit plans that by means of their voluntary, contractual relationships, are participants in preferred provider benefit plans?

2. If so, does ERISA preempt that applicability?

SUMMARY OF ARGUMENT

The applicability section of the Texas Prompt Pay Act ("TPPA") encompasses every (i) preferred provider benefit plan, in which (ii) an "insurer," (iii) "provides for" payment of preferred provider benefits, through (iv) the insurer's "health insurance policy." The single, unified contract composed of (a) Aetna's contract with its customer, i.e., the self-funded ERISA employee benefit plan, (b) Aetna's contracts with its preferred providers, like the Hospitals here, and (c) the contractual arrangements of the self-funded plans with their members, is a preferred provider benefit plan. In every such preferred provider benefit plan: Aetna is an insurer, even if its function is limited to administration; Aetna "provides for" payment of preferred provider benefits; and Aetna does so through its "health insurance policy." This is so because in the TPPA, "health insurance policy" is a defined term meaning simply any contract providing benefits for medical or surgical expenses.

The express language of the TPPA's applicability section therefore demonstrates that the Act applies to Aetna in every instance at issue in this case, including when its function is that of administrator. Every

such instance involves a preferred provider benefit plan in which Aetna, an insurer, provides for payment of preferred provider benefits through one or more contracts comprising a single, unified contract that, because it provides benefits for medical or surgical expenses, is a health insurance policy and that, because it is created by Aetna (by contracting with ERISA plans on the one hand and providers on the other) is *Aetna's* policy. TPPA thus applies.

The legislative history of the statute supports that construction of the TPPA's applicability provision, and any conflicting interpretation by the Texas Department of Insurance defies the unambiguous language of the statute and, in any event, was not promulgated through the rule-making process and is not binding.

Nor is TPPA's applicability preempted by ERISA, as the District Court correctly held in an opinion supported by both Supreme Court and Fifth Circuit precedent. (ROA.7964).

First, long-standing decisions of the Supreme Court reveal that ERISA's preemptive scope, although broad, is not limitless. The Supreme Court has made clear that ERISA does not preempt state law having only minor connections to the federal statute.

Second, Aetna has failed to meet its burden in proving either element of this Court's two-pronged test for express preemption. The Hospitals' TPPA claims do not address an area of exclusive federal concern, nor do the claims directly affect the relationship among traditional ERISA entities. Indeed, decisions from this Court – as well as the district courts in this Circuit – addressing both complete and express preemption demonstrate that TPPA claims brought by providers against insurers with whom they are in contractual privity do not "relate to" an employer benefit plan.

Further, Aetna's attempt to rely on non-binding authority from outside of this Circuit does not rescue its flawed preemption argument. More specifically, *America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) addressed a prompt pay statute vastly different from the TPPA. That statute interposed itself into the business of traditional ERISA entities by permitting penalties to be levied on health benefit plans and on entities with which it had no contractual relations whatsoever. Moreover, *Hudgens* was not decided using the Fifth Circuit's two-pronged express preemption test.

Finally, the TPPA deadlines and penalties are not conflict preempted by ERISA. Because the TPPA applies and is not preempted, the District Court's Order applying the penalty provisions of TPPA to Aetna should be affirmed.

ARGUMENT

I. The Prompt Payment Provisions of Chapter 1301 of the Texas Insurance Code Apply to Aetna because it is an Insurer that Provided for Payment of Preferred Provider Benefits through its Health Insurance Policy

Although the parties raised TPPA applicability below, the district court abstained from ruling on the issue. Instead, it deferred to the ruling of a state district court that had held TPPA applicable. The court below correctly accepted the state district court's applicability ruling as correct because the Texas Supreme Court would likewise have held TPPA applicable. That holding enforces the express wording of the statute and fulfills the ends that the statute was intended to achieve.

A. If the District Court Abused its Discretion in Refusing to Rule on the Applicability Issue by Deferring to the State District Court, Remand is Appropriate

Aetna's motion for summary judgment argued that the TPPA is not applicable to the administrator of a self-funded plan. (ROA.4438; ROA.4619). Methodist's motion argued that the TPPA applied to qualifying entities, whether they insured the plans or simply administered them. (ROA.3943). The district court did not resolve the

issue, deferring to the decision of a state district judge in Tarrant County, Texas, who held in favor of applicability. (ROA.7946).

Rulings on abstention are reviewed for abuse of discretion following a *de novo* determination as to whether the requirements for abstention have been satisfied. *See Texas Ass'n of Bus. v. Earle*, 388 F.3d 515, 518 (5th Cir. 2004). Those requirements were met, and Aetna has shown no abuse of discretion. Abstention was proper. If, however, the deference accorded was an abuse of discretion, then the appropriate remedy is remand of the issue to the district court for determination.

B. The Express Language of the TPPA Makes Clear its Application to Insurers that Administer Self-Funded Plans

Assuming the record permits the Court to consider the applicability of the statute in the first instance, Texas law compels the conclusion that the statute applies to Aetna in this context.

The Applicability provision of Chapter 1301 reads:

> 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). Thus the whole of chapter 1301 applies to the preferred provider benefit plans described in § 1301.0041(a), and the late-payment penalty provisions of § 1301.137 apply to the late-paying insurers involved.

A preferred provider benefit plan will fall within the scope of Section 1301.0041(a) if it meets three criteria: (1) an "insurer" (2) provides for the payment of a different level of coverage depending on whether the provider used is preferred or non-preferred (3) and makes such provision through that insurer's "health insurance policy." Only the first and third of those requirements are sincerely in dispute in this appeal and each is readily met in this case.

1. Aetna is an "Insurer"

Aetna fits the statutory definition of an "insurer":

> "Insurer" means a life, health, and accident insurance company, health and accident insurance company, health 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 this state health insurance policies.

TEX. INS. CODE § 1301.001(5). Aetna is a life, health, and accident insurance company, operating under Chapter 841 of the Insurance Code, which applies to life, health, or accident insurance companies.

(ROA.519-520). Aetna is licensed to issue policies of life, health, and accident insurance in Texas. (ROA.3945, 3989). Aetna thus fits the statutory definition of an insurer exactly. That Aetna may not directly insure the risks assumed by the plans is irrelevant here. *See Texas Dep't of Ins. v. American Nat'l Ins. Co.*, 410 S.W.3d 843, 849 (Tex. 2012)(noting Texas Insurance Code employs contextual definitions of terms, deeming entities "insurers" for one purpose but not for another).[1]

Aetna disregards the statutory definition chosen by the Legislature and argues that when it functions as an administrator, it is not an insurer. *See Br.* at 21. In fact, the Supreme Court of Texas has construed a textually similar statutory definition of "insurer" to apply to a plan administrator of a governmental plan that met the applicable statutory definition of "insurer." *Toranto v. Blue Cross & Blue Shield of Tex., Inc.*, 993 S.W.2d 648, 649 (Tex. 1999)(per curiam). In that case, a provision of the Texas Insurance Code prohibited "an insurer" from restricting the right of an insured to assign his or her benefits under a

[1] This broad view of the term based upon the Legislature's definition is consistent with other features of Chapter 1301, which also suggest an intentionally broad scope to the term. Most acutely, the Legislature has made clear that the prompt payment deadlines in Chapter 1301 apply to any person with whom an insurer contracts for the performance of various administrative functions, including processing or paying of claims. *See* TEX. INS. CODE § 1301.109.

policy to a physician or other health care provider. *Id.* at 648 (citing TEX. INS. CODE art. 21.24-1 § 3(a), *now codified* at TEX. INS. CODE § 1204.053(a)). The statute in *Toranto*, like § 1301.001(5), defined "insurer" to include "an insurance company, association, or organization authorized to do business in this state" under various chapters of the Insurance Code. *Id.* at 649 (citing TEX. INS. CODE art. 21.24-1, § 1(6), *now codified* at TEX. INS. CODE § 1204.051(6)).

In *Toranto*, a patient had assigned her claim for benefits under her plan to Dr. Toranto, who then filed a claim with BCBS, the administrator of the patient's plan. BCBS paid the claim, but not to Dr. Toranto; because he was not a network provider, it remitted payment directly to the insured in contravention of the assignment, relying on an anti-assignment clause set out in the plan provisions. Dr. Toranto sued BCBS, alleging that the anti-assignment clause was statutorily prohibited and invalid. BCBS argued, as Aetna does here, that it was not an insurer, that it was only an administrator; it maintained that the anti-assignment prohibition applied only to insurers, and that it was not subject to the prohibition as a mere administrator. The lower courts agreed, but the Supreme Court rejected that argument, holding

that "BCBS [was] an 'insurer' because it is authorized to act as ERS' administrating firm under" one of the chapters enumerated in the definition. *Id.* at 649.

For the same reason, Aetna is an "insurer" as that term is used in Section 1301.0041(a): it meets § 1301.001(5)'s definition of an "insurer," regardless of whether its function within a given preferred provider benefit plan is limited to administering. It is an "insurer"/administrator, but ultimately it is still an insurer precisely because it satisfies the statutory definition of that term.[2]

2. The Single, Unified Contracts Aetna forms with Payor Plans and Preferred Providers are "Health Insurance Policies"

Aetna also meets the statutory requirement that it "provide[] . . . for" paying the preferred provider claims through "its" "health insurance policy." *See* TEX. INS. CODE § 1301.0041(a).

Aetna's health insurance policy here consists of two documents that form one contract. *See Baylor Univ. Med. Ctr. v. Epoch Grp., L.C.*, 340 F. Supp. 2d 749, 754-55 (N.D. Tex. 2004). The first constituent

[2] Indeed, anything Aetna does in Texas constitutes the business of insurance. *See* TEX. INS. CODE § 101.051(b)(10)(conduct constituting business of insurance includes "any other transaction of business in this state by an insurer.") Serving as a TPA in Texas is a transaction of business in Texas. When an insurer, like Aetna, serves as a TPA, it is conducting the business of insurance.

document is Aetna's contract with its customer self-funded ERISA plans, by which Aetna promises to administer the self-funded plan for a fee and to grant the self-funded plan members access to Aetna's network of preferred providers; it also secures the promise from the preferred providers to accept the rates negotiated by Aetna as payment in full for the medical and surgical services rendered to plan members. The second constituent document is Aetna's contract with its preferred provider, by which Aetna promises to pay or provide for payment of the provider's services for members of self-funded plans in contract with Aetna. It promises to provide for such payment at the preferred provider rates set out in the Aetna/preferred provider contract.

These two constituent documents form as a matter of law one, single, unified contract. *See Baylor Univ. Med. Ctr.,* 340 F. Supp. 2d at 754-55 (multiple documents may, as a matter of law, comprise one contract and court may construe all documents as if they were part of single, unified instrument). This single, unified contract is a "health insurance policy" as defined by § 1301.001(2) because it is a "contract providing benefits for medical or surgical expenses . . ." Any contrary conclusion would defy the fundamental purpose of the contract. *See,*

e.g. Guidry v. American Public Life Ins. Co., 512 F.3d 177, 182 n. 6 (5th Cir. 2007)("the fundamental purpose of ordinary health insurance coverage is to indemnify against loss from disease or illness.").

And this single, unified contract is preeminently and ineluctably *Aetna's* health insurance policy because Aetna formed it and it could not exist without Aetna. Indeed, Aetna elected to enter into contracts with the self-funded plans, making the plans payors while giving the members covered by those plans access to preferred providers. Aetna likewise contracted with providers to be preferred providers to service the plan members. (ROA.197; ROA.221; ROA.227-231; ROA.233-269). Those documents -- with Aetna in the middle, extending one hand to its customer/self-funded plans and the other to its preferred providers -- form *Aetna's* one, single contract/health insurance policy. This arrangement is the archetype of a "health insurance policy" under Chapter 1301's definition of that term. *See American Nat'l Ins. Co.*, 410 S.W.3d at 848-49 (recognizing that a self-funded health care plan's activities constitute the "business of insurance" and qualify the plan as an "insurer" for at least some purposes under the Texas Insurance Code).

This contract/health insurance policy is Aetna's whether it provides the coverage or simply administers it. Aetna's self-funded plan customers cannot provide any preferred provider coverage to their members because there is no contract between the self-funded plan and any preferred provider. Aetna, an insurer, has bridged that gap by coupling its administrative agreements with the self-funded plans and the contracts with its network of preferred providers. It forms one contract that, because it provides benefits for medical or surgical expenses, ***is*** a "health insurance policy" for all purposes of Chapter 1301, and it is Aetna's policy.

Not coincidentally, when the individuals covered by such a policy seek medical or surgical services from a preferred provider, those plan members present an *Aetna* card. That card shows to all the world that their coverage is provided or administered *by Aetna* and that it is *Aetna* who is going to pay for those services at preferred provider rates. Whether it pays with its own money or with money it gets as administrator from its customer/self-funded plans is irrelevant. Whether Aetna bore any financial risk, a point much belabored by Aetna, is utterly irrelevant.

The result would not change if the health insurance policy in this case were deemed to consist only of the self-funded plan. That plan is a contract. The parties to it include the plan as an entity (*see* 29 U.S.C. § 1132(d)(1)[plan my sue or be sued as an entity]) and the individuals covered. It provides benefits for medical and surgical expenses. It is thus also a "health insurance policy" as defined by § 1301.001(2). And it, too, is Aetna's policy because Aetna claims to be a fiduciary of it. *See Br.* at 47. Aetna either formed or adopted it. It is thus part of a preferred provider benefit plan in which an "insurer," Aetna, provides, through "its" health insurance policy (the self-funded plan it has created or adopted and in either event administers), for the payment of preferred provider benefits. *See* § 1301.0041(a). TPPA thus applies to Aetna the insurer.

3. Aetna "Provides . . . for" Payment to Providers, like Methodist and THR, through Aetna's Health Insurance Policy

Finally, TPPA applies because Aetna's health insurance policy "provide[s] . . . for" payment to a preferred provider. TEX. INS. CODE § 1301.0041(a). Aetna contends that the statute can apply "only to 'preferred provider benefit plan[s]' in which an 'insurer' **provides**

payment 'through the insurer's health insurance policy." *See Br.* at 19 (emphasis added). But that misstates the statutory text. The Legislature did not limit the statute's applicability to insurers who pay. It expanded applicability to all insurers who provide for payment. The distinction is significant.

TPPA does not define "provide for," leaving the Court to apply the plain meaning of the words chosen. *See City of Houston v. Bates*, 406 S.W.3d 539, 543 (Tex. 2013). The word "provide" is commonly understood to mean "to make, procure, or furnish for future use, prepare," as well as "to supply or make available." *See* BLACK'S LAW DICTIONARY at 1224 (6th ed. 1990); *accord Appalachian States Low-Level Radioactive Waste Comm'n v. Pena*, 126 F.3d 193, 197 (3rd Cir. 1997). The Oxford Dictionary more specifically defines the phrase "provide for" to mean "to make adequate preparation for (a possible event)," with the word "for" bringing an anticipatory meaning rather than connoting immediate and direct action.[3]

The common meaning of "provide . . . for" in § 1301.0041(a) extends the statute's applicability beyond those who actually make

[3] *See http://www.oxforddictionaries.com/us/definition/american_english/provide.*

payment to any insurer who, through its health insurance policy, supplies or otherwise facilitates payment for preferred provider coverage. The "for" in "provide . . . for" cannot be ignored. *See Columbia Med. Ctr. of Las Colinas, Inc. v. Hogue*, 271 S.W.3d 238, 256 (Tex. 2008)(prohibiting interpretations that render statutory language superfluous).

Had the Legislature desired to limit the applicability of the statute as Aetna proposes, it could have predicated applicability on bearing financial risk. Instead of saying "provides . . . for," it could have said, "bears the financial risk of" payment. It did not do that, though, and that choice must be honored. *See Tex. Lottery Comm'n v. First State Bank of DeQueen*, 325 S.W.3d 628, 635 (Tex. 2010)(Legislature is presumed to have chosen statutory language deliberately and purposefully). Thus, an insurer that "provides . . . *for*" payment of benefits through its policy falls within the ambit of the statute, whether or not it bears any financial risk.

Aetna unquestionably "provides . . . for" payment through its health insurance policies. In the amended agreement between Aetna and the Hospitals, Aetna expressly agrees to "pay Hospital for Covered

Services rendered to members of full risk Plans, and . . . notify Payors to forward payment to [Aetna] for payment to Hospital for Covered Services rendered to Payor's Members." (ROA.228)(Section 3.1); (ROA.245).[4] The second clause of that covenant clearly "provides . . . for" payment of claims on which Aetna's customers, rather than Aetna itself, bear the financial risk of payment. In another of the governing agreements, Aetna expressly retained the right to "pay claims on behalf of Payors" even where it had no obligation to do so. (ROA.229)(Section 3.4). In both instances, Aetna affirmatively "provided . . . for" the payment of preferred provider claims.

Aetna's agreements unquestionably facilitate payment to preferred providers like the hospitals. By facilitating payment in that way, Aetna has "provided for" payment to preferred providers through its health insurance plan.[5]

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[4] At least one of the agreements in issue also contains provisions by which Aetna agrees to pay penalties for late payments of claims or to "require Plan Sponsors to pay a penalty" in accordance with the contract's terms. (ROA.245)(4.1.2.1-4.1.2.2).

[5] This is also true with respect to Aetna's administrative services agreements with the self-funded plans themselves. Those agreements ensure that plan members will receive treatment at discounted rates from preferred providers; in them, Aetna assumes obligations to provide administrative services that includes the facilitation of payment to the providers as a complement to the payment obligations Aetna undertakes with the those providers.

C. The Legislative History of the Statute Supports that Construction of its Unambiguous Terms

The conclusion that TPPA applies to Aetna in the circumstances of this case is buttressed by the legislative history of the statute. The 2001 effort (HB 1862) to revise then-existing prompt payment laws failed to become a law after Governor Perry vetoed the bill for the want of a provision allowing arbitration of disputes. *See* Veto Message of Gov. Perry, Tex. H.B. 1862, 77th Leg., R.S. (2001)[6]; (ROA.3948-3949). Significantly, though, the Governor's veto recognized that expansion of Prompt Payment laws was a crucial need, explaining that "unless significant improvements are soon realized and health plans demonstrate a strong commitment to prompt pay law and to honoring their contractual relationships with physicians and health care providers, Texas may have to adopt stronger laws than those proposed by HB 1862." *See id.*

As an expression of the Governor's concerns, that testimony demonstrated that the failure of insurers to make timely payments was having deleterious effects on the provision of health care services in Texas. (ROA.3949-3950). Legislators, therefore, sought to bring more

[6] *http://www.lrl.state.tx.us/scanned/vetoes/77/hb1862.pdf* (visited July 28, 2015).

claims within the protections of the TPPA while avoiding the possibility of ERISA preemption by regulating the contract between the health care provider and the insurer. (ROA.3950-3951).

The resulting bill (SB 418) was broadly understood by concerned constituencies to have accomplished the goal of broad applicability by extending the prompt payment requirements to self-funded ERISA plans. (ROA.3952-3953). In fact, numerous witnesses -- representing industry advocacy groups for and against the bill -- offered testimony recognizing the accomplishment of its goal of strengthening the prompt payment laws by expanding their scope. (ROA.3954-3957). And that version of the bill was signed into law. (ROA.3958-3960).

The plain text of the statute ensures that the prompt payment requirements and the associated penalties reach self-funded plans like those at issue here. Helpfully, the legislative history demonstrates that to have been precisely what the Legislature intended.

D. No Binding Administrative Construction of the Statute Suggests a Different Result

Aetna claims that applying TPPA according to its plain, unambiguous meaning would conflict with interpretations of the TDI. But "[a]n administrative agency's construction of a statute it

implements ordinarily warrants deference [only] when: (1) the agency's interpretation has been formally adopted; (2) the statutory language at issue is ambiguous; and (3) the agency's construction is reasonable." *See R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 625 (Tex. 2011). Not one of those three requirements has been met in this case. No TDI statement on the applicability of TPPA has even been subjected to formal rulemaking, much less been formally adopted. Section 1301.0041(a) is not ambiguous, and no construction exempting Aetna from the scope of TPPA in the circumstances of this case would be reasonable. *See Fleming Foods of Tex., Inc. v. Rylander*, 6 S.W.3d 278, 282 (Tex. 1999)("an administrative agency's construction of a statute cannot contradict the statute's plain meaning."). Therefore, no TDI statement relied on by Aetna is entitled to any judicial deference.

E. Aetna's Preferred Provider Benefit Plans Meet all of Section 1301.0041(a)'s Applicability Criteria; TPPA thus Applies to Aetna

Aetna is an "insurer." The documents it has signed with self-funded plans on the one hand and preferred providers on the other constitute one, unified contract, and that contract provides benefits for

medical or surgical expenses. It is thus a "health insurance policy," and that policy is Aetna's. Through that policy, Aetna "provides . . . for" the payment of preferred provider benefits. The policy is part of a preferred provider benefit plan. TPPA thus applies to Aetna's preferred provider benefit plans. When § 1301.137 imposes prompt-pay penalties on "insurers" who do not pay timely, it imposes them on Aetna.[7]

[7] In *St. Luke's Episcopal Hospital v. Principal Life Insurance*, No. H-05-3825, 2007 WL 189375 at *3 (S.D. Tex. Jan. 22. 2007), the court did not hold otherwise. The insurer in *St. Luke's* contended that the TPPA was inapplicable to it because it was not an insurer and had not issued a health insurance policy. *Id.* at *3. The district court noted that the plaintiff/provider had not responded to that argument and summarily found that the defendant's proof demonstrated the statute's inapplicability. That conclusion is of no value here, because the district court did not determine the applicability question. It simply accepted what one party argued and the other did not respond to.

II. Aetna Has the Burden to Prove Preemption

Noticeably absent from Aetna's brief is any mention of which party bears the burden of proof regarding ERISA preemption. Nevertheless, this Court has made clear that a party pleading ERISA preemption "bears the burden of proof" on such affirmative defense. *Bank of La. v. Aetna U.S. Healthcare, Inc.*, 468 F.3d 237, 242 (5th Cir. 2006); *see also Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 378 (5th Cir. 2011). A party moving for summary judgment on an affirmative defense "must establish beyond peradventure all of the essential elements of the defense to warrant judgment in his favor." *Access Mediquip L.L.C.*, 662 F.3d at 378. Further, when a movant seeks summary judgment based on the affirmative defense of preemption, any allegations are construed in the light most favorable to the non-movant. *Id.*

Accordingly, as it did in the District Court, Aetna bears the burden to prove any and all elements of its ERISA preemption defense to this Court. As explained throughout the remainder of this brief, Aetna cannot meet this burden. Therefore, the District Court did not err in holding that the TPPA is not preempted by ERISA.

III. The District Court Correctly Held that ERISA Does Not Preempt the Hospitals' TPPA Claims

A. Long Standing Decisions of the United States Supreme Court Show that ERISA's Preemption Scope Is Not Unlimited and Does Not Preempt the Hospitals' TPPA Claims

Section 514(a) of ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). This provision is commonly known as "express preemption." *E.I. DuPont de Nemours & Co. v. Sawyer*, 517 F.3d 785, 797 (5th Cir. 2008). Aetna would have this Court believe that the scope of ERISA's express preemption provision has virtually no limit. *Br.* at 37 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001)). That assertion, however, is belied by over thirty years of Supreme Court jurisprudence repeatedly holding otherwise.

1. The Supreme Court's Limiting Principles for ERISA Preemption

As early as 1981, the Supreme Court cautioned against the overly-broad application of preemption, even in the ERISA context: "pre-emption of state law by federal statute or regulation is not favored in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that Congress

has unmistakably so ordained." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Indeed, "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'" *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 19 (1987) (quoting *Alessi*, 451 U.S. at 522); *see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997) ("[W]here federal law is said to bar state action in fields of traditional state regulation, . . . we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.") (omitting internal quotations). The Court accordingly has "recognized limits to ERISA's pre-emption clause." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990).

The Court has repeatedly explained these limits by focusing on ERISA's primary purpose. The Court has noted that "ERISA is a comprehensive statute designed to promote the interests of *employees and their beneficiaries* in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983) (emphasis added). The Court later

expounded on ERISA's primary purpose of protecting employees and their beneficiaries:

> In ERISA, Congress set out to 'protect . . . *participants in employee benefit plans and beneficiaries*, by requiring the disclosure and reporting to *participants and beneficiaries* of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987) (quoting 29 U.S.C. § 1001(b)) (emphasis added). Given this purpose, "pre-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) (omitting internal quotations); *see also Fort Halifax Packing Co.*, 482 U.S. at 7 (rejecting argument that ERISA "forecloses virtually all state legislation regarding employee benefit[ ] [plans].").

2. The "Relate To" Requirement of Section 514(a) -- "Connection With or Reference to Such a Plan"

Based on these limiting principles, the Supreme Court has recognized that the term "relate to" in Section 514(a) "cannot be taken

'to extend to the furthest stretch of its indeterminacy,' or else 'for all practical purposes preemption would never run its course.'" *Egelhoff*, 532 U.S. at 146 (quoting *Travelers Ins. Co.*, 514 U.S. at 655). Moreover, the Court has "unequivocally concluded" that the "relates to" language was not intended to modify "the starting presumption that Congress does not intend to supplant state law." *De Buono v. NYSA-ILA Med. And Clinical Servs. Fund*, 520 U.S. 806, 813 (1997) (quoting *Travelers Inc. Co.*, 514 U.S. at 654). Accordingly, the Court has held that a state law "relates to" an ERISA plan "if it has a connection with or reference to such a plan." *Egelhoff*, 532 U.S. at 147 (quoting *Shaw*, 463 U.S. at 97).

With respect to determining whether a state law refers to a plan, the Court has provided that "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation, . . . that 'reference' will result in pre-emption." *Dillingham Constr.*, 519 U.S. at 325. Concerning the "connection with" standard, the Court recognized that uncritical literalism in applying it offered scant utility in determining Congress' intent for the extent of ERISA's reach. *Id.* (citing *Travelers Ins. Co.*, 463

U.S. at 656) ("For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections."). Consequently, the Court clarified that "to determine whether a state law has the forbidden connection, we look both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Id.* (quoting *Travelers Ins. Co.*, 463 U.S. at 658).

3. The TPPA Has Neither a Reference to nor a Connection with ERISA Plans, and therefore is not Preempted

Under either prong of the Supreme Court's "relate to" test, the TPPA is not preempted by ERISA. First, the "reference to" prong is not met because no reference to the plan is needed in determining whether the insurer complied with the TPPA, or in determining what penalties are owed. As a result, Chapter 1301 does not "act[ ] immediately and exclusively upon ERISA plans," *Dillingham Constr.*, 519 U.S. at 325, but instead, merely covers the relationship between an insurer and a health care provider who are in privity of contract with one another. TEX. INS. CODE § 1301.103. Likewise, "the existence of ERISA plans is

[not] essential to the [TPPA's] operation." *Dillingham Constr.*, 519 U.S. at 325. To the contrary, the TPPA's prompt payment deadlines operate independently of ERISA plans, again regulating only the payment relationship between insurer and provider where a contract exists between the two parties. TEX. INS. CODE § 1301.103. Stated simply, no reference to an ERISA plan is required to calculate the Hospitals' TPPA remedies.

Neither does the TPPA have an impermissible "connection with" ERISA plans. As the Supreme Court has made clear, one must look to "the objectives of the ERISA statute as a guide" in determining whether the state law has such a forbidden connection. *Egelhoff*, 532 U.S. at 147. As explained above, the primary objective of ERISA is to protect "*employees and their beneficiaries* in employee benefit plans." *Shaw*, 463 U.S. at 90. In no way does the TPPA impact, directly or indirectly, employees or beneficiaries of ERISA plans. Again, a TPPA claim lies solely between a provider and insurer. The fact that the insurer may be a third-party administrator of a self-funded ERISA plan makes no difference—the prompt pay penalties come out of the insurer's pocket, not from the employee's or beneficiaries' plan benefits. As the Supreme

Court has held, "laws with only an indirect economic effect [on ERISA plans] . . . are a far cry from those conflicting directives from which Congress meant to insulate ERISA plans." *Travelers Ins. Co.*, 514 U.S. at 662. Accordingly, the TPPA "is one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not relate to them within the meaning of the governing statute." *De Buono*, 520 U.S. at 815 (internal quotations omitted).

Despite this clarity, Aetna argues that the TPPA "directly regulates [ERISA] claim processing," and therefore has an impermissible relation to ERISA plans.[8] In support of its argument, Aetna cites four Supreme Court decisions: *Egelhoff, McClendon, Coyne and Dedeaux*. *Br.* at 38-44. Aetna's reliance on these decisions is misplaced.

First, *Egelhoff* dealt with a Washington statute requiring ERISA plan administrators to "pay benefits to the *beneficiary* chosen by state law, rather than those identified in the plan documents." *Egelhoff*, 532 U.S. at 147 (emphasis added). For that reason, the statute had an

[8] The Hospitals will address this argument more fully in Sections C and D below.

"impermissible connection with ERISA plans." *Id.* Here, by contrast, the TPPA does not alter any beneficial interest, and thus has no effect on ERISA beneficiaries. Nor does the TPPA conflict with ERISA's command that an ERISA fiduciary shall administer the plan "in accordance with the documents and instruments governing the plan." *Id.* To calculate TPPA penalties, it is necessary to consult only the contract between insurer and provider and the TPPA – the plan documents and instruments are irrelevant. Accordingly, *Egelhoff* provides no support for Aetna's argument.

Second, in *McClendon*, the Supreme Court found preemption of a state common law claim brought by an employee alleging unlawfull discharge to prevent his attainment of benefits under an ERISA plan. *McClendon*, 498 U.S. at 135. The Court's decision hinged on the fact that the "the existence of a plan is a critical factor in establishing liability . . . and the court's inquiry must be directed to the plan." *Id.* at 139-140, 141. As previously explained, the existence of an ERISA plan is irrelevant to a TPPA claim. Further, the TPPA does not regulate the benefits provided under such plans, but regulates only the payments an insurer agrees to make to a provider with whom it has contracted. TEX.

INS. CODE § 1301.103. Aetna's reliance on *McClendon*, therefore, is unavailing.

Third, Aetna's citation to *Coyne* is curious given that the Court found no preemption. *Coyne,* 482 U.S. at 22-23. Indeed, the Court held that a Maine statute requiring employers to provide one-time severance payments to employees in the event of a plant closing did not relate to an ERISA plan within the meaning of Section 514(a). *Id.* Of utmost importance in the Court's decision was the fact that to hold otherwise would effectively have read the word "plan" out of the statute. *Id.* at 8. In other words, just like the TPPA, the Maine statute had no reference to or connection with an ERISA *plan* whatsoever.

Finally, Aetna cites *Dedeaux* for the proposition that Section 514(a) preempts state law remedies for "improper processing of a claim for benefits." *Br.* at 41 (quoting *Dedeaux*, 481 U.S. 41). What Aetna fails to acknowledge, however, is that *Dedeaux* involved state common law causes of action by an *employee* of an ERISA plan against an insurer for improper processing of benefits payable under the ERISA plan. *Dedeaux*, 481 U.S. at 43. Given these facts, the Court had no problem determining that the common law causes of action were related

to an employee benefit plan. In contrast, the TPPA has no effect on an employee or beneficiary of an ERISA plan, nor does it affect benefits under the plan. It affects the timing of the payments paid by the plan's insurance company under a contract that was entered into between the insurer and a healthcare provider, and that was completely independent from the plan itself. Aetna's reliance on *Dedeaux* is misplaced.

Based on Section 514(a) as interpreted through numerous decisions of the Supreme Court, the TPPA "has only a tenuous, remote, or peripheral connection with [ERISA] plans. *Travelers Ins. Co.*, 514 U.S. at 661. Such a connection fails to satisfy the Court's "relate to" test. Accordingly, the District Court's Order should be affirmed.

B. Decisions from this Court and District Courts in the Fifth Circuit Regarding Complete Preemption further Demonstrate the Lack of Connection TPPA Claims have with ERISA

In addition to express preemption under Section 514(a), claims may be preempted under the doctrine of *complete preemption*. In the ERISA context, complete preemption applies when a party asserts state law claims seeking relief that falls squarely within the scope of ERISA § 502(a)(1)(B). *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield,* 331

F. Supp. 2d 502, 506 (N.D. Tex. 2004). This section states, "A civil action may be brought: (1) by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption grants state-court defendants the right to remove such actions to federal court.

This Court, as well as numerous district courts within the Fifth Circuit, have analyzed the TPPA (and other state laws) with respect to complete ERISA preemption. Although the complete preemption test is not identical to the express preemption doctrine, these cases likewise illustrate that TPPA claims lack the necessary connection with ERISA plans, and therefore do not warrant preemption. In the vast majority of these cases, this Court and district courts have held that ERISA does not completely preempt TPPA late payment claims submitted by a medical provider pursuant to a provider contract.[9] The facts and

[9] *See, e.g. Methodist Hospitals of Dallas v. Aetna Health, Inc.*, Civ.A.No. 3:13-CV-4992-B, 2014 WL 3764879 (N.D. Tex July 30, 2014)(Boyle, J.); *Texas Health Resources v. Aetna Health, Inc.*, Civ.A.No. 4:13-CV-1013, 2104 WL 553263 (N.D. Tex. Feb. 12, 2014)(McBryde, J.); *Plano Orthopedics & Sports Med. Ctr., P.A. v. Aetna U.S. Healthcare of North Texas, Inc.*, Civ.A. No. 3:09-CV-2124-L (October 30, 2012)(Lindsay, J.); *Plano Orthopedics & Sports Med. Ctr., P.A. v. Aetna U.S.*

reasoning behind these decisions further illustrate the fallacy of Aetna's ERISA express preemption argument. Indeed, the District Court viewed the analysis in the complete preemption cases "as applicable in this case" (ROA.7956).

First and foremost, this Court, in *Lone Star OB/GYN Assocs. v. Aetna Health, Inc.*, 579 F.3d 525 (5th Cir. 2009), held that ERISA did not completely preempt TPPA claims made solely for the late payment of claims deemed payable by an insurer administering claims for an ERISA self-funded plan. *Id.* at 530-32. Although procedurally different, *Lone Star* is factually equivalent to the present case, and thus the analysis applies. Lone Star was a health care provider that entered into a provider contract with Aetna to provide services for individuals

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Healthcare of North Texas, Inc., Civ.A. No. 3:09-CV-2124-L (April 12, 2011)(Lindsay, J.); *Lone Star OB/GYN Assoc. v. Aetna Health, Inc.*, 557 F. Supp. 2d 789, 808 (W.D. Tex. 2008) (Rodriguez, J.), *aff'd,* 579 F.3d 525 (5th Cir. 2009); *Mem'l Hermann Hosp. Sys. v. Aetna Health,* CIV.A. H-06-00828, 2007 WL 1701901, at *5 (S.D. Tex. June 11, 2007) (Miller, J.); *Northeast Hosp. Auth. v. Aetna Health, Inc.*, CIV.A. H-07-2511, 2007 WL 3036835, at *10 (S.D. Tex. 2007) (Miller, J.); *Halliburton Co. Benefits Comm. v. Mem'l Hermann Hosp. Sys.,* CIV.A. H-04-1848, 2005 WL 2138137, at *5 (S.D. Tex. Sept. 1, 2005) (Rosenthal, J.), *aff'd as modified,* 2006 WL 148901, at *6 (S.D. Tex. 2006)*; Mem'l Hermann Hosp. Sys. v. Great-W. Life & Annuity Ins. Co.,* CIV.A. H-05-1234, 2005 WL 1562417, at *6 (S.D. Tex. 2005) (Atlas, J.); *S. Texas Spinal Clinic, P.A. v. Aetna Healthcare, Inc.,* CIV.A. SA-03-CA0089FB, 2004 WL 1118712, at *4 (W.D. Tex. 2004) (Biery, J.); *Baylor Univ. Med. Ctr. v. Arkansas Blue Cross Blue Shield,* 331 F. Supp. 2d 502, 509 (N.D. Tex. 2004)(Fish, J.)*; Foley v. Southwest Texas HMO, Inc.,* 226 F. Supp. 2d 886, 901 (E.D. Tex. 2002) (Cobb, J.).

enrolled in Aetna-administered insurance plans. *Id.* at 528. Lone Star asserted TPPA claims against Aetna only for claims Aetna had deemed payable, yet paid late. *Id.*

In finding no complete preemption, this Court's reasoning was noteworthy on two points. First, the Court emphasized that determining the rate Aetna owed Lone Star under the provider agreement "does not require any kind of benefit determination under the ERISA plan." *Id.* at 530. Second, the Court held that mere consultation of an ERISA plan is not enough to result in complete preemption. *Id.* Thus, claims that implicate the *rate of payment* as set out in the Provider Agreement, rather than the *right* to payment under the terms of the benefit plan" do not result in ERISA preemption. *Id.* (emphasis in original).

Although decided under the complete preemption doctrine, the Court's reasoning in *Lone Star* bears a striking similarity to the Supreme Court's "relate to" test (i.e. reference to or connection with) for express preemption under Section 514(a). Indeed, "the existence of ERISA plans is [not] essential to the [TPPA's] operation." *Dillingham Constr.*, 519 U.S. at 325. As the Court held, the TPPA "only overlaps

with [] ERISA . . . if there is a dispute over whether a claim is 'payable' – whether there has been a denial of benefits because there is a lack of coverage." *Lone Star*, 579 F.3d at 532. Here, as in *Lone Star*, the Hospitals seek only TPPA remedies for claims that Aetna paid, but paid late. (ROA.2140, 2145). Accordingly, *Lone Star* illustrates the lack of connection TPPA claims have with an ERISA plan, particularly in the factual scenario present here (as in *Lone Star*)—suggesting that no express preemption exists under ERISA.[10] The District Court agreed. (ROA.7957-7958).

Moreover, *Lone Star's* reasoning—and its applicability to express preemption—has prevailed in a multitude of district court decisions addressing complete preemption of TPPA claims. Indeed, in finding that plaintiff's TPPA claims were not completely preempted by ERISA, Judge Miller of the Southern District of Texas noted that "while ERISA plans may provide the factual context for these [TPPA] claims, the plans are peripheral to the statutory obligation to pay plaintiff promptly for services rendered," and that "the plaintiff's rights do not derive entirely from the particular rights and obligations established by the

[10] Aetna attempts to dispense with *Lone Star* by pointing out simply that it was decided under the complete preemption doctrine, not express preemption. (*Br.* at 44-45). Such attempt ignores the overlapping rationale between the doctrines.

ERISA benefit plans." *Memorial Hermann Hosp. Sys.*, 2007 WL 1701901, at *5. Likewise, in holding that ERISA did not completely preempt the hospital's TPPA claims, Judge Rosenthal of the Southern District reasoned that although "the ERISA plan . . . provides the factual context for these [TPPA] claims, . . . the plan is peripheral to the statutory obligation to pay Memorial Hermann promptly for services rendered . . . Memorial Hermann has a right of recovery under the [TPPA] independent of [the employee's] rights as a Plan participant." *Haliburton Co. Benefits Comm.*, 2005 WL 2138137, at *5; *see also Great-West Life & Annuity Ins. Co.*, 2005 WL 156242417, at *6 ("[The] ERISA plans provide only factual background for [the hospital's] statutory [TPPA] claims; the plans are peripheral to Great-West's statutory obligation to promptly pay [the hospital] for services rendered."); *Cf. Northeast Hosp. Authority*, 2007 WL 3036835, at *10 ("[T]he crux of the parties' dispute in this case arises from the terms of a contract—the Hospital Agreement—that is independent of the ERISA patients' plans.")

Further, even before the aforementioned cases, Judge Fish of the Northern District of Texas utilized almost identical reasoning in finding

no complete preemption of TPPA claims in *Baylor Univ. Med. Cen.*, 331 F. Supp. 2d at 511-12. As here, a hospital sued an insurer with whom it had contracted for violations of the TPPA. *Id.* at 504–05. Unlike *Lone Star* and the previously discussed district court cases, however, the *Baylor* court analyzed the TPPA under ***both complete and express preemption*** principles. *Id.* at 506–508. In finding no preemption, the Court stated the following:

> ERISA does not preempt generally applicable state laws that impact ERISA plans only tenuously, remotely or peripherally. In this case, [the TPPA] requires insurers to promptly pay the claims of physicians and other health care providers. Wall's ERISA plan provides only factual background for Baylor's statutory claims; the plan is peripheral to the statutory obligation Baylor seeks to enforce in this case, namely, prompt payment of Baylor for services rendered. ***The Court will not, in the name of ERISA, insulate an insurer from liability against a third party health care provider seeking to enforce its rights under a state statute that requires prompt payment of claims.***
>
> The substance of Baylor's statutory claims are governed by state laws that enforce the prompt payment of claims by insurers—not to plan participants or beneficiaries, but to independent health care providers. Nothing in ERISA prevents the Texas legislature from making this determination. ***By enforcing the Texas statutes at issue, plan participants' actual obligations under the terms of their various plans would remain constant and the plans' terms would be unmodified.***

Id. at 511–12 (emphasis added).

Like *Lone Star*, the Court's use of language and reasoning akin to the Supreme Court's "relate to" test under Section 514(a) is telling. Indeed, the Court virtually quotes verbatim Supreme Court language from *Shaw* regarding ERISA not preempting a law that impacts ERISA plans "only tenuously, remotely, or peripherally. *Id.* at 511 (citing *Shaw*, 463 U.S. at 100 n.21). Judge Fish's reasoning clearly illustrates the lack of connection TPPA claims like those asserted by the Hospitals here have with ERISA plans. *Id.* at 511–12; *see also S. Tex. Spinal Clinic, P.A.*, 2004 WL 1118712, at *7 – 9 (holding no ERISA preemption of the TPPA under both complete and express preemption doctrines, and stating that "[i]n total, [the TPPA] has very little impact on the administrations of the defendants' ERISA-governed plans."); *Foley*, 226 F. Supp. 2d at 894, 896 – 97, 901 (holding no ERISA preemption of the TPPA under both complete and express preemption doctrines, and stating that "[w]hile ERISA plans may provide the factual background for the plaintiffs' [TPPA] claim, the plans are not the source of the

obligation the plaintiffs seek to enforce.").[11] Accordingly, such claims are not ERISA preempted—either completely or expressly.[12]

In summary, *Lone Star*, as well as the prior district court decisions finding no complete preemption, demonstrate the repeated conclusion that TPPA claims lack any real connection with or reference to ERISA plans within the "relate to" requirement of Section 514(a). Although technically decided under the umbrella of complete preemption, many of these cases—specifically *Baylor*, *Foley* and *South Texas Spinal, P.A.*—incorporate the elements of express preemption in their analysis. Consequently, these decisions provide ample support for the District Court's conclusion that the Hospitals' TPPA claims are not expressly preempted by ERISA. The District Court's Order should be affirmed.

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[11] Aetna attempts to avoid *Baylor's* applicability here, contending that "by relying on *Baylor*, the district court conflated the [express preemption] standard with the standard for complete preemption." *Br.* at 50. But the District Court did no such thing. To the contrary, it merely recognized, correctly, the applicability of the Court's reasoning to the issue of express preemption. (ROA.7958-7959, 7961-7963). Moreover, as previously explained, *Baylor*, in fact, analyzed the TPPA under both complete and express preemption principles. *Baylor Univ. Med. Cen.,* 331 F. Supp. 2d at 506-08. That alone defeats Aetna's attempt to cast *Baylor* aside. Aetna fails to address either *S. Tex. Spinal* or *Foley*.

[12] As discussed in Section C.2. below, *Baylor* also illustrates Aetna's failure to prove the second prong of the Fifth Circuit's two-prong test for express preemption.

C. Aetna Has Failed to Prove Express Preemption Under this Court's Two-Prong Test

In order to aid courts within the Fifth Circuit to decide whether a claim is expressly preempted under Section 514(a) using the Supreme Court's "reference to or connection with" test, this Court has developed a two-prong test. "A [party] pleading preemption must prove that: (1) the claim addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of the Plan; and (2) the claim directly affects the relationship among traditional ERISA entities – the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Bank of Louisiana*, 468 F.3d at 242; *see also Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 245 (5th Cir. 1990) (utilizing two-prong test in holding that hospital's DTPA and misrepresentation claims against insurer were not expressly preempted by ERISA.). As previously explained, Aetna bears the burden of proof on both elements. *Id.* Aetna has failed to meet that burden.

1. The Hospitals' TPPA Claims Do Not Address an Area of Exclusive Federal Concern

Aetna's preemption argument initially fails because the TPPA claims here—those brought by Hospitals in contractual privity with

Aetna for only those claims deemed payable by Aetna, but paid late—do not address an area of exclusive federal concern. In analyzing the first prong, this Court has noted that congressional intent behind enactment of ERISA is the "ultimate touchstone" in determining whether the claim addresses an area of exclusive federal concern. *Memorial Hosp. Sys.*, 904 F.2d at 245. In so doing, the Court reiterated the Supreme Court's determination that Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans . . . and to protect contractually defined benefits." *Id.* (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)).

As explained in Section A above, the TPPA claims here pose no threat to the interests of employees and their beneficiaries in employee benefit plans, and certainly do not encroach on contractually defined benefits. Indeed, a TPPA claim lies solely between a provider and insurer, and the prompt pay penalties are paid by the insurer, not by the employee or beneficiary. *See S. Tex. Spinal Clinic, P.A.*, 2004 WL 1118712, at *7 (The TPPA "does not address an area of exclusive federal concern, but rather it allows a party that has not received payment to bring suit to make another party pay in accordance with a contract that

party has with a third party. The enforcement of contracts can hardly be said to be an area of exclusive federal concern."). As such, "preemption in this case would [not] further the congressional goal of protecting the interests of employees and their beneficiaries in employee benefit plans." *See Memorial Hosp. Sys.*, 904 F.2d at 247 (holding that the first prong of the express preemption test was not met).

Despite this fact, Aetna makes two primary arguments in hopes of establishing that the TPPA invades an area of exclusive federal concern: (1) that the statute "directly regulates claim processing;" and (2) that the statute "directly regulates the amount of claim payments." (*Br.* at 38-46). Both contentions fail.

a. The TPPA Does Not Regulate Claims Processing

First, regarding the TPPA's purported direct regulation of claim processing, Aetna baldly claims that this Court "has twice held that claims under the [TPPA] are preempted on that basis," citing *N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare*, 781 F.3d 182, 198-201 (5th Cir. 2015) and *Ellis v. Liberty Life Assur. Co.*, 394 F.3d

262, 274-78 & n. 53 (5th Cir. 2004). Aetna's reliance on these cases is misplaced.

Ellis first dealt with common law and statutory claims brought by a *participant* in an ERISA benefit plan against the plan fiduciary as a result of the *denial* of plan benefits. *Ellis*, 394 F.3d at 274-75 (emphasis added). Not surprisingly, the participant's claims went directly to the issue of claims processing, and thus addressed an area of exclusive federal concern. Here, by contrast, the Hospitals' TPPA claims do not involve a plan participant or the denial of plan benefits. Thus, the TPPA claims have no impact on plan participants, beneficiaries, or the benefits themselves, and therefore do not address an area of exclusive federal concern. *See Memorial Hosp. Sys.*, 904 F.2d at 245.

Next, *North Cypress* is equally inapposite. There, the plaintiff-provider was an "out-of-network" provider with no privity of contract with the insurer, and thus no independent duty to enforce its late-pay claims. *N. Cypress Med. Ctr. Operating Co*, 781 F.3d at 188. Indeed, the Court identified these facts as the distinguishing factors in breaking from the Court's prior holding in *Lone Star*. *Id.* at 201. In that regard, pursuant to Texas Supreme Court precedent, the Hospitals' TPPA

claims here could not even have been brought absent contractual privity with Aetna. *See Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651, 654 (Tex. 2013) ("[T]he Prompt Pay provisions presume HMO-provider privity. The Legislature's words, and thus the result, are straightforward: Aetna must have directly contracted with the Hospitals to fall under the TPPA."); *see also* TEX. INS. CODE § 1301.103(1) ("[I]n accordance with the *contract* between the preferred provider and the insurer.").[13] The factual distinctions *in Ellis* and *North Cypress* from the present one belie Aetna's overly broad pronouncement that the TPPA directly regulates claim processing and addresses an area of exclusive federal concern.

Further, Aetna's contention that the TPPA overrides ERISA regulations regarding the timeframe to process claims is erroneous because the cited provision, 29 C.F.R. § 2560.503-1, governs only "claims for benefits by *participants and beneficiaries*." *Id.* at §

[13] Aetna also cites *Bank of Louisiana*, contending that the Court there recognized that "claims alleging delayed processing and payment 'require inquiry into an area of exclusive federal concern.'" (*Br.* at 41-42 (quoting *Bank of Louisiana*, 468 F.3d at 242)). But Aetna again ignores the facts – that the state law claims were brought by an employer against an insurer related to an ERISA plan. Moreover, Aetna ignores the Court's true holding: that it is only "inquiry into the administration of the Plan . . . that would require inquiry into an area of exclusive federal concern." *Bank of Louisiana*, 468 F.3d at 242. Here by contrast, the Hospitals' TPPA claims for late payment require no inquiry into the administration of any ERISA plan.

2560.503-1(a). Aetna does not cite to any ERISA statutory provision or regulation which would cover the Hospitals' TPPA claims here – claims made by a provider in contractual privity with an insurer for claims deemed payable, but paid untimely. Accordingly, Aetna's claim-processing-regulation argument fails.

b. The TPPA Does Not Directly Regulate the Amount of Claim Payments

Aetna's argument that the TPPA directly regulates the amount of claim payments fundamentally miscomprehends the TPPA itself. Simply stated, the TPPA does not change the contract rate negotiated with providers. To the contrary, it states expressly that insurer shall pay the provider the "contracted rate." TEX. INS. CODE § 1301.137(a). The TPPA merely adds penalties on top of that rate if, and only if, a claim is deemed payable, but paid untimely. TEX. INS. CODE §§ 1301.103; 1301.137. Stated differently, the statutory penalties only apply when a payable claim is paid late. *See id.* at § 1301.137(a). This in no way "regulates the amount of claim payments" between the insurer and provider. And even if it did, as previously explained, the statute has no effect on claims made by plan participants and beneficiaries.

Aetna relies on *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) for the proposition that ERISA "preempts state statutes regulating a plan's 'method for calculating pension benefits.'" (*Br.* at 45-46 (quoting *id.*)). But as previously explained, the TPPA has nothing to say about the calculation of plan benefits, only the calculation of penalties for claims—made by providers in contractual privity with insurers—that were paid late. *See* TEX. INS. CODE §§ 1301.103; 1301.137. Moreover, *Alessi* dealt with an ERISA provision preempting "directly or indirectly . . . [state regulations] [of] the terms and conditions of employee benefit plans covered by this subchapter." *Alessi*, 451 U.S. at 525 (quoting 29 U.S.C. § 1144(c)(2)). Because the TPPA regulates only payments from insurers to the providers with whom they contract, it does not regulate the terms and conditions of employee benefit plans themselves.

The TPPA claims here do not address an area of exclusive federal concern. Accordingly, Aetna's argument fails the first prong of this Court's two-pronged express preemption test. For this reason alone, the District Court's Order should be affirmed.

2. The Claims Do Not Directly Affect the Relationship Among Traditional ERISA Entities

Even it could prove the first prong of the Court's express preemption test—which it cannot—Aetna's preemption defense still would fail under the second prong because the TPPA claims here do not directly affect the relationship among traditional ERISA entities. As this Court has made clear, "traditional ERISA entities" include "the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Memorial Hosp. Sys.*, 904 F.2d at 245. Here, it is undisputed that neither Aetna nor the Hospitals are an employer, a plan, participants and beneficiaries. Only Aetna is arguably an ERISA fiduciary.[14]

Long ago, this Court held that the second prong would not be met if the state law "affects relations between one of these entities [i.e. the employer, the plan and its fiduciaries, and the participants and beneficiaries] and an outside party, or between two outside parties with

[14] Aetna cites a litany of cases for the proposition that as a plan administrator, it is considered an ERISA fiduciary. *Br.* at 47 (collecting cases). While the Hospitals do not necessarily dispute that assertion – and it ultimately is irrelevant to the resolution of this issue – it is worth noting that this Court has pointed out that "obligations of ERISA fiduciaries run only toward the plan, for the benefit of participants and beneficiaries." *Memorial Hosp. Sys.*, 904 F.2d at 247. As such, "[t]he Act imposes no fiduciary responsibilities in favor of third-party health care providers . . . regarding any other matter." *Id.*

only an incidental effect on the plan." *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986). That is exactly the situation presented in this case – the TPPA affects relations only between the Hospitals (non-ERISA entities) and Aetna (a third-party administrator and arguable ERISA fiduciary) by providing penalties for late payment of claims deemed payable, yet paid untimely. Thus, the Hospitals' TPPA claims are "claims by a non-participant and nonbeneficiary to a plan [that] do not affect the relationship between the traditional ERISA entities." *Weaver v. Employers Underwriters, Inc.*, 13 F.3d 172, 177 (5th Cir. 1994).

Aetna claims the TPPA "regulates the relationships among administrators, plans and beneficiaries because it directs administrators how to process claims." *Br.* at 47. The Hospitals have already addressed the flawed "processing of claims" argument in Section C.1.a. above, and in the interest of brevity, will not repeat it again here. However, the Hospitals' TPPA claims, "standing alone, [are] not preempted by ERISA because [they] affect only [Aetna's] relationship with [the Hospitals] and *not"* its administrator relationship

with plan participants and beneficiaries. *Hook v. Morrison Milling Co.*, 38 F.3d 776, 783 (5th Cir. 1994) (emphasis in original). Further, as this Court explained in *Bank of Louisiana*, "[t]he critical determination is whether the claim itself *created a relationship between the plaintiff and defendant* that is so intertwined with an ERISA plan that it cannot be separated." *Bank of Louisiana*, 468 F.3d at 243 (emphasis added). The relationship between the Hospitals and Aetna was created by the preferred provider contracts they voluntarily entered into. (*See, e.g.* ROA.29-42). The TPPA merely provides remedies for claims deemed payable under those contracts, but paid late. *See* TEX. INS. CODE §§ 1301.103; 1301.137.

Aetna attacks the District Court's Opinion on this issue by claiming it relied exclusively on the fact that "the parties in this case are not all traditional ERISA entities." *Br.* at 48 (quoting ROA.7961). But multiple courts in this Circuit have held that TPPA claims have no effect on the relationship between traditional ERISA entities. *See Foley*, 226 F. Supp. 2d at 897 ("There is no claim that [the TPPA] will prevent beneficiaries from receiving benefits or change beneficiaries' entitlement to benefits. In sum, this claim does not encroach upon the

relationship between plan participants and the plan."); *S. Tex. Spinal, P.A.*, 2004 WL 1118712, at *7 (same holding). Judge Fish's reasoning in *Baylor* is worth repeating here:

> The substance of Baylor's statutory claims are governed by state laws that enforce the prompt payment of claims by insurers—not to plan participants or beneficiaries, but to independent health care providers. Nothing in ERISA prevents the Texas legislature from making this determination. By enforcing the Texas statutes at issue, plan participants' actual obligations under the terms of their various plans would remain constant and the plans' terms would be unmodified. ***Baylor's statutory claims, thus, do not directly affect the relationship between traditional ERISA entities.***

Baylor Univ. Med. Ctr., 331 F. Supp. 2d at 511-12 (emphasis added).[15]

Finally, Aetna relies primarily on *Mayeaux v. La. Health and Serv. Indem. Co.*, 376 F.3d 420 (5th Cir. 2004) and *Access Mediquip L.L.C.*, 662 F.3d at 376 to support its argument that the Hospitals' TPPA claims affect the relationship between traditional ERISA entities. Both of those cases, however, are easily distinguishable. First, in *Mayeaux*, both a plaintiff and defendant were traditional ERISA

[15] Aetna again attempts to distinguish *Baylor*, arguing that the court there "did not consider or address whether a provider's prompt pay claims affect traditional ERISA entities. *Br.* at 50. The quoted language above directly refutes Aetna's assertion. And as previously explained in fn. 10, despite the case being decided under the complete preemption doctrine, the *Baylor* court, in fact, utilized the two-prong express preemption test.

entities—the plaintiff was the plan participant, and the defendant was the insurer. *Mayeaux*, 376 F.3d at 423. Second, the state law claim dealt exclusively with the insurer's *denial of coverage*. *Id.* Thus, the Court had "no difficulty holding that the existence of an ERISA plan is a critical factor in establishing liability for the state law causes of action asserted by [the plaintiff]." None of these facts exists in the present case, and an ERISA plan is not a "critical factor" in establishing the Hospitals' TPPA claims.

Second, *Access Mediquip* offers no support for Aetna's argument because in that case, the Court actually found no preemption of the state law misrepresentation claim wherein it discussed the traditional ERISA entities issue. *Access Mediquip L.L.C.*, 662 F.3d at 385. Instead, it only found preemption of the state law unjust enrichment and quantum meruit claims because not doing so "would run afoul of Congress's intent that the causes of action created by ERISA be the exclusive means of enforcing an ERISA plan's terms." *Id.* at 387. In contrast, here, the Hospitals' TPPA claims do not interfere with any cause of action created by ERISA, nor affect ERISA plan terms.

In summary, Aetna has failed to prove the second prong of this Court's two-prong express preemption test. Accordingly, the District Court's Order should be affirmed.

D. *Hudgens* and Other Non-Fifth Circuit Authority Offer No Support for Aetna's Preemption Argument

Throughout its brief, Aetna relies heavily on case law from outside the Fifth Circuit, primarily the Eleventh Circuit's decision in *America's Health Insurance Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014), to support its express preemption argument. *Hudgens*, however, is readily distinguishable from this case. Thus, none of the non-binding authorities should trump the clear mandate from Fifth Circuit law that the Hospitals' TPPA claims here are not preempted by ERISA.

1. *Hudgens* Addressed a Statute Significantly Different from the TPPA

In *Hudgens*, the Eleventh Circuit Court of Appeals held that Georgia's prompt pay statute (referred to as the "IDEA") was expressly preempted by ERISA. *Hudgens,* 742 F.3d at 1319. But that decision construed a Georgia statute that manifestly implicates traditional ERISA concerns through its attempts to regulate the administration of employer self-funded plans themselves, and thereby clearly gives rise to

ERISA preemption under that circuit's law. *See id.* The Georgia statute was preempted because it explicitly authorized penalties against plans themselves and expressly applied to non-participating providers—neither of which is true about the TPPA. Indeed, the TPPA is fundamentally different than the Georgia prompt pay law as it was carefully drafted to avoid ERISA preemption by narrowly providing for penalties imposed upon insurers serving as administrators for such plans *only if* the insurer has a contract with the provider. *See* TEX. INS. CODE § 1301.103. It is this contract that creates a duty to timely pay, which is independent of ERISA plan terms themselves. Accordingly, *Hudgens* is inapposite to the TPPA claims asserted here.

In *Hudgens*, the Eleventh Circuit Court of Appeals found that ERISA preempted sections 4, 5 and 6 of the IDEA. Yet, in each of these sections, the Georgia Legislature dramatically exceeded the scope of regulations drawn up by the Texas Legislature. In short, Georgia sought – regardless of the absence of any contractual agreement between a healthcare provider and an employer self-funded plan – to regulate self-funded plans themselves. By contrast, Texas, through the TPPA, confined its regulations only to those *insurers* administering

claims *who also had entered into contracts with healthcare providers*. This fact destroys Aetna's reliance on *Hudgens*.

2. Aetna's Reliance on Other Non-Fifth Circuit Authority Is Equally Unavailing

Besides *Hudgens*, Aetna cites various other circuit court decisions, arguing that "every circuit to address the issue has held that ERISA [ ] preempts prompt pay claims." *Br.* at 42-43. Not one of those cases, however, can bear the weight Aetna places on them.

First, in *Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872 (8th Cir. 2009), an *out-of-network provider* sued an insurer for *wrongfully denied or reduced claims*. *Id.* at 873-75. Here, by contrast, the Hospitals' TPPA claims are brought only by virtue of their provider contract with Aetna. Indeed, the *Schoedinger* court pointed out this key distinction in dismissing the plaintiff's reliance on *Baylor*: "Moreover, the state law claim in *Baylor* was based on a provider agreement, whereas Dr. Schoedinger's ERISA claims are based on assignments of plan benefits . . . [t]hus, the impact of the MPPA on plan administration is not remote. Further, the Hospitals' have brought no claims for wrongfully denied or reduced claims. These key factual distinctions render *Schoedinger* inapplicable here.

Next, Aetna cites *Cicio v. Does 1 – 8*, 321 F.3d 83 (2d Cir. 2003), a case arising from an HMO's *denial* of a request to cover a specific cancer treatment regimen. *Id.* at 88. As to the New York statute requiring benefit determinations to be made and communicated "within one business day of receipt of the necessary information," the court found conflict preemption existed because ERISA mandated its own timetables for such determinations, and because the New York law "conflicts with regulations established pursuant to ERISA" and "establishes a different rule from ERISA." *Id.* at 95. Here, as explained in more detail in Section E below, there is no conflict between the TPPA requirements for paying healthcare providers and any provision of ERISA.

Third, in *Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57 (1st Cir. 2002), unlike here, the plaintiff was an actual plan participant. *Id.* at 58. More importantly, the plaintiff conceded that her state law claim for unfair claim settlement practices fell within Section 514(a)'s express preemption, and argued only that Section 514(b)(2)(A)'s "savings clause" preserved her claim as one brought under a state law that "regulates insurance. *Id.* at 60. Here, the

Hospitals' TPPA claims do not meet the Fifth Circuit's two-pronged test for preemption, so any analysis of the savings clause is unnecessary.

Finally, Aetna's reliance on *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1989) is misplaced because that case involved suit by plan participants for a *denial* of coverage. *Id.* at 491. Moreover, like in *Hotz*, the plaintiffs argued only that their state law claims were covered by 514(b)(2)(A)'s savings clause. *Id.* at 493-94.

Accordingly, this Court should disregard Aetna's reliance on these inapposite, non-binding authorities. The District Court's Order should be affirmed.

E. The TPPA Deadlines and Penalties are not Conflict Preempted

Finally, Aetna argues that the TPPA claims are "conflict preempted" pursuant to ERISA Sections 503 and 502(a). *Br.* at 56-62. Here, Aetna's entire argument is based on the allegation that the Hospitals either did take, or could have taken, assignments from beneficiary patients, thus allowing them to step into the shoes of the beneficiaries for purposes of ERISA and bring suit in federal court pursuant to ERISA's civil enforcement scheme. *Id.*; *see also id.* at 50-

51. The assignment argument, however, has no support in fact or law.[16]

First, with respect to Section 503, Aetna argues that the TPPA conflicts with the deadlines contained in 29 C.F.R. § 2560.503-1. However, as previously explained, that regulation governs only "claims for *benefits* by *participants and beneficiaries*." *Id.* at § 2560.503-1(a) (emphasis added). The Hospitals are not participants or beneficiaries, and even if they could step into the shoes of a beneficiary pursuant to an assignment, their TPPA claims are not "claims for *benefits*." To the contrary, the Hospital's TPPA claims seek only penalties from Aetna for late payment of claims already deemed payable based on the parties provider agreement.

[16] As the District Court noted, the Hospitals' have expressly disclaimed any claims by virtue of any right to step in the shoes of individual patients via assignment. (ROA.7963-7964; *see also* ROA.2141, 2145-2146). Courts in this Circuit have made clear that a court should not re-characterize a plaintiff's claims as ones based on assignment. *See Baylor Univ. Med. Ctr. v. Epoch Group, L.C.*, 340 F. Supp. 2d 749, 760 n. 9 (N.D. Tex. 2004) ("That plaintiff could have sued as an assignee is not dispositive . . . . Given plaintiff's independent right of action as a creditor, the court will not recharacterize it as an assignee."); *Tenet Healthsystem Hosps., Inc. v. Crosby Tugs, Inc.*, 2005 WL 1038072, at *3 n. 3 (E.D. La. Apr. 27, 2005) ("That plaintiff may, in fact, have an assignment, is not itself dispositive, if the rights at issue are those provided by a third-party agreement, rather than an ERISA plan."); *see also Children's Hosp. Corp. v. Kindercare Learning Ctr., Inc.*, 360 F. Supp. 2d 202, 206 (D. Mass. 2005) ("As a master of its own complaint, plaintiff had the right to assert independent causes of action regardless of the assignment.").

Aetna's Section 502(a) conflict preemption argument meets the same fate. That section permits a "participant or beneficiary" to bring a civil suit "to recover *benefits* due to him *under the terms of his plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). As just explained, the Hospitals TPPA claims are not seeking *benefits* due under the terms of a plan, nor are they enforcing rights under the plan or clarifying such rights. To the contrary, the Hospital's TPPA claims are enforcing rights only pursuant to the parties' contract. Accordingly, because no conflict preemption exists[17], the District Court's Order should be affirmed.

CONCLUSION

This Court should affirm the District Court's Order and Opinion that the Hospital's TPPA claims are not preempted by ERISA. Regarding applicability of the TPPA to self-funded claims, the Texas Supreme Court would rule in favor of applicability. To the extent this Court believes the District Court acted improperly in deferring to the

[17] It is worth noting that "the mere existence of a federal regulatory or enforcement scheme, however, even a considerably detailed one, does not by itself imply pre-emption of state remedies." *McClendon*, 498 U.S. at 485 (internal citations omitted).

Tarrant County state court on the applicability issue, this Court should remand the case to allow the District Court to rule. To the extent this Court decides to address the applicability issue on its merits, this Court should find that the TPPA applies to self-funded claims.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing has been served upon the parties registered with the Clerk's Office electronic noticing facilities as listed on the Master Service list, by email, on this 3rd day of August, 2015.

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CERTIFICATE OF ELECTRONIC COMPLIANCE

I hereby certify that, on August 3, 2015, this Brief for Appellees 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 and (2) the electronic submission is an exact copy of the paper document pursuant to this Court's Rule 25.2.1.

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