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, d/b/a Methodist Medical Center, d/b/a Charlton Medical Center; TEXAS HEALTH RESOURCES; MEDICAL CENTER EAR, NOSE & THROAT ASSOCIATES OF HOUSTON, P.A.,

Defendants-Appellees.

Appeal Under 28 U.S.C. § 1291 From A Final Decision Of The United States District Court For The Northern District of Texas
Case No. 3:14-cv-00347-M
The Honorable Barbara M.G. Lynn

BRIEF OF HEALTH CARE SERVICE CORPORATION AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF-APPELLANT AETNA LIFE INSURANCE COMPANY

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CERTIFICATE OF INTERESTED PERSONS

Pursuant to Fifth Circuit Rule 28.2.1, the undersigned counsel of record certifies that the following listed persons 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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STATEMENT OF INTEREST OF *AMICUS CURIAE*

Health Care Service Corporation ("HCSC") is the nation's largest customer-owned health insurance services company. As an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), HCSC offers a wide variety of health products and related services through its operating divisions, including Blue Cross and Blue Shield of Texas ("BCBSTX"), Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, and Blue Cross and Blue Shield of Oklahoma. HCSC serves nearly 14 million members nationwide and nearly five million members in Texas alone. Moreover, there are over 80,000 different health care providers in BCBSTX's networks in Texas.

HCSC fully supports the position of Plaintiff-Appellant Aetna Life Insurance Company ("Aetna") that the prompt pay provisions in Chapter 1301 of the Texas Insurance Code do not apply to plans that are administered, but not insured, by companies licensed to provide insurance services in Texas, such as Aetna and BCBSTX. HCSC writes separately to emphasize the impact that a contrary ruling would have on state-government plans for which BCBSTX

serves as a third party administrator ("TPA"), as well as out-of-state Blue Cross and Blue Shield plans that BCBSTX administers through its BlueCard program.

Although Aetna and BCBSTX each serve as TPAs for self-funded plans (typically employer-funded welfare benefit plans), BCBSTX also provides claims administrative services for state government employee plans that are not at issue in this litigation. BCBSTX further provides claims administrative services for out-of-state plans licensed through the BCBSA, thus allowing members of out-of-state plans access to BCBS coverage when receiving medical services in Texas. Because BCBSTX merely provides administrative services, rather than funding, for these plans, HCSC believes—and the Texas Department of Insurance has so instructed—that Chapter 1301's prompt pay provisions do not apply to BCBSTX when it administers these government and out-of-state plans. Adopting the expansive interpretation of Chapter 1301 that Appellees urge in this proceeding would not only lead to the imposition of onerous prompt pay penalties in connection with self-funded employee welfare benefit plans, but could also impose such penalties in connection with state-government employee plans and out-of-state plans

BCBSTX administers through the BlueCard program, thus dramatically increasing the potential liabilities under Chapter 1301.

HCSC has no direct interest, financial or otherwise, in the outcome of this litigation. However, as a payor and third-party administrator operating in Texas as BCBSTX, HCSC will be affected directly and significantly by the Court's interpretation of Chapter 1301. Moreover, HCSC is a party to a pending lawsuit against Defendant-Appellee Methodist Hospitals ("Methodist"), involving the same state statute and a similar demand to impose prompt pay penalties on BCBSTX arising from plans for which BCBSTX merely provides administrative services. The Northern District of Texas held, in *HCSC v. Methodist Hosps.*, No. 3:13-cv-4946, 2015 U.S. Dist. LEXIS 54357 (N.D. Tex. Jan. 28, 2015), that Chapter 1301's prompt pay provisions do not apply to self- and state-government-funded plans that BCBSTX administers rather than insures (the "*HCSC* Order"). Methodist has appealed that ruling, and that appeal is currently pending before this Court in the case styled *HCSC v. Methodist Hosp. of Dallas*, No. 15-10154. Thus, the Court's ruling in this proceeding will have a direct and substantial

effect on HCSC's interests in case number 15-10154, and on its business practices throughout Texas.

As required by Fed. R. App. P. 29, HCSC represents that no party's counsel authored this brief in whole or in part or contributed money that was intended to fund preparing or submitting this brief. No person, other than HCSC, contributed money that was intended to fund preparing or submitting the brief.

SUMMARY OF ARGUMENT

For over twenty years, HCSC has included Methodist as a preferred provider in its BCBSTX network. In this time, BCBSTX has processed and paid hundreds of thousands of claims that Methodist has submitted for payment. Until 2013, the parties consistently operated under the understanding that Chapter 1301's prompt pay requirements applied only to plans that BCBSTX insured, and BCBSTX had historically paid penalties to Methodist only for late-paid claims submitted under plans that BCBSTX insured.

As it has with Aetna, Methodist has now sought—for the first time—to expand the scope of Chapter 1301 and impose millions in dollars in prompt pay penalties against BCBSTX with respect to

self-funded employee benefit plans, and other plans that BCBSTX administers rather than insures. And like Aetna, BCBSTX filed a complaint in the federal court, seeking a declaratory judgment that Chapter 1301's prompt pay requirements apply only to fully-insured health care plans.

Judge Boyle's 30-page *HCSC* Order addressing BCBSTX's prompt pay dispute with Methodist provides a comprehensive explanation why Chapter 1301's text forecloses Methodist's attempt to impose prompt pay penalties for claims arising under plans that Aetna does not insure. Judge Boyle considered and rejected each of the arguments Methodist raised in its attempt to broaden the scope of Chapter 1301 beyond its plain language and its traditional application. Although Methodist raised these same flawed arguments to the District Court below, Judge Lynn did not address the merits of Methodist's Chapter 1301 interpretation. As a result, the *HCSC* Order remains the only decision by any court—state or federal—providing a substantive discussion of Chapter 1301's application to claims arising under self-funded plans. It therefore warrants careful consideration by this Court as it addresses Aetna's parallel appeal.

This Court's interpretation of Chapter 1301 is critically important to HCSC. While BCBSTX and Aetna each serve as a TPA for self-funded benefit plans, and face demands from Methodist for millions of dollars in prompt pay penalties stemming from their respective administration of these plans, BCBSTX also services state government-funded plans, as well as private out-of-state plans through its BlueCard program, that it does not fund. Methodist has demanded prompt pay penalties from HCSC in connection with its administration of these plans as well. Methodist's demand not only ignores the plain language of Chapter 1301 establishing that statute's scope, but well-established state and federal laws that prohibit Methodist from imposing Chapter 1301 penalties upon HCSC in connection with these government and BlueCard plans. This Court, therefore, should reject Methodist's unilateral and groundless attempt to expand Chapter 1301 beyond its plain language, and reverse the District Court's Memorandum Opinion and Order (Dkt. 70) below.

ARGUMENT

A. This Court Should Adopt Judge Boyle's Careful And Comprehensive Analysis In Holding That Chapter 1301 Applies Only To Fully-Insured Plans.

1. Chapter 1301 Does Not Apply Self-Funded Plans Because A TPA Does Not Act As An "Insurer" And Does Not "Provide" Payment Through A "Health Insurance Policy."

HCSC shares Aetna's view that the plain text of Chapter 1301 precludes its application to claims arising under anything other than fully-insured plans. Chapter 1301.0041(a), titled "Applicability," defines the scope of Chapter 1301 and sets out in unambiguous terms precisely when and to whom the prompt pay provisions of Chapter 1301 apply:

> 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) (emphases added) (hereinafter, the "Applicability Section").

The Applicability Section's plain language demonstrates that Chapter 1301's prompt pay requirements reach only those PPO health insurance policies issued by an insurer in Texas. When

Aetna or BCBSTX administers a self-funded plan, it does not provide any "health insurance policy" to any insureds. Rather, it simply offers claims processing and other administrative services; the funds used to cover the medical services rendered are paid by the party bearing the risk of loss—*i.e.*, the employer in the case of a self-funded employee welfare benefit plan. *Id.* Thus, by the plain language of Chapter 1301's threshold Applicability Section, Chapter 1301's prompt pay requirements do not apply to Aetna or BCBSTX unless it is the insurer of its own health insurance policy that it has issued to Texas insureds.

2. The Factual And Legal Circumstances Behind The *HCSC* Order Are Materially Indistinguishable From This Case.

By any measure, Judge Boyle's *HCSC* Order presents a direct parallel to this case. The same provider, Methodist, seeks prompt pay penalties and attorney's fees from Aetna and BCBSTX alike under the same provisions of Chapter 1301 of the Texas Insurance Code. *See* TEX. INS. CODE § 1301.137. Methodist is represented by the same counsel in both proceedings, and—as set forth in greater detail below—raised the same arguments before the District Court in this case that Judge Boyle rejected in the *HCSC* Order.

BCBSTX and Aetna are also situated similarly. Like Aetna, BCBSTX offers a variety of services to individual consumers and employee welfare benefit plans alike, and wears multiple hats, depending upon the function it provides to the various plans it serves. On the one hand, BCBSTX is a licensed insurance carrier and acts as an insurer for plans that BCBSTX underwrites.[1]

On the other hand, like Aetna, BCBSTX functions as a TPA when it provides claims processing, customer relations, and other administrative services for plans where an employer, government body, or other non-BCBSTX entity funds the plan. BCBSTX does not underwrite or bear the financial risk for such plans, and thus does not "provide" for payment of health care expenses through its "health insurance policy" for these plans.

Methodist's demands for Chapter 1301 penalties for claims arising under these latter categories of plans—commonly called "self-funded plans"—prompted HCSC, as Aetna did in these

[1] There is no dispute that these "fully insured plans" typically are subject to Chapter 1301's prompt pay requirements, and BCBSTX has traditionally paid Methodist Chapter 1301 penalties for late-paid claims arising under fully insured plans to which Chapter 1301 applies.

proceedings, to seek a declaratory judgment that Chapter 1301 applies only to fully insured plans.

3. Judge Boyle Considered, And Rejected, Each Argument That Methodist Has Raised In These Proceedings To Expand Chapter 1301 To Apply To Self-Funded Plans.

In opposing Aetna's summary judgment motion below, Methodist asserted "nine reasons" why it believed Chapter 1301 extended to apply to self-funded plans. *See* Def.'s Resp. to Mot. for Summ. J., Dkt. 26, at 3. Methodist asserted virtually the same "reasons" in opposing HCSC's Motion for Summary Judgment, *see* Def.'s Br. in Supp. of its Resp. to Mot. for Summ. J., No. 3:13-cv-4946 (N.D. Tex.), at 3 (asserting "ten reasons"), and Judge Boyle considered and rejected each of them. *HCSC* Order at *17. Methodist's reasons generally fell into three categories, as Judge Boyle observed: (1) arguments from the text of Chapter 1301.0041(a)'s Applicability Section; (2) arguments from a hodgepodge of canons of construction; and (3) Methodist's assertions of what the Texas Legislature intended to accomplish in Chapter 1301. *Id.* None of these arguments withstood Judge Boyle's scrutiny.

First, Judge Boyle addressed Methodist's argument that the text of Chapter 1301's Applicability Section applied to self-funded plans. *HCSC* Order at *12-14. Methodist argued (reiterated in its summary judgment brief below at p. 7) that its PPO Agreement constituted a "health insurance policy" as Chapter 1301 defined the term. *See* TEX. INS. CODE § 1301.001(2) (defining "health 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"). Under Methodist's interpretation, a "health insurance policy" is comprised of any one of the following: (1) a "group or individual insurance policy," (2) a "certificate," or (3) a "contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness." Judge Boyle rejected this interpretation of "health insurance policy" as far-fetched, explaining:

> The Applicability Section outlines what entities are included in the scope of Chapter 1301, and it explicitly states that it applies to "each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy," for specified levels of payment. Tex. Ins. Code § 1301.0041. Methodist agrees that HCSC does not provide insurance "as classically defined" when it administered Non-BCBSTX Insured Plans, yet it argues that HCSC's PPO Agreement somehow qualifies as a

> health insurance policy. Methodist Resp. Br. 8. This argument is based on a convoluted reading of the definition of "health insurance policy," which the Court cannot adopt. As HCSC notes, Methodist's interpretation of the definition of "health insurance policy" would lead to an absurd result, as any certificate or contract issued by an insurer would qualify as a "health insurance policy," even if it is unrelated to insurance services.

HCSC Order at *14 (emphases added).[2]

Judge Boyle then turned to Methodist's argument (raised again in its summary judgment brief here below at pp. 3-4) that the supposedly "specific" provisions of Section 1301.103 (which sets the deadlines insurers must follow in making and communicating claims determinations) and 1301.137 (which establishes the penalties owed if the § 1301.103 deadlines are not met) should control over the "general" Applicability Section set forth in §

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[2] Judge Boyle similarly dismissed Methodist's claim (repeated below in its summary judgment brief at 5-6) that interpreting the Applicability Section to exclude self-funded plans from Chapter 1301's reach would read an "exclusion" into the Chapter that the Texas legislature did not intend. "Such a reading of the statute," Judge Boyle explained, "comports neither with the plain meaning of its provisions nor with common sense." *HCSC* Order at *18. Because the plain text of the Applicability Section established Chapter 1301's contours, Judge Boyle found there was no need for self-funded plans to be excluded in those precise terms. *Id.* at *18-19.

1301.0041(a). *HCSC* Order at *14-17. Judge Boyle again rejected Methodist's arguments as unpersuasive "in light of the plain meaning of the Applicability Section and the lack of conflict among the provisions of Chapter 1301." *Id.* at *17. As Judge Boyle explained, the canons of construction upon which Methodist relies require an actual conflict between the Applicability Section and the deadlines/penalties section before they come into play. *Id.* But no such conflict exists, for "the Applicability Section is not merely a 'general' section, but is rather the section that defines the scope of the entire Chapter 1301. Though the 'specific' Sections . . . establish the prompt payment deadlines and corresponding penalties for violations of those deadlines, they do not specifically target administrators such as HCSC." *Id.* Because there is no conflict between the Applicability Section and Chapter 1301's prompt pay requirements, Methodist's argument that the specific must control over the general necessarily failed.

Third, Judge Boyle similarly dismissed Methodist's invocation of the supposed legislative intent behind the prompt pay provisions in Chapter 1301 (repeated by Methodist in its summary judgment opposition brief below at pp. 4-5). Rejecting Methodist's "reliance

on statements made by lobbyists and other commentators" as having "questionable relevance and significance," *id.* at 20, Judge Boyle recognized that the unambiguous text the legislature chose, not the comments various legislators and lobbyists made concerning drafts of the bill, controls its meaning. *Id.* (citing *Asadi v. G.E. Energy (USA), L.L.C.*, 720 F.3d 620, 622 (5th Cir. 2013)). Thus, "[b]y pointing to the legislative history of Chapter 1301's prompt payment and penalty provisions and by emphasizing that commentators speculated the TPPA would not infringe on ERISA, Methodist is in no way advancing its argument that insurers who do not provide benefits through their own insurance plans are subject to Chapter 1301." *HCSC* Order at *20-21.

Fourth, and finally, Judge Boyle rejected Methodist's claim that when "HCSC provides to employer plans its stop-loss coverage together with its administration of their claims, it remains an insurer covered" by Chapter 1301. *HCSC* Order at *21-22; *see also* Methodist Opp. to Summ. J., Dkt. 26, at 10-11 (repeating same argument below verbatim as to Aetna). Noting that this Court has already distinguished stop-loss insurance from health insurance in *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990), as the latter

provides insurance against loss caused by accident or sickness while the former insures the plan against catastrophic financial loss, *id.* at 1354, Judge Boyle held that "the stop-loss insurance discussed by Methodist is not sufficient to render HCSC an insurer who provides its own health insurance policy within the purview of Chapter 1301." *HCSC* Order at *22.

After a detailed reading of Chapter 1301, Judge Boyle concluded her statutory interpretation analysis by holding that the "Applicability Section is unambiguous" and finding "that it does not apply to plans which HCSC merely administers and for which BCBSTX does not provide its own health insurance policy." *HCSC* Order at *34. Judge Boyle explained: "[T]he Applicability Section unambiguously provides that Chapter 1301 '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.' The prompt payment provisions of Chapter 1301 then outline the deadlines with which such insurers must comply. By the plain meaning of these provisions, a preferred provider benefit plan under which an entity

is not an insurer who provides its own health insurance policy is not within the reach of Chapter 1301's prompt payment provisions." *Id.* at *35-36.

Deeming each of Methodist's arguments for a contrary reading to be an improper attempt to stretch the statute beyond its plain meaning, Judge Boyle explained that Methodist had offered no basis to depart from the text of the Applicability Section and to consider Methodist's accounts of the legislative history behind the Chapter: "Methodist's arguments based on unconventional readings of definitions, general rules of statutory construction, and comments made during the legislative process are irrelevant and fail to demonstrate that the language of Chapter 1301's Applicability Section and related definitions is either ambiguous or in need of clarification. Accordingly, the Court's inquiry must end with the text." *Id.* at *23 (internal citations omitted).[3]

[3] Following her analysis of the scope of Chapter 1301 to self-funded plans, Judge Boyle next held that the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901 *et seq.*, preempts the application of Chapter 1301's prompt pay requirements to a nationwide plan for federal employees (the "FEP") that BCBSTX services in Texas. As Judge Boyle correctly found, this Court's decision in *Burkey v. Gov't Emps. Hosp. Ass'n*, 983 F.2d 656 (5th

The District Court below erred in refusing to follow Judge Boyle's comprehensive 30-page *HCSC* Order. Judge Boyle issued the *HCSC* Order on January 28, 2015. The very next day, Aetna brought the *HCSC* Order to Judge Lynn's attention, noting that Aetna had previously cited the parallel *HCSC*/Methodist litigation in proceedings before Judge Lynn, and that Judge Boyle had rejected Methodist's arguments in the *HCSC* Order "[o]n precisely the same grounds asserted by [Aetna] in this Court. . . ." ROA.7906. In response, Methodist did not—because it could not—dispute that Judge Boyle's *HCSC* Order addressed the very same arguments and issues raised in Aetna's summary judgment motion. Instead,

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Cir. 1993), which held that FEHBA preempted a Louisiana state law that imposed penalties for delays in paying health and accident insurance claims, made it clear that FEHBA's broad express preemption provision encompassed Methodist's demand for prompt pay penalties for claims arising under the FEP. *HCSC* Order at 25-28. Although Judge Boyle found it unnecessary to address HCSC's ERISA preemption argument, ERISA's express preemption test is similar to the FEHBA preemption analysis. *See Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 926 (9th Cir. 1987). HCSC supports Aetna's view that ERISA preempts the application of Chapter 1301's prompt pay requirements to self-funded plans, *see* Aetna Br. at 36-62, and Judge Boyle's FEHBA analysis in the *HCSC* Order thus further supports that view.

Methodist argued Judge Lynn should ignore the *HCSC* Order and instead defer to the one-paragraph state court order in *Methodist Hosps. of Dallas v. Aetna Health Inc.*, No. 13-13865 (Tex. Dallas Cty. Dist. Oct. 3, 2014) (the "Tarrant County Order"). ROA.7945-7946.

Judge Boyle's opinion applies with full force to this case, and stands in stark contrast to the thin reed on which Judge Lynn rested her holding that Chapter 1301 applies to self-funded plans. While the District Court deferred to the Tarrant County Order, that Order provided no analysis or reasoning for Judge Lynn (or this Court) to follow. Rather, the interlocutory Tarrant County Order offered only the conclusory statement that Chapter 1301 "applies to Aetna with respect to claims administered by Aetna for self funded plans." ROA.7945-7946. By comparison, the *HCSC* Order stands alone as the only decision by any court to provide a reasoned analysis coupled with a textually focused parsing of the scope of Chapter 1301 and its application to self-funded plans. That Judge Boyle addressed and rejected the very same arguments to expand Chapter 1301 beyond its textual meaning and traditional interpretation—when raised by the very same provider and

represented by the very same counsel—renders the *HCSC* Order particularly instructive to Aetna's appeal here.

4. The *HCSC* Order Is Consistent With The Texas Department Of Insurance's Longstanding Interpretation Of Chapter 1301.

Judge Boyle rested her interpretation of Chapter 1301 on the plain language of the statute. *HCSC* Order at *18 n.3. This Court can, and should, do the same. *See Forte v. Wal-Mart Stores, Inc.*, 780 F.3d 272, 277 (5th Cir. 2015) ("When we interpret a Texas statute, we follow the same rules of construction that a Texas court would apply – and under Texas law the starting point of our analysis is the plain language of the statute."); *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 505 (Tex. 1997) ("Courts must take statutes as they find them. More than that, they should be willing to take them as they find them. They should search out carefully the intendment of a statute, giving full effect to all of its terms. But they must find its intent in its language and not elsewhere"); *see also Asadi v. GE Energy United States, LLC*, 720 F.3d 620, 622 (5th Cir. 2013) ("If the statutory text is unambiguous, our inquiry begins and ends with the text."). Yet, should the Court find any ambiguity in Chapter 1301's language, the interpretation of the statute given

by Aetna's and BCBSTX's regulator further confirms that Chapter 1301's prompt pay requirements apply only to fully-insured plans.

The Texas Department of Insurance ("TDI") is the administrative body tasked with interpreting and enforcing the prompt pay provisions of the Texas Insurance Code. *See* TEX. INS. CODE § 31.002(1). While enforcing the statute, TDI has consistently taken the position that Chapter 1301's payment deadlines and penalties apply only to fully-insured claims. Consistent with the plain statutory language, TDI has expressly and repeatedly stated that Chapter 1301 does not reach self-funded, government, or out-of-state plans. *See* 26 Tex. Reg. 7545 (Sept. 28, 2001). The industry—providers and payors alike—have followed this guidance for over a decade. In fact, TDI adopted rules implementing the legislation and interpreted the prompt pay requirements to apply to only fully-insured, non-governmental plans, stating:

> Even though a physician or provider has a contract with a carrier, if the claim is for an enrollee covered under <u>a self-funded ERISA plan</u>; workers' compensation; <u>self-funded government</u>, school and church health plans, including self-funded plans for Employees Retirement System of Texas, the Teacher Retirement System of Texas, the University of Texas and the Texas Association of School Boards; out-of-state insureds; Medicaid/Medicare; <u>federal employee plans</u>; and

> TRICARE standard (CHAMPUS), then the prompt pay statutes and rules do not apply.

26 Tex. Reg. 7555 (emphases added).

The Texas legislature enacted the prompt pay provisions of Chapter 1301 in 1999. Neither the Texas Legislature nor TDI altered the application of Chapter 1301 despite the statute being re-codified in 2003 and 2005. In 2003, the Legislature amended Article 3.70-3C (S.B. 418) to establish new prompt pay regulations, and required the Commissioner of Insurance to appoint a technical advisory committee on claims. Despite this development, TDI's view as to the applicability of Chapter 1301 remained unchanged. The 2004 Report on the Activities of the Technical Advisory Committee on Claims Processing (the "Report") included this statement:

> SB 418 does not apply to plans that TDI does not directly regulate, such as valid self-funded ERISA plans; workers' compensation coverage; government, school and church health plans; federal employee plans; Medicaid; and various Medicare-related plans.

Report, at p. 1.[4]

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[4]The Report continues in this same vein when it states:

> [S]pecific references to insurers and HMOs [in the prompt pay statutes] limits the applicability of the prompt pay

Similarly, during the comment and notice period for S.B. 418, TDI declared its "longstanding" interpretation of the applicability of Chapter 1301's prompt pay requirements as follows:

> Comment: A commenter seeks clarification regarding whether the statute and rules are applicable to Employee Retirement Income Security Act (ERISA) plans and non-ERISA self-funded plans.
>
> Agency Response: As with the prompt pay rules that have been in effect since 2000, the rules under SB 418 do not apply to self-funded ERISA plans, nor to certain non-ERISA plans (government, school and church plans). The department's longstanding position on the issue of applicability of prompt pay to self-funded ERISA plans is consistent with the testimony from the Office of Attorney General before the Senate Health and Human Services Committee when SB 418 was first laid out, stating that SB 418 does not apply to self-funded ERISA plans.

See 28 Tex. Reg. 8651 (Oct. 3, 2003). *See also* Report On The Activities Of The Technical Advisory Committee On Claims Processing—2004, Texas Department of Insurance, September 1, 2004 (*available at* http://www.tdi.texas.gov/

> statutes to licensed insurers and HMOs that are operating pursuant to their authority to offer preferred provider benefit plans and HMO evidences of coverage and not to a self-funded plan's third party administrator. . . .

Report, at p. 36.

reports/life/lhtaccp.html (last visited June 3, 2015) (stating the "department's long-standing interpretation of [the Chapter 1301 prompt pay provisions], based upon consultation with the Office of the Attorney General, is that TDI may not regulate self-funded ERISA plans and instead may only regulate the carriers from whom a fully-insured ERISA plan purchases coverage" and the fact that a licensed insurance carrier serves as a TPA "does not change this interpretation")).

From 2006 to the present, TDI provided numerous educational presentations on the prompt pay statutes and related rules as well as resources (including a website) for assistance in applying the statute. These public comments have stated consistently that the prompt pay laws do "not apply to certain plans, such as self-funded plans; worker's compensation coverage; and government plans." Report on the Activities of the Technical Advisory Committee on Claims Processing, September 2008, p. 2. *See also* Report on the Activities of the Technical Advisory Committee on Claims Processing, September 2006, pp. 11-12; Report on the Activities of the Technical Advisory Committee on Claims Processing, September

2008, p. 2; Report on the Activities of the Technical Advisory Committee on Claims Processing, September 2010, p. 2.

Moreover, the Legislature has not taken any action to amend or clarify Chapter 1301 in the face of TDI's consistent, longstanding guidance that it does not apply to self-funded plans and administrators. *See Texas Dep't of Protective & Regulatory Servs. v. Mega Child Care, Inc.*, 145 S.W.3d 170, 176 (Tex. 2004) (if a statute is "given a longstanding construction by a proper administrative officer [and] is re-enacted without substantial change, the Legislature is presumed to have been familiar with that interpretation and to have adopted it"); *Central Power & Light Co. v. Sharp,* 919 S.W.2d 485, 489 (Tex. 1997) ("When an agency interpretation is in effect at the time the legislature amends the law without making substantial change in the statute, the legislature is deemed to have accepted the agency's interpretation."). The Legislature amended Chapter 1301 in 2005, 2007 (Tex. H.B. 2636, 80th Leg., R.S. (2007)), and 2011 (Tex. H.B. 1772, 82nd Leg., R.S. (2011)), even as TDI submitted reports and notice and comment to the Legislature stating that Chapter 1301 does not apply to self-funded plans. Given that the Legislature has never amended

Chapter 1301 in any way to indicate that self-funded plans are covered, the Legislature is presumed to have adopted TDI's interpretation. *Texas Dep't of Protective & Regulatory Servs.*, 145 S.W.3d at 176.

Thus, TDI's long-standing interpretation of Chapter 1301, and the Texas Legislature's presumed acquiescence to that interpretation, is entirely consistent with Judge Boyle's 30-page *HCSC* Order, and provides further assurance that this Court should reject Methodist's demand for prompt pay penalties for claims arising under self-funded plans.

B. Applying Chapter 1301 Outside Of Fully-Insured Plans Will Have Significant Consequences Beyond Those Addressed In Aetna's Appeal.

HCSC writes separately not only to highlight Judge Boyle's instructive 30-page *HCSC* Order, but also to inform the Court of the potential impact of adopting Methodist's interpretation of Chapter 1301 and applying its prompt pay requirements beyond fully-insured plans. Aetna's brief addresses the application of Chapter 1301 only to self-funded health benefit plans for which Aetna serves as a TPA. *See* Aetna Br. at, *e.g.*, 1, 6. BCBSTX, however, services two additional types of plans that it does not insure and as to which

Methodist has also sought inapplicable prompt pay penalties.[5] Adopting Methodist's interpretation of Chapter 1301 could therefore result in a substantial increase in prompt pay penalties not contemplated by Aetna's briefing in this case.

1. BCBSTX Services State Government And Out Of State Plans Through The BlueCard Program.

In addition to self-funded employee benefit plans, BCBSTX services two types of plans that it does not insure, and thus are not subject to Chapter 1301's prompt pay requirements: (1) state government-funded plans and (2) BlueCard plans.

State government-funded plans are sponsored by state agencies and provide health care coverage for Texas state government employees. These state government plans operate similarly to self-funded employee plans in that the relevant government entity—and not BCBSTX—provides the health benefit plan that covers medical services provided to the state government entity's employees. TDI has consistently taken the position that

[5] Methodist's demand for prompt pay penalties for these types of penalties is addressed in the *HCSC* Order, which Methodist has appealed to this Court.

these plans are outside the scope of Chapter 1301. *See, e.g.,* 26 Tex. Reg. 7555 (Sept. 28, 2001); 28 Tex. Reg. 8651 (Oct. 3, 2003).

BCBSTX also services—but does not insure—claims under its BlueCard program. Claims processed under the BlueCard system are claims for members of out-of-state Blue Cross and Blue Shield plans. For example, if a member of Blue Cross and Blue Shield of Alabama ("BCBSAL") requires medical services in Texas, those claims are submitted to BCBSTX because BCBSTX has the contractual relationship with the Texas-based provider. For such claims submitted for reimbursement by Texas providers, BCBSTX (referred to as the "host plan") prices the claims in accordance with the Texas provider's agreement with BCBSTX. The claim information is transmitted to the member's "home plan" (in the example, that would be BCBSAL) which is located outside of Texas to determine if the member can receive benefits for the service under the terms of the relevant plan. When processing a BlueCard claim as the "host plan," BCBSTX does not bear the cost of reimbursement of health care benefits—rather, the home plan does. Additionally, the home plan, not BCBSTX, decides whether and when to make payment under the plan. In such circumstances,

BCBSTX prices the claim on behalf of the member's "home plan," but does not have ultimate financial responsibility for paying the claim. Rather, that financial responsibility falls on the "home plan" as the insurer or administrator of the plan. Because the "home plans" are regulated by the state where they are located and cannot be regulated by TDI since they are not Texas healthcare plans, they are not subject to Chapter 1301.

2. Methodist's Interpretation Of Chapter 1301 Could Impose Prompt Pay Penalties On BCBSTX For State Government Plans And BlueCard Claims.

Methodist offers an interpretation of Chapter 1301 that is as simplistic and reductionist as it is wrong. As Methodist would have it, any claim processed by an entity licensed to provide health insurance is subject to Chapter 1301's reach and may trigger prompt pay penalties, regardless of whether the entity is acting as an "insurer" or whether it is providing a "health insurance policy." As explained above, and in Aetna's opening brief at p. 19, that interpretation ignores the plain text of the Applicability Section and is refuted by the regulator entrusted to apply and enforce Chapter 1301. *Supra*, § A. Were this Court to adopt Methodist's view and expand Chapter 1301 to apply to any plans administered by a

licensed insurance carrier, however, it could subject BCBSTX to prompt pay liability for processing claims arising under state government and BlueCard plans. Such an expansion of Chapter 1301 would conflict with state and federal laws governing these plans. *See, e.g., Ex parte Enriquez*, 227 S.W.3d 779, 783 (Tex. Ct. App. 2005) ("If possible, a court construing a statute should interpret it so that it does not render another provision ineffective or cause an unnecessary conflict. Also, we must presume that the Legislature was cognizant of existing law when enacting a statute that seems to conflict with another provision.") (internal citations omitted); *Margraves v. State*, 56 S.W.3d 673, 687 (Tex. Ct. App. 2001) ("when possible, statutes should be interpreted such as to avoid conflicts in application"); *see also Doe v. Rumsfeld*, 435 F.3d 980, 988 (9th Cir. 2006) ("When interpreting statutory schemes, the court should, where possible, read the provisions of the statute so as not to create a conflict with other statutes.").

First, such an interpretation would run afoul of Texas law that explicitly prohibits the application of Insurance Code provisions like Chapter 1301.137 to state government employee plans. State law provides that a governmental unit may establish a self-insurance

fund to protect the government unit and its employees from insurable risks, including health care risks. TEX. GOV'T. CODE § 2259.031(a). The Government Code then provides that the "Insurance Code and other laws of this state relating to the provision or regulation of insurance *do not apply* to: (1) an agreement entered into under this subchapter[.]" TEX. GOV'T. CODE § 2259.037(1) (emphasis added). As the Court of Appeals of Texas has observed, the "plain and unambiguous meaning" of this section "is that self-insurance funds established by 'government units' pursuant to this statute are exempt from the Insurance Code." *Hill v. Texas Council Risk Mgmt. Fund*, 20 S.W.3d 209, 213 (Tex. Ct. App. 6th Dist. 2000) (interpreting previous iteration of section with same operative language). Any agreement, including a contract for administrative services, between a self-funded Texas government unit and BCBSTX is thus not subject to the Insurance Code, including the prompt pay provisions of Chapter 1301. *Id.* at 215 (concluding that plaintiff "failed to present any legitimate basis for avoiding the express language" of the statute that "unambiguously provides that the Insurance Code does not apply to self-insurance funds for governmental units established pursuant to the statute"

and holding that insurance coverage "cannot be presumed to exist in the present case merely because the coverage was not rejected in writing as required by the Insurance Code").

Second, Methodist's interpretation would result in the State of Texas regulating health insurance and employee welfare benefits emanating outside its borders. When BCBSTX processes a BlueCard claim, BCBSTX prices the claim on behalf of the member's "home plan," but does not have ultimate financial responsibility for paying the claim. Rather, that financial responsibility falls on the "home plan" as the insurer or administrator of the plan. The "home plans," in turn, are regulated by the state where they are located, but they cannot be regulated by TDI since they are not Texas healthcare plans. *See* TEX. INS. CODE § 31.002(1) (TDI's enabling statute, which authorizes TDI to "regulate the business of insurance in this state") (emphasis added); *Combs v. STP Nuclear Operating Co.*, 239 S.W.3d 264, 270 (Tex. Ct. App. 2007) (policies that are lawfully solicited, written, and delivered outside the State and which cover subjects that are not resident, located, or expressly to be performed in Texas "are not subject to regulation by the Texas Department of Insurance").

Indeed, allowing Texas to regulate the home plans written and funded in another state would run afoul of the McCarran Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* *See FTC v. Travelers Health Ass'n*, 362 U.S. 293, 301 (1960) (holding that Act limits states to regulate insurance operating within their borders, and noting statement by bill's sponsor that "[n]othing in the proposed law would authorize a State to try to regulate for other States").

Thus, Methodist's attempt to stretch Chapter 1301 to regulate these out-of-state and state-government-funded plans is not only inconsistent with the plain language of Chapter 1301's Applicability Section, but also prohibited by state and federal laws that prohibit Texas and TDI from regulating these plans.

CONCLUSION

Amicus curiae Health Care Service Corporation respectfully urges this Court to adopt the position of Aetna Life Insurance that Texas Insurance Code Chapter 1301 does not apply to self-funded employee welfare benefit plans and other plans that are not "insured" by a third party administrator. For the reasons stated above, and for the reasons stated in Aetna's opening brief, the District Court's judgment should be reversed, and the District

Court should be instructed to enter a declaratory judgment in Aetna's favor.

Respectfully submitted,

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CERTIFICATE PURSUANT TO FED. R. APP. P. 32(A)(7)(C)

This brief complies with the type-volume limitation of Fed. R. App. 32(a)(7)(B) because this brief contains 6,259 words, excluding the part of the brief exempted by Fed. R. App. P. 32(1)(7)(B)(iii).

This brief complies with the typeface requirements of Circuit Rule 32(b) and the type style requirements of Fed. R. App. P. 32(a)(6) because the font in this brief is Bookman Old Style, a proportionally-spaced font, and the font size is 14 point.

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