No. 15-10210

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

AETNA LIFE INSURANCE COMPANY,
Plaintiff–Appellant,

v.

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

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

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INTRODUCTION

In arguing to expand Texas's prompt-pay statute to self-funded health plans, the hospitals have abandoned their principal interpretative argument below—that the statute's applicability provision does not limit its scope. Yet, the hospitals have no meaningful response to that provision's plain text, stating that Chapter 1301 (which includes the prompt-pay statute) applies only to an "insurer" that provides for payment of claims "through that insurer's health insurance policy." The hospitals stretch and contort these terms, but they have no way around the Texas Department of Insurance's ("TDI's") long-standing determination that the statute applies only to insured plans (for which insurers assume the financial risks of coverage and pay claims under insurance policies they underwrite), but not self-funded plans (for which employers, acting through administrators, pay claims from their own assets without any insurance policy).

Federal law compels the same conclusion because ERISA would preempt the prompt-pay statute if the hospitals' expansive interpretation were adopted. The hospitals do not dispute that applying the statute to self-funded plans would interfere with coverage and eligibility determinations by requiring those plans' administrators to process claims more quickly, and make higher claim payments, in Texas than in other states. Those effects on plan administration easily satisfy this Court's two-pronged test for express preemption under ERISA § 514(a) and

demonstrate the statute's conflict with the Department of Labor's ("DOL's") claim-processing regulation under ERISA § 503. And because the prompt-pay statute is meant to remedy delayed claim processing—for which ERISA's comprehensive remedial provision, Section 502(a), provides the exclusive remedy—that conflict also requires preemption. The district court's decision therefore should be reversed.

ARGUMENT

I. The Texas Prompt-Pay Statute Does Not Apply To Self-Funded Plans.

The hospitals' attempt to force self-funded plans within the Texas prompt-pay statute misreads that statute's plain language, ignores its prior codifications, and disregards TDI's long-standing interpretation that the statute does not apply to such plans. The district court's decision—which erroneously adopted the hospitals' position based on their invitation to defer to a non-final ruling by the Tarrant County court—should be reversed.

A. The Statute's Plain Text Excludes Self-Funded Plans.

The hospitals have now abandoned their principal textual argument below (ROA.2218-23): They no longer dispute that the Texas prompt-pay statute's "applicability" provision, Section 1301.0041(a), limits its scope. Instead, they strain to argue that self-funded ERISA plans "fall within the scope of Section 1301.0041(a)." Hospitals'-Br.9.

Their forced construction of this provision comes too late and lacks merit.

As the hospitals now concede, the prompt-pay statute applies only to plans for which (1) "an 'insurer'" (2) provides for payment "through that insurer's 'health insurance policy.'" Hospitals'-Br.9 (quoting Section 1301.0041(a)). Self-funded ERISA plans satisfy neither requirement.

1. Aetna Life does not act as "an insurer" when it administers self-funded plans; these plans have elected not to be insured, and thus under controlling precedent states "may not regulate" them. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 64 (1990); *see* Aetna-Br.21-22.

Section 1301.001(5) of the prompt-pay statute reflects this distinction by limiting the definition of "insurer" to companies "operating under Chapter 841" and other enumerated chapters. The hospitals argue that Aetna Life meets this definition because—as an insurer for *insured* plans not at issue here—it is "*licensed*" as a "life, health, or accident insurance compan[y]" under "Chapter 841." Hospitals'-Br.9-10 (emphasis added). But Section 1301.001(5) applies only when Aetna Life is "*operating under*" Chapter 841 (emphasis added); operating as an insurer for some plans does not make Aetna Life an insurer for all purposes. *Cf. U.S. Fidelity & Guar. Co.* v. *Goudeau*, 272 S.W.3d 603, 609 (Tex. 2008) (definition of "opposing party" excludes "the same party acting in a different capacity"); *Howard* v. *Simons*, 285 S.W.2d 478, 480 (Tex. App.

1955) (exemption for licensed securities dealers was inapplicable when such dealers "were not acting as securities dealers, but were acting only as real estate dealers").

Aetna Life is not an "insurer" "operating under" Chapter 841 when it administers self-funded plans, because it does not "indemnify" any beneficiary "for any risk," Tex. Ins. Code § 841.301(a), or conduct any other activity regulated by Chapter 841. Rather, when administering such plans, Aetna Life operates under a separate statute, Chapter 4151, which to the extent applicable regulates "third-party administrators," including many that do not qualify as insurers. *Compare* TDI, Data Lookup, https://apps.tdi.state.tx.us/sfsdatalookup/StartAction.do (listing "Authorized Insurance Companies"), *with ibid.* (listing licensed "Third Party Administrators"). Administrators operating under Chapter 4151 are not included in the laundry list of entities considered "insurers" under Section 1301.001(5), further underscoring that the prompt-pay statute does not apply to administrators.

The hospitals' arguments that Section 1301.001(5) is satisfied even when Aetna Life "functions as an administrator" are meritless:

First, the hospitals contend that in *Toranto* v. *Blue Cross & Blue Shield of Texas, Inc.*, 993 S.W.2d 648 (Tex. 1999) (per curiam), the Texas Supreme Court "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.'" Hospitals'-Br.10-

11. *Toranto* involved a separate article of the Texas Insurance Code—Article 21.41-1, § 1(6), now codified at Section 1205.051(6)—that defined "insurer," under that article only, as a company "authorized to do business in [Texas]" under Chapter 3 and other enumerated chapters of the Insurance Code. 993 S.W.2d at 649. The Texas Supreme Court construed that definition to include *any* entity "acting as [the governmental plan's] administering firm," because such entities were regulated *as administrators* under Chapter 3. *Ibid.* ("BCBS is an 'insurer' because it is authorized to act as ERS' administering firm under Chapter 3."). Administrators of self-funded plans, by contrast, are not regulated in that capacity under any chapter listed in Section 1301.001(5). *Toranto*'s reasoning therefore does not apply to Section 1301.001(5) because "the definition of 'insurer' [it] considered" is "not similar to the definition of 'insurer' in section 13[01].001." *N. Cypress Med. Ctr. Operating Co.* v. *MedSolutions, Inc.*, No. 10-cv-2608, 2010 WL 4702298, at *6 (S.D. Tex. Nov. 10, 2010).

Second, the hospitals argue in a footnote that under Texas Insurance Code § 1301.109 the prompt-pay statute "appl[ies] to any person with whom an *insurer* contracts" to perform "administrative functions." Hospitals'-Br.10 n.1 (emphasis added). The hospitals did not cite Section 1301.109 below or in the Tarrant County action, with good reason: That section is inapplicable to Aetna Life when it enters administrative-services contracts with self-funded plans because those plans are not

"insurer[s]" under Section 1301.001(5). *See* Aetna-Br.20-21. If self-funded plans were "deemed" "insurer[s]"—and were therefore subjected to the prompt-pay statute themselves—the statute would be even more clearly preempted because, again, under the deemer clause, states "may not regulate" self-funded plans. *FMC Corp.*, 498 U.S. at 64.

Third, according to the hospitals, administering self-funded plans qualifies Aetna Life as an insurer because, under their expansive interpretation of Texas Insurance Code Chapter 101, literally "*anything* Aetna does in Texas constitutes the business of insurance." Hospitals'-Br.12 n.2 (emphasis added). That interpretation ignores controlling precedent that the "business of insurance" excludes activity by "self-funded employee health-benefit plans because they are not regulated like insurance companies," and because ERISA bars states from deeming them to be "engaged in the business of insurance." *Tex. Dep't of Ins.* v. *Am. Nat'l Ins. Co.*, 410 S.W.3d 843, 849 (Tex. 2012) ("*TDI*"). *A fortiori*, administrators performing those same activities for self-funded plans are not engaged in insurance either. Even if their activities met Chapter 101's definition of "insurance," that definition applies "only for purposes of that particular chapter" (*id.* at 849)—preventing *any* "*person*, *including an insurer*" (Tex. Ins. Code § 101.102(a) (emphasis added)) from "conducting the business of insurance in the state without authorization" (*TDI*, 410 S.W.3d at 849)—and not for Chapter 1301's prompt-

pay requirements, which apply only to "insurer[s]" operating under Chapter 841 and other enumerated chapters.

2. Even if Aetna Life qualified as an insurer under Chapter 1301, the prompt-pay statute still does not apply to claims under self-funded plans, because Aetna Life is not providing for payment "through th[at] insurer's health insurance policy." Tex. Ins. Code § 1301.0041(a); *see* Aetna-Br.21. Claims under self-funded plans are paid through the plan sponsor's own assets—not any Aetna Life "insurance policy." The essence of the administrator's job is that the plan sponsor, not the administrator, underwrites the financial risks of coverage.

The hospitals strain to argue that their *own* network participation agreements with Aetna Life, together with Aetna Life's administrative-services contracts with plan sponsors, form a "single, unified contract" that purportedly qualifies as a "health insurance policy." Hospitals'-Br.12-15. The hospitals claim this purported "unified contract" satisfies Section 1301.001(2)'s definition of "[h]ealth insurance policy" as an "insurance policy, certificate, or contract providing benefits for medical or surgical expenses." But the hospitals' contortions ignore that a key definitional term, "insurance," modifies "policy," "certificate," and "contract." *See* Aetna-Br.24-25. For a "contract" to be a "health insurance policy" under the statutory definition, therefore, it needs to provide "insurance" for medical or surgical expenses.

The provider contracts and administrative-services contracts cited by the hospitals do not provide insurance. As the hospitals concede, an "insurance policy" (or contract) is an agreement to "'indemnify against loss.'" Hospitals'-Br.14 (quoting *Guidry* v. *Am. Pub. Life Ins. Co.*, 512 F.3d 177, 182 n.6 (5th Cir. 2007)); *see also TDI*, 410 S.W.3d at 848 ("Insurance consumers *reallocate their risk* by purchasing direct insurance." (emphasis added)). Whether viewed separately or as a "unified contract," neither Aetna Life's network participation agreements with hospitals nor its administrative-services agreements with plan sponsors "indemnify against loss" or reallocate risk.

The hospitals' belated attempt to stitch together a new argument on appeal—by knitting a patchwork of separate contracts among Aetna Life, its affiliates, and numerous other employers nationwide into a "unified" quilt—merely underscores the desperate implausibility of their claims. The hospitals' principal case (Hospitals'-Br.12) makes clear that these disparate contracts cannot be treated as "unified" unless "'the parties' inten[ded]'" that result. *Baylor Univ. Med. Ctr.* v. *Epoch Grp., L.C.*, 340 F. Supp. 2d 749, 754 (N.D. Tex. 2004). Here there is no record support for the implausible assertion that each of the numerous parties with whom Aetna Life contracted intended to create a single, unified contract, and thereby trigger burdensome prompt-pay deadlines and expensive penalties under Texas law. Indeed, Aetna

Life's administrative-services contracts are not even in the record because this argument was never raised below.

The hospitals also contend that self-funded *plans* could be considered "Aetna's" "'health insurance polic[ies]'" because Aetna Life "created or adopted and in either event administers" them. Hospitals'-Br.16. But, again, Texas does not treat self-funded plans as insurance (Aetna-Br.20-21), and ERISA's "deemer clause" bars such treatment (*id*. at 53-55). Moreover, self-funded plans are not "Aetna's" insurance policies; rather, they are "established and maintained by the Employer" (Solomon Declaration ¶ 5 (ROA.785)), attributed to those employers in summary plan descriptions (*e.g.* ROA.2000 ("SCI's benefits plans"); ROA.3164 ("JPMorgan Chase's Medical Plan options")), and merely administered by Aetna Life, often in conjunction with other administrators (*e.g.* ROA.1911 (different administrators for different benefits); ROA.3147 (administrator "[d]epend[s] upon [beneficiary's] address")). Self-funded plans therefore are not "health-insurance polic[ies]" under the Texas prompt-pay statute, and they plainly are not "Aetna's" insurance policies.

B. Prior Codifications And Long-Standing Agency Interpretations Confirm That The Statute Excludes Self-Funded Plans.

Although the Court need not look beyond the prompt-pay statute's plain text, prior codifications and TDI's concurring interpretation confirm Aetna Life's interpretation. Aetna-Br.26-29.

1. The prompt-pay statute is in all relevant respects identical to earlier codifications—which the hospitals have conceded did not apply to self-funded plans. Aetna-Br.26. Yet the hospitals nonetheless contend that the 2003 TPPA somehow—without changing a single word of the "applicability" provision's materially identical predecessor, which was then in effect (*Compare* Tex. Ins. Code, Art. 3.70-3C § 2 (2000), *with id.* (2004); Tex. Ins. Code § 1301.0041(a))—extended the statute to self-funded plans. Hospitals'-Br.20-21. Rather than cite any specific changes that the TPPA enacted to specific statutory provisions, the Hospitals rely on vague characterizations of legislative history, which they assert shows a "goal" of "expanding [the prompt-pay statute's] scope." *Id.* at 21. As Aetna Life has explained, however, Texas courts would not consider that legislative history, and in any event when viewed in context that history shows that the statute never was extended to self-funded plans. Aetna-Br.27. The TPPA's principal goal and effect—as reflected in the Act's actual changes to the statute and its legislative history—was not to extend the statute to self-funded plans, but to make other changes, by "establish[ing] new prompt-payment regula-

tions for transactions between health-care providers and insurers," covering, among other things, "clean claims," "payment timelines," and "penalties." House Research Organization Analysis of S.B. 418 (ROA.2446-47).

2. The hospitals also ask this Court to ignore TDI's long-standing interpretation that the prompt-pay statute does not regulate self-funded plans because, they claim, that interpretation was not "formally adopted." Hospitals'-Br.21-22. That ignores TDI's Clean Claim regulations codifying its interpretation. Aetna-Br.28-29. The hospitals also misquote *Railroad Commission of Texas* v. *Texas Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 625 (Tex. 2011), as stating that an agency's interpretation "'warrants deference [only] when'" "'formally adopted.'" Hospitals'-Br.21-22 (alteration in original). *Railroad Commission* did hold that "formally adopted" interpretations (like TDI's Clean Claim regulations) warrant deference, but also made clear that "[i]nformal interpretations" "may merit some deference." 336 S.W.3d at 625. This Court therefore should consider TDI's reasonable—and persuasive—interpretation that the statute excludes self-funded plans.

C. The Tarrant County Court's Non-Final Order Is Not Entitled To Deference.

The hospitals offer nothing to rebut Aetna Life's showing that the district court erred in deferring to the Tarrant County court's non-final, one-paragraph decision that the prompt-pay statute applies to self-

funded plans. Aetna-Br.31-32. They merely assert that the district court's "[*a*]*bstention* was proper." Hospitals'-Br.8 (emphasis added). Yet they cite no theory of abstention permitting one court to defer to another court's non-binding order. Because the Tarrant County order is non-final and therefore non-binding (Aetna-Br.32-33), there was no basis for relying on that order.

D. This Court Should Hold That The Statute Excludes Self-Funded Plans.

This Court should rule that the prompt-pay statute does not apply to self-funded plans. Aetna-Br.35. The hospitals propose that this Court "remand" that question to the district court (Hospitals'-Br.8), but a "remand" is "unnecessary" because that question "presents no genuine issue as to any material fact." *Armstrong* v. *Collier*, 536 F.2d 72, 77 (5th Cir. 1976). Statutory interpretation is a pure question of law reviewed *de novo* by this Court. Aetna-Br.17; *Nerren* v. *Livingston Police Dep't*, 86 F.3d 469, 473 n.25 (5th Cir. 1996) (remand "unnecessary" on question reviewed "*de novo*"). That question is fully briefed in this Court, and is a logical predicate to the ERISA-preemption decision under review. The *HCSC* order, moreover, already addresses the hospitals' statutory arguments in detail. Aetna-Br.13. And the parties have already briefed the issue multiple times. There is no reason to remand merely to let the hospitals manufacture even more strained arguments

that administrators who do not underwrite the financial risks of coverage are the same thing as "insurers" who do.

This Court should reverse the district court and rule that the Texas prompt-pay statute does not apply to self-funded plans. If this Court believes that the statute's scope is ambiguous, it should not remand the case, but instead should certify that question to the Texas Supreme Court. Aetna-Br.35-36; *see*, *e.g.*, *Federated Mut. Ins. Co.* v. *Grapevine Excavation Inc.*, 197 F.3d 720, 729 (5th Cir. 1999) (certifying, rather than remanding, question that first arose on appeal).

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

The hospitals' prompt-pay claims under self-funded plans are independently barred by ERISA. Their attempt to avoid preemption under ERISA § 514(a) has no basis in this Court's two-pronged express-preemption standard or the Supreme Court jurisprudence on which that standard is based. It also ignores the prompt-pay statute's effect on uniform plan administration by self-funded plans and their administrators, who would be required, under the hospitals interpretation, to alter the way they determine beneficiaries' eligibility and coverage and the amounts they pay out for covered services. Even if the statute is not expressly preempted, it cannot be applied to self-funded plans because doing so would conflict with DOL's claim-processing regulation adopted under ERISA § 503, and with ERISA's exclusive remedial scheme,

ERISA § 502. The hospitals' terse response mischaracterizes the conflict and fails to reconcile the prompt-pay statute with ERISA's requirements. The district court's preemption holding should be reversed.

A. The Prompt-Pay Statute Is Expressly Preempted.

The hospitals concede that under this Court's precedent the prompt-pay statute is "expressly preempted under Section 514(a)" if it (1) "'addresses an area of exclusive federal concern'" and (2) "'directly affects the relationship among traditional ERISA entities.'" Hospitals'-Br.43; *accord* Aetna-Br.37. The hospitals' assertions under both prongs, and their additional arguments against preemption, are unavailing.

1. The Prompt-Pay Statute Addresses Areas Of Exclusive Federal Concern.

a. The Statute Directly Regulates Claim Processing.

The hospitals inexplicably question Aetna Life's conclusion that the prompt-pay statute "[r]egulate[s] [c]laims [p]rocessing." Hospitals'-Br.45-48. But they do not dispute the straightforward premises that lead inexorably to that conclusion: that the prompt-pay statute, as interpreted by the hospitals, requires administrators of self-funded plans to determine beneficiaries' coverage and eligibility more quickly in Texas than in other states (Aetna-Br.38, 43), and that those determinations are precisely the activities that courts refer to as "claim processing" and "plan administration" (*id*. at 37-44). Instead, the hospitals search for

irrelevant distinctions in the specific facts of the numerous cases cited by Aetna Life without addressing their consistent holdings on these "areas of exclusive federal concern" under ERISA. *See* Hospitals'-Br.31-34, 45-46, 55-59.

1. The hospitals first challenge Aetna Life's reliance on *Egelhoff* v. *Egelhoff*, 532 U.S. 141 (2001), *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990), and *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987), Hospitals'-Br.31-34, which expressly recognize ERISA's central goal of establishing uniform national standards for processing claims to minimize the costs to plans of complying with a patchwork of state regulations. Aetna-Br.39-41.

The hospitals would ignore that goal and cabin each case to its specific result. Hospitals'-Br.31-34. But this Court "is bound not only by the result[s] of [Supreme Court cases], 'but also [by] those portions of [each] opinion necessary to th[ose] result[s].'" *United States* v. *Rodriguez*, 602 F.3d 346, 358 (5th Cir. 2010). The Supreme Court's account of ERISA's central goal is essential to each case's result, and is therefore binding. *See Egelhoff*, 532 U.S. at 148 (statute had "a prohibited connection with ERISA plans because it interferes with nationally uniform plan administration," which is "[o]ne of [ERISA's] principal goals"); *Ingersoll-Rand*, 498 U.S. at 142 ("The conclusion that the cause of action in this case is pre-empted by § 514(a) is supported by our understanding of the purposes of that provision" to "minimize the administra-

tive and financial burden of complying with conflicting directives among States."); *Fort Halifax*, 482 U.S. at 11 ("The purposes of ERISA's pre-emption provision"—"to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations"—"make clear that the Maine statute in no way raises the types of concerns that prompted pre-emption.").

This Court has recognized the same goal of ERISA—a goal that is undermined when states burden "administrators of ERISA-governed employee benefit plans" with "complying with conflicting state regulations." *NGS Am., Inc.* v. *Barnes*, 998 F. 2d 296, 300 (5th Cir. 1993) ("It is these burdens" that "Congress sought to eliminate by enacting ERISA."). That goal is critical here because, as the hospitals acknowledge, this Court "must look to 'the objectives of the ERISA statute as a guide'" to the areas of exclusive federal concern that implicate preemption under ERISA § 514(a). Hospitals'-Br.30.

The hospitals propose that ERISA's goal was simply "to protect 'employees and their beneficiaries in employee benefit plans.'" Hospitals'-Br.30 (emphasis omitted). They ignore, however, that Congress pursued that goal by preempting conflicting state regulations of ERISA plans, to spare employers from "considerable inefficiencies" that might be "offset by lowering benefit levels." *Fort Halifax*, 482 U.S. at 10. State laws governing claim processing thus fall directly within an area

of exclusive federal concern under ERISA, and preempting those laws directly advances Congress's goal of protecting beneficiaries.

2. The hospitals also attempt to distinguish (Hospitals'-Br.33-34, 45-46, 55-59) the numerous cases from the Supreme Court, this Court, and other circuits holding that ERISA preempts claim-processing regulations, including the Texas prompt-pay statute (Aetna-Br.41-44):

First, the hospitals contend that several of these cases are irrelevant because they involve claims by beneficiaries or out-of-network providers, rather than claims by preferred providers. Hospitals'-Br.33-34, 46-47, 56-58. That argument conflates the first prong of this Court's test for preemption (addressing what *area* the regulation affects) with the second prong (addressing the *entities* affected). Even considering both prongs, the hospitals' distinction fails because preemption turns on the area and entities *affected*, not on the litigants' identities. Aetna-Br.46-49.

The hospitals repeatedly assert that their prompt-pay claims "have no impact on plan participants [or] beneficiaries" because those participants or beneficiaries are not parties to this action. *E.g.* Hospitals'-Br.33-34, 45-46, 58-59. But, again, they do not deny that, to comply with the prompt-pay statute and avoid penalties, Aetna Life must perform its traditional ERISA duties to plans and beneficiaries—by determining coverage and eligibility—within the prompt-pay statute's state-specific deadlines. Aetna-Br.38, 43. These state-specific rules—

and the related prospect of a patchwork of different rules in different states—are precisely the kind of costly threat to uniform plan administration that Congress feared employers might offset by lowering benefit levels.

According to the hospitals, claims by preferred providers are nonetheless uniquely exempt from preemption because they purportedly implicate "'[t]he enforcement of contracts,'" which is not "'an area of exclusive federal concern.'" Hospitals'-Br.44-45; *see also id.* at 46-47, 56-57. That argument fails at every step: The prompt-pay statute does not *enforce* the terms of preferred-provider contracts; it *overrides* them by imposing earlier deadlines, different procedures, and steeper penalties than those in the parties' contracts. Aetna-Br.51-53. And even if the statute's goal were to enforce rather than rewrite provider contracts, it would still be preempted because it interferes with claim processing. Preemption "is not limited to 'state laws specifically *designed to* affect employee benefit plans.'" *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 47-48 (1987) (emphasis added). Instead, the question is simply whether such plans *are* "'*affect*[*ed*].'" Hospitals'-Br.43 (emphasis added); Aetna-Br.37.

The hospitals' contract-enforcement theory is also belied by this Court's holding, in *Bank of Louisiana* v. *Aetna U.S. Healthcare Inc.*, that ERISA preempted an ERISA plan's breach-of-contract claims alleging that the plan's administrator "improperly delayed processing and

paying" claims to reduce the administrator's liability on a "stop-loss" insurance policy. 468 F.3d 237, 242 (5th Cir. 2006), *cited at* Aetna-Br.41-42. This Court held that the plan's claims implicated "an area of exclusive federal concern" even though they involved the administrators' performance of its "administrative services contract" and its alleged breach of a non-ERISA insurance contract. *Id.* at 239, 242, 244. The goal of enforcing independent contractual relationships thus cannot excuse interference with plan administration.

Second, the hospitals attempt to characterize *Schoedinger* v. *United Healthcare of Midwest, Inc.*, 557 F.3d 872 (8th Cir. 2009), *Cicio* v. *Does*, 321 F.3d 83 (2d Cir. 2003), and *Kanne* v. *Conn. Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988) (per curiam) (*see* Aetna-Br.42-43), as suits challenging "denial[s] of coverage." Hospitals'-Br.57-59 (emphasis omitted). But *Schoedinger* addressed preemption *only* as to the plaintiff's statutory claims for "delayed payment," because coverage was not disputed. 557 F.3d at 874-86. *Cicio* addressed *both* claims for denied coverage *and*, in a separate holding, separate claims for "failure to respond promptly" to a request for coverage that was ultimately approved. 321 F.3d at 88, 94-95.[1] Similarly, *Kanne* held that ERISA preempted claims

[1] The hospitals also mischaracterize *Cicio*'s holding as based solely on "conflict preemption." Hospitals'-Br.58. *Cicio* held that the statute it addressed was *both* conflict preempted under ERISA § 502(a) because it attempted to provide an alternative enforcement mechanism for rights

[Footnote continued on next page]

for a "'delay in payments'" for physician and hospitals bills that were eventually paid. Aetna-Br.43-44. The Ninth Circuit also addressed claims alleging denial of *other benefits*, but did not limit its holding to those claims. 867 F.2d at 491.

Third, the hospitals attempt to distinguish *America's Health Insurance Plans* v. *Hudgens*, 742 F.3d 1319, 1324 (11th Cir. 2014) by arguing that it addressed "penalties against plans themselves." Hospitals'-Br.56. But the Eleventh Circuit rejected that distinction as "irrelevan[t]," and enjoined the statute "as applied to [both] self-funded health plans *and their administrators*," including at least one provision (Section 4) that applied *only* to administrators. 742 F.3d at 1326, 1331, 1334 (emphasis added). And this Court has already recognized that regulating "administrators of ERISA-governed employee benefit plans" poses the same concerns under ERISA as regulating the underlying plans. *NGS Am.*, 998 F.2d at 300.

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

Plans' "method[s] for calculating [ERISA] benefits" are also an area of exclusive federal concern under ERISA. Aetna-Br.45-46. The hospitals attempt to distinguish "penalties" from "benefits," Hospitals'-

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[Footnote continued from previous page]
under ERISA plans, *and* "preempted by § 514" due to its "'effect on the primary administrative functions of benefit plans.'" 321 F.3d at 95.

Br.49, but whatever they are called, the impact of prompt-pay penalties on the plan is direct and substantial: They increase the amounts owed for covered medical services provided to beneficiaries. Aetna-Br.8-9. They also subject plans to a patchwork of rules requiring them to pay different amounts in different states.

The hospitals also argue that the prompt-pay penalties do not regulate benefits because they are imposed on administrators rather than plans, and are paid directly to providers, Hospitals'-Br.49, but those distinctions are equally unavailing because administrators will inevitably pass the increased charges on to plans, either directly or through higher services fees. Chamber-of-Commerce-*Amicus*-Br.12. ERISA § 514(a) bars such "indirec[t]" regulation of self-funded plans. *FMC Corp.*, 498 U.S. at 64.

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

The hospitals' claims against self-funded plans also satisfy the second prong of this Court's express preemption test because they affect the relationship among administrators, plans, and beneficiaries, all of whom are undisputedly traditional ERISA entities. Aetna-Br.47-48; Hospitals'-Br.50 n.14. Rather than meaningfully addressing the myriad ways in which those claims affect administrators' performance of their claim-processing duties to plans and plan beneficiaries, the hospitals at-

tempt to characterize themselves as "non-ERISA entities." Hospitals'-Br.50-51. That characterization is irrelevant and baseless.

1. To start, [i]t is "irrelevan[t]" whether the parties themselves are "'ERISA entit[ies]'" if, as here, the claims "would 'affect relations among [such] entities.'" *Hudgens*, 742 F.3d at 1331 (rejecting argument that "there can be no "connection with' ERISA because [the statute's] focus is on the regulation of non-fiduciary TPAs and *medical providers*" (emphasis added)). "The critical distinction" for purposes of this requirement, "is not whether the parties to a [state-law] claim are traditional ERISA entities, but whether the claims *affect* an aspect of a relationship that is comprehensively regulated by ERISA." *Access Mediquip L.L.C.* v. *UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011), *reinstated*, 698 F.3d 229 (5th Cir. 2012) (en banc) (emphasis altered). Plainly, claims by non-ERISA entities such as providers can affect the relationship between ERISA entities if they implicate the "'handling, review, and disposition of a request for coverage.'" *Mayeaux* v. *La. Health Serv. & Indem. Co.*, 376 F.3d 420, 432-33 (5th Cir. 2004); *see also* Aetna-Br.48-49. After all, ERISA can preempt actions initiated by States, which clearly are not ERISA entities. *E.g.*, *Hudgens*, 742 F.3d at 1323.

The hospitals' responses to these points each fail:

First, the hospitals attempt to limit *Access Mediquip* to its facts (Hospitals'-Br.54), but they cite no contrary authority suggesting that it

is the identity of the parties that matters for preemption. Instead, their own cases (Hospitals'-Br.51-52) confirm that it is the relationship affected that matters. *See*, *e.g.*, *Sommers Drug Stores Co. Emp. Profit Sharing Trust* v. *Corrigan Enters., Inc.*, 793 F.2d 1456, 1468 (5th Cir. 1986) (minority-shareholder's-rights claims by ERISA trust against its sponsor and administrator not preempted because claims affected only shareholder relationship, not administration of the trust); *Hook* v. *Morrison Milling Co.*, 38 F.3d 776, 783 (5th Cir. 1994) (worksite-injury claim against employer by participant in employer's ERISA plan not preempted because claims "affect[ed] only [an] employer/employee relationship" and "not [an] administrator/beneficiary relationship" (emphasis omitted)).

Second, the hospitals attempt to distinguish *Mayeaux* because *one plaintiff* in that case "was the plan participant," and thus a "traditional ERISA entit[y]." Hospitals'-Br.53-54. But *Mayeaux*'s key holding related to separate claims by a separate plaintiff—a physician who was not an ERISA entity. 376 F.3d at 432. Those claims were preempted because they "directly affect[ed] the relationship between the plan and its beneficiary, two traditional ERISA entities"—not because a plan participant was also a plaintiff. *Id.* at 433. The hospitals also argue that *Mayeaux* is limited to claims challenging "denial of coverage," (Hospitals'-Br.54 (emphasis omitted)), but that distinction is irrelevant. *See* Aetna-Br.43-44. Challenging a denial of coverage is one way that a

provider can affect plan administration, and forcing administrators to determine eligibility and coverage under state-imposed deadlines is another. Either way, claims by non-ERISA entities may affect traditional ERISA relationships, and if they do, ERISA § 514 preempts those claims.

Third, the hospitals argue that the prompt-pay statute's effect on traditional ERISA relationships is only "'incidental.'" Hospitals'-Br.50-51. But by the hospitals' interpretation the statute tells administrators, acting as fiduciaries for self-funded plans, when and how to "determin[e]" "whether [a] claim is payable," Tex. Ins. Code § 1301.103, and thus when and how to determine whether a provider's services were covered under a beneficiary's plan. It thus directly regulates administrators' performance of their duties to plans and beneficiaries. Aetna-Br.47-48.

Fourth, the hospitals cite several cases in which courts denied preemption because they found that the claims at issue did not affect traditional ERISA relationships, but none of those cases addressed the effect that Aetna Life has identified here. In *Weaver* v. *Employers Underwriters, Inc.* (*cited at* Hospitals'-Br.51), this Court held that a contractor's claims seeking benefits from his employer did not affect a traditional ERISA relationship—and was not preempted—because the contractor was not a plan beneficiary. 13 F.3d 172, 177 (5th Cir. 1994). The plaintiff's status was decisive only because his claims affected no

other traditional ERISA entities. *See ibid*. Here, regardless of whether the providers are ERISA entities, their claims affect the relationship between administrators, plans, and beneficiaries who, again, all undisputedly qualify as such entities.

The hospitals also cite district court cases—*S. Tex. Spinal Clinic, P.A.* v. *Aetna Healthcare, Inc.*, No. 03-cv-89, 2004 WL 1118712 (W.D. Tex. Mar. 22, 2004), *Foley* v. *Southwest Texas HMO, Inc.*, 226 F. Supp. 2d 886 (E.D. Tex. 2002), and *Baylor Univ. Med. Ctr.* v. *Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502 (N.D. Tex. 2004)—holding that prompt-pay claims did not satisfy the requirements for federal removal under the complete-preemption doctrine. Hospitals'-Br.52-53. But none of those cases addressed those claims' effect on administrators' performance of claim-processing duties to plans and beneficiaries.

2. In any event, the hospitals do not dispute that the second prong of this Court's preemption standard is satisfied when providers bring claims dependent on and derived from assignments of beneficiaries' rights. Aetna-Br.50-51. Nor do they deny that, absent an assignment, they cannot recover under the prompt-pay statute because the claims they submitted to Aetna Life would not have been "payable" under the terms of their contracts with Aetna Life, which expressly require assignments. *Id*. at 51; *see also* Methodist Contract § 4.5 (ROA.202); THR Contract § 4.1.1 (ROA.243). *All* of the hospitals' claims thus depend on assignments.

The hospitals argue that they have "disclaimed any claims by virtue of any right to step in the shoes of individual patients via assignment." Hospitals'-Br.60 n.16. That ambiguous statement is either too narrow to avoid preemption, or broad enough to eliminate all of the hospitals' claims. Individual patients cannot sue under the prompt-pay statute, so if the hospitals mean to disclaim only assigned *causes of action* from patients, their disclaimer is so narrow that it is meaningless—and in any event does not cover the underlying assignments of *benefits* or the prompt-pay claims that depend on those assigned benefits. If the hospitals mean to disclaim the underlying *benefits* claims that they originally submitted to Aetna Life under assignments—and all penalties derived from those claims and assignments—they are forfeiting their right to recovery in this case: There is no dispute that all of their benefits claims were submitted as purportedly "payable" based on the hospitals' representations that they had assignments, and otherwise those claims could not support penalties.

The hospitals contend that this Court "should not re-characterize [their] claims" as "based on assignment" because they are the "'master of [their] own complaint.'" Hospitals'-Br.60 n.16. But this Court need not "re-characterize" those claims; it need only examine the statutory and contractual provisions on which they are based. Unlike in the hospitals' cases (*ibid.*), the hospitals cannot disclaim their way around their assignments without sacrificing their right to recovery. And even

if the hospitals could somehow avoid *express* preemption by disclaiming their assignments, they cannot artfully plead around ERISA § 502(a), which completely preempts any claim that "*could have* [been] brought" under that exclusive remedy provision, regardless of "'the plaintiff's statement of his own claim.'" *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 207, 210 (2004) (emphasis added); *see infra* Part II.B.2.

3. The Hospitals' Remaining Arguments Fail.

The hospitals' remaining arguments also fail:

First, the hospitals argue that Aetna Life "bears the burden of proof regarding ERISA preemption," Hospitals'-Br.24, but Aetna Life's preemption argument involves no factual disputes, and "the allocation of burdens of proof is irrelevant" to "question[s] of law." *Scott* v. *Snelling & Snelling, Inc.*, 732 F. Supp. 1034, 1038 (N.D. Cal. 1990).

Second, the hospitals make a number of arguments based on the Supreme Court's limits on Section 514 preemption, but none alters the analysis under this Court's two-pronged preemption test. They quote the Court's statements that preemption is "'not favored'" and is thus inapplicable to laws that have "'only a tenuous, remote, or peripheral connection with covered plans.'" Hospitals'-Br.25-27. And they cite the requirement that plans have a "'connection with or reference to'" an ERISA plan. *Id.* at 27-28. But the Court's two-pronged test already reflects those limits. *See*, *e.g.*, *Hook*, 38 F.3d at 781 (two-pronged test adopted to "narro[w] [this Court's] preemption inquiry" within limits

recognized by the Supreme Court). The prompt-pay statute thus has the requisite "connection with" ERISA plans because it implicates Congress's exclusive concern with regulating how those plans process claims and calculate benefits, *see supra* Part II.A.1, and affects the relationship between ERISA plans, beneficiaries, and administrators. *See supra* Part II.A.2.[2]

Third, the hospitals argue that cases involving "the complete preemption test" (Hospitals'-Br.34-42) "illustrate that [prompt-pay] claims lack the necessary connection with ERISA plans, and therefore do not warrant preemption." *Id*. at 35. But complete preemption cases are based on ERISA § 502, which both creates federal-question jurisdiction *and* conflict preempts "any state-law cause of action that duplicates, supplements, or supplants" the exclusive remedies that ERISA provides for *all* benefits claims. *Davila*, 542 U.S. at 209. It is, of course, possible for state laws to be expressly preempted under Section 514 without also being preempted under Section 502. *See* Aetna-Br.44 (cit-

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[2] After Aetna Life filed its opening brief, the Supreme Court granted certiorari in *Gobeille* v. *Liberty Mutual Insurance Company*, No. 14-181, which addresses whether ERISA "preempts Vermont's health care database law as applied to the third-party administrator for a self-funded ERISA plan." Petition for Certiorari at i (Aug. 13, 2014). *Gobeille* is unlikely to implicate any of the questions presented in this case because it does not involve claim processing; rather, it turns largely on the burden posed by a Vermont law's reporting requirements and its relationship to ERISA's reporting requirements. *See id*. at 18-35.

ing *Copling* v. *Container Store, Inc.,* 174 F.3d 590, 594-95 (5th Cir. 1999)). Here, however, the prompt-pay requirements are preempted under both.[3] They are preempted under Section 514 because they affect administrators' claim processing and benefit calculations on behalf of self-funded plans and their beneficiaries (*id*. at 37-53), and they are preempted under Section 502 because the hospitals are seeking additional or supplemental remedies for rights to coverage under ERISA plans. *Id.* at 58-62; *infra* Part II.B.2.

The hospitals' complete-preemption cases are distinguishable because they primarily involve breach-of-contract claims alleging that the insurer "failed to pay the correct contractual rate for services." *Lone Star OB/GYN Assocs.* v. *Aetna Health Inc.*, 579 F.3d 525, 529 (5th Cir. 2009). Such "rate" claims—asserting contractual rights *independent* of plan provisions—plainly do not impact plan administration in the same way as a state-imposed requirement, backed by significant penalties, regarding how quickly claims must be paid under the plan. *Id.* at 532; *see* Aetna-Br.44-45. Although some of the "contractual rate" cases, including *Lone Star*, involved claims seeking Texas-law prompt-pay penalties, those claims were based entirely and *independently* on the al-

[3] Because this Court has diversity jurisdiction over this action, Aetna-Br.4, the jurisdictional dimension of Section 502 is unnecessary to Aetna Life's claims, but Section 502 remains a source of conflict preemption.

leged *contractual* underpayment—*i.e.*, the insurer's failure to pay the correct contractual rate *after* the claims had "already been deemed 'payable'" and partially paid, 579 F.3d at 532—and not on any alleged requirement to determine coverage and eligibility under the plan more quickly, or any penalties for not making those determinations quickly enough.

Contractual rate claims thus do not affect claim processing in the same manner as the hospitals' claims here. Indeed, *none* of the hospitals' complete-preemption cases is relevant here because *none* addresses the effect of prompt-pay deadlines and penalties on uniform claim processing and benefit calculations. And as explained below, the hospitals "contractual rate" cases are also distinguishable under the Supreme Court's test for preemption under Section 502(a) because those cases involve remedies for breaches of contract that are not remediable under ERISA. *See infra* Part II.B.2.

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

Even if the prompt-pay statute is not expressly preempted, its deadlines and penalties are barred by conflict preemption.

1. ERISA § 503 preempts state laws that require plans to process claims more quickly than DOL's regulations allow. Aetna-Br.56-58. As noted above, it is undisputed that to comply with the prompt-pay statute, Aetna Life must hasten claim processing. *Ibid.*

The hospitals contend, though, that absent "assignments from beneficiary patients"—which the hospitals purportedly "disclaimed"—their claims fall outside DOL's regulations. Hospitals'-Br.59-60 & n.16. But they do not deny that the allegedly late-paid claims for which they now seek penalties were originally submitted to Aetna Life under an assignment of "claims for benefits by participants and beneficiaries," 29 C.F.R. § 2560.503-1(a); thus, those claims indisputably were subject to DOL's claim-processing deadlines when Aetna Life processed them. Aetna-Br.51; *see also Baptist Mem'l Hosp.–DeSoto Inc.* v. *Crain Auto. Inc.*, 392 F. App'x 288, 293-94 (5th Cir. 2010) (per curiam) (applying those deadlines to claims that provider submitted under assignment), *cited at* Aetna-Br.60. Accordingly, those deadlines trump the shorter deadlines that the hospitals claim Texas law imposes on self-funded plans, Aetna-Br.56-58, and the hospitals cannot enforce those shorter deadlines now, regardless of how they frame their claims.

2. The hospitals' claims also are conflict preempted because the hospitals "could have brought [them] under ERISA § 502(a)(1)(B)." *Davila*, 542 U.S. at 210; *see* Aetna-Br.58-59. If, as the hospitals contend, Aetna Life's payments were untimely, the hospitals could have sought relief under Section 502(a)(1)(B) based on assignments. Aetna-Br.59-60. Instead, they seek additional relief—in the form of severe financial penalties—beyond what is available under ERISA. Those claims are therefore preempted.

Rather than confront any of those well-founded premises, the hospitals argue that they are "enforcing rights only pursuant to the parties' contract." Hospitals'-Br.61. But they do not allege a breach of contract, and have not identified *any* rights under the parties' contracts that were violated. Aetna-Br.51-53. That fact further distinguishes the hospitals' purely *statutory* claims under the prompt-pay statute from the "contractual rate" claims that *Lone Star* held were not removable to federal court under the "complete preemption" test. *See supra*, at __. As this Court recently explained, "a dispute concerning only the contractual rate of payment is a breach-of-contract claim, not an ERISA claim" subject to complete preemption, because it is not remediable under ERISA. *Kelsey-Seybold Med. Grp. PA* v. *Great-West Healthcare of Tex., Inc.*, No. 14-20506, slip op. at 2 (5th Cir. Aug. 10, 2015). By contrast, disputes over delayed claim processing, which are not dependent on the terms of the parties' contract, are governed by ERISA. Section 502(a)(1)(B) thus provides the only remedy.

The hospitals also cite district court cases suggesting that a provider can escape preemption under Section 502(a) merely by asserting that it "'seek[s] to enforce its rights under a state statute.'" Hospitals'-Br.40 (quoting *Baylor,* 331 F. Supp. 2d at 511-12) (emphasis omitted). After *Baylor* was decided, the Supreme Court rejected that argument in *Davila*, reversing an appellate decision that certain claims under a state statute were exempt from preemption because they involved "'an

external, statutory imposed duty.'" 542 U.S. at 215. As the Court explained, states may not "supplement" the remedies available under ERISA by enacting statutory duties that parallel the obligations created by ERISA while providing additional statutory remedies. *Id.* at 216. Unlike the remedies for breach of contract in *Lone Star*, state statutory remedies for "delayed payment of claims" "'conflic[t[with the clear congressional intent to make the ERISA remedy exclusive and [are] therefore pre-empted.'" *Schoedinger*, 557 F.3d at 874-76 (quoting *Davila*, 542 U.S. at 208-09).

CONCLUSION

The district court's orders should be reversed. The Texas prompt-pay statute does not apply to self-funded plans, and if it did, it would be preempted under ERISA § 514 and principles of conflict preemption.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 20, 2015, an electronic copy of the foregoing Reply Brief for Appellant was filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service will be accomplished by the appellate CM/ECF system.

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

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CERTIFICATE OF ELECTRONIC COMPLIANCE

I hereby certify that, on August 20, 2015, this Brief for Appellant was transmitted to the Clerk of the United States Court of Appeals for the Fifth Circuit through the Court's CM/ECF document filing system, https://ecf.ca5.uscourts.gov. I further certify that: (1) required privacy redactions have been made pursuant to this Court's Rule 25.2.13, (2) the electronic submission is an exact copy of the paper document pursuant to this Court's Rule 25.2.1, and (3) the document has been scanned with the most recent version of Microsoft Forefront Endpoint Protection and is free of viruses.

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