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 a Final Judgment of the United States District Court for the Northern District of Texas
No. 3:14-cv-347

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF APPELLANT AND REVERSAL

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SUPPLEMENTAL STATEMENT OF INTERESTED PERSONS

No. 15-10210

Aetna Life Insurance, Co. v. Methodist Hospitals of Dallas, et al.

The undersigned counsel of record for the *amicus curiae* certifies that the following listed persons and entities, as described in the fourth sentence of Rule 28.2.1, have an interest in the outcome of this case in addition to those already identified in the certificate appearing in the opening brief. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

- The Chamber of Commerce of the United States of America
- Mayer Brown LLP
- Tyler R. Green
- Brian D. Netter
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Dated: June 8, 2015 /s/ *Brian D. Netter*

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INTRODUCTION AND INTEREST OF THE *AMICUS*[*]

An employer that offers healthcare benefits to its employees may structure the benefits in one of two ways. In a fully-insured arrangement, the employer pays an insurance company to provide the benefits. The insurer then bears the risk of claims and the responsibilities of plan administration. In a self-funded arrangement, by contrast, the employer funds the benefits and bears the risk of claims. In a self-funded plan, a third-party administrator may be retained to process the claims, but the claims are paid from the employer's funds.

Self-funded benefit plans are "comprehensively regulate[d]" by the Employee Retirement Income Security Act of 1974 (ERISA). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987); *see* ERISA § 3(1), 29 U.S.C. 1002(1); *see also Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 361 (1980) (describing ERISA as a "comprehensive and reticulated statute"). Through ERISA, Congress sought a "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans."

* No party or counsel for any party authored this brief in whole or in part or otherwise contributed monetarily towards its preparation or submission. No other person other than the *amicus*, its members, or its counsel contributed monetarily towards the preparation or submission of this brief. All parties have consented to the filing of this brief.

Pilot Life, 481 U.S. at 54. To "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" (*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)), Congress "capped off the massive undertaking of ERISA with . . . provisions relating to the pre-emptive effect of the federal legislation" (*Pilot Life*, 481 U.S. at 44).

Among other issues, this case presents the question whether federal law preempts laws that impose state-specific rules for processing and paying claims in self-funded plans, either through the Supremacy Clause's preemption of state laws that conflict with federal laws or the preemption provisions tailored specifically to ERISA.

This case is critically important to the Chamber of Commerce of the United States of America and its members. The Chamber is the world's largest business federation, representing 300,000 direct members and indirectly representing the interests of three million businesses and professional organizations of every size in every state. The Chamber regularly advocates on issues of vital concern to the business community, and has frequently participated as amicus curiae before the

courts of appeals and the Supreme Court. A majority of the Chamber's members provide health benefits for their employees.

About 150 million Americans receive their health benefits through their employment, and a majority of those workers receive these benefits from self-funded plans. Employers that offer self-funded plans benefit from ERISA's uniform national rules for plan administration. Subjecting those employers to a patchwork of state-specific rules would impose substantial burdens and inefficiencies that would compromise the ability of some employers to provide such benefits to employees. *See infra* Part A.4. Indeed, research indicates that "each one percent increase in . . . plans' costs . . . results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers*: 1999-2003, at iii (1998).

The district court's preemption ruling fails to appreciate the significance of the conflict between Texas's prompt pay statute and ERISA's core objectives, which require that these plans remain free from variable state regulation in order to continue providing employees across the country with efficient, cost-effective coverage.

ARGUMENT

If this Court construes Texas's prompt pay statute to apply to self-funded plans in the first instance, this Court should further hold that ERISA preempts that statute.

ERISA preempts state laws in two ways. As with any federal statute, ERISA preempts any state law that "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). Moreover, ERISA contains an express preemption provision that "supersede[s] any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute." ERISA § 514(a), 29 U.S.C. 1144(a).

Here, Texas's prompt pay statute is incompatible with ERISA's core objectives. And the statute interferes with the administration of the plan in a way that necessarily "relate[s] to" the plan within the meaning of ERISA's preemption provision. Accordingly, to the extent Texas's prompt pay statute was designed to regulate self-funded benefit plans, it is preempted by federal law.

A. Enforcement of Prompt Pay Statutes Would Conflict with ERISA's Core Purposes and Impose Massive New Burdens on Self-Funded Plans.

1. Through ERISA, Congress sought simultaneously to regulate employee benefits and to encourage employers to provide them. Predictability and uniformity are essential components of that design. "ERISA 'induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)). Meanwhile, Congress sought to avoid a system "so complex that administrative costs, or litigation expenses, [would] unduly discourage employers from offering [ERISA] plans in the first place.'" *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

ERISA's preemption provision, which guarantees consistent rules and regulations across jurisdictions, is the linchpin of that design. Congress recognized that "requir[ing] plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies

that employers might offset with decreased benefits." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990). Without a uniform national scheme, plan administrators would have "to master the relevant laws of 50 States" (*Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149 (2001)) and "'administer their plans differently in each State in which they have employees'" (*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (quoting *Shaw v, Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983)). State-by-state regulations plainly "would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators." *Egelhoff*, 532 U.S. at 149

Thus one of Congress's core objectives with ERISA was to ensure "'uniform national treatment of [covered] benefits.'" *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 17 (2004) (quoting *Patterson v. Shumate*, 504 U.S. 753, 765 (1992)). Otherwise, a "patchwork scheme" of state-by-state regulation would "introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing*, 482 U.S. at 11. And that is just what experience bears out:

"each one percent increase in . . . plans' costs . . . results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers*: 1999-2003, at iii (1998).

2. Through ERISA and its regulations, federal law comprehensively regulates the process of payment of benefits from self-funded benefit plans.

ERISA requires every plan to be established and maintained by a written instrument that names fiduciaries who have authority to control and manage the operation and administration of the plan. 29 U.S.C. 1102(a)(1). The plan must specify, among other things, the basis on which payments are made to and from the plan. 29 U.S.C. 1102-(b)(4). And the fiduciary must discharge his or her duties with respect to the plan "for the exclusive purpose" of "providing benefits to participants and their beneficiaries" and defraying reasonable plan expenses. 29 U.S.C. 1104(a)(1)(A).

Before a claim is paid, it must be processed. Each claim is different and may require a range of determinations before any payments are made, including whether the patient is a *bona fide* partici-

pant or beneficiary in the plan (which may require obtaining information about dates of employment and the like from the employer plan sponsor), whether the plan covers the medical procedures for the patient's condition (which may require application of the plan's terms, plus consideration of clinical factors for a particular condition or treatment), and the amount the plan will pay for a covered medical procedure (which may also require analysis of plan provisions).

The Department of Labor has promulgated extensive and detailed regulations governing claims processing procedures. *See generally* 29 C.F.R. § 2650.503–1. Briefly, those regulations require that every employee benefit plan establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. 29 C.F.R. § 2650.503–1(b). Additional and more rigorous requirements apply to the claims procedures applicable to group health plans. *See* 29 C.F.R. § 2650.503–1(c). Generally, if a health benefit claim is denied, these regulations provide an extendable thirty-day deadline within which the plan must provide notice of the denial and specify the circumstances in which the deadline may be extended. See 29 C.F.R. § 2560.503–1(f)(2)(iii)(B).

Claimants must be provided at least 180 days thereafter within which to appeal an adverse decision, 29 C.F.R. § 2560.503–1(h)(3)(i), and the plan must then issue a decision, generally within sixty days of receiving the appeal, a time period that can be extended for an additional sixty days under specified circumstances. 29 C.F.R. § 2560.503–1(i)(2)(iii).

ERISA also expressly requires that every employee benefit plan include a claims procedure, pursuant to which a participant or beneficiary must be notified if his claim for benefits has been denied, and afforded an opportunity for a full and fair review of the decision by a fiduciary of the plan. *See* 29 U.S.C. § 503.

3. Given ERISA's general approach and the specific federal requirements at play here, state-by-state enforcement of variable prompt pay laws would be inimical to Congress's goal of ensuring a uniform system of national regulation. "If these provisions were to go into effect, employers offering self-funded health benefit plans would be faced with different timeliness obligations in different states," which would "fly in the face of one of ERISA's main goals" and "frustrat[e] Congress's intent." *America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014).

For large plans operating nationally (like the ones administered by Aetna here), enforcement of state-by-state prompt pay laws would introduce staggering variability and complexity. As the district court in *Hudgens* observed:

> Three states, including Georgia, have strict provisions requiring that insurers pay claims in as little as 15 days, while South Carolina stands alone in allowing up to 60 days. However, 18 states and the District of Columbia require that "clean" claims be paid within 30 days, while ten states demand that payment be made within 45 days. Seven states distinguish between electronically submitted claims, which must be paid within 45 days, and paper claims, which must be paid within 30 days. Virginia provides 40 days, and West Virginia allows 40 days upon manual submission of a claim and 30 days on an electronic claim, while Hawaii permits 30 days for paper claims and 15 days for electronic claims. Tennessee provides 30 days for paper claims and 21 days for electronic claims. New Hampshire gives 45 days for a paper claim and 15 days on electronic claims, and Louisiana allows 45 days for in-network claims if submitted within 45 days of rendering service, 60 days for in network claims submitted after 45 days from the time of service, 30 days for out of network claims, and 25 days for electronic claims. New Jersey and Rhode Island provide 30 days on paper claims and 40 days on electronic claims. Mississippi provides 25 days on electronic claims and 35 days on paper claims.

America's Health Ins. Plans v. Hudgens, 915 F. Supp. 2d 1340, 1360 n.25 (N.D. Ga. 2012), *aff'd*, 742 F.3d 1319 (11th Cir. 2014). In light of such dizzying variability of regulation, "[t]o say that the imposition of

state prompt pay legislation on ERISA plans would 'interfere' with uniformity" is "an understatement." *Id.*

Indeed it is. If prompt pay laws are applied to self-funded plans, a plan administrator—for each individual claim that it receives—would have to, among other things: (1) identify which state the affected employee or dependent resides, where the plan or employer is located, or where the medical services were rendered, as well as applicable choice-of-law rules, all of which may be necessary just to determine which state's rules apply to a claim under a nationwide plan; (2) determine whether the applicable state has a prompt pay law that governs the processing and paying the claim; (3) identify the specific requirements for that particular state and that specific claim and what factors are relevant to determining the relevant deadline (*e.g.*, whether the claim was submitted electronically or by paper and whether the health care provider was in-network or out-of-network); (4) take all necessary steps to ensure that it processes that claim within the state's idiosyncratic deadline, which could require allocating additional resources, or moving a claim ahead in the queue of claims to be processed from various states; and (5) calculate applicable interest payments

(which also vary by state) for claims that are deemed untimely under that state's rules.

In light of those complexities, the costs of complying with a patchwork of prompt pay statutes would be crushing. The costs of complying with a hodgepodge of state rules and the penalties for non-compliance would be borne by third-party administrators. The administrators, in turn, would be expected to pass along these local-rule costs to the plan sponsors, which, in turn, would need to determine whether to pay the increased costs by reducing benefits or cutting costs elsewhere. However the finances might play out, there can be no doubt that allowing states to impose their own idiosyncratic rules on self-funded plans for timely processing of claims "would generate administrative difficulties" and "hardly [would be] consistent with a national uniformity goal." *Raymond B. Yates*, 541 U.S. at 17.

4. The stakes at issue here are enormous, both within the Fifth Circuit and nationwide. Self-funded health plans are increasingly common, in large measure because they give employers greater control over cash flow, plan design, and administrative efficiency. As recently as fifteen years ago, just 44 percent of workers covered by employer-

sponsored health plans were participants in self-funded plans; today, that number has risen to 61 percent. Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* 177, *available at* perma.cc/-EV5H-44YH.

Because self-funding is ordinarily economical only for large companies with large workforces, there is a very strong correlation between company size and the likelihood that the company self-funds its health benefit plan. Presently, 81 percent of employees who work for companies with more than 200 employees are covered by a self-funded plan; among workers at companies with fewer than 200 employees, that number is just 15 percent. *2014 Annual Survey* 176. And even among companies with over 200 employees, there is substantial stratification: whereas 55 percent of companies with more than 200 but fewer than 1,000 employees use self-funded plans, an astounding 91 percent of companies with 5,000 or more employees do so. All of that has direct bearing here because, of course, the larger a company is and the more workers it employs, the more likely it is to operate in multiple states.

Uniformity of regulation of self-funded plans in particular is therefore tremendously important. For many companies, it simply

would not be practicable to tailor employee health benefit programs on a state-by-state basis to comply with a patchwork of prompt pay laws. And for other employers willing to take on the added administrative burden, much of the cost would be passed on to employees, whose premiums would increase while their benefits decreased. Both experience and common sense suggest that employers have finite resources to cover employment costs. The increased expense resulting from the additional burden of having to comply with different states' claims processing requirements are therefore likely to result in reductions in other employment costs, including decreased health benefits or the termination of an ERISA-protected health plan altogether. Those are precisely the outcomes that ERISA was designed to prevent.

B. The Texas Prompt Pay Act Is Expressly Preempted by Section 514(a) of ERISA.

Texas's prompt pay statute also runs afoul of ERISA's express preemption provision, § 514(a).

Where, as here, a state statute makes no explicit reference to ERISA, the law impermissibly "relates to" an employee benefit plan, in violation of Section 514(a), if "it has a connection with . . . such a plan." *Shaw*, 463 U.S. at 96-97. To "determine whether [the] state law has the

forbidden connection," in turn, a court must "look both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147 (quoting *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997)).

This Court, in particular, employs a two-pronged test: If the law (1) "addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of the plan" and (2) "directly affects the relationship among traditional ERISA entities," then it "relates to" the plan and is preempted. *Bank of La. v. Aetna U.S. Healthcare Inc.*, 468 F.3d 237, 242 (5th Cir. 2006) (quoting *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420, 432 (5th Cir. 2004)). Prompt pay laws implicate both of those concerns. The district court's contrary conclusion rests on a fundamental misunderstanding on how self-funded health plans operate.

1. Prompt pay statutes trespass upon matters of exclusive federal concern.

As this Court held in *Bank of Louisiana*, a state law necessarily "require[s] inquiry into an area of exclusive federal concern" when it

"require[s] inquiry into the administration of [a] Plan," including the "processing of benefit claims" and an assessment of "delayed processing and pay[ment of] benefit claims." 468 F.3d at 242. That is because the rules governing *when* claims must be paid are part of the broader set of rules governing "*how* benefit claims [are] processed" under ERISA-protected plans. *Id.* (emphasis added) (citing *Hubbard v. Blue Cross & Blue Shield Ass'n*, 42 F.3d 942, 946 (5th Cir. 1995)).

We have already highlighted ERISA's general provisions regarding claims processing and its detailed regulations imposing nationwide claims-processing standards. *See supra* pp. 7-9. Prompt pay statutes directly interfere with those federal procedures. Confirming factors like participant eligibility, procedure coverage, and negotiated rates can be a complex undertaking, particularly within the context of a large plan with thousands of members. *Cf. Pilot Life*, 481 U.S. at 48, 57 (Section 514(a) preempts state-law remedies for "improper processing of a claim for benefits"). As we noted earlier, plan administrators faced with variable prompt pay laws would have to establish complicated systems to track all of the various states' timeliness requirements, including claim-specific facts, such as when each claim is received and in what

form and when it needs to be processed and paid; they might even have to interrupt processing of other claims not subject to a prompt-pay deadline in order to prioritize claims that are subject to such deadlines. And rushing administrators of self-funded plans to make eligibility and coverage determinations is certain to affect both the accuracy and cost of the process—exactly the factors that federal regulations already cover. Moreover, because Texas's law would penalize administrators even for good-faith claim denials that proved unwarranted, administrators would have incentives to grant Texas claims (out of an abundance of caution) even if the claims would not be payable elsewhere.

Rules governing *when* benefit eligibility determinations are made thus have a self-evident impact on *how* they are made. In that way, Texas's prompt pay statute "binds ERISA plan administrators to a particular choice of rules" (*Egelhoff*, 532 U.S. at 147) concerning when and how claims must be paid within Texas, just as other state prompt pay laws impose different rules applicable within their own borders. Such regulation of claims processing procedures is quintessentially a matter of federal concern. There is thus little doubt that, with respect to self-funded health plans, the first ERISA preemption prong is satisfied.

2. Prompt pay statutes interfere directly with the relationship between plan fiduciaries and beneficiaries.

Prompt pay statutes also directly affect the relationships among traditional ERISA entities.

a. As an initial matter, to the extent the district court appeared to find that third-party administrators like Aetna are not traditional plan entities, it was mistaken. *See Aetna Life Ins. Co. v. Methodist Hospitals of Dallas*, No. 3:14-cv-347, 2015 WL 918586, at *11 (N.D. Tex. Mar. 4, 2015) (finding that the Texas statute "has no effect on traditional ERISA entities"). Under ERISA, any entity that exercises discretion with regard to plan administration is, by definition, an ERISA fiduciary. *See* ERISA § 3(21), 29 U.S.C. § 1002(21)(A). Exercising discretion as to whether a benefit claim is covered by the plan and is therefore eligible to be paid, and in what amount, is thus a fiduciary function. Most self-funded plans grant discretion to the third-party administrator to make coverage decisions. Such administrators, with "authority to grant, deny, or review denied claims," are ERISA fiduciaries. *Reich* v. *Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995).

b. Prompt pay laws also have a direct and substantial effect on the relationship between beneficiaries and fiduciary administrators. On this score, "the critical distinction is not whether the parties to a [state law] claim are traditional ERISA entities in some capacity, but instead whether the relevant state law affects an aspect of the relationship that is comprehensively regulated by ERISA." *Bank of La.*, 468 F.3d at 243.

That is a perfect description of this case: prompt pay laws dictate when beneficiaries (or hospitals in their stead) can demand payment on a claim from plan administrators, and under what circumstances they can seek penalties from those administrators and for what amounts. As the Eleventh Circuit has described it, although prompt pay laws do "not necessarily directly alter the coverage decision-making process, . . . they [do] compel certain action (prompt benefit determinations and payments) by plans and their administrators" and "impact the amount paid to beneficiaries in the case of late payment or notice." *Hudgens*, 742 F.3d at 1331 (emphasis omitted).

Against that backdrop, it is factually incorrect to say that such regulations do not directly affect the relationship between plan beneficiaries and plan administrators (who are very often fiduciaries). To the

extent it is interpreted to apply to self-funded plans, the Texas prompt pay law accordingly "relates to" employee benefit plans within the meaning of Section 514(a).

* * *

When addressing ERISA, the Supreme Court has repeatedly confirmed "the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997). Proper enforcement of ERISA's preemption provision is essential to the achievement of the statute's goals to encourage the creation of such plans and ensure their fair and efficient operation.

To the extent the state-law at issue in this case was ever intended to apply to self-funded plans, it meddles with the overarching purposes and specific requirements of ERISA. The decision below accordingly should be reversed.

CONCLUSION

The district court's judgment should be reversed.

Dated: June 8, 2015

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Appellate Rule 32(a)(7)(C), the undersigned counsel for the United States Chamber of Commerce certifies that this brief:

(i) complies with the type-volume limitation of Rule 29(d) because it contains 3,942 words, including footnotes and excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii); and

(ii) complies with the typeface and typestyle requirements of Rule 32(a) and Fifth Circuit Rule 32.1 because it has been prepared using Microsoft Office Word 2007 and is set in Century Schoolbook font in a size equivalent to 14 points or larger, excepting footnotes, which are set in a size equivalent to 12 points or larger.

Dated: June 8, 2015 /s/ *Brian D. Netter*

CERTIFICATE OF ELECTRONIC COMPLIANCE

I hereby certify that on June 8, 2015, the foregoing brief was transmitted to the Clerk of the U.S. Court of Appeals for the Fifth Circuit via the Court's CM/ECF system, and that (1) the required privacy redactions were made pursuant to Circuit Rule 25.2.13, (2) the electronic submission is an exact copy of the paper document pursuant to Circuit 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.

Dated: June 8, 2015 /s/ *Brian D. Netter*

CERTIFICATE OF SERVICE

I hereby certify that that on June 8, 2015, the foregoing brief was served by overnight courier upon counsel of record for Defendants-Appellees. Digital versions of the same were served electronically via the Court's CM/ECF system.

Dated: June 8, 2015 /s/ *Brian D. Netter*