No. 15-10154

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

METHODIST HOSPITALS OF DALLAS,
Defendant-Appellant,

v.

HEALTH CARE SERVICE CORP.,
Plaintiff-Appellee.

On Appeal from the United States District Court
For the Northern District of Texas

BRIEF OF APPELLANT

Mikal C. Watts
Michael J. Murray
Travis C. Headley
WATTS GUERRA, LLP
4 Dominion Drive, Bldg. 3, Ste. 100
San Antonio, Texas 78257
210.447.0500

Blair G. Francis
Bobby D. Amick
FRANCIS & TOTUSEK, LLP
500 North Akard Street, Ste. 1830
Dallas, Texas 75201
214.740.4250

LAW OFFICE OF
JOSEPH V. GIBSON, PC
Joseph V. Gibson, IV
17618 Wagner Point Court
Tomball, Texas 77377
281.370.1810

Counsel for Appellant

CERTIFICATE OF INTERESTED PERSONS

No. 15-10154

METHODIST HOSPITALS OF DALLAS,
Defendant-Appellant,
v.

HEALTH CARE SERVICE CORP.,
Plaintiff-Appellee.

The undersigned counsel of record 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. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

1. Defendant-Appellant

Methodist Hospitals of Dallas d/b/a Methodist Health System

2. Attorneys for Defendant-Appellant

Mikal C. Watts
Michael J. Murray
Travis C. Headley
WATTS GUERRA, LLP
4 Dominion Drive, Building 3, Suite 100
San Antonio, Texas 78257
210.447.0500

Blair G. Francis
Bobby D. Amick
FRANCIS & TOTUSEK, LLP
500 North Akard Street, Ste. 1830
Dallas, Texas 75201
214.740.4250

Joseph V. Gibson, IV
THE LAW OFFICES OF JOSEPH V. GIBSON
17618 Wagner Point Court
Tomball, Texas 77377
281.370.1810

3. Plaintiff-Appellee

Health Care Service Corp., an Illinois Legal Mutual Reserve Company

4. Attorneys for Plaintiff-Appellee

Martin J. Bishop
William J. Katt, Jr.
Meredith A. Shippee
Foley & Lardner, LLP

William D. Cobb
Cobb Martinez Woodward PLLC

/s/ Mikal C. Watts .
Mikal C. Watts
Attorney of Record for Appellant
Methodist Hospitals of Dallas

STATEMENT CONCERNING ORAL ARGUMENT

Defendant-Appellant Methodist Hospitals of Dallas respectfully requests oral argument. This appeal is related to another pending appeal – No. 15-10210, *Aetna Life Ins. Co. v. Methodist Hospitals of Dallas* – that involves similar issues addressing the scope of Chapter 1301.001 et seq. of the Texas Insurance Code, known more commonly as the Texas Prompt Pay Act. While the issues raised in each appeal can largely be resolved as a matter of law, they are issues of first impression as a matter of Texas state law and within this Circuit. The issues raised in this appeal are also critical because of the large number of individuals in Texas covered by self-funded insurance plans and the number of health care providers – including the Hospital in this case – that provide health care services to those people. The decisional process will be significantly aided by oral argument. *See* FED. R. APP. P. 34(a)(2).

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS ii

STATEMENT CONCERNING ORAL ARGUMENT iv

TABLE OF CONTENTS v

TABLE OF AUTHORITIES viii

STATEMENT OF JURISDICTION 2

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW 4

STATEMENT OF THE CASE 5

STATEMENT OF FACTS 7

SUMMARY OF THE ARGUMENT 15

STANDARD OF REVIEW 16

ARGUMENT 17

I. Prompt Pay Applies to HCSC because it Qualifies Under the Statute's Express Definitions as an "Insurer" that "Provided for" Payment of Preferred Provider Benefits through its "Health Insurance Policy" 17

A. Statutory Construction by the Supreme Court of Texas 17

1. Precedent Concerning Statutory Construction 18

2. Legislation Concerning Statutory Construction 19

B. The Express Language of the TPPA, as a Whole, Makes Clear its Application to Entities that Administer Self-Funded Plans 20

TABLE OF CONTENTS
(continued)

1. HCSC is an "Insurer" Within the Contemplation of the TPPA 21

2. The Unified Contracts HCSC Forms with Payor Plans and Preferred Providers are "Health Insurance Policies" as Defined by the TPPA 26

3. HCSC "Provides . . . for" Payment to Providers through its Health Insurance Policy 39

C. The Legislative History of the Statute Confirms Methodist's Construction 41

D. No Binding Administrative Construction of the Statute Suggests a Different Result 43

E. HCSC's Preferred Provider Benefit Plans Meet all of Section 1301.0041(a)'s Applicability Criteria; the District Court Erred in Concluding that the TPPA Does Not Apply to HCSC as an Administrator of Self-Funded Plans 44

II. THE FEHBA DOES NOT PREEMPT CLAIMS FOR PENALTIES AVAILABLE UNDER THE PROMPT PAYMENT PROVISIONS OF CHAPTER 1301 45

A. FEHBA Allows the Federal Government and its Agencies to Contract with Private Insurance Carriers to Provide Federal Employees' Health Insurance 47

B. FEHBA's Limited Preemptive Effect 48

TABLE OF CONTENTS
(continued)

C. The District Court Erred in Holding that FEHBA preempts Methodist's TPPA Claims Arising From Services Provided to Beneficiaries of HCSC's Federal Government Plans 50

CONCLUSION 58

CERTIFICATE OF SERVICE 60

TABLE OF AUTHORITIES

Cases

Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.,
662 F.3d 376 (5th Cir. 2011) 47

Baylor Univ. Med. Ctr. v. Epoch Grp., L.C.,
340 F. Supp. 2d 749 (N.D. Tex. 2004) 34, 35

Botsford v. Blue Cross & Blue Shield of Mont., Inc.,
314 F.3d 390 (9th Cir. 2002) 51, 58

Brazil v. OPM,
35 F.Supp.3d 1101 (N.D. Cal. 2014) 52

Brown v. Granatelli,
897 F.2d 1351 (5th Cir. 1990) 37, 38

Burkey v. Gov't Emp. Hosp. Ass'n,
983 F.2d 656 (5th Cir. 1993) 50, 52, 56, 57

Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters of the U.S.,
497 F.3d 972 (9th Cir. 2007) 58

City of Austin v. Sw. Bell Tel. Co.,
92 S.W.3d 434 (Tex. 2002) 41

City of Houston v. Bates,
406 S.W.3d 539 (Tex. 2013) 39

City of LaPorte v. Barfield,
898 S.W.2d 288 (Tex. 1995) 20

Columbia Med. Ctr. of Las Colinas, Inc. v. Hogue,
271 S.W.3d 238 (Tex. 2008) 41

Crosstex Energy Servs., L.P. v. Pro Plus, Inc.,
430 S.W.3d 384 (Tex. 2014) 41

Dukes v. US Healthcare, Inc.,
57 F.3d 350 (3rd Cir. 1995) 51

Empire HealthChoice Assurance, Inc. v. McVeigh,
396 F.3d 136 (2nd Cir. 2005) 49, 50

Empire HealthChoice Assurance, Inc. v. McVeigh,
547 U.S. 677 (2006) 48

English v. General Elec. Co.,
496 U.S. 72 (1990) 50

Entergy Gulf States, Inc. v. Summers,
282 S.W.3d 433 (Tex. 2009) 18

Fischer v. United States,
529 U.S. 667 (2000) 29

Fleming Foods of Tex., Inc. v. Rylander,
6 S.W.3d 278 (Tex. 1999) 45

Forte v. Wal-Mart Stores, Inc.,
780 F.3d 272 (5th Cir. 2015) 18

Franks Inv. Co. v. Union Pac. R. Co.,
593 F.3d 404 (5th Cir. 2010) 16

GE Capital Comm., Inc. v. Washington Nat'l Bank,
754 F.3d 297 (5th Cir. 2014) 18

Guidry v. American Public Life Ins. Co.,
512 F.3d 177 (5th Cir. 2007) 35

Houston Cmty. Hosp. v. Blue Cross & Blue Shield of Tex., Inc.,
481 F.3d 265 (5th Cir. 2007) 48

In re Ford Motor Co.,
442 S.W.3d 265 (Tex. 2014) 18

In re Office of the Atty. Gen. of Tex.,
456 S.W.3d 153 (Tex. 2015) 41

Jaster v. Comet II Const., Inc.,
438 S.W.3d 556 (Tex. 2014) 27, 44

Kaluom v. Stolt Offshore, Inc.,
504 F.3d 511 (5th Cir. 2007) 16

Kight v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.,
34 F.Supp.2d 334 (E.D. Va. 1999) 53

Kroger Co. v. Keng,
23 S.W.3d 347 (Tex. 2000) 32

Leland v. Brandal,
257 S.W.3d 204 (Tex. 2008) 18

Liberty Mut. Ins. Co. v. Garrison Contractors, Inc.,
966 S.W.2d 482 (Tex. 1998) 44

Lippencott v. Whisenhunt,
462 S.W.3d 507 (Tex. 2015) 19

Marks v. St. Luke's Episcopal Hosp.,
319 S.W.3d 658 (Tex. 2010) 20

Medtronic v. Lohr,
518 U.S. 470 (1996) 50

Molinet v. Kimbrell,
356 S.W.3d 407 (Tex. 2011) 19

N.H. Motor Transp. Ass'n v. Rowe,
448 F.3d 66 (1st Cir.2006).. 50

NCDR, L.L.C. v. Mauze & Bagby, P.L.L.C.,
745 F.3d 742 (5th Cir. 2014) 16

New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995) 52

Provident Life & Acc. Ins. Co v. Knott,
128 S.W.3d 211 (Tex. 2003) 54

R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water,
336 S.W.3d 619 (Tex. 2011) 44

Roach v. Mail Handlers Ben. Plan,
298 F.3d 847 (9th Cir. 2002) 52, 55

S & P Consulting Eng'rs, PLLC v. Baker,
334 S.W.3d 390 (Tex. App.—Austin 2011, no pet.)........................ 27

Simmons v. Sabine River Auth., La.,
732 F.3d 469 (5th Cir. 2013) 47

Texas Dep't of Ins. v. American Nat'l Ins. Co.,
410 S.W.3d 843 (Tex. 2012) 22, 23, 31, 33, 36

Toranto v. Blue Cross & Blue Shield of Tex., Inc.,
993 S.W.2d 648 (Tex. 1999) 23, 24, 25

Truong v. Bank of Am, N.A.,
717 F.3d 377 (5th Cir. 2013) 18

University of Texas at Arlington v. Williams,
459 S.W.3d 48 (Tex. 2015) 41

Weight Loss Healthcare Ctrs. of Am., Inc. v. Office of Personnel Mgmt., 655 F.3d 1202 (10th Cir. 2011) 51

Statutes

28 U.S.C. § 1291 2

28 U.S.C. § 1331 2

28 U.S.C. § 1332 2

38 U.S.C. § 4303 28

5 U.S.C. § 8902 .... 6, 48, 49

5 U.S.C. § 8906 48

5 U.S.C. § 8909 48

TEX. GOV'T CODE § 311.023 19

TEX. GOV'T CODE § 312.005 19

TEX. INS. CODE § 1301.001 .... 21, 22, 26, 34

TEX. INS. CODE § 1301.0041 .... 20, 33, 39, 44

TEX. INS. CODE § 1301.006 30

TEX. INS. CODE § 1301.056 30

TEX. INS. CODE § 1301.067 30

TEX. INS. CODE § 1301.101 6

TEX. INS. CODE § 1301.102 7

TEX. INS. CODE § 1301.103 .... 7, 10, 52

TEX. INS. CODE § 1301.108 10

TEX. INS. CODE § 1301.109 22

TEX. INS. CODE § 1301.131 10

TEX. INS. CODE § 1301.137 .... 7, 10, 20, 45, 52

TEX. INS. CODE § 841.001 21

TEX. INS. CODE § 841.002 21

TEX. INS. CODE § 841.051 21

TEX. INS. CODE § 841.101 21

TEX. INS. CODE § 841.151 21

Other Authorities

Act of June 17, 2003, 78th Leg., R.S., ch. 214, §§ 2-3,
2003 Tex. Gen. Laws 1016, 1016-1023 (2003) 10

Act of June 19, 1999, 76th Leg., R.S., ch. 1343, § 1,
1999 Tex. Gen. Laws 4556, 4556-4559 (1999) 9

Act of June 6, 1991, 72nd Leg., R.S., ch. 242, § 11.87,
1991 Tex. Gen. Laws 939, 1108 25

BLACK'S LAW DICTIONARY (6th ed. 1990) 39

House Office of Bill Analysis, Bill Analysis,
Tex. H.B. 610, 76th Leg., R.S. (1999) 8

House Research Org., Bill Analysis,
Tex. H.B. 418, 78th Leg., R.S. 9

Op. Tex. Att'y Gen. No. KP-0036 at (2015) 22

Veto Message of Gov. Perry, Tex. H.B. 1862, 77th Leg., R.S. (2001)..... 42

Regulations

48 C.F.R. § 1632.170.. 48

No. 15-10154

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

METHODIST HOSPITALS OF DALLAS,
Defendant-Appellant,
v.

HEALTH CARE SERVICE CORP.,
Plaintiff-Appellee.

On Appeal from the United States District Court
For the Northern District of Texas

BRIEF OF APPELLANT

TO THE HONORABLE JUDGES OF THE COURT:

Defendant-Appellant Methodist Hospitals of Dallas submits this brief requesting that the Court reverse the district court's summary judgment, which erroneously held that the penalty provisions of Chapter 1301 of the Texas Insurance Code are not: (1) applicable to an entity that is a state-licensed insurer, but who provides services related to health insurance contracts it does not directly insure, and (2) that the prompt payment provisions of the same Chapter are preempted by a

federal act with respect to health care claims by certain federal employees and their beneficiaries.

STATEMENT OF JURISDICTION

1. Jurisdiction of the District Court

Jurisdiction was proper in the district court pursuant to 28 U.S.C. § 1332(a)(1), based on the complete diversity of the parties and an amount in controversy that exceeds the sum specified in 28 U.S.C. § 1332. HCSC further claimed federal question jurisdiction pursuant to 28 U.S.C. § 1331, contending that the action arises under specific provisions of federal statutory law. ROA.16.

2. Basis for Jurisdiction in the Court of Appeals

This Court has jurisdiction over this appeal under 28 U.S.C. § 1291, which provides jurisdiction of appeals from all final decisions of the district courts of the United States.

3. Filing Dates

United States District Judge Jane J. Boyle signed an order and opinion granting summary judgment to HCSC on January 28, 2015. ROA.1053. That order and opinion has not been reported. Methodist noticed its appeal of that order on February 27, 2015. ROA.1064. When

the order was issued, it did not address some of the claims between the parties. After the parties resolved those remaining issues, they filed an Agreed Motion to Dismiss and Enter Final Judgment on April 15, 2015. ROA.1075. On April 16, 2015, Judge Boyle signed an Order of Dismissal and Final Judgment. ROA.1079.

Methodist filed its motion for new trial on May 14, 2015. ROA.1858. After an abatement of the appeal to permit the resolution of that motion, the District Court denied the motion for new trial by a Memorandum Opinion and Order dated August 28, 2015. ROA.1933.

4. Finality of Judgment

This appeal arises from the district court's final judgment disposing of all claims asserted by all parties. ROA.1083.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. The district court erred in granting HCSC's motion for summary judgment because the prompt payment provisions of Chapter 1301 of the Texas Insurance Code must apply to an insurer that is administering a self-funded preferred provider plan, even when it is not directly insuring the risks covered by those plans. That conclusion is compelled by express statutory language and is necessary to effectuate the Legislature's intent in enacting the statute.

II. The district court erred in granting HCSC's motion for summary judgment because the Federal Employee Health Benefit Act does not preempt the prompt payment requirements of Chapter 1301 of the Texas Insurance Code.

STATEMENT OF THE CASE

This appeal arises from the district court's order, and ultimately a final judgment, granting Plaintiff Health Care Service Corporation's motion for summary judgment and making certain declarations primarily concerning the scope of a Texas statute. ROA.1053; ROA.1083. Health Care Service Corporation instituted this action by filing its Complaint for Declaratory Relief on December 19, 2013 in the United States District Court for the Northern District of Texas, Dallas Division. ROA.13. It sought *inter alia* declarations that prompt payment provisions of Chapter 1301 of the Texas Insurance Code (the Texas Prompt Pay Act) does not apply to insurers that administer rather than provide the patient's coverage and that the Federal Employee's Health Benefits Act preempts the prompt payment provisions as to claims arising from FEHBA-governed plans. ROA.21.

Methodist answered the complaint on January 13, 2014. ROA.54. Along with its denial of most of the assertions in HCSC's Complaint, Methodist asserted counterclaims seeking the penalties specified under the TPPA. ROA.67-70. HCSC answered the counterclaim on February

3, 2014, essentially asserting its theories for declaratory relief as affirmative defenses. ROA.77-80.

HCSC moved for summary judgment as to its claims and Methodist's counterclaims on May 15, 2014 and filed an extensive brief in support of that motion. ROA.134, ROA.138. Methodist responded to that motion on June 5, 2014 and filed its own extensive brief in support of that response. ROA.189, ROA.192. HCSC filed its Reply Brief on June 19, 2014. ROA.405.

By its January 28, 2015 Memorandum Opinion and Order, the District Court granted HCSC's Motion for Summary Judgment. ROA.1024. The District Court made two express declarations: (1) "the prompt payment provisions of Texas Insurance Code § 1301.101 et seq. do not apply to plans that are not initially insured by [HCSC]"; and (2) "the TPPA does not apply to plans HCSC processes under the Federal Employee Program because application of the TPPA to such plans is preempted by 5 U.S.C. § 8902(m)(1)." ROA.1052.

The Order did not dispose of all parties and claims asserted in the parties' Complaint and Counterclaim. Methodist nevertheless perfected its appeal of the order on February 27, 2015. ROA.1064. The Parties

resolved the remaining claims between them and jointly moved to dismiss the claims that the District Court's order had not resolved. ROA.1075-1077. On April 16, 2015, the District Court granted that motion and rendered final judgment for HCSC. ROA.1083.

Methodist moved for new trial, ROA.1858, and the District Court denied that motion on August 28, 2015. ROA.1933.

STATEMENT OF FACTS

When certain Texas physicians or institutional providers render health care services to a patient insured by a preferred provider benefit plan, they are required to submit a claim for payment for those services to an insurer within 95 days of the date service has been provided. TEX. INS. CODE § 1301.102(a). If the submitted claim is "clean" – a concept defined by the statute and in regulations animating its operation – the insurer must pay the claim (subject to certain other conditions) within a statutorily prescribed period of time. TEX. INS. CODE § 1301.103. If the insurer fails to comply with that requirement, the statute imposes a monetary penalty that graduates in severity as the delay lengthens. TEX. INS. CODE § 1301.137.

Methodist identified more than 6,000 instances in which HCSC (though its subsidiary, Blue Cross and Blue Shield of Texas) violated the prompt payment provisions of the TPPA and demanded the concomitant penalties and attorney's fees made statutorily available to those who are harmed by such tardiness. ROA.24; ROA.69-70. In response to that demand, HCSC instituted this action for declaratory relief and obtained declarations that the TPPA is wholly inapplicable to the substantial majority of those claims. ROA.13. This appeal concerns the extent to which the TPPA applies to a statutory "insurer" like HCSC whether it provides coverage or administers that coverage.

A. The Texas Prompt Pay Act

In the late 1990's the Texas Legislature acted to curb what was then understood to be a looming health care crisis in the State. ROA.396. At the time, there was no law requiring timely payments to health care providers by insurers and others who remit payments for covered health care services. *See, e.g.,* House Office of Bill Analysis, Bill Analysis, Tex. H.B. 610, 76th Leg., R.S. (1999).[1] The Legislature recognized that the payors in those situations were exploiting the lack

[1] http://www.capitol.state.tx.us/tlodocs/76R/analysis/html/HB00610H.htm

of any mandated deadline for making payments. As a result, the hospitals and physicians who provided those services often waited for extended periods of time for payment. ROA.396. Many physicians contemplated leaving the practice of medicine, citing the lack of timely payments as the cause of financial difficulties in maintaining medical practices. ROA.397 (noting that delays in payment by insurers made "it difficult, if not impossible, for providers to evaluate the health of their business."). In response, the Legislature enacted a prompt payment law in the 1999 legislative session. *See* Act of June 19, 1999, 76th Leg., R.S., ch. 1343, § 1, 1999 Tex. Gen. Laws 4556, 4556-4559 (1999).2

That law, however, was riddled with holes and failed to offer the comprehensive curb on late payments that its sponsors had hoped to achieve. *See* House Research Org., Bill Analysis, Tex. H.B. 418, 78th Leg., R.S. at 8.[3] Subsequent curative efforts were aimed at expanding the types of payors covered to maximize the number of claims that would be subject to the law. ROA.387-388, 396-398. The result was the

[2] *See* http://www.lrl.state.tx.us/scanned/sessionLaws/76-0/HB_610_CH_1343.pdf

[3] *See* http://www.hro.house.state.tx.us/pdf/ba78r/sb0418.pdf#navpanes=0 ("HB 610 [the 1999 law] . . . sought to accelerate payment to providers for their services. However, insurers have been able to work around some of these requirements in ways that run counter to prompt payment, leaving providers in similarly dire situations as before HB 610 was enacted.").

2003 enactment of the prompt payment provisions of Chapter 1301 of the Texas Insurance Code. *See* Act of June 17, 2003, 78th Leg., R.S., ch. 214, §§ 2-3, 2003 Tex. Gen. Laws 1016, 1016-1023 (2003).[4]

Those provisions require health care providers to submit "clean claims" to the payors who are responsible for the physical remission of payment, even if those payors are administrators and do not pay with their own funds. *See* TEX. INS. CODE § 1301.131. Upon the submission of these clean claims, the payor adjudicates each claim. *See* TEX. INS. CODE § 1301.103. For claims that are adjudicated to be payable under the terms of a preferred provider plan, the payor must remit its payment in the amount agreed to in the preferred provider agreement within a specified number of days. *See id.* Where the claim is not paid within the allotted time period, the payor is subject to penalties that escalate with the duration of the delay. *See* TEX. INS. CODE § 1301.137. The statute permits the provider to bring a private cause of action to recover these penalties and further contemplates awards of attorneys' fees and other costs in those actions. *See* TEX. INS. CODE § 1301.108.

[4] http://www.lrl.state.tx.us/scanned/sessionLaws/78-0/SB_418_CH_214.pdf

B. The Relationship Between the Parties and Their Dispute

HCSC, an Illinois mutual legal reserve company, claims to be the largest customer-owned health insurance services company in the United States, with nearly 14 million members nationally. ROA.151. Of that membership, more than 33% – roughly 5 million members – are in Texas. ROA.151. It operates in Texas through an unincorporated division known as Blue Cross Blue Shield of Texas. ROA.151.

Since 1992, Methodist Hospitals of Dallas has maintained a PPO agreement with BCBSTX. ROA.157. Pursuant to that PPO agreement, Methodist provides medical services to patients with health insurance plans issued by BCBSTX. ROA.157. Between 2007 and 2013, Methodist submitted more than 450,000 claims for payment to BCBSTX, which insists that it "is committed to timely payment of health care claims" and claims to process nearly 800,000 claims a day, and more than 200 million claims annually. It further maintains that in 2013, it paid 90% of all claims within 14 days and more than 98% of all claims within 30 days, though it provides no particular date – such as a date the claim was submitted or the date the claim was adjudicated – for either assertion. ROA.156.

Despite its claimed commitment to making timely payments to health care providers, Methodist discovered that HCSC had, in thousands of instances, remitted payment to it beyond the statutory deadlines. ROA 18, 24.[5] This discovery led to the presentation of a demand for arbitration upon HCSC, seeking payment of penalties and fees arising from those late payments. ROA.18, 24. The contracts between the parties, however, did not call for arbitration of such a dispute. ROA.19. HCSC insisted, though, that an actual controversy existed and instituted an action against Methodist by filing its Complaint for Declaratory Relief on December 19, 2013. ROA.13, 19. Methodist answered and asserted, by way of counterclaim, its claims for the penalties, interest, and attorneys' fees for violations of the prompt payment provisions of the TPPA. ROA.69-70.

C. HCSC's Defenses to the Prompt Pay Claims

HCSC maintains that it fills one of two roles with regard to the plans that it provides to its members in Texas.

With some plans, which HCSC itself underwrites, it directly bears the risk of the costs of health care provided under the plans. ROA.153.

[5] To be certain, these are all claims that BCBSTX actually paid and paid in full; Methodist's claims are based on the fact that those payments were not timely made.

In these so-called fully-insured plans, BCBSTX collects premiums from the insured and when a claim for benefits is made, it pays the claim directly from its own funds. ROA.153. With other plans, HCSC does not bear the risk of the costs of health care provided under the plans. In such plans, HCSC provides administrative services like claims processing, pricing, or network access while bearing no financial risk. ROA.153-154. Under these plans, the employer pays the costs of healthcare claims out of its own funds. ROA.153. For these types of welfare benefit plans, BCBSTX enters into an administrative services agreement with these employers who are the plan sponsors; it is paid a fee by the employer or plan to serve as the plan's administrator. ROA.153-154. Several types of plans fit this description, including self-insured employee benefit plans organized under ERISA. ROA.154.

Finally, BCBSTX provides health benefits to federal employees through plans established pursuant to the Federal Employee Health Benefit Act. ROA.155. The federal Office of Personnel Management negotiates these plans with various insurers. ROA.155. When a Blue Cross plan is selected by OPM, the contract providing coverage is between OPM and the Blue Cross and Blue Shield Association and that

local affiliates like BCBSTX administer the plan within the State of Texas. ROA.155. BCBSTX draws money from a treasury fund to pay claims and its own fees for plan administration. ROA.156.

D. The Proceedings In the District Court

HCSC moved for summary judgment as to its claims for declaratory relief. ROA.134. After the parties fully briefed the issues, the District Court issued a Memorandum Opinion and Order on January 28, 2015, granting HCSC's motion for summary judgment, making the two declarations its sought. ROA.1052. The parties agreed to resolve any additional claims that were not subject to the Court's order and the dismissal of those additional claims resulted in a final judgment. ROA.1083. Methodist filed a timely motion for new trial, which the District Court denied by a separate memorandum opinion and order on August 28, 2015. ROA.1933. This appeal ensued.

SUMMARY OF THE ARGUMENT

In concluding that HCSC is not subject to the prompt pay penalties when it serves as an administrator of employer funded preferred provider plans the District Court disregarded the plain text of the statute. The statute requires only that a payor meet a broad statutory definition of "insurer," and HCSC meets that threshold under existing Texas law even if it does not act as an insurer in the classical sense. HCSC's contracts qualify as "health insurance policies," and through those policies, HCSC "provides for" the payment of coverage for plan beneficiaries who seek treatment from preferred providers. Giving the statute that reach is consistent with the Texas Legislature's intent to protect health care providers by broadened prompt pay laws.

The District Court also erred in concluding that FEHBA preempts prompt pay claims arising from services rendered to beneficiaries of FEHBA plans. The availability of statutory prompt pay remedies does not implicate the FEHBA plans or the terms and conditions of those plans. Because the prompt pay claims do not relate to the plans, FEHBA offers no basis for preempting the Texas statute.

The District Court's erroneous judgment should be reversed.

STANDARD OF REVIEW

The principal questions presented in this appeal concern the construction of state and federal statutes. The district court's summary judgment is reviewed *de novo*. *See Kaluom v. Stolt Offshore, Inc.*, 504 F.3d 511, 514 (5th Cir. 2007).

The District Court committed an error of law in concluding that the Texas Prompt Pay Act does not apply to "insurers" like HCSC when they make late payments of claims as administrators rather than insurers of coverage. Ascertaining the District Court's misconstruction of the Act requires the construction of a Texas state statute, which is also reviewed *de novo*, interpreting the state statute the way the state supreme court would, based on precedent, legislation, and relevant commentary. *See NCDR, L.L.C. v. Mauze & Bagby, P.L.L.C.*, 745 F.3d 742, 753 (5th Cir. 2014).

A secondary question is whether the Texas statute is preempted by FEHBA. Whether a federal statute displaces state law in a given context is a question of law that likewise subject to *de novo* review. *See Franks Inv. Co. v. Union Pac. R. Co.*, 593 F.3d 404, 407 (5th Cir. 2010).

ARGUMENT

Chapter 1301 of the Texas Insurance Code broadly governs the tripartite relationships among preferred provider plans, beneficiaries, and their preferred providers. One aspect of that governance is the obligation imposed on those contractually obligated for remitting payment to make those payments in a timely manner. Texas law imposes penalties for non-compliance. Methodist seeks to recover the penalties owed by HCSC under the terms of the TPPA. The District Court's judgment, holding that the Act is inapplicable to insurers that only administer plans and that some of Methodist's claims are preempted by FEHBA, is erroneous in both respects.

I. Prompt Pay Applies to HCSC because it Qualifies Under the Statute's Express Definitions as an "Insurer" that "Provided for" Payment of Preferred Provider Benefits through its "Health Insurance Policy"

A. Statutory Construction by the Supreme Court of Texas

Where, as here, the Supreme Court of Texas has not directly construed the statute at issue, this Court must make an *Erie* guess. *See GE Capital Comm., Inc. v. Washington Nat'l Bank*, 754 F.3d 297, 303 (5th Cir. 2014); *Truong v. Bank of Am, N.A.*, 717 F.3d 377, 381 (5th Cir.

2013). Making that guess requires the Court to construe the TPPA in the same way that the Supreme Court of Texas would, as determined by precedent, legislation, and relevant commentary. *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.").

1. Precedent Concerning Statutory Construction

Texas courts treat statutory interpretation as a question of law, and the Supreme Court of Texas considers giving "effect to the Legislature's intent" to be its primary objective in construing a statute. *See Leland v. Brandal*, 257 S.W.3d 204, 206 (Tex. 2008). That effort begins with the plain language of the statute, which is "the truest manifestation of what lawmakers intended." *In re Ford Motor Co.*, 442 S.W.3d 265, 271 (Tex. 2014); *Entergy Gulf States, Inc. v. Summers*, 282 S.W.3d 433, 572 n. 57 (Tex. 2009). Therefore, where the statute's language is clear and unambiguous, the statute should be construed in accordance with its plain meaning. *See Molinet v. Kimbrell*, 356 S.W.3d 407, 414 (Tex. 2011)("When a statute's language is clear and unambiguous it is inappropriate to resort to the rules of construction or

extrinsic aids to construe the language."). The Supreme Court is also cognizant of legislative directives to construe statutes to fully effectuate the intent behind them and fulfill their purposes. *See Lippencott v. Whisenhunt*, 462 S.W.3d 507, 509 (Tex. 2015).

2. Legislation Concerning Statutory Construction

The Texas Code Construction Act makes clear that courts may consider matters beyond the statutory text "whether or not the statute is considered ambiguous on its face." *See* TEX. GOV'T CODE § 311.023. Thus, even in construing statutes that may be considered unambiguous, Texas courts are permitted to consider the purpose of the statute, the circumstances of its enactment, its legislative history, and the consequence of a particular construction. *Id.* Importantly, Chapter 312 of the Government Code, which "applies to the construction of all civil statutes," imposes a duty – at all times – to determine and apply legislative intent[6] in interpreting statutes: "In interpreting a statute, a court shall diligently attempt to ascertain legislative intent shall consider *at all times* the old law, the evil, and the remedy." *See* TEX. GOV'T CODE § 312.005 (emphasis added).

[6] Legislative intent is "the polestar of statutory construction." *See Marks v. St. Luke's Episcopal Hosp.*, 319 S.W.3d 658, 663 (Tex. 2010)(citing *City of LaPorte v. Barfield*, 898 S.W.2d 288, 292 (Tex. 1995)).

B. The Express Language of the TPPA, as a Whole, Makes Clear its Application to Entities that Administer Self-Funded Plans

The focal point of the District Court's analysis in granting HCSC's motion for summary judgment was the Applicability provision of Chapter 1301, which reads:

> Except as otherwise specifically provided by this chapter, this chapter applies to each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider.

TEX. INS. CODE § 1301.0041(a); ROA.1033. All of chapter 1301 – and, specifically, its prompt payment requirements and the penalties for the violation of those requirements – applies to the preferred provider benefit plans described in § 1301.0041(a), and the late-payment penalty provisions of § 1301.137 apply to the late-paying insurers involved.

By the express terms of the Applicability provision, a preferred provider benefit plan will fall within the ambit of Chapter 1301 upon the satisfaction of three conditions: (1) an "insurer" (2) provides for the payment of a different level of coverage depending on whether the provider used is preferred or non-preferred (3) and makes such provision through that insurer's "health insurance policy." There is no

dispute that the second element is satisfied; the only genuine disputes concern the first and third requirements, but each is readily satisfied.

1. HCSC is an "Insurer" Within the Contemplation of the TPPA

The threshold applicability question is whether HCSC fits the definition of "insurer" in Chapter 1301. The District Court held that when HCSC functions only as an administrator, it does not fit the statutory definition. But the statute does not say that. An "insurer" is, instead, broadly defined to be "a life, health, and accident insurance company, health and accident insurance company [or] health insurance company . . . operating under" particular chapters of the Insurance Code[7] that is "authorized to issue, deliver, or issue for delivery in this state health insurance policies." *See* TEX. INS. CODE § 1301.001(5).

By its express terms, the statutory definition takes no account of the role or function of an insurer in any particular preferred provider

---

[7] HCSC is "operating under" one or more of those chapters when administering a self-funded plan. Chapter 841, for instance, governs the formation of certain types of insurance entities, limits their authority to conduct business in Texas, and spells out management parameters of their operations. *See, e.g.,* TEX. INS. CODE § 841.051 et seq. (formation), § 841.101 et seq. (authority), § 841.151 et seq. (management). Chapter 841 defines a "health insurance company" as "a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of loss resulting from disability incurred as a result of sickness or ill health," and requires such entities to comply with Chapter 1301. *See* TEX. INS. CODE §§ 841.001(6) & 841.002(8).

benefit plan. The language of Section 1301.001(5)[8] shows that the Legislature considered the function of an insurer within such a plan irrelevant. *See Texas Dep't of Ins. v. American Nat'l Ins. Co.*, 410 S.W.3d 843, 849 (Tex. 2012)(noting Texas Insurance Code employs contextual definitions of terms, deeming entities "insurers" for one purpose but not for another).[9] Instead, the touchstone for determining that an entity is an "insurer" is whether: (a) it is among several types of companies, and (b) it is authorized to provide health insurance policies in Texas. *Id.*

HCSC meets the first criterion, as it is indisputably a health insurance company that operates under Chapter 841 of the Insurance Code. ROA.242-243. HCSC is also authorized to issue policies of life, health, and accident insurance in Texas and, thus, satisfies the second

---

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

[9] While it is merely suggestive of the breadth of the statute, the Attorney General of Texas has recently issued a formal opinion regarding the applicability of Section 1301.057 of the Insurance Code to pharmacy benefit managers acting on behalf of PPOs and acknowledged that "under some circumstances a PPO itself could be considered an insurer" with respect to the requirements imposed by Chapter 1301. *See* Op. Tex. Att'y Gen. No. KP-0036 at *2 (2015).

requirement as well. *Id.* It is thus a statutory "insurer" whether, with respect to any particular preferred provider benefit plan, its function was limited to administration or not. In such a case, it would merely be an insurer/administrator.

This is (and should be) the only test for determining the scope of Chapter 1301's application. That is borne out by the constructions of similarly broad definitions of "insurer" in other portions of the Insurance Code. *Toranto v. Blue Cross & Blue Shield of Tex., Inc.*, 993 S.W.2d 648, 649 (Tex. 1999)(per curiam). In *Toranto*, the Supreme Court held that there-applicable definition of "insurer" extended to a plan administrator like HCSC. There, a provision of the Texas Insurance Code prohibited "an insurer" from restricting the right of an insured to assign benefits under a policy to a health care provider. *Id.* at 648. A patient had assigned her claim for benefits under her plan to Dr. Toranto, who then filed a claim with BCBS, the administrator of the patient's plan. While BCBS paid the claim, it remitted payment directly to the insured in contravention of the assignment, relying on an anti-assignment clause set out in the plan provisions.

Dr. Toranto sued BCBS, alleging that the anti-assignment clause in the plan provisions was statutorily prohibited and invalid. BCBS made the same argument that HCSC made below: that the statutory anti-assignment prohibition applied only to "insurers," that it was not (as a mere administrator) subject to the prohibition as a mere administrator. The lower courts agreed, but the Supreme Court held that "BCBS [was] an 'insurer' because it is authorized to act as ERS' administrating firm under" one of the Insurance Code chapters enumerated in the statutory definition. *Id.* at 649.

In ruling on Methodist's motion for new trial, the District Court refused to accord any persuasive weight to *Toranto*, holding that the Supreme Court's decision had addressed a separate portion of the Insurance Code with a distinct definition of insurer applicable to a different context. ROA.1938-1939. But, contrary to the District Court's conclusion, *Toranto* involved the construction of a textually similar statutory definition of "insurer" and the application of that definition to a plan administrator.

For sake of comparison, these similar provisions are presented side-by-side here:

Toranto	**TPPA**
(6) "Insurer" means an insurance company, association, or organization authorized to do business in this state under Chapter 3, 8, 10, 11, 12, 13, 14, 15, 18, 19, or 22 of this code[10]	"Insurer" means a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

The similarity in the provisions is clear and the District Court erred in holding otherwise. The definitions each require that the entity: (a) be of a particular type ("an insurance company" in *Toranto*; "a . . . health insurance company" under Chapter 1301); (b) that it operate under particular provisions of the Insurance Code; and (c) and that it meet the broad generalized criteria that it either is "authorized to do business" in Texas or that it be "authorized to issue" health insurance policies in Texas.

For the same reason that BCBS was an "insurer" in *Toranto*, HCSC is an "insurer" under Chapter 1301: it is a life, health and accident insurance company that operates under a listed chapter of the Insurance Code and is authorized to issues insurance policies in Texas.

---

[10] Act of June 6, 1991, 72nd Leg., R.S., ch. 242, § 11.87, 1991 Tex. Gen. Laws 939, 1108.

HCSC continues to be such a company even where its function within a given preferred provider benefit plan is limited to administering. In that instance, it would be an "insurer"/administrator, but ultimately it would remain an insurer precisely because it would continue to satisfy the statutory definition of that term.

2. The Unified Contracts HCSC Forms with Payor Plans and Preferred Providers are "Health Insurance Policies" as Defined by the TPPA

The second statutory requirement in dispute here is whether HCSC makes provision for payment to health care providers for covered services through its "health insurance policy." Section 1301.001(2) defines the phrase "health insurance policy:"

> "Health insurance policy" means a [1] group or individual insurance policy, [2] certificate, or [3] contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

See TEX. INS. CODE § 1301.001(2)(numbering and emphasis supplied). While HCSC insists (and the District Court held, ROA.1035-1037) that the phrase "group or individual insurance" necessarily modifies each of the three choices for establishing the existence of a "health insurance policy," both are wrong as a matter of grammar and law. *See, e.g., S & P Consulting Eng'rs, PLLC v. Baker*, 334 S.W.3d 390 (Tex.

App.—Austin 2011, no pet.)("negligent" in "negligent act, error, or omission" in certificate of merit statute to modify only "act," not omission).

The District Court's interpretation, which limits the statute's applicability exclusively to preferred provider benefit plans in which an insurer issues a classic insurance policy, violates the rule of statutory construction requiring the Court to give meaning to each word used by the Legislature. *Jaster v. Comet II Const., Inc.*, 438 S.W.3d 556, 562 (Tex. 2014)(statutory construction must honor each word chosen). If "group or individual insurance" is made to modify all three of "policy," "certificate," and "contract" then the second and third alternatives – certificates and contracts – would be rendered superfluous and, thus, impermissibly meaningless. "Group or individual insurance certificate" and "group or individual insurance contract" say nothing more than "group or individual insurance policy." A "certificate . . . providing benefits" and a "contract providing benefits" are both something different than a group or individual insurance policy in the classic sense of insurance. The Legislature need not have used "certificate" and "contract" to say nothing different than "group or individual insurance

policy". It used the different terms because it intended to say something different with each. It wanted the statutory definition to include not only insurance policies as classically understood, but also certificates and contracts providing benefits for medical or surgical expense whether or not those certificates and contracts fit the mold of classic insurance.

Insisting that "insurance" modifies each of succeeding terms – so as to circumscribe the scope of the Act – also does violence to the Legislature's intent to expansively extend prompt payment requirements in Texas. The Legislature's definition of "health insurance policy" necessarily contemplates that a "contract providing benefits" for health care expenses will qualify.

Accordingly, because the contract between Methodist and HCSC is a "contract providing benefits" for health care expenses, it fits the statutory definition of a "health insurance policy." A plan, like the one formalized in that contract, fits the plain meaning of a "benefit." *See, e.g.,* 38 U.S.C. § 4303(2)(defining "benefit" to include "an employer policy, plan, or practice and includes rights and benefits under . . . a health plan."); *Fischer v. United States*, 529 U.S. 667, 676 (2000)("[i]t is

commonplace for individuals to refer to their retirement or health plans as 'benefits.'"). That contract unquestionably offers considerable benefits to the plan beneficiaries, including the delivery of health care services at an agreed-upon, reduced rate. A conclusion that HCSC's plan is a "health insurance policy" as that term is defined in Chapter 1301 is wholly consistent with the express language of the statute.

Holding that the Applicability provision cannot reach HCSC to enforce prompt payment laws when it acts as an administrator of self-funded plans compels the erroneous conclusion that the Applicability provision cannot reach HCSC when it acts as an administrator with respect to any other term of the chapter.

Chapter 1301 is the Texas Legislature's mechanism for regulating the entire relationship between preferred provider plans, the beneficiaries of those plans, and the providers who offer care to those beneficiaries. For example, Chapter 1301 requires the preferred provider plan to ensure the availability and accessibility of health care services, protects providers by limiting restrictions on payment and reimbursement, and curbs the plan's ability to interfere in the relationships between patients and health care providers. *See* TEX. INS.

CODE §§ 1301.006, 1301.056(a), 1301.067. The District Court acknowledged that when HCSC acts as the third party administrator of preferred provider plans, its functions include negotiating pricing and ensuring network access for plan beneficiaries – matters clearly regulated by the foregoing provisions and others like them. ROA.1025. The District Court's construction of the Applicability provision, however, undermines the power of the State of Texas to regulate the manner in which a plan administrator performs those functions. That result is not countenanced by the statute's deliberately broad express language. A lack of regulation is deleterious to the interests of other stakeholders, including the plan beneficiaries the laws are designed to protect. The narrow construction imposed by the District Court is wrong because it is at odds with the statute's deliberately broad definitions, by which the Legislature intended to expand the scope of the statute.[11]

The District Court's construction also means that Texas has anomalously protected the prompt payment needs of health care providers who render services to beneficiaries of HMO plans (even those

[11] *Cf. American Nat'l Ins. Co.*, 410 S.W.3d at 848 (Legislature broadly defined the term "insurer" in Chapter 101 of the Texas Insurance Code where necessary to extend the State's regulatory authority). That observation demonstrates concretely that where the Texas Legislature has identified a gap in insurance laws, it has addressed that problem by expanding statutory definitions to fill the gap.

that might be self-funded) but declined to extend the same protection to "preferred" health care providers who render services to beneficiaries of self-funded PPO plans. ROA.207-208. Stated another way, under the district court's construction, self-funded HMO plans are subject to the Texas Prompt Pay Act, but self-funded PPO plans are not. *Id.* The District Court discounted the absurdity of that result, holding that nothing compelled the HMO and PPO chapters to be applied similarly. ROA.1043-1044. It would be remarkable, however, if the Legislature intended two related statutes aimed at alleviating precisely the same problem to be read in a manner that renders the HMO chapter to be read quite broadly but the PPO chapter to be extraordinarily narrowly. The Supreme Court of Texas has admonished courts engaged in statutory construction to consider not only the consequences of a particular construction of a specific statute but also the manner in which similar statutes have been construed. *See Kroger Co. v. Keng*, 23 S.W.3d 347, 349 (Tex. 2000)("When construing a statute, we must give effect to the Legislature's intent," by ascertaining a statute's plain meaning in light of the words chosen while "also consider[ing], among other things, the circumstances under which a statute was enacted,

former statutory provisions, including laws on the same or similar subjects, and the consequences of a particular construction.")(internal citations omitted).

Construed in accordance with its express terms (and in a manner consistent with the Legislature's intent) the Applicability provision reaches HCSC's PPOs because there is a contract providing benefits for medical or surgical expenses. That contract is HCSC's, and HCSC, as an insurer, provides through that contract for the payment of preferred provider benefits. The penalty provisions of Chapter 1301 therefore apply to HCSC.

HCSC's essential role in the formation and the carrying out of the preferred provider benefit plan is indisputable. This plan is HCSC's whether it provides the coverage or simply administers it. HCSC's self-funded plan customers cannot provide any preferred provider coverage to their members because there is no contract between the self-funded plan and any preferred provider.[12] HCSC, an insurer, has bridged that gap by coupling: (a) its administrative agreements with the self-funded

---

[12] Significantly, too, the Supreme Court of Texas has explained that "employers who self fund their employee health-benefit plans are clearly not insurance companies," even though they perform similar services. *See American Nat'l Ins. Co.*, 410 S.W.3d at 848.

plans; and (b) the contracts with its network of preferred providers. Those two components form one contract that, because it provides benefits for medical or surgical expenses, ***is*** a "health insurance policy" for all purposes of Chapter 1301. It is thus part of a preferred provider benefit plan in which an "insurer," provides, through "its" health insurance policy (the self-funded plan it has created or adopted and in either event administers), for the payment of preferred provider benefits. *See* TEX. INS. CODE § 1301.0041(a).

But even if the definition of "health insurance policy" could be understood to require an "*insurance* contract providing benefits" for healthcare, the record demonstrates that such a contract does, in fact, exist between Methodist and HCSC. The District Court refused to consider the merits of this contention, ROA.1939-1941, but the relevant documents bear out the cohesive contractual regime by which the costs of health benefits for plan beneficiaries are insured.

The "health insurance policy" here consists of two documents that form one contract. *See Baylor Univ. Med. Ctr. v. Epoch Grp., L.C.*, 340 F. Supp. 2d 749, 754-55 (N.D. Tex. 2004). The first constituent document is HCSC's contract with its customer self-funded plans, by

which HCSC promises to administer the self-funded plan for a fee and to grant the self-funded plan members access to HCSC's network of preferred providers; it also secures the promise from the preferred providers to accept the rates negotiated by HCSC as payment in full for the medical and surgical services rendered to plan members. The second constituent document is HCSC's contract with its preferred provider, by which HCSC promises to pay or provide for payment of the provider's services for members of self-funded plans in contract with HCSC. It promises to provide for such payment at the preferred provider rates set out in the HCSC/preferred provider contract.[13]

These documents form – as a matter of law – a single, unified contract. *See Baylor Univ. Med. Ctr.,* 340 F. Supp. 2d at 754-55. That single, unified contract is a "health insurance policy" as defined by § 1301.001(2) because it is a "contract providing benefits for medical or

[13] Notably, those contracts exist solely by virtue of HCSC's sheer gravity; HCSC (or its licensee) unites payors and the providers, relying on aggregation of beneficiaries that HCSC can gather under the umbrella of a particular plan – all of whom necessarily seek benefits for medical or surgical services – to entice providers who render medical and surgical services to seek recognition as preferred providers and offer discounts for the right to serve those individuals. ROA.1919. Those contracts – with HCSC in the middle, extending one hand to its customer/self-funded plans and the other to its preferred providers – that form the health insurance policy that plan beneficiaries rely upon. That single, unified contract is preeminently and ineluctably *HCSC's* health insurance policy because HCSC formed it and it could not exist without HCSC. ROA.1879.

surgical expenses . . ." It ensures that plan beneficiaries will receive medical and surgical treatment from preferred providers and ensures that the monetary charges assessed by those providers will be paid by the plan. Whether it pays with its own money or with money it receives as administrator from its customer/self-funded plans is irrelevant. Whether HCSC bore any financial risk, a point much belabored below by HCSC, is likewise irrelevant.

Any contrary conclusion would defy the fundamental purpose of the contract. *See, e.g. Guidry v. American Public Life Ins. Co.*, 512 F.3d 177, 182 n. 6 (5th Cir. 2007)("the fundamental purpose of ordinary health insurance coverage is to indemnify against loss from disease or illness."). Indeed, this arrangement is the archetype of a "health insurance policy" under Chapter 1301's definition of that term. *See American Nat'l Ins. Co.*, 410 S.W.3d at 848-49 (a self-funded health care plan's activities constitute the "business of insurance" and qualify the plan as an "insurer" for at least some purposes under the Texas Insurance Code).

Finally, even if the contracts do not form an integrated whole, other facets of HCSC's relationships with providers and plans

demonstrate that HCSC's agreements suffice to constitute "health insurance policies" as that term is statutorily defined. Specifically, HCSC markets stop-loss policies to self-funded plans. ROA.208. As the Supreme Court of Texas has explained, a stop-loss policy provides a mechanism for an insurer to reimburse a self-funded plan for healthcare costs exceeding a contractually determined amount. *See American Nat'l Ins. Co.*, 410 S.W.3d at 847-48. These stop-loss policies are not excess insurance or reinsurance; they are direct insurance policies purchased by a self-funded plan from an insurer who agrees to bear the risk of losses beyond a certain level of coverage for medical and surgical expenses incurred by the plan's beneficiaries. *See id.* at 855.

The District Court agreed with HCSC that stop-loss insurance does not insure "against loss from sickness or from bodily injury or death by accident." ROA.1044-1045. It based that conclusion on this Court's plurality decision in *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990). ROA.1045 ("stop-loss insurance is not accident and sickness insurance," citing *Brown*). That conclusion is untenable because it is only a partially correct reading of the opinions in *Brown*. In fact, Judge Higginbotham's lead opinion in *Brown,* rejected any categorical rule

decoupling stop-loss insurance from accident and sickness insurance. *See Brown*, 897 F.2d at 1354 (agreeing with the argument that stop-loss insurance was not "accident and sickness insurance," but only with "one important qualification."). Indeed, Judge Higginbotham expressly observed that a stop-loss policy might be an accident-and-sickness policy if coverage were to trigger at an unreasonably low amount because in that circumstance the insurer would retain the obligation to cover virtually all of the medical and surgical benefits contemplated by the self-funded plan. *See Brown*, 897 F.2d at 1355.[14]

Thus, where the stop-loss policy actually imposes the burden of health care costs predominantly upon the insurer rather than the plan, the plan's beneficiaries are covered by the insurer's insurance contract providing benefits for medical and surgical expenses, even if denominated a stop-loss policy. *Id.* ("If, for example, a plan paid only the first $500 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage."). It is the substance of the relationship

[14] Rejecting a narrow construction "lest an overly literal reading of the statute frustrate an otherwise manifest legislative purpose." *Brown*, 897 F.2d at 1355.

created by a stop-loss policy – not the denomination of the policy itself – that is dispositive in characterizing the stop-loss policy's function; where that function is a proxy for the plan's coverage, the stop-loss policy becomes the functional equivalent of an insurance policy within the contemplation of Chapter 1301. *Id.* at 1355 ("We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants.").

That caveat recognizes the reality that by offering stop-loss insurance, and contractually reassuming at least a portion of the risk associated with the costs of medical and surgical services, HCSC actually "insures" the benefits afforded by the plan and does that through an insurance contract providing benefits for medical or surgical expenses.[15]

[15] While it may be that some stop-loss policies issued by HCSC to the self-funded plans do not fall below the threshold recognized in *Brown*, HCSC has not proven that all stop-loss policies it has issued maintain the disproportionate share of the risk in the plans themselves. Notably, HCSC's Reply Brief in Support of its Motion for Summary Judgment does not dispute that it issues such policies, ROA.424-425, but does not attempt to prove the allocation of risk in those policies.

3. HCSC "Provides . . . for" Payment to Providers through its Health Insurance Policy

HCSC's health insurance policy also "provide[s] . . . for" payment to a preferred provider. TEX. INS. CODE § 1301.0041(a). TPPA does not define the phrase "provide for," leaving the Court to apply the plain meaning of the words chosen. *See City of Houston v. Bates*, 406 S.W.3d 539, 543 (Tex. 2013). The word "provide" is commonly understood to mean "to make, procure, or furnish for future use, prepare," as well as "to supply or make available." *See* BLACK'S LAW DICTIONARY 1224 (6th ed. 1990). Other sources more specifically define the phrase "provide for" to mean "to make adequate preparation for (a possible event)," with the word "for" bringing an anticipatory meaning rather than connoting immediate and direct action.[16] The common meaning of "provide . . . for" in § 1301.0041(a), in the absence of a statutory definition of that term, extends the statute's applicability beyond those who actually make payment to any insurer who, through its health insurance policy, supplies or otherwise facilitates payment for preferred provider coverage. Thus, it is of no moment whether HCSC pays preferred providers with its own money or with money received from the employer

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

sponsors of the plans HCSC administers. The Legislature did not limit the statute's applicability to insurers who pay from their own funds. It expanded applicability to all insurers who *provide for* payment. The distinction is significant.

Had the Legislature intended to limit the statute's applicability to only those who pay with their own money, it could have predicated applicability on bearing financial risk. Instead of making "provides . . . for," the threshold, it could have required a showing that the insurer "bears the financial risk of" payment. It did not do that, however, and that choice must be honored; the "for" in "provide . . . for" cannot be ignored. *See Columbia Med. Ctr. of Las Colinas, Inc. v. Hogue*, 271 S.W.3d 238, 256 (Tex. 2008)(prohibiting interpretations that render statutory language superfluous).

Texas law does not contemplate that singular phrases, clauses, or sentences should be read in isolation from the rest of the statute. *See City of Austin v. Sw. Bell Tel. Co.*, 92 S.W.3d 434, 442 (Tex. 2002). The holistic reading of statutes effectuates the presumption that the entire act is intended to be effective and protects against interpretations that would leave some part of a statute meaningless. *See Crosstex Energy*

Servs., L.P. v. Pro Plus, Inc., 430 S.W.3d 384, 390 (Tex. 2014). Consideration of the broader context of a statute "is fundamental" to statutory construction because "meaning cannot ordinarily be drawn from isolated words or phrases, but must typically be determined from statutory context." *University of Texas at Arlington v. Williams*, 459 S.W.3d 48, 52 (Tex. 2015); *In re Office of the Atty. Gen. of Tex.*, 456 S.W.3d 153, 155 (Tex. 2015)("courts should resist rulings anchored in hyper-technical readings of isolated words or phrases.").

Thus, an insurer that "provides . . . *for*" payment of benefits through its policy falls within the ambit of the statute, whether or not it bears any financial risk. HCSC's agreements facilitate payment to preferred providers and by facilitating payment in that way, HCSC has "provided for" payment to preferred providers through its health insurance plan. In both instances, HCSC affirmatively "provided . . . for" the payment of preferred provider claims.

C. The Legislative History of the Statute Confirms Methodist's Construction

The conclusion that an insurer acting as an administrator of a self-funded plan is subject to the TPPA is compelled by the text of

Chapter 1301. The legislative history of the statute readily confirms that the Legislature intended precisely that result.

To a significant extent, legislators debated what is the current version of the TPPA before and during the 2001 legislative session. The 2001 effort (HB 1862) failed to become a law after Governor Perry vetoed the bill for the want of a provision allowing arbitration of disputes. *See* Veto Message of Gov. Perry, Tex. H.B. 1862, 77th Leg., R.S. (2001).[17] The Governor's veto, though, recognized that expansion of prompt payment laws was a crucial need in the State, explaining that "unless significant improvements are soon realized and health plans demonstrate a strong commitment to prompt pay law and to honoring their contractual relationships with physicians and health care providers, Texas may have to adopt stronger laws than those proposed by HB 1862." *See id.*; ROA.387-388. Legislators, therefore, sought to bring more claims within the protections of the TPPA. ROA.209-210.

The resulting bill, SB 418, was broadly understood – by both legislators and lobbyists who opposed it – to have accomplished that very goal, achieving broad applicability of the law by extending the

---

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

prompt payment requirements to self-funded ERISA plans.[18] ROA.209. Indeed, when the bills – which went materially unchanged before being signed into law – were reported out of committee in 2003, all constituencies agreed that the prompt payment provisions had reached self-funded plans. ROA.210.

The plain text of the statute does precisely what the Legislature intended: it ensures that the prompt payment requirements and the associated penalties reach self-funded plans like those at issue here.[19]

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

Finally, there is no administrative construction of the TPPA that is entitled to any judicial deference. As a matter of Texas law, "An administrative agency's construction of a statute it implements ordinarily warrants deference [only] when: (1) the agency's interpretation has been formally adopted; (2) the statutory language at

[18] In fact, numerous witnesses – representing industry advocacy groups for and against SB 418 – offered committee testimony recognizing that the Legislature had accomplished the goal of strengthening the prompt payment laws by expanding the scope of the law to encompass self-funded plans. ROA.210.

[19] A contrary result functionally means that the Legislature accomplished nothing (or virtually nothing) in attempting to incorporate prompt payment requirements and penalties into Chapter 1301 to statutorily address a specifically identified problem. Texas courts cannot "lightly presume that the Legislature may have done a useless act." *See Jaster*, 438 S.W.3d at 569 n. 17 (quoting *Liberty Mut. Ins. Co. v. Garrison Contractors, Inc.*, 966 S.W.2d 482, 485 (Tex. 1998)).

issue is ambiguous; and (3) the agency's construction is reasonable." *See R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water*, 336 S.W.3d 619, 625 (Tex. 2011). Not one of those three requirements has been met in this case.

No Texas Department of Insurance statement on the applicability of TPPA has even been subjected to formal rulemaking, and none has endured the rigors of formal adoption. Section 1301.0041(a) is not ambiguous, and no construction exempting HCSC from the scope of TPPA in the circumstances of this case would be reasonable. *See Fleming Foods of Tex., Inc. v. Rylander*, 6 S.W.3d 278, 282 (Tex. 1999)("an administrative agency's construction of a statute cannot contradict the statute's plain meaning."). Therefore, no TDI statement concerning the scope of Chapter 1301 and its prompt payment provisions is entitled to any judicial deference.

E. HCSC's Preferred Provider Benefit Plans Meet all of Section 1301.0041(a)'s Applicability Criteria; the District Court Erred in Concluding that the TPPA Does Not Apply to HCSC as an Administrator of Self-Funded Plans

HCSC is an "insurer." The documents it has signed with self-funded plans on the one hand and preferred providers on the other

constitute one, unified contract, and that contract provides benefits for medical or surgical expenses. It is thus a "health insurance policy," and that policy is HCSC's. Through that policy, HCSC "provides . . . for" the payment of preferred provider benefits. The policy is part of a preferred provider benefit plan. TPPA thus applies to HCSC's preferred provider benefit plans. When § 1301.137 imposes prompt-pay penalties on "insurers" who do not pay timely, it imposes them on HCSC precisely as the Texas Legislature intended.

The District Court erred in holding otherwise.

II. THE FEHBA DOES NOT PREEMPT CLAIMS FOR PENALTIES AVAILABLE UNDER THE PROMPT PAYMENT PROVISIONS OF CHAPTER 1301

Beyond its obligations as a qualifying insurer with respect to the self-funded plans it administers, HCSC is also liable for late-payment penalties related to claims arising from services rendered to beneficiaries of federal government funded plans. In the District Court, HCSC argued that the Federal Employee Health Benefits Act preempts Methodist's TPPA claims arising from those services. ROA.184-186. It contended allowing Methodist's TPPA claims to proceed would "inappropriately expand the payor's obligations beyond what is required

by FEHBA," and that FEHBA's preemptive reach is implicated because Methodist's claims arise under a state statute rather than a private contract and because that statute "attempts to control the timing of 'payments with respect to benefits' and 'relates to health insurance or plans.'" ROA.186. The District Court agreed with those arguments, holding ultimately that "a demand for penalties under the TPPA for claims paid through [FEHBA] necessarily relates to and depends upon the health insurance plan." ROA.1050-1051. Finding that FEHBA preempts Methodist's TPPA claims as to federal government employee plans, the District Court granted HCSC's motion for summary judgment as to claims for penalties under those plans. ROA.1052.

"Federal preemption is an affirmative defense that a defendant must plead and prove." *Simmons v. Sabine River Auth., La.*, 732 F.3d 469, 473 (5th Cir. 2013). A party moving for summary judgment on an affirmative defense "must establish beyond peradventure all of the essential elements of the defense to warrant judgment in his favor." *Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 378 (5th Cir. 2011). When a movant seeks summary judgment based on

preemption, any allegations are construed in the light most favorable to the non-movant. *Id.*

A. FEHBA Allows the Federal Government and its Agencies to Contract with Private Insurance Carriers to Provide Federal Employees' Health Insurance

The FEHBA authorizes the federal Office of Personnel Management to contract with private insurance carriers to provide health insurance to federal employees. *See Houston Cmty. Hosp. v. Blue Cross & Blue Shield of Tex., Inc.*, 481 F.3d 265, 267 (5th Cir. 2007). Where FEHBA applies, OPM negotiates and largely regulates the health-benefit plans that cover federal employees. *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 682-83 (2006); ROA.1047. In fulfilling that role, OPM has negotiated contracts with HCSC's licensee, Blue Cross and Blue Shield Association.[20] ROA.1047. BCBSTX carries out the processing of claims arising under those contracts for insureds in Texas and provides customer service to those insureds. ROA.1047.

[20] Indeed, the Supreme Court recognized in *McVeigh* that the "largest of the plans for which OPM has contracted, annually since 1960, is the Blue Cross Blue Shield Service Benefit Plan, administered by local Blue Cross Blue Shield companies." *McVeigh*, 547 U.S. at 682.

As the employer or sponsor of these FEHBA plans, the federal government pays 75% of the coverage premium while the individual insureds pay the remainder. *McVeigh*, 547 U.S. at 684; *see also* 5 U.S.C. § 8906(b); ROA.1047. The premiums are paid into a Treasury Fund from which insurance carriers draw to pay for health care benefits covered by the plans. ROA.1047-1048; 48 C.F.R. § 1632.170(b). What funds remain at the end of a fiscal year are the property of the federal government and OPM is vested with discretion to use that remainder in any number of ways. *See* 5 U.S.C. § 8909(b).

FEHBA does require that OPM's contracts with carriers "contain a detailed statement of benefits offered," and requires that such a statement specify, among other things, "maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." *See* 5 U.S.C. § 8902(d). The contracts must also "prescribe reasonable minimum standards for health benefits plans [and carriers]." 5 U.S.C. § 8902(e).

B. FEHBA's Limited Preemptive Effect

FEHBA itself includes a preemption clause, which provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including

> payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

See 5 U.S.C. § 8902(m)(1). Through that clause, FEHBA preempts state law only when two circumstances are present: (1) when "the FEHBA contract terms at issue 'relate to the nature, provision, or extent of coverage benefits;'" and (2) when the state law "relate[s] to health insurance or plans." *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 (2nd Cir. 2005), *aff'd*, 547 U.S. 677 (2006). Thus, "Section 8902(m)(1)'s text does not purport to render inoperative any and all state laws that in some way bear on federal employee benefit plans." *Id.* at 698.

Determining whether a statute displaces state law is fundamentally "a question of Congressional intent." *Burkey v. Gov't Emp. Hosp. Ass'n*, 983 F.2d 656, 659 (5th Cir. 1993)(quoting *English v. General Elec. Co.*, 496 U.S. 72, 78-79 (1990)); *see also Medtronic v. Lohr*, 518 U.S. 470, 485 (1996)(enshrining Congressional intent as "the ultimate touchstone" in assessing whether federal law expressly preempts state law). In determining the preemptive scope of a congressional enactment, courts rely on the plain language of the

statute and its legislative history to develop "a reasoned understanding of the way in which Congress intended the statute" to operate. *See N.H. Motor Transp. Ass'n v. Rowe,* 448 F.3d 66, 74 (1st Cir.2006).

FEHBA is intended to "ensure nationwide uniformity of the administration" of benefits within its purview, recognizing that the "advantages of a uniform, nationwide interpretation of [FEHBA] plans [are] manifest," and "Congress was motivated by those advantages" in adopting the preemption *See Weight Loss Healthcare Ctrs. of Am., Inc. v. Office of Personnel Mgmt.,* 655 F.3d 1202, 1206 (10th Cir. 2011).

C. The District Court Erred in Holding that FEHBA preempts Methodist's TPPA Claims Arising From Services Provided to Beneficiaries of HCSC's Federal Government Plans

The fundamental issue in assessing whether TPPA claims are swept within FEHBA's preemptive wake is whether Chapter 1301's prompt payment requirements "relate to health insurance or plans." Here, there is no basis to find preemption under FEHBA because Methodist's claims under the TPPA do not relate to the FEHBA health insurance plans.

A law "'relates to' [a] plan, in the normal sense of the phrase, if it has a connection with or a reference to such a plan." *Botsford v. Blue*

Cross & Blue Shield of Mont., Inc., 314 F.3d 390, 394 (9th Cir. 2002); *cf. Dukes v. US Healthcare, Inc.*, 57 F.3d 350, 356 (3rd Cir. 1995)(no preemption of claims concerning the quality of benefits received). This is a deliberately narrow approach to the term; "if 'relate to' were taken to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course for 'really, universally, relations stop nowhere.'" *See New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995).[21] Indeed, preemption jurisprudence generally includes a presumption that Congress did not intend to preempt state laws in fields of traditional state regulation. *Id.*

Where courts have found that FEHBA displaces state law, they have reached that conclusion because those state laws either change the terms of the plan itself, by modifying procedures available under FEHBA to enforce plan terms, or by modifying the relationship between the plan beneficiary and the plan. For instance, a California law requiring "every health care service plan contract" to "provide coverage

[21] *Travelers* concerns the preemptive effect of ERISA, but its admonitions about narrowly construing the preemptive effect of federal laws have found utility in caselaw considering FEHBA preemption as well. *See, e.g., Roach v. Mail Handlers Ben. Plan*, 298 F.3d 847, 850 (9th Cir. 2002); *Burkey*, 983 F.2d at 660 (recognizing the similarity of FEHBA's preemption language to ERISA's).

for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age" was a law that related to a FEHBA plan by seeking to create new coverage terms and was, therefore, preempted. *See Brazil v. OPM*, 35 F.Supp.3d 1101, 1112-13 (N.D. Cal. 2014). Similarly, a plan beneficiary's claims for damages alleging that she had been denied medical benefits by physicians seeking to avail themselves of the plan's physician financial incentive program were preempted because they challenged the plan's "administration of plan benefits" and did so in a manner that was inconsistent with FEHBA's civil enforcement provisions. *See Kight v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 34 F.Supp.2d 334, 339-40 (E.D. Va. 1999).

The TPPA has no such forbidden connection to FEHBA plans. A claim for statutory penalties for late payment arises only after issues concerning the plan's terms and applicability have already been decided. *See* TEX. INS. CODE §§ 1301.103(1)(establishing for paying a claim "if the insurer determines the entire claim is payable"); 1301.137 (establishing penalties for noncompliance with the timetables established by Section 1301.103). Thus, Methodist's claims against HCSC for the penalties allowed under the TPPA do not involve any

issues implicating the scope of the plan or the construction of its terms. The prompt payment claims asserted by Methodist necessarily recognize that the plan beneficiaries' rights to health care have already been vindicated by virtue of the treatment provided by Methodist and that the plan has already acknowledged its duty to pay for those services. In fact, as to every claim asserted by Methodist in this action, HCSC has already determined that the claims made arise from services that are within the coverage afforded by the FEHBA plan and has, in fact, fully paid the amounts owed to Methodist for those services. ROA.67 ("Methodist . . . brings suit herein only for those claims paid by HCSC, but paid late.").

There is no further inquiry about the plan necessary to assess the TPPA's application to Methodist's claims. Those claims have no bearing on the relationship between the plan beneficiary and the plan itself, and they do not seek to modify (in any way) the financial terms of the contract by which Methodist is promised payment for providing qualifying treatment to plan beneficiaries. Methodist does not seek to limit or expand its treatment obligations with respect to the beneficiaries of preferred provider plans that cover federal employees

and it does not seek a variance from the pricing terms previously reached with the plans. Rather, Methodist simply seeks an extra-contractual remedy[22] relative to HCSC that is wholly detached from the plans themselves. The remedy that Methodist seeks arises only after the contract's terms have been fully performed.[23]

Further, permitting an aggrieved provider from obtaining statutory penalties that do not limit, expand, or modify the terms of the plan does nothing to threaten consistent application of FEHBA benefits within a particular State or nationwide. Indeed, allowing the provider to seek and recover statutorily authorized penalties harmonizes FEHBA with state-level initiatives intended to protect healthcare providers and encourage their vigorous participation in the marketplace. *See, e.g., Roach*, 298 F.3d at 850 (recognizing the need "to protect both the federal interest in uniform administration of FEHBA benefits and a state's interest in the quality of medical care."). Nothing about that

---

[22] *See, e.g., Provident Life & Acc. Ins. Co v. Knott*, 128 S.W.3d 211, 220 (Tex. 2003)(characterizing claims seeking statutory remedies for violations of the Deceptive Trade Practices Act and Insurance Code as "extra-contractual"). It also warrants mention that FEHBA affords Methodist no competing remedy for the late payments made by HCSC in this context.

[23] Precisely as the Texas Legislature intended, the TPPA claims impose no burden on the terms of the plans or the coverage they afford.

allowance changes the scope of plan coverage in a particular state. It is simply a state chosen condition of doing business, little different than a requirement that an entity meet certain conditions before being allowed to do business in a state or mandated compliance with income tax laws on a state-by-state basis.

Rejecting those truths, the District Court accepted HCSC's invitation to rest its conclusion on substantially on this Court's holding in *Burkey*. ROA.1049-1050. That case, however, is distinguishable and that distinction demonstrates a line dividing preempted state laws from those that remain enforceable.

In *Burkey,* the plan beneficiary was hospitalized following a catastrophic accident that left him a quadriplegic. *See Burkey*, 983 F.2d at 658. A coverage dispute ensued and in a succeeding lawsuit, the Burkeys sought to recover statutory penalties available under Louisiana law for unreasonable delays in paying health and accident insurance claims. *See id.* at 657. When the District Court awarded those penalties, the FEHBA plan appealed, arguing that the state law penalty statute was preempted. *Id.* at 659. This Court held that FEHBA preempted the Louisiana penalty statute, concluding that "tort

claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract that governs benefits," and that the claims related to the plan because they "necessarily refer[ed] to [the] plan to determine coverage and whether the proper claims handling process was followed." *Id.* at 660.

The temptation to equate *Burkey* to the present situation is admittedly great. But acquiescing to that temptation is also wrong for several reasons. First, while the District Court found it to be inapposite, it is significant that the relationship between the beneficiary and the plan was at issue in *Burkey*, and that the same relationship is not implicated here. ROA.233; ROA.1051. It is not just the identity of those parties that is important, as the District Court's opinion suggests in identifying cases in which medical providers' claims were preempted by FEHBA. What does matter is the nature of the facts that must be resolved in each case to determine whether the penalty is applicable.

In the *Burkey* situation, application of the Louisiana penalty provision required a determination that the delayed benefits were actually available under the plan and the extent of that availability.

Indeed, a crucial factual issue in *Burkey* was the fact that the beneficiary's coverage actually lapsed at some point during his hospitalization. *Burkey*, 983 F.2d at 658-59. Here, by contrast, there is no question that the benefits were within the scope of coverage afforded by the plan and no question about the extent of that coverage.

Thus, resolving Methodist's right to penalties does not require *any* consideration of the plan's terms or conditions. Contrary to the District Court's refusal to discern that significant distinction, ROA.1051, the Ninth Circuit has dealt with precisely this difference in the nature of claims. In those decisions, it has expressly cited that difference as the basis to conclude that claims brought by plan beneficiaries seeking to vindicate contractual rights created by the plan itself via unique state laws were preempted, while claims brought by third-parties who treat plan participants are not. *Compare Botsford*, 314 F.3d at 395 (recognizing FEHBA preemption of plan beneficiary's claims alleging underpayment of plan benefits through various state law theories) *with Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters of the U.S.*, 497 F.3d 972, 977 (9th Cir. 2007) (distinguishing *Botsford* and holding that hospital's claims against plan for underpayment of benefits arose from

the plan's contractual obligation to the hospital rather than under the terms of the plan itself and did not "relate to" benefits under the plan). The District Court erred in disregarding that difference.[24]

Methodist's claims for penalties under the TPPA do not relate to any FEHBA plan. Those claims, accordingly, are not within the scope of FEHBA's preemption provision and the District Court erred in granting HCSC's motion for summary judgment on that ground.

CONCLUSION

The Texas Prompt Pay Act is applicable as a matter of law to HCSC, even when it serves as the mere administrator of self-funded preferred provider benefit plans. Further, FEHBA does not preempt TPPA claims asserted against an insurer or plan administrator. Since the District Court's contrary rulings are erroneous as a matter of law, its judgment should be reversed and this cause should be remanded for trial on the merits. To the extent that the Court might find error in one of those rulings but not in the other, the judgment should be reversed and the cause remanded to the extent of that error.

[24] In that way, too, the fact that § 8902(m)(1) provides that the terms of FEHBA contracts relating to "benefits (including payments with respect to benefits)" preempt state laws should not change the outcome here.

Respectfully submitted,

By: /s/ Mikal C. Watts

WATTS GUERRA, LLP
Mikal C. Watts
Texas Bar No. 20981820
mcwatts@wattsguerra.com
Michael J. Murray
Texas Bar No. 24007721
mmurray@wattsguerra.com
Travis C. Headley
Texas Bar No. 24032283
theadley@wattsguerra.com
4 Dominion Drive, Bldg. 3, Ste. 100
San Antonio, Texas 78257
210.447.0500

FRANCIS & TOTUSEK, LLP
Blair G. Francis
Texas Bar No. 07354900
blair.francis@frtllp.com
Bobby D. Amick
Texas Bar No. 24059377
bobby.amick@frtllp.com
500 North Akard Street, Ste. 1830
Dallas, Texas 75201
214.740.4250

LAW OFFICE OF
JOSEPH V. GIBSON, PC
Joseph V. Gibson, IV
Texas Bar No. 24007236
jgibson@jvglaw.com
17618 Wagner Point Court
Tomball, Texas 77377
281.370.1810

Counsel for Appellant Methodist Hospitals of Dallas

CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing has been served upon the parties registered with the Clerk's Office electronic noticing facilities as listed on the Master Service list, by email, on this 17th day of September 2015.

/s/ Mikal C. Watts

Mikal C. Watts
mcwatts@wattsguerra.com
WATTS GUERRA, LLP
4 Dominion Drive, Bldg. 3, Ste. 100
San Antonio, Texas 78257
210.447.0500