NO. 15-10154

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

METHODIST HOSPITALS OF DALLAS d/b/a METHODIST HEALTH SYSTEM,
Appellant

vs.

HEALTH CARE SERVICE CORP.,
Appellee.

On Appeal from the U.S. District Court for the Northern District of Texas Dallas Division; Civil Action No. 3:13-CV-4946-B

BRIEF OF AMICI CURIAE MEMORIAL HERMANN HEALTH SYSTEM, TENET HEALTHCARE CORPORATION AND TEXAS ORGANIZATION OF RURAL & COMMUNITY HOSPITALS IN SUPPORT OF APPELLANT METHODIST HOSPITALS OF DALLAS d/b/a METHODIST HEALTH SYSTEM

Micah E. Skidmore
HAYNES AND BOONE, LLP
2323 Victory Ave., Suite 700
Dallas, Texas 75219
(214) 651-5000 (Telephone)
(214) 651-5940 (Telecopier)

ATTORNEY FOR AMICI CURIAE

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 29(c) and 26.1(a), Amicus Curiae Memorial Hermann Health System has no parent corporation, and no publicly held corporation owns more than ten percent (10%) of Memorial Hermann Health System.

Amicus Curiae Tenet Healthcare Corporation has no parent corporation, and no publicly held corporation owns more than ten percent (10%) of Tenet Healthcare Corporation.

Amicus Curiae Texas Organization of Rural & Community Hospitals ("TORCH") has no parent corporation, and no publicly held corporation owns more than ten percent (10%) of TORCH.

/s/Micah E. Skidmore
Micah E. Skidmore

TABLE OF CONTENTS

CORPORATE DISCLOSURE STATEMENT i

TABLE OF CONTENTS ii

TABLE OF AUTHORITES iii

STATEMENT OF AMICI CURIAE'S INTEREST vi

SUMMARY OF THE ARGUMENT 1

ARGUMENT AND AUTHORITIES 5

I. TPPA Penalties Provide a Necessary Incentive for Payors to Fulfill Their Contractual Obligations. 5

II. The Text of Chapter 1301 Applies to "Insurers" and TPAs 8

III. Chapter 1301 Applies to HCSC as Insurer for BCBSTX and Non-BCBSTX Plans 10

IV. Chapter 1301 Applies to Self-Insured Plans and Third-Party Administrators for Such Plans. 16

V. The TPPA is not Preempted by ERISA. 21

CONCLUSION AND PRAYER 29

CERTIFICATE OF SERVICE 31

ECF CERTIFICATION 31

CERTIFICATE OF COMPLIANCE 32

TABLE OF AUTHORITES

Page(s)

Cases

Aetna Life Ins. Co. v. Methodist Hosps. of Dallas,
2015 U.S. Dist. LEXIS 26455 (N.D. Tex. Mar. 4, 2015) 19

Arnold v. Nat'l County Mut. Fire Ins. Co.,
725 S.W.2d 165 (Tex. 1987) 6

Bank of La. v. Aetna U.S. Healthcare Inc.,
468 F.3d 237 (5th Cir. 2006) 24

Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield,
331 F. Supp. 2d 502 (N.D. Tex. 2004) 25

Burlington Northern & Santa Fe Ry. Co. v. Poole Chemical Co.,
419 F.3d 355 (5th Cir. 2005) 1

Bush v. Gore,
531 U.S. 98 (2000).....19

*Chatham Surgicore, Ltd. v. Health Care Service Corporation d/b/a
Blue Cross Blue Shield of Illinois*,
826 N.E.2d 970 (Ill. Ct. App. 2005) 11

Foley v. Southwest Texas HMO, Inc.,
226 F. Supp. 2d 886 (E.D. Tex. 2002).....25

Harris County Hosp. Dist. v. Alief Indep. Sch. Dist.,
1992 Tex. App. LEXIS 558 (Tex. App.—Houston [14th Dist.]
Mar. 5, 1992, writ denied) 20

Health Care Servs. Corp. v. Methodist Hosps.,
2015 U.S. Dist. LEXIS 54357 (N.D. Tex. Jan. 28, 2015) .....*passim*

Hogan v. Kraft Foods,
969 F.2d 142 (5th Cir. 1992) 19

Int'l Turbine Servs., Inc. v. VASP Brazilian Airlines,
278 F.3d 494 (5th Cir. 2002) 5

John Hancock Mut. Life Ins. Co. v. Schroder,
349 F.2d 406 (5th Cir. 1965) 14

Kelsey-Seybold Medical Group PA v. Great-West Healthcare of Texas, Inc.,
2015 U.S. App. LEXIS 14140 (5th Cir. Aug. 10, 2015) 27

Lone Star OB/GYN Assocs. v. Aetna Health, Inc.,
579 F.3d 525 (5th Cir. 2009) 24, 27

Mass. Mut. Life Ins. Co. v. Russell,
473 U.S. 134 (1985).....19

Mayeaux v. La. Health Serv. & Indem. Co.,
376 F.3d 420 (5th Cir. 2004) 23

McNeil v. Time Ins. Co.,
205 F.3d 179 (5th Cir. 2000) 1

Mem'l Hermann Hosp. Sys. v. Aetna Health Inc.,
2007 WL 1701901 (S.D. Tex. June 11, 2007).....26

Methodist Hosps. of Dallas v. Aetna Health, Inc.,
2014 U.S. Dist. LEXIS 104291 (N.D. Tex. July 30, 2014)..... 24, 25, 26-27

Ne. Hosp. Auth. v. Aetna Health Inc.,
2007 WL 3036835 (S.D. Tex. Oct. 17, 2007) 26

Railroad Comm'n v. Pullman Co.,
312 U. S. 496 (1941).....19

Tex. Dep't of Ins. v. Am. Nat'l Ins. Co.,
410 S.W.3d 843 (Tex. 2012) 20

Universe Life Ins. Co. v. Giles,
950 S.W.2d 48 (Tex. 1997).....6

Statutes

29 U.S.C. § 1144(a) 22

29 U.S.C. § 1144(b)(2)(A).....23

29 U.S.C. § 1144(b)(2)(B) 21, 23

TEX. CIV. PRAC. & REM. CODE § 38.001 5

TEX. INS. CODE ART. 21.42 14

TEX. INS. CODE § 841.001(6) 9, 17

TEX. INS. CODE § 843.336 8

TEX. INS. CODE § 1301.001(2) 9, 11, 18

TEX. INS. CODE § 1301.001(5) ..... *passim*

TEX. INS. CODE § 1301.041(a) 12, 13

TEX. INS. CODE § 1301.101 7

TEX. INS. CODE § 1301.103 7

TEX. INS. CODE § 1301.109 ..... *passim*

TEX. INS. CODE § 1301.137 ..... 7, 8

TEX. INS. CODE § 1301.138 ..... *passim*

Other Authorities

HOUSE COMM. ON EDUC. & LABOR, ERISA OVERSIGHT REPORT OF THE PENSION TASK FORCE OF THE SUBCOMM. ON LABOR STANDARDS 10 22

House Research Org., Bill Analysis, Tex. H.B. 418, 78th Leg., R.S. 7

Op. Att'y Gen. No. DM-276 (Dec. 17, 1993) 21

Op. Att'y Gen. No. KP-0036 (Aug. 14, 2015) 20

Jay Hancock, *Some small businesses chose to self-insure*, USA TODAY (Mar. 14, 2013), *available at* http://www.usatoday.com/story/money/business/2013/03/14/some-small-businesses-choose-to-self-insure/1988481/ 17-18

STATEMENT OF AMICI CURIAE'S INTEREST

Amici Curiae, Memorial Hermann and Tenet, are among the largest healthcare providers in Texas. Memorial Hermann is the largest non-profit health system in Southeast Texas with thirteen (13) hospitals and numerous specialty programs. Memorial Hermann provides health care services to patients within the greater Houston area through its 5,500 affiliated physicians and 21,000 employees. Tenet is a healthcare provider serving patients through eighty-three (83) hospitals (25 of which are located in Texas) and more than four hundred (400) outpatient centers, including over 250 ambulatory surgery centers, across the country.

TORCH is a full-service trade association and serves as the voice and advocate for the more than 150 rural and community hospitals in Texas. TORCH provides leadership in addressing the special needs and issues of these rural and community hospitals, their staffs and the patients they serve. Memorial Hermann, Tenet and TORCH are collectively referred to as "Amici Curiae."

Together, Memorial Hermann, Tenet, the members of TORCH and their affiliated physicians serve hundreds of thousands of patients throughout Texas. Many of these patients are insured through some form of employee welfare benefit plan, which may be funded either by a third-party insurance company or by an employer. In recent years, more and more employers have chosen to "self-insure" their employee benefit plans. Today, 80% to 85% of employee benefit plans are

"self-funded." For these self-insured plans, employers will typically contract with a third-party administrator or administrative services contractors to review, process and pay claims to providers.

Given the significant proportion of patients participating in self-funded employer plans, healthcare providers are increasingly reliant on third-party administrators (who are often insurers as well) and those employers self-insuring employee plans to receive prompt and complete payment for services rendered to patients. The Prompt Payment of Claims statute ("TPPA" or "Chapter 1301") in the Texas Insurance Code was intended to protect healthcare providers by establishing specific deadlines and other payment requirements for insurers responding to healthcare claims. TPPA also authorizes penalties for insurers and third-party administrators, who do not comply with these requirements.

TPPA's payment requirements and penalties provide a necessary incentive for insurers and administrators to ensure that claims are paid completely and on time. Unless reversed, the trial court's decision effectively to exempt self-insured plans from the scope of TPPA's application creates a significant risk that payments owed to providers for services rendered to patients in employer self-funded plans will be materially delayed or improperly denied. This Court's interpretation of TPPA will have a direct and substantial effect on Memorial Hermann, Tenet, the members of TORCH and other providers dependent on prompt payment of claims

for healthcare services. Amici Curiae have a clear interest in seeing that the incentives intended by the drafters of TPPA are not eliminated and that claims are paid completely and promptly regardless of whether the patients served are insured by a fully-funded or self-insured plan.

For purposes of Federal Rule of Appellate Procedure 29(c)(5), Amici Curiae represent that (1) no party's counsel authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund preparing or submitting the brief; and (3) no person—other than the Amici Curiae—contributed money that was intended to fund preparing or submitting the brief.

SUMMARY OF THE ARGUMENT

At a fundamental level, this case presents to the Court an issue of statutory interpretation: do the terms of Chapter 1301 apply to employer self-insured plans? "In Texas, the cardinal rule of statutory construction is to ascertain the 'legislature's intent,' and to give effect to that intent." *McNeil v. Time Ins. Co.*, 205 F.3d 179, 183 (5th Cir. 2000); *see also Burlington Northern & Santa Fe Ry. Co. v. Poole Chemical Co.*, 419 F.3d 355, 364 (5th Cir. 2005) (describing "common sense" as a "fundamental principle of statutory construction"). Because common sense dictates that the Legislature did not and could not have intended to hold insurers and administrators for fully-funded and self-insured plans to different standards of conduct vis-à-vis their providers, Amici Curiae urge the Court reverse the judgment of the trial court and hold that TPPA applies to Health Care Service Corp. ("HCSC") as administrator for employer self-insured benefit plans. HCSC's self-serving exemption for self-funded plans is not supported by the purpose of TPPA, the plain language of the statute or ERISA.

Chapter 1301 was created to provide insurers a necessary incentive to fulfill their contractual duties to health care providers. Without the penalties authorized under Section 1301.137, insurers have historically delayed and withheld payment with relative impunity. After all, absent the reward of interest and attorneys' fees, even the most tenacious providers willing to pursue litigation can only hope to

recover what the insurer was obligated to pay all along. To manufacture an exception to TPPA's payment requirements and penalties for self-insured plans not only destroys any incentive to honor contractual obligations to providers, but creates the perverse incentive for insurers to opt out of the statute's proscriptions by transitioning from fully-insured to self-insured status.

Nothing in the terms of Chapter 1301 supports such a wide separation between self-insured and fully-funded plans. TPPA expressly applies to "insurers" as well as those third-party administrators ("TPAs"), who contract with insurers to pay or process claims. An insurer, by statutory definition, is any company (1) authorized by charter to pay money or other items of value in the event loss resulting from a disability because of sickness or ill health; and (2) authorized to issue or deliver any contract in Texas providing benefits for medical expenses incurred because of an accident or sickness. HCSC is an "insurer" licensed and engaged in the business of insurance in Texas. Likewise, the employer opting out of a fully-insured employee benefit plan is not only self-insured, but is also a *self-insurer*. As confirmed by courts construing other provisions of the Texas Insurance Code, an employer authorized by charter to self-insure an employee benefit plan can qualify as an "insurer" engaged in the business of insurance in Texas and subject to TPPA.

Because HCSC is an "insurer," a TPA acting on its behalf is also subject to the payment requirements and penalties set forth in Chapter 1301. Blue Cross and Blue Shield of Texas ("BCBSTX") can be liable under TPPA for its conduct in paying and processing claims on behalf of HCSC, whether HCSC is acting under the name of BCBSTX or any other assumed name operating in any other state, because HCSC—as a single entity—is a Texas "insurer." In the same way, BCBSTX can be liable under TPPA for its processing and payment of claims on behalf of any self-insured employer as long as the employer qualifies as an "insurer" as defined in the statute.

To find that a self-insured employer is an "insurer" for purposes of TPPA is not precluded by ERISA. Nor are TPPA claims against the TPA for a self-insured employer preempted by ERISA. Express preemption under ERISA requires a showing that the state law claim addresses an area of exclusive federal concern and directly affects the relationships of traditional ERISA entities. Contrary to the sole out-of-state authority exclusively relied upon by HCSC to the exclusion of the many Texas cases reviewing ERISA preemption of TPPA claims, those claims asserted by Methodist Hospitals of Dallas ("MHD") in this matter are not made on behalf of plan beneficiaries and do not involve determinations of coverage under any ERISA plan. Instead, as MHD's claims involve issues relating to the rate and timing of payment, as opposed to the right of payment, ERISA preemption does

not apply. Because ERISA and TPPA claims against HCSC as TPA for self-insured plans do not overlap for preemption purposes, there is no basis to withhold application of TPPA to HCSC in this matter. This Court should, therefore, reverse the underlying trial court's grant of summary judgment in favor of HCSC.

ARGUMENT AND AUTHORITIES

I. TPPA Penalties Provide a Necessary Incentive for Payors to Fulfill Their Contractual Obligations.

The business of insurance is heavily influenced by risk and incentives. Insurers understand and depend upon the moral hazard reflected in the risks taken by their policyholders. However, insurers themselves are also influenced by incentives and are not immune from moral hazard. Absent any incentive to perform a duty or when the risk associated with nonperformance is small, it is likely that an insurer's duties will go unperformed, even if those duties are contractually owed.

Without the TPPA, insurers and their TPAs have no incentive to pay health care providers promptly for the full amount of a covered claim. Even if a health care provider prevails on a claim for breach of the contract between provider and insurer/payor, at most, the insurer will be required to pay the amount originally owed, the providers' attorneys' fees, and prejudgment interest. *See* TEX. CIV. PRAC. & REM. CODE § 38.001; *Int'l Turbine Servs., Inc. v. VASP Brazilian Airlines*, 278 F.3d 494, 499–500 (5th Cir. 2002) ("Texas common law allows prejudgment interest to accrue at the same rate as postjudgment interest on damages awarded for breach of contract." (citing *Johnson & Higgins of Tex., Inc. v. Kenneco Energy, Inc.*, 962 S.W.2d 507, 532 (Tex. 1998))). With the exception of the provider's fees and interest in the breach of contract suit, the amount owed to the provider under a judgment for breach of contract is precisely what the payor was obligated to pay

from the outset. To the extent that the insurer's internal rate of return is greater than the prejudgment interest rate, which is currently only five percent (5%) per annum, the delay in payment may be profitable for the insurer.

By contrast, as recognized by the Texas Supreme Court in *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 52 (Tex. 1997), for the provider, the consequences of the insurer's untimely or incomplete payment, may be significant:

> When an insurer unreasonably denies a claim, an insured [provider] who has suffered a loss [or provided covered services] that should rightfully be covered may reluctantly choose to drop the claim rather than suffer the emotional and financial burden of litigation. Even insureds [providers] who go so far as to hire a lawyer may often be inclined to settle for only a part of their contract damages due to financial stress or other pressures stemming from the loss.

Id. Insurers aware of these facts will no doubt conclude that the potential benefit of avoiding or delaying payment significantly outweighs the risk of a judgment or settlement for breach of contract. The provider's claim for breach of contract fails to create the necessary incentive for insurers to fulfill their obligations to pay covered claims promptly or completely.

In the face of these undeniable economic asymmetries, courts have recognized the necessity to offer insureds and those acting on their behalf a means to properly incentivize insurers to perform their contractual duties. *Cf. Arnold v. Nat'l County Mut. Fire Ins. Co*., 725 S.W.2d 165, 167 (Tex. 1987) (finding that a "duty of good faith and fair dealing" exists between insurers and insureds because

(1) "[a]n insurance company has exclusive control over the evaluation, processing and denial of claims;" and (2) "without such a cause of action, insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed.").

For preferred providers, Chapter 1301 creates a much needed incentive to offset the economic forces that drive insurers to deny and delay payment for otherwise covered claims. In fact, the Legislature intended Chapter 1301 to "provide an incentive for insurers to pay sooner rather than later" and to avoid "leaving providers in [the] dire situations" that existed prior to its enactment. *See* House Research Org., Bill Analysis, Tex. H.B. 418, 78th Leg., R.S. at 8-9.

Chapter 1301 creates specific deadlines for submission, acknowledgment and payment of "clean claims." TEX. INS. CODE §§ 1301.101-1301.103. If those deadlines are violated, Chapter 1301 also authorizes specific penalties for non-compliance. TEX. INS. CODE § 1301.137. The incentives created by Chapter 1301 and the necessity for such incentives exist, whether the provider is seeking payment from an insurer through a fully-funded or self-insured plan. There is no reason, and statute's text and the Legislative history surrounding TPPA offer no reason, why TPPA would seek to protect providers against untimely and insufficient payments for covered claims by fully-funded plans while exempting self-funded plans. Indeed, BCBSTX, as an unincorporated division of HCSC, has

only one contract with MHD—not separate contracts with different reimbursement rates and payment terms for fully-insured and self-funded plans. Because the text of TPPA does not support separate treatment of self-funded and fully-funded employer health plans, and insurers require statutory incentive to provide prompt payment of healthcare claims, the trial court's summary judgment in favor of HCSC should be reversed.

II. The Text of Chapter 1301 Applies to "Insurers" and TPAs.

Although Chapter 843 of the Texas Insurance Code contains its own provisions governing the deadlines and penalties for delayed payment of certain healthcare claims, TEX. INS. CODE 843.336 *et seq.*, the trial court's opinion and this appeal exclusively concern the scope and interpretation of Chapter 1301's prompt payment provisions and specifically whether such terms apply to HCSC as administrator for a variety of plans, including self-funded employer plans, state government plans and so-called Blue Card Plans. *Health Care Serv. Corp. v. Methodist Hosps*., 2015 U.S. Dist. LEXIS 54357, at *12 (N.D. Tex. Jan. 28, 2015) ("[A]ny reference to the TPPA specifically relates to the prompt payment provisions of Chapter 1301 of the Texas Insurance Code.").

Section 1301.137, which addresses penalties for violations of payment requirements applies specifically to "insurers." TEX. INS. CODE § 1301.137 ("[I]f a clean claim submitted to an insurer is payable and the insurer does not determine

under Subchapter C that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay the preferred provider making the claim the contracted rate owed on the claim plus a penalty ....”). An “insurer” is “a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982 or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.” TEX. INS. CODE § 1301.001(5). A “health insurance company,” as defined in Section 841.001 of the Texas Insurance Code, includes “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.” TEX. INS. CODE § 841.001 (6). A “health insurance policy” is “a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.” *Id*. at § 1301.001(2).

Construed together, an “insurer” includes any company, whose charter authorizes (1) the payment of money or other items of value in the event loss resulting from a disability because of sickness or ill health; and (2) the issuance or delivery of any contract in Texas providing benefits for medical expenses incurred because of an accident or sickness. Nothing in the statutory definitions of

"insurer," "health insurance company," or "health insurance policy" distinguishes between fully-funded or "BCBSTX Insured" and self-funded employer health plans.

The terms of Chapter 1301 also explicitly apply to TPAs in the role occupied by HCSC in this matter. Section 1301.109 expressly states as follows:

> **§ 1301.109 Applicability To Entities Contracting With Insurer**
>
> ***This subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to:***
>
> ***(1) process or pay claims;***
>
> (2) obtain the services of physicians and health care providers to provide health care services to insureds; or
>
> (3) issue verifications or preauthorizations.

TEX. INS. CODE § 1301.109 (emphasis added). While Section 1301.109 refers specifically to Subchapter C, dealing with deadlines for prompt payment of claims, under Section 1301.138, the penalties authorized under Subchapter C-1 are applicable to "a person described by Section 1301.109." TEX. INS. CODE § 1301.138.

III. Chapter 1301 Applies to HCSC as Insurer for BCBSTX and Non-BCBSTX Plans

The trial court's decision that TPPA does not apply to BCBSTX as TPA for Blue Cross and Blue Shield plans outside of Texas, *i.e.*, the so-called BlueCard

plans, rests on a distinction between HCSC divisions that is entirely disconnected from the terms of the statute. TPPA applies to "insurers," not the assumed names used by HCSC to operate in different states. An "insurer" is a discrete company with a specific charter, authorized to issue an insurance policy in Texas. TEX. INS. CODE §§ 1301.001(2), (5) (defining "insurer" and "health insurance policy").

BCBSTX is the name under which HCSC operates in Texas. 2015 U.S. Dist. LEXIS 54357, at *2 ("[HCSC] is an Illinois mutual legal reserve company that operates in Texas as Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation ('BCBSTX')."). HCSC operates under different names in other states. *See, e.g., Chatham Surgicore, Ltd. v. Health Care Service Corporation d/b/a Blue Cross Blue Shield of Illinois*, 826 N.E.2d 970 (Ill. Ct. App. 2005). BCBSTX and Blue Cross Blue Shield of Illinois, for example, are not separate companies and for that matter can never be separate "insurers" as that term is used in the statute. BCBSTX and other individual state variants are assumed names for one company—HCSC.

There is no gainsaying that HCSC qualifies as an "insurer" as that term is defined in Section 1301.001(5). HCSC is licensed with the Texas Department of Insurance as a life, health or accident insurance company and is authorized to issue, deliver and issue for delivery in Texas health insurance policies, as defined

in the Texas Insurance Code.[1] HCSC is the "insurer," who bears the cost of reimbursement and ultimate financial responsibility for claims, whether the claim is paid on behalf of a member of BCBSTX or some other state. How that financial responsibility is allocated internally by HCSC among BCSBTX or other divisions is frankly irrelevant to the terms of the statute making an "insurer" liable for violations of payment requirements. Otherwise, HCSC could avoid any liability under Chapter 1301, even for those claims made by members of BCBSTX, simply by transferring liability to another division within HCSC. The application of Chapter 1301's payment requirements and penalties is not and should never become dependent on strategic bookkeeping or accounting gimmickry.

To read Chapter 1301's payment requirements and penalty terms to apply broadly to a single "insurer" without regard to internal divisions or assumed names is not only consistent with the plain language of Section 1301.137, but the letter of Section 1301.041(a). As a preliminary matter, Section 1301.041(a) is expressly subject to other provisions in Chapter 1301, like Sections 1301.109 and 1301.138, which also address the statute's application. TEX. INS. CODE § 1301.041(a) ("Except as otherwise specifically provided by this chapter ...."). In any event, pursuant to Section 1301.041(a), Chapter 1301 applies to "each preferred provider

---

1 https://apps.tdi.state.tx.us/pcci/pcci_show_profile.jsp?tdiNum=94686&companyName=BLUE%20CROSS%20AND%20BLUE%20SHIELD%20OF%20TEXAS,%20A%20DIVISION%20OF%20HEALTH%20CARE%20SERVICE%20CORPORATION&sysTypeCode=CL.

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 § 1301.041(a). Because HCSC is an "insurer," as that term is defined in the statute, any preferred provider benefit plan offered through a health insurance policy insured by HCSC and providing differing levels of coverage between preferred and nonpreferred providers is subject to Chapter 1301, whether or not the plan was insured by HCSC under the name of BCBSTX, Blue Cross Blue Shield of Illinois or some other BCBS name. Nothing in Section 1301.041(a) mentions, much less conditions the statute's application on whether one assumed name for an "insurer" bears financial responsibility for claims or even whether another assumed name is associated with a state other than Texas.

The notion that so-called BlueCard plans cannot be "regulated" by TDI, as argued by HCSC, again ignores the fact that HCSC—the insurer for the BlueCard plans—is an entity licensed by TDI as a life, health or accident insurance company and unquestionably engaged in the business of insurance in Texas. This is not a case of an impermissible extraterritorial application of the Texas Insurance Code when the claim is (1) payable to a Texas provider; (2) for services rendered in Texas to an individual while in the state of Texas; and (3) paid for, even if only initially, by BCBSTX as the Texas intermediary. 2015 U.S. Dist. LEXIS 54357, at

*6 ("When a member of a Blue Cross and Blue Shield Plan of another state requires medical services in Texas, the resulting claim is submitted to BCBSTX.... BCBSTX pays the claim and is virtually simultaneously reimbursed by the home plan.... BCBSTX functions as an intermediary between the home plan and the provider.").

In the past, this Court has upheld the application of a penalty against a Texas licensed insurer for a loss on an out-of-state policy involving an insured in Texas. *See John Hancock Mut. Life Ins. Co. v. Schroder*, 349 F.2d 406, 408 (5th Cir. 1965) ("If Texas chooses to invoke its penalty statute on behalf of the estate of a Texan whose last employment was in Texas against a group insurer licensed to do business there, we see nothing in the Constitution that stands in its way."). This case is no different. Indeed, the Texas Insurance Code itself expressly calls for the application of Texas law to policies payable to a Texas citizen, including a Texas health provider, even if the underlying policy is issued outside of Texas. TEX. INS. CODE art. 21.42 ("***Any contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State shall be held to be a contract made and entered into under and by virtue of the laws of this State relating to insurance, and governed thereby, notwithstanding such policy or contract of insurance was executed and the premiums and policy (in case it becomes a demand) should be payable without***

this State, or at the home office of the company or corporation issuing same." (emphasis added)).

Even if the fiction of BCBSTX's separation from HCSC is entertained for purposes of its role as TPA for so-called BlueCard plans, HCSC remains the "insurer" for such plans. 2015 U.S. Dist. LEXIS 54357, at *3 ("BCBSTX has the following different roles depending upon the function it is providing to the various plans it serves.... (2) as an administrator (providing some form of administrative services, such as claims processing, pricing and network access) for plans where an employer, government entity, or other non-BCBSTX entity funds the plan and bears the risk of loss ...."). The TPPA's payment deadlines and penalties are applicable to "a person ... with whom an insurer contracts to (1) process or pay claims ...." TEX. INS. CODE §§ 1301.109, 1301.138. This includes BCBSTX as TPA for HCSC.

HCSC's repeated assertions Chapter 1301 does not apply because BCBSTX does not bear final financial responsibility for BlueCard claims is a non-sequitur. The only distinction between a BCBSTX plan and any other BCBS or BlueCard plan is a name, not a different entity. So long as HCSC is the "insurer" for even BlueCard claims, HCSC and BCBSTX, as administrator for purposes of Sections 1301.109 & 1301.138, are subject to the terms of the statute. To the extent that the trial court (1) relied on arbitrary distinctions between BCBSTX and so-called

BlueCard plans without considering HCSC's status as the sole, indivisible "insurer"; and (2) failed to consider the application of Sections 1301.109 and 1301.138 to BCBSTX as administrator for HCSC, the trial court erred. HCSC is subject to the TPPA with respect to the "BlueCard" claims, and the trial court's grant of summary judgment to HCSC should be reversed on this basis alone.

IV. Chapter 1301 Applies to Self-Insured Plans and Third-Party Administrators for Such Plans.

Just as fictional distinctions between the financial responsibility of BCBSTX and other HCSC assumed names do not avoid the application of Chapter 1301, arguments to exempt generally all self-funded plans or the TPAs, who administer them, ignore the broad terms of the statute. Whether the Court focuses on Section 1301.041(a), 1301.109, 1301.138 or the payment and penalty provisions, Chapter 1301 applies to "insurers" and those with whom "insurers" contract to process or pay claims. In arguing that Chapter 1301 does not apply to any self-funded plan, HCSC is effectively asserting that there is no "insurer" for a self-funded plan, and a TPA does not contract with any "insurer" to process or pay claims. Reason and common sense dictate otherwise. As even HCSC concedes, the insurer for a ***self-insured*** plan is the employer. 2015 U.S. Dist. LEXIS 54357, at *4-5 ("These employer self-insured plans are funded by the employer out of funds the employer has specifically set aside for health care costs. Therefore, the

employer provides the health benefit plan, and the employer self-funded plan bears the financial risk of loss associated with health care costs.").

The idea that Chapter 1301 applies to self-funded employer plans satisfies both the spirit and letter of the statute. An "insurer" is a "life, health, and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982 or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies." TEX. INS. CODE § 1301.001(5). A "health insurance company," as defined in Section 841.001 of the Insurance Code, is "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." TEX. INS. CODE 841.001(6). Nothing in these definitions purports to exclude an employer with a self-funded, self-insured employee benefit plan.

Employers with self-insured employee benefit plans include corporations, who are authorized by a corporate charter to engage in business involving the payment of money, whether to employee beneficiaries or providers, in the event of a loss resulting from employee sickness or illness. Indeed, for many corporations, the decision to self-fund is an economic one, driven by the desire to save money. *See, e.g.*, Jay Hancock, *Some small businesses chose to self-insure*, USA TODAY (Mar. 14, 2013), *available at* http://www.usatoday.com/story/money/

business/2013/03/14/some-small-businesses-choose-to-self-insure/1988481/ ("Self-insured employers pay for most worker health costs directly, though they contract with an insurer or other company to administer claims. The employers also buy coverage known as stop-loss for claims exceeding a certain amount. *Brokers say a growing number of firms see such plans as low-cost alternatives to conventional coverage, as they're exempt from ACA requirements such as insurance taxes and specified benefits*." (emphasis added)). If a corporate employer was not authorized by a company charter to pay money in the event of an employee's sickness or ill health, the employer would not have a self-insured plan. Accordingly, a self-insured employer is a "health insurance company" under the plain language of Section 841.001(6).

Is an employer with a self-funded plan authorized to issue, deliver, or issue for delivery in this state health insurance policies for purposes of Section 1301.001(5)'s definition of "insurer"? A "health insurance policy" includes "a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness." TEX. INS. CODE 1301.001(2). Whether an employee welfare benefit plan is "self-funded" or "fully insured," the plan is a contract providing employees with benefits for medical or surgical expenses incurred as a result of an accident or sickness. Indeed, ERISA, which governs employees' claims for benefits under a

self-insured plan, was enacted "to protect ***contractually defined*** benefits." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (emphasis added); *cf. Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992) (finding that a claim for breach of contract was "most analogous" to plaintiffs' claim to enforce rights under an ERISA plan).

Most importantly, while the Texas Supreme Court has not addressed itself to the issue of TPPA's application to self-insured plans, at least one Texas state court has—finding that "the Texas Prompt Pay Act applies to Aetna with respect to claims administered by Aetna for self-funded plans." *See Aetna Life Ins. Co. v. Methodist Hosps. of Dallas*, 2015 U.S. Dist. LEXIS 26455, at *6 (N.D. Tex. Mar. 4, 2015) (Lynn, J.) (quoting the order of a state court and deferring to the decision of the state judge: "***TPPA applies to self-funded plans, because one of the state district courts presiding over the related proceedings was about to rule on that precise issue***" (emphasis added)). The decision of a state court judge on a matter of state law interpretation is entitled to deference by this Court. *Bush v. Gore*, 531 U.S. 98, 114 (2000) ("[W]e generally defer to state courts on the interpretation of state law ....'" (citation omitted)); *see also generally Railroad Comm'n v. Pullman Co.*, 312 U. S. 496, 499 (1941).

Because a Texas employer sponsoring a "self-insured" plan is a "health insurance company" authorized to issue or deliver health insurance policies in

Texas, such self-funded employer is an "insurer." TEX. INS. CODE § 1301.001(5). There is no textual reason, and in all of the briefing filed to date, HCSC has not offered one, why an employer with a self-insured employee benefit plan cannot qualify as an "insurer" as that term is broadly defined in Section 1301.001(5) of the Texas Insurance Code. *See, e.g.*, *Tex. Dep't of Ins. v. Am. Nat'l Ins. Co.*, 410 S.W.3d 843, 848 (Tex. 2012) ("Without question, ***self-funded employee health-benefit plans operate much like insurers. Their activities not surprisingly then fit the definitions of 'insurer' and 'business of insurance' found in the chapter designed to prohibit the unauthorized business of insurance***." (emphasis added)); *Harris County Hosp. Dist. v. Alief Indep. Sch. Dist.*, 1992 Tex. App. LEXIS 558, at *6-9 (Tex. App.—Houston [14th Dist.] Mar. 5, 1992, writ denied) (holding that a self-funded plan set up by the Alief Independent School District was engaged in the business of insurance, including "[t]he making of or proposing to make, as an insurer, an insurance contract" and the "issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state"); *cf.* Tex. Op. Att'y Gen. No. KP-0036 (Aug. 14, 2015) ("The Insurance Code does not define PPO; however, 'preferred provider benefit plan' is defined as 'a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred

provider. *Thus, under some circumstances a PPO itself could be considered an insurer for purposes of section 1301.057*." (emphasis added)); Tex. Op. Att'y Gen. No. DM-276 (Dec. 17, 1993) (concluding that a county's single-employer, self-funded employee benefit plan is subject to certain provisions of the Texas Insurance Code).

If the employer for a self-insured plan qualifies as an "insurer," HCSC is subject to the payment and penalty provisions of TPPA as the TPA for such plans under Sections 1301.109 and 1301.138. TEX. INS. CODE § 1301.109 ("This subchapter applies to a person, ... with whom an insurer contracts to (1) process or pay claims."); § 1301.138 ("This subchapter applies to a person described in Section 1301.109.").

V. The TPPA is not Preempted by ERISA.

HCSC may argue that a self-funded employer's status as an "insurer" under Section 1301.001(5) conflicts with ERISA's "deemer clause," whereby "[n]either an employee benefit plan described in section 1003(a) ..., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. 1144(b)(2)(B). There is no conflict. ERISA's "deemer

clause" governs the application of ERISA, not Chapter 1301 of the Texas Insurance Code. *Cf.* HOUSE COMM. ON EDUC. & LABOR, ERISA OVERSIGHT REPORT OF THE PENSION TASK FORCE OF THE SUBCOMM. ON LABOR STANDARDS 10 (Comm. Print 1977) (concluding that the deemer clause "create[s] what may amount to a legal fiction in a given circumstance" in which a plan engages in insurance activities). Nor is the "deemer clause" a tool to be used for construing state statutes. At most, the "deemer clause" begs the question: does ERISA preempt TPPA claims against an administrator for a self-funded plan? This Court and others have already ruled repeatedly that it does not.

Under ERISA's "express preemption" provision, Section 514(a), "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter ***relate to*** any employee benefit plan ...." 29 U.S.C. § 1144(a) (emphasis added). Under the statute's "savings" and "deemer" clauses, respectively, "any law of any State which regulates, insurance, banking or securities," is excepted from preemption, provided that "[n]either an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of

any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." *Id*. at §§ 1144(b)(2)(A), (B).

Unless a statute "relates to" an employee benefit plan in the first instance, the "savings" and "deemer" clauses have no application and are irrelevant. A statute "relates to" ERISA for purposes of preemption if (1) the state law addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) directly affects the relationship among traditional ERISA entities—the employer, the plan and its fiduciaries, participants and beneficiaries. *See, e.g., Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420, 432 (5th Cir. 2004) ("Although the term 'relate to' is intended to be broad, 'pre-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.' If the facts underlying a state law claim bear *some* relationship to an employee benefit plan, we evaluate the nexus between ERISA and state law in the framework of ERISA's statutory objectives. Relevant statutory objectives include establishing uniform national safeguards 'with respect to the establishment, operation, and administration of [employee benefit] plans,' and 'establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans.' Thus, ERISA preempts a state law claim if a two-prong test is satisfied: (1) The state law claim addresses an area of exclusive federal concern,

such as the right to receive benefits under the terms of an ERISA plan; and (2) the claim directly affects the relationships among traditional ERISA entities — the employer, the plan and its fiduciaries, and the participants and beneficiaries." (citations omitted)); *Bank of La. v. Aetna U.S. Healthcare Inc.*, 468 F.3d 237, 242 (5th Cir. 2006) (reciting the same two-prong test for ERISA preemption).

TPPA does not touch upon an area of exclusive federal concern precisely because the assessment of penalties for untimely payment of claims requires no evaluation of the right to receive benefits under a plan. *Lone Star OB/GYN Assocs .v.Aetna Health, Inc.* , 579 F.3d 525, 532 (5th Cir. 2009) ("[I]n seeking remedies under the Texas Prompt Pay Act, Lone Star is not seeking relief that 'duplicates, supplements or supplants' that provided by ERISA.... [W]here claims do not involve coverage determinations, but have already been deemed 'payable,' and the only remaining issue is whether they were paid at the proper contractual rate, ERISA preemption does not apply."); *Methodist Hosps. of Dallas v. Aetna Health, Inc.*, 2015 U.S. Dist. LEXIS 26455, at *29-30 (N.D. Tex. July 30, 2014) (holding that the TPPA does not address an area of exclusive federal concern: "Here, the Providers have demanded late-payment penalties arising from the Provider Agreements with ALIC, a third-party administrator of self-funded plans, leaving the ERISA plans untouched. The only impact on ERISA plans asserted by ALIC is the increased cost it will incur for administering ERISA plans as a result of the

imposition of prompt payment penalties, which the Court finds speculative at best. Although uniformity is important to ERISA, it does not preclude all regulation of related entities, especially when those entities have contracted between themselves.").

By the same token, TPPA also does not directly affect the relationship among traditional ERISA entities. *Id*. at *30 ("[T]he parties in this case are not all traditional ERISA entities, nor do the Providers 'stand in the shoes' of ERISA plan beneficiaries. The Providers' demands arise by virtue of their contractual privity with ALIC under the Provider Agreements, not because any ERISA plan beneficiaries have assigned their rights to the Providers."); *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502, 511-12 (N.D. Tex. 2004) (finding no ERISA preemption of prompt payment claims under the Texas Insurance Code because "[t]he substance of Baylor's statutory claims are governed by state laws that enforce the prompt payment of claims by insurers — not to plan participants or beneficiaries, but to independent health care providers . . . . Baylor's statutory claims, thus, do not directly affect the relationship between traditional ERISA entities."); *Foley v. Southwest Texas HMO, Inc.*, 226 F. Supp. 2d 886, 897 (E.D. Tex. 2002) (finding no ERISA preemption of prompt payment claims under the Texas Insurance Code because "[t]he Fifth Circuit has stated that health care providers were not a party to the ERISA bargain struck between plans

and plan participants by Congress. As such, in their role as doctors or health care providers, the plaintiffs are not parties to any health insurance plan formed under ERISA, and therefore the plaintiffs have no relationship with the defendants that would be governed by ERISA." (citation omitted)).

HCSC's argument that ERISA preempts TPPA claims between a provider and either a TPA or insurer—solely because the provider served a beneficiary of a self-funded plan—is akin to arguing that providers are exempt from state regulation when offering healthcare services to patients insured by self-funded employer plans. This is not the law in Texas. Where the obligations running between the provider and TPA are independent of the terms of the employer plan, there is no ERISA preemption. *Cf. Ne. Hosp. Auth. v. Aetna Health Inc.*, 2007 WL 3036835, at *10 (S.D. Tex. Oct. 17, 2007) (holding that plaintiff's claims were not preempted by ERISA because the "crux of the parties' dispute in this case arises from the terms of a contract—the Hospital Agreement—that is independent of the ERISA patients' plans"); *Mem'l Hermann Hosp. Sys. v. Aetna Health Inc.*, 2007 WL 1701901, at *5 (S.D. Tex. June 11, 2007) (concluding that claims alleging "defendants breached the managed care contracts by failing to make full and prompt payment of certain claims as required by Texas law" were not preempted by ERISA).

Even Judge Boyle has ruled that ERISA preemption does not apply to TPPA claims. *Methodist Hosps. of Dallas v. Aetna Health, Inc.*, 2014 U.S. Dist. LEXIS 104291, at *20-22 (N.D. Tex. July 30, 2014) (finding that (1) Aetna failed to demonstrate that Methodist's TPPA claims address an area of exclusive federal concern; and (2) Methodist's claims do not directly affect the relationship among traditional ERISA entities because "Methodist's right to recovery exists independently of plan members' rights").

Likewise, with regard to so-called "complete preemption," the Court in *Lone Star OB/GYN Associates v. Aetna Health, Inc.* adopted the rule followed in both the Third and Ninth Circuits, whereby "[a] claim that implicates the rate of payment as set out in the Provider Agreement, rather than the *right* to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA." 579 F.3d 525, 530 (5th Cir. 2009) (citations omitted). This Court has continued to follow the "rate of payment"/"right of payment" distinction in subsequent decisions, including as recently as last month in *Kelsey-Seybold Medical Group PA v. Great-West Healthcare of Texas, Inc.*, 2015 U.S. App. LEXIS 14140, at *3 (5th Cir. Aug. 10, 2015) ("Great-West has not shown that any of Kelsey's claims concern 'the *right* to payment under the terms of the benefit plan,' as opposed to 'the *rate* of payment as set out' in the parties' contractual

agreement. Thus, Great-West has not satisfied its burden to establish federal jurisdiction." (citation omitted)).

As applied to TPPA claims for underpayment or untimely payment under a Provider Agreement, the *Lone Star* Court found that such claims were not preempted because they "are entirely separate from coverage and arise out of the independent legal duty contained in the contract and the TPPA." 579 F.3d at 531, 532 ("[W]here claims do not involve coverage determinations, but have already been deemed 'payable,' and the only remaining issue is whether they were paid at the proper contractual rate, ERISA preemption does not apply."). Because, in this case, the dispute turns, not on any "right to payment," but rather the timing of payment for covered claims, there is no need to interpret the underlying ERISA plans or make determinations of coverage, and there is no preemption under ERISA. *See* 2015 U.S. Dist. LEXIS 54357, at *7 ("HCSC filed its Complaint for Declaratory Relief ('Complaint') (doc. 1) on December 19, 2013 in response to Methodist's indication that it intends to seek relief from HCSC under the TPPA based on the allegedly late payments of some of its claims.").

ERISA preemption does not preclude MHD's TPPA claims. Because MHD's TPPA claims do not even "relate to" ERISA for purposes of express preemption, ERISA's "savings" and "deemer" clauses do not apply. Without ERISA preemption, whether pursuant to the express provisions of Section 514 or

otherwise, there is no basis to assert that self-insured plans should be exempt from the application of TPPA in the first place. The trial court's grant of summary judgment in favor of HCSC should be reversed.

CONCLUSION AND PRAYER

TPPA is an essential tool for health care providers to obtain timely and complete payment for services rendered to patients, whether those patients are beneficiaries of a fully-funded or self-insured employer plan. The terms of TPPA make no distinction between fully-funded and self-insured plans. TPPA applies broadly to all "insurers," including the self-insured employers sponsoring self-insured employee benefit plans, and those administrators paying and processing claims on their behalf. TPPA claims do not implicate determinations of coverage but merely address the timing of payments owed to health care providers. Nor do TPPA claims brought directly by a provider against a plan TPA affect the relationship between the plan and its beneficiaries. As such, TPPA's scope, even that portion touching self-insured plans, does not offend and is not preempted by ERISA.

WHEREFORE, AMICI CURIAE MEMORIAL HERMANN HEALTH SYSTEM, TENET HEALTHCARE CORPORATION and TEXAS ORGANIZATION OF RURAL & COMMUNITY HOSPITALS respectfully

request that this Court grant MHD's appeal and reverse the underlying judgment of the trial court.

Respectfully submitted,

/s/Micah E. Skidmore
Micah E. Skidmore
State Bar No. 24046856
HAYNES AND BOONE, LLP
2323 Victory Avenue, Suite 700
Dallas, Texas 75219
Telephone: (214) 651-5641
Telecopier: (214) 200-0519
micah.skidmore@haynesboone.com

ATTORNEY FOR AMICI CURIAE

CERTIFICATE OF SERVICE

I hereby certify that on the 24th day of September, 2015, I electronically transmitted the attached document to the Clerk of the Court of the 5th Circuit Court of Appeals using the ECF System of the Court. The electronic case filing system sent a "Notice of Electronic Filing" to the attorneys of record who have consented in writing to accept this Notice as service of this document by electronic means.

/s/ Micah E. Skidmore
Micah E. Skidmore

ECF CERTIFICATION

I hereby certify (i) the required privacy redactions have been made pursuant to 5TH CIR. R. 25.2.13; (ii) the electronic submission is an exact copy of the paper document pursuant to 5TH CIR. R. 25.2.1; (iii) the document has been scanned for viruses using Symantec Endpoint Protection active scan and is free of viruses; and (iv) the paper document will be maintained for three years after the mandate or order closing the case issues, pursuant to 5TH CIR. R. 25.2.9.

/s/ Micah E. Skidmore
Micah E. Skidmore

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of FED. R. APP. P. 32(a)(7)(B) because:

■ this brief contains 6,713 words, excluding the parts of the brief exempted by FED. R. APP. P. 32(a)(7)(B)(i).

2. This brief complies with the typeface requirements of FED. R. APP. P. 32(a)(5) and the type style requirements of FED. R. APP. P. 32(a)(6) because:

■ this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2003 in 14 point Times New Roman font.

/s/ Micah E. Skidmore
Micah E. Skidmore