CASE NO. 15-10154

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

HEALTH CARE SERVICE CORP.,

Plaintiff-Appellee,

v.

METHODIST HOSPITALS OF DALLAS,

Defendant-Appellant.

On Appeal from the United States District Court
for the Northern District of Texas
No. 3:13-CV-4946

OPPOSED MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS, THE CHAMBER OF COMMERCE OF THE UNITED STATES, AND THE AMERICAN BENEFITS COUNCIL IN SUPPORT OF APPELLEE AND AFFIRMANCE

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Pursuant to Federal Rule of Appellate Procedure 29, America's Health Insurance Plans (AHIP), the Chamber of Commerce of the United States (the Chamber), and the American Benefits Council (the Council) move for leave to file the attached *amici curiae* brief in support of Appellee Health Care Service Corporation's (HCSC's) position in this case and affirmance of the district court's judgment.

1. *Amici*'s motion for leave to file is timely filed pursuant to Federal Rule of Appellate Procedure Rule 29(e). HCSC consents to the motion. Appellant Methodist Hospitals of Dallas (Methodist), however, opposes it. As discussed below, leave to file is warranted because *amici* have substantial interests in the subject matter of the case and because the points made in their brief will, *amici* submit, assist the Court in its consideration of the case. In particular, by virtue of *amici*'s in-depth experience concerning the role of self-funded employee benefit plans in the financing of employer-provided healthcare and the manner in which those plans function, *amici* can provide the Court with a broader perspective from additional entities that will be affected by the Court's ruling.

2. This is a highly significant case with potentially far-reaching implications. Texas is the nation's second most populous state, and numerous employers with operations in Texas provide healthcare to tens of thousands—and probably more—employees and employee family members. Most such coverage is provided

through self-funded employee benefit plans governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*.

3. Methodist argues in this case that a prompt pay statute applicable to insured preferred provider plans (Texas Insurance Code chapter 1301) also applies to ERISA self-funded employee benefit plans. Self-funded plans, however, do not provide healthcare through insurance; instead, claims against a self-funded plan are the responsibility of the plan sponsor. As explained below, the members of each *amicus* either provide healthcare coverage to employees located in Texas or provide administrative services to ERISA self-funded plans that cover plan sponsors' Texas employees. *Amici* therefore have a significant interest in (1) ensuring that the Texas statute in issue is properly construed, (2) protecting the uniformity of ERISA's nationwide administrative scheme, and (3) promoting the availability and affordability of health coverage through the workplace. Methodist's arguments in this case threaten all three of those interests.

4. America's Health Insurance Plans ("AHIP") is a national trade association representing companies that provide or administer health insurance benefits to more than 200 million Americans, including participants and beneficiaries in employee benefit plans governed by ERISA. Its members offer a wide range of insurance and health coverage options to consumers, employers of all sizes, and governmental purchasers nationwide, providing AHIP with a unique understanding

of how the Nation's healthcare and health insurance processes work. AHIP advocates for public policies that expand access to affordable healthcare coverage for all Americans through a competitive marketplace that fosters choice, quality, and innovation. AHIP's interest in the subject matter of this case is amply demonstrated by the Eleventh Circuit's recognition of AHIP's associational standing to challenge a Georgia prompt pay statute that functioned similarly to the way that Methodist argues the statute at issue here (Texas Insurance Code chapter 1301) should be interpreted. *America's Health Insurance Plans v. Hudgens*, 742 F.3d 1319, 1351-52 (11th Cir. 2014).

5. The Chamber is the world's largest business federation, representing 300,000 direct members and indirectly representing the interests of three million businesses and professional organizations of every size in every state. The Chamber regularly advocates on issues of vital concern to the business community, and has frequently participated as *amicus curiae* before the courts of appeals and the Supreme Court. A majority of the Chamber's members provide health benefits for their employees.

6. The Council is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Coun-

cil's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

7. *Amici* note that Memorial Hermann Healthsystem, Tenet Healthcare Corporation and the Texas Organization of Rural & Community Hospitals have filed an *amici* brief in support of Methodist's position, to which HCSC consented. *Amici* submit that their brief would provide a helpful counter-view.

Request for Relief

Amici respectfully request that they be granted leave to file the attached brief in support of Appellee Health Care Service Corporation's position in this case and in support of affirmance of the district court's judgment.

Respectfully submitted,

BAKER BOTTS L.L.P.

By: /s/ *Robert I. Howell*

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CERTIFICATE OF CONFERENCE

I hereby certify that I have conferred with counsel for Appellant Methodist and Appellee HSCS regarding this motion. HSCS does not oppose the motion. Methodist advises that it does oppose.

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CERTIFICATE OF SERVICE

I hereby certify that on October 27, 2015, an electronic copy of the foregoing Opposed Motion for Leave to File Brief of *Amici Curiae* America's Health Insurance Plans, the Chamber of Commerce of the United States, and the American Benefits Council was filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service on all parties will be accomplished by the appellate CM/ECF system.

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INTEREST OF AMICI

This brief is filed by America's Health Insurance Plans (AHIP), the Chamber of Commerce of the United States (the Chamber), and the American Benefits Council (the Council) as *amici curiae* in support of the positions taken by Appellee Health Care Service Corp. (HSCS) that:

- The prompt pay provisions of Texas Insurance Code, Chapter 1301 (subchapters C and C-1, and related sections) cannot be construed to encompass self-funded health plans and companies that administer such plans;[1] and
- Even if the Chapter 1301 prompt pay provisions could be so construed, they would be expressly preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a). Among other things, application of Chapter 1301 to self-funded plans would impermissibly encroach on ERISA's nationally uniform administrative scheme.[2]

AHIP is a national trade association whose members administer or provide health coverage to more than 200 million Americans. The association's goals are to provide a unified voice for the healthcare financing industry, expand access to high quality, cost-effective healthcare to all Americans, and ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

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[1] Appellee's Brief at 14-25.

[2] *Id.* at 43-51.

The Chamber is the world's largest business federation, representing 300,000 direct members and indirectly representing the interests of three million businesses and professional organizations of every size in every state. The Chamber regularly advocates on issues of vital concern to the business community, and has frequently participated as *amicus curiae* before the courts of appeals and the Supreme Court. A majority of the Chamber's members provide health benefits for their employees.

The Council is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 400 members are primarily large, multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

Amici and their respective members, therefore, are vitally interested in (1) insuring that the Texas statute in issue is properly construed, (2) protecting the uniformity of ERISA's nationwide administrative scheme, and (3) promoting the availability and affordability of health coverage through the workplace. Methodist's arguments in this case threaten all three of those interests.

Amici, because of their in-depth experience with the role of self-funded employee benefit plans in the financing of employer-provided healthcare and the manner in which those plans function, can provide the Court with a broader perspective from additional entities that the Court's ruling will affect.

SUMMARY OF ARGUMENT

Texas Insurance Code Chapter 1301 is unambiguous and, as a matter of law, cannot be construed to cover self-funded employee benefit plans or third-party administrators of such plans. Chapter 1301 applies only to "insurers" that issue "health insurance policies" that cover "insureds." A self-funded health plan is not an insurer, does not issue health insurance policies, and its members are not insureds. Claims against a self-funded plan are not paid by insurance; they are the responsibility of the plan sponsor. Also, third party administrators (TPAs)—even those that may hold a type of insurance license—do not function as insurers when administering claims for a self-funded plan. For the claims in issue, HCSC functioned solely as a TPA for self-funded plans and therefore is not liable for late-payment penalties under Chapter 1301.

Furthermore, *even if* Chapter 1301 could be construed to apply to self-funded health plans and those who administer them, ERISA § 514(a), would expressly preempt it. To contain administrative costs and encourage employers to provide benefits, ERISA establishes a nationwide uniform administrative scheme

for processing claims and disbursing benefits. Section 514(a) express preemption protects that uniform administrative scheme from encroachment by a patchwork of differing state regulations. If Chapter 1301 applied to self-funded employee benefit plans, it would constitute such an encroachment and would therefore be preempted.

ARGUMENT

I. How employer-provided healthcare works.

An appreciation of some aspects of employer-provided healthcare coverage can facilitate the Court's review of the issues presented.

Of the population with health coverage, 54% receive coverage through the workplace.[3] Most employment-based coverage is provided through plans governed by ERISA.[4] To encourage employers to establish benefit plans, ERISA provides a nationally uniform regulatory regime that makes health coverage easier—and far less costly—to administer. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

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[3] Jessica C. Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013*, United States Census Bureau (Sept. 2014), https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.

[4] *Health Benefits, Retirement Standards, and Workers' Compensation: Employee Benefit Plans*, United States Department of Labor (Sept. 2009), http://www.dol.gov/elaws/elg/erisa.htm#who.

ERISA plans provide coverage in either or both of two ways. "Insured" plans purchase insurance for plan members and their dependents. The insurer agrees to pay for necessary healthcare, and accordingly bears the risk that costs will exceed the premiums it is paid.[5] "Self-funded" plans retain the obligation to pay members' healthcare costs. Under this approach, the plan sponsor (the employer) bears the risk that costs will exceed member contributions.[6]

Many employers lack the experience and infrastructure necessary to administer a self-funded plan. Such plans, therefore, typically enter into an "Administrative Services Only" arrangement[7] with a TPA.[8] Such administrative services can include assessment for medical necessity, treatment preauthorization, claim review for coverage and completeness, and payment processing. A TPA may also make its network of physicians, hospitals, and other providers available to plan members. Most such companies have assembled a network of providers

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[5] Thomas Perez, Secretary of Labor, *Annual Report to Congress on Self-Insured Group Health Plans*, at iv (March 2015), http://www.dol.gov/ebsa/pdf/acareporttocongress2015.pdf.

[6] *Id*.

[7] "Administrative Services Only" refers to "[a]n arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims." *Definitions of Health Insurance Terms*, Federal Interdepartmental Committee on Employment-based Health Insurance Surveys (Federal Bureau of Labor Statistics 2002), http://www.bls.gov/ncs/ebs/sp/healthterms.pdf.

[8] A third party administrator (TPA) is "an individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer." *Id*.

that have agreed to provide care to plan members and their dependents at contractually-agreed rates. Network providers benefit not only from the compensation they receive for the care they provide, but also from the increased business directed their way.

TPAs often are *also* licensed insurers or affiliates of a licensed insurer. But the capacity in which a TPA acts in processing a given claim will depend on whether the plan covering the claim is insured or self-funded. In the case of self-funded plans, the claims are paid not by insurance, but by the plan, and agreements between TPAs and providers typically recognize that the plan sponsor, and not the TPA, is liable on self-funded claims. *See NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993) (recognizing that administrators of self-funded plans do not bear risk). The insured versus self-funded distinction is well-known in the healthcare industry.[9]

II. The Chapter 1301 prompt pay provisions do not apply to self-funded employee benefit plans or to Third Party Administrators that administer such plans.

The district court correctly concluded that the prompt pay provisions in Chapter 1301 are unambiguous and that, by their plain language, they do not

[9] *See, e.g.*, discussion at *Fast Facts*, Employee Benefit Research Institute, (Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf.

cover self-funded employee benefit plans or those who administer such plans. The court's reasoning and conclusion are correct. Its judgment should be affirmed.

A. An unambiguous statute must be given its plain meaning.

The pertinent provisions of Chapter 1301 are unambiguous. Under Texas law, the proper construction of an unambiguous statute is a question of law for the court. *Texas Dep't of Transp. v. Needham*, 82 S.W.3d 314, 318 (Tex. 2002).[10] In construing a statute, "[the] objective is to determine and give effect to the Legislature's intent." *Nat'l Liab. & Fire Ins. Co. v. Allen*, 15 S.W.3d 525, 527 (Tex. 2000). And "[o]rdinarily, the truest manifestation of what legislators intended is what lawmakers enacted, the literal text they voted on." *Alex Sheshunoff Mgmt. Servs., L.P. v. Johnson*, 209 S.W.3d 644, 651-52 (Tex. 2006). "[W]hen a statute's words are unambiguous and yield a single inescapable interpretation, the judge's inquiry is at an end." *Id.* "Where text is clear, text is determinative." *In re Office of Att'y Gen.*, 422 S.W.3d 623, 629 (Tex. 2013) (quoting *Entergy Gulf States, Inc. v. Summers,* 282 S.W.3d 433, 437 (Tex. 2009)).

[10] A federal appellate court "reviews a district court's interpretation of a state statute *de novo*, interpreting the state statute the way the state supreme court would …." *NCDR, L.L.C. v. Mauze & Bagby, P.L.L.C.*, 745 F.3d 742, 753 (5th Cir. 2014).

B. Methodist cannot recover because, within the meaning of the applicable statutory provisions, HCSC is not an "insurer," there is no "health insurance policy," and there are no insureds.

When a statute uses a defined term, "[the] court is bound to construe that term by its statutory definition only." *Needham*, 82 S.W.3d at 318; TEX. GOV'T CODE § 311.011(b). This rule disposes of Methodist's statutory construction argument because the provisions on which it relies employ statutorily defined terms that unambiguously restrict the application of those provisions to "insurers" that issue a "health insurance policy" covering claims incurred in the treatment of an insured covered by that policy.

Section 1301.103,[11] which sets the deadline for claim payment, and §1301.137, which provides the penalty for late-payment, provide a sensible starting place. Section 1301.103 provides that:

> not later than … the 30th day after the date an ***insurer*** receives a clean claim from a ***preferred provider*** that is electronically submitted, the ***insurer*** shall make a determination of whether the claim is payable and (1) if the ***insurer*** determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the ***preferred provider*** and ***insurer***…[12] (emphasis added)

(Emphasis added.) Section 1301.137 then provides that:

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[11] Unless otherwise indicated, all statutory citations are to the Texas Insurance Code.

[12] If a claim is submitted in paper form, the payment deadline is 45 days. §1301.103.

> If 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….(emphasis added)

(Emphasis added.)

The Legislature did not leave these two terms—"insurer" and "preferred provider"—to be generally construed. It defined them, as well as other interlocking terms, for use "[i]n this chapter," meaning the entirety of Chapter 1301. TEX. INS. CODE §1301.001.

- "***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.

  § 1301.001(5).[13]

- "***Preferred provider***" means—

  a physician or health care provider, or an organization of physicians or health care providers, who contracts

[13] Chapter 841 concerns life, accident, and health insurers; Chapter 842, Group Hospital Service Corporations; Chapter 884, Stipulated Premium Insurance Companies; Chapter 885, Fraternal Benefit Societies; Chapter 982, Foreign and Alien Insurance Companies; and Chapter 1501, insurers providing coverage under the Health Insurance Portability and Availability Act.

> with an ***insurer*** to provide medical care or health care to ***insureds*** covered by a ***health insurance policy***.
>
> § 1301.001(8) (emphasis added).

- **"Health insurance policy"** means—

  > 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.
  >
  > § 1301.001(2).

And while "*insured*" is not defined, it is apparent from the above definition of *preferred provider* that it refers to a person covered by a *health insurance policy.*

All of the above definitions are combined in section 1301.041(a), which defines the scope of Chapter 1301:

> 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 non-preferred provider.

(Emphasis added.)

When sections 1301.103 and 1301.137 are read, as they must be, in accordance with the statutory definitions and the specified scope of Chapter 1301, the inescapable conclusion is that they apply only to claims for health care rendered to an ***insured*** under a ***health insurance policy*** issued by an ***insurer***. As dis-

cussed, self-funded employee benefit plans are not insurers and do not issue health insurance policies.[14] Likewise, TPAs providing solely administrative services to self-funded plans—even those who might hold insurance licenses—do not issue health insurance policies insuring enrollees of self-funded plans. Therefore, neither self-funded plans nor TPAs providing administrative services to those plans are subject to penalties under Chapter 1301.

The Legislature was fully aware of the insured versus self-funded distinction. Methodist's discussion of what it calls "legislative history"[15] establishes this.[16] Yet, the Legislature did not insert "self-funded plan" into the definition of "health insurance policy," nor "self-funded plan sponsor" into the definition of "insurer." This is significant because, in construing statutory language, a court is to presume that "words not included were purposefully omitted." *In re M.N.*, 262

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[14] *Amici* note that the Texas Department of Insurance has long considered this to be the clear and proper construction of Chapter 1301. See Brief for Appellee at 19-20.

[15] Appellant's Brief at 27.

[16] Methodist's attempt to alter the clear and plain meaning of Chapter 1301 with what it calls "legislative history" (mostly statements by lobbyists) is unavailing. Appellant's Brief at 41-43. As the Texas Supreme Court has stated, "while the Code Construction Act expressly authorizes courts to use a range of construction aids, including legislative history, TEX. GOV'T CODE § 311.023, … *[i]f the text is unambiguous, we must take the Legislature at its word and not rummage around in legislative minutiae.*" *Alex Sheshunoff Mgmt. Serv., L.P. v. Johnson*, 209 S.W.3d 644, 652 n.4 (Tex. 2006) (emphasis added). *See also Fleming Foods, Inc. v. Rylander*, 6 S.W.3d 278, 283–84 (Tex. 1999) ("[P]rior law and legislative history cannot be used to alter or disregard the express terms of a code provision when its meaning is clear from the code when considered in its entirety, unless there is an error such as a typographical one.").

S.W.3d 799, 802 (Tex. 2008). *See also Union Carbide Corp. v. Synatzske*, 438 S.W.3d 39, 52 (Tex. 2014) (Courts are to "presum[e] the Legislature included words that it intended to include and omitted words it intended to omit.").

Moreover, when Methodist argues that the definitions of "insurer" and "health insurance policy" should be read to encompass self-funded plans and the sponsors of those plans, it is asking the court to add language that those definitions simply do not contain. This is impermissible. A court may not read words into a statute, even if it believes the addition of those words would make the statute more substantively reasonable. *In re Office of Att'y Gen.*, 422 S.W.3d at 629.

While this is true for all statutes, it is especially true for penalty statutes, such as those at issue. That is because a penalty statute must be "strictly" construed, and thus given "a limited, narrow, or inflexible reading and application." *In re Hecht*, 213 S.W.3d 547, 572 (Tex. 2006). The construction that Methodist advocates is the opposite of limited, narrow, and inflexible. Indeed, it departs completely from the clear text of the pertinent provisions.

HCSC cannot be liable for penalties for the late-payment of claims that it did not insure, and it did not insure the claims at issue. The claims at issue were instead covered by self-funded employee benefit plans and were processed by HCSC acting solely in its capacity as a TPA. The sponsors of the self-funded plans retained the obligation to pay the claims.

C. *Toranto v. Blue Cross & Blue Shield*, on which Methodist heavily relies, demonstrates the flaw in Methodist's reasoning.

Toranto v. Blue Cross & Blue Shield of Texas, Inc., 993 S.W.2d 648 (Tex. 1999), does not support Methodist's argument that an administrator of a self-funded plan is an "insurer" as defined in § 1301.001(5). To the contrary, that position cannot survive *Toranto*.

Toranto concerned a self-funded health benefit plan established for Texas state employees pursuant to the Texas Employees Uniform Group Insurance Benefits Act, Vernon's Ann. Tex. Stat., Insurance Code art. 3.50-2. That Act authorized the Employee Retirement System (ERS) to self-fund and to hire an "administering firm" to administer its self-funded plans. Art. 3.50-2 § 5(f) & (h). BCBS was the "administering firm" for the ERS plan at issue.

A payment dispute arose and one of the relevant issues was whether BCBS was an "insurer" for purposes of an anti-assignment prohibition contained in art. 21.24-1 of the "pre-codified" Texas Insurance Code.[17] The supreme court decided the issue based not on general principles or loose reasoning but on the clear text of the specifically applicable definition of "insurer." That definition, found in

[17] Before the Texas Legislature began its program of systematically codifying the Texas statutes (see Tex. Const., art. III, § 43), the general body of Texas statutes already contained certain "codes." The previous Texas Insurance Code, of which articles 21.24-1 and 3.50-2 were part, was one such code. Pursuant to the ongoing codification effort, the previous code was non-substantively codified in the current Texas Insurance Code.

art. 21.24-1, § 1(6), defined "insurer" to mean "an insurance company, association, or organization authorized to do business in this state under Chapter 3, … or 22 of this code." The court noted that BCBS was organized as a "hospital service corporation" under Chapter 20 of the Insurance Code, which was *not* one of the chapters listed in article 21.24-1's definition of "insurer." Nonetheless, BCBS was providing administrative services to ERS pursuant to art. 3.50-2, which was part of Chapter 3, and Chapter 3 *was* specifically included in the art. 21.24-1 definition of "insurer." Thus, the court held, BCBS fit precisely the applicable definition of "insurer" and was therefore subject to art. 21.24-1's anti-assignment prohibition.

Significantly, there is no such *Toranto*-like fit between the definition of "insurer" in Chapter 1301 and a self-funded employee benefit plan or the administrator of such a plan. Moreover, *Toranto* disposes of Methodist's argument that, simply because HCSC is a licensed insurer, it is subject to Chapter 1301 even when it is acting as a TPA. *Toranto* demonstrates that, in determining whether or not a company meets a specific statutory definition of "insurer," a court must look to the function the company is performing in relation to the subject matter addressed by the particular statute. As the *Toranto* court explained,

> Although BCBS is organized as a hospital service corporation under Chapter 20, when BCBS is acting as ERS' administering firm, it does so under Chapter 3, article 3.50-2, section 4. . . . BCBS is an "insurer" because it is authorized to act as ERS administering firm under Chapter 3. . . . BCBS is subject to the anti-assignment prohibition. . . .

993 S.W.2d at 649.

Just as BCBS in *Toranto* was not acting as a hospital service corporation under Chapter 20 when it administered ERS's plan, HCSC was not acting as an insurer under any of the chapters listed in § 1301.001(5) when it administratively processed claims on behalf of self-funded clients. In relation to self-funded claims, HCSC acted solely as a TPA.

Indeed, a license to issue life, health, and accident insurance policies is neither necessary nor sufficient to authorize a company to act as a TPA.[18] It is nonsensical, therefore, for Methodist to say that HCSC was acting as an "insurer" under Chapter 1301 when its insurer's license was irrelevant to the administrative functions it was performing.

D. In the § 1301.001(2) definition of "health insurance policy," "insurance" modifies "certificate" and "contract."

HCSC has amply demonstrated why, in the § 1301.001(2) definition of "health insurance policy," "insurance" necessarily modifies "certificate" and "contract," as well as "policy." Brief for Appellee at 17. *Amici* wish to add one point. Methodist advocates that the proper reading should be simply "… certificate, or contract providing benefits for medical or surgical expenses incurred…."

[18] *See* TEX. INS. CODE § 4151.051(a) ("An individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter.").

Appellant's brief at 26-28. Methodist's argument ignores who the beneficiaries of these benefits are. They are "insureds." This is clear from numerous provisions—§§ 1301.001(1), (8), (9), 1301.0041(a), and 1301.0046, to list just a few. For example, § 1301.001(8), defines "preferred provider" as a provider "who contracts with an insurer to provide medical care or health care ***to insureds covered by a health insurance policy***." (emphasis added). If the "certificates" and "contracts" referred to in § 1301.001(2) provide benefits to "insureds," as clearly they do, then "insurance" must modify "certificate" and "contract." Methodist's argument for decoupling "insurance" from "certificate" and "contract" therefore defies the clear language of the quoted provisions.

E. Two non-insurance contracts, each arising from a separate transaction, cannot be read together to constitute an insurance policy.

Methodist makes the untenable argument that two non-insurance policies can be read together to create an insurance policy. The rule Methodist invokes applies only to writings that "pertain to the same transaction." *DeWitt Cnty. Elec. Coop. v. Parks*, 1 S.W.3d 96, 102 (Tex. 1999). Here, there was no "same transaction." Typically, a contract for TPA services between a TPA and a given self-funded plan and a contract between the TPA and a provider result from different transactions between different parties, executed at different times. In addition, each contract is stand-alone. The TPA contract is not limited to a specific provider

and the provider contract is not limited to a specific plan. Given these circumstances, Texas law will not permit such contracts to be read together.

Furthermore, even if the two contracts could be read together, the meaning of the combined documents would depend on what they say. And provider contracts almost always include provisions whereby the provider recognizes that some claims will be covered by benefit plans for which the TPA is providing administrative services, and that for such claims, the obligor for payment is the plan sponsor and not the TPA.[19]

III. Even if the Chapter 1301 prompt pay provisions encompassed self-funded ERISA plans and administrators for such plans, they would nonetheless be preempted by ERISA § 514(a).

Amici and their members are vitally interested in the continued integrity of the ERISA regime. This brief, therefore, addresses ERISA preemption in some detail.

A. ERISA establishes and protects a nationally uniform administrative scheme.

ERISA was enacted in 1974 to "promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*,

[19] On this point, *amici* speak based on their general experience. They have not seen a copy of the contract between HCSC and Methodist because it is protected by a confidentiality order. However, for an example of typical language, the Court can take judicial notice of Aetna's provider contract in the related case of *Aetna Life Ins. Co. v. Methodist Hospitals of Dallas*, Case No. 15-10210. The relevant language is quoted in AHIP's *amicus* brief in that case (Document 00513071188) at p. 5, n.11.

463 U.S. 85, 90 (1983). The Act accomplishes this by establishing "'a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff,* 532 U.S. 148 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

The nationwide uniformity of this scheme is central and indispensable to ERISA's mission. Uniformity "minimize[s] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133, 142 (1990). "[A] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation." *Fort Halifax*, 482 U.S. at 10. "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." *FMC Corp.*, 498 U.S. at 60.

B. If interpreted to cover self-funded plans, the Chapter 1301 prompt pay provisions would be preempted by § 514(a).

"[To] ensure that benefit plans will be governed by only a single set of regulations," Congress included within ERISA an express preemption clause providing that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a) (29 U.S.C. § 1144(a)). This preemption clause is both "conspicuous for its breadth," *FMC*

Corp., 498 U.S. at 58, and "clearly expansive." *Egelhoff*, 532 U.S. at 146. It "establish[es] as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp*., 498 U.S. at 58. Differing state regulations for '"processing claims and paying benefits' [would] impose 'precisely the burden that ERISA pre-emption was intended to avoid.'" *Egelhoff*, 532 U.S. at 142 (quoting *Fort Halifax, supra*). That is why the Supreme Court "[has] not hesitated to apply ERISA's preemption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *FMC Corp.,* 498 U.S. at 59.

For purposes of § 514(a) preemption, a state law "relate[s] to" an ERISA plan if it "has 'a connection with or reference to such a plan.'" *Id.* at 58 (quoting *Shaw*, 463 U.S. at 96-97). A law that interferes with nationally uniform plan administration has a connection with ERISA plans and is therefore preempted. *See Egelhoff*, 132 U.S. at 148 (holding that a Washington state statute had a prohibited connection with ERISA because it "interfere[d] with nationally uniform plan administration.").

Prompt pay laws are a prime example of the kind of state regulation that ERISA preempts. This Court has held in three different cases that § 514(a) preempts prompt pay provisions.[20] In addition, the Eleventh Circuit, in *America's*

[20] *See N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare*, 781 F.3d 182, 197 (5th

Health Insurance Plans v. Hudgens, 742 F.3d 1319, 1331-32 (11th Cir. 2014), recently held that a Georgia prompt pay statute that applied to self-funded plans (the interpretation that Methodist asks this Court to place on Chapter 1301) was expressly preempted. In doing so, the court cited "ERISA's overarching purpose of uniform regulation" and the Georgia statute's "impermissible encroachment upon federal law." *Id*. at 1331, 1334.

The Fifth Circuit applies a two-prong test to determine when a state law "relates to" ERISA plans. This test asks whether the law (1) addresses an area of exclusive federal concern, and (2) directly affects the relationship among traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Bank of La. v. Aetna U.S. Healthcare Inc*., 468 F.3d 237, 242 (5th Cir. 2006). Assuming Chapter 1301 could be interpreted in the manner Methodist advocates, it would meet both prongs of the "relates to" test and therefore would be preempted by ERISA § 514(a). As to the first prong, the statute's assumed terms would undermine uniform national requirements for the administration of self-funded plans; and as to the second prong, the administrative difficulties

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Cir. 2015) (Section 514(a) preempts Texas HMO prompt-pay provisions); *Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 274-76 (5th Cir. 2004) (§ 514(a) preempts Texas Insurance Code Section 21.55, a prompt-pay provision applicable to a wide variety of claims); *NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993) (§ 514(a) preempted Texas Insurance Code art. 21.07-6, which, among other things, required TPAs to adjudicate claims within 60 days of receipt).

that would invariably result from having to comply with a Texas-specific standard would strain and could weaken the relationship among the traditional ERISA entities, especially between the plan sponsor and plan administrator. To demonstrate why this is so, we examine the outsized role that self-funded plans play in the financing of employer-provided healthcare and the impact that patchwork regulation would have on the administration of such plans.

As of 2012, 49% of all employer plans were either completely or partially self-funded.[21] That 49% of plans, however, covered 84% of plan enrollees—a population of 58.6 million employees and employee dependents.[22] Many of these plans are regional or national, which means they (or TPAs on their behalf) must process claims from multiple—or even all—states. To contain costs and make claims administration easier, two of ERISA's fundamental goals,[23] many plans and TPAs process claims from multiple states at one or more central locations. For this to work, however, nationwide uniformity is essential. The Supreme Court has rec-

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[21] Constantin W. A. Panis, PhD and Michael J. Brien, PhD, *Self-Insured Health Benefit Plans 2015* at 1, (Sept. 16, 2014) http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport2015.pdf (Deloitte Financial Advisory Services LLP, under contract with the U.S. Department of Labor).

[22] *Id.* The 58.6 million population figure was derived by applying 84%—the percentage of employee benefit plans in 2012 that were wholly or partially self-funded, as the cited report states on page 1—to the total 2012 population of 69.8 million covered by employee benefit plans of all types, as the report states on page 5.

[23] *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

ognized that subjecting self-funded plans to differing state claim processing regulations would produce inefficiencies and adversely affect plans and plan members. *Fort Halifax*, 482 U.S. at 10-11; *FMC Corp.*, 498 U.S. at 60.

The issue, therefore, is not just claim administration in Texas, but claim administration nationwide. If Methodist's position is adopted, courts could construe prompt-pay laws in other states as applying to self-funded plans, or state legislatures could be emboldened to amend their state prompt-pay laws to include such plans. Administrators of self-funded plans would then have to conform to widely disparate claim-processing rules and guidelines. The result would be significantly greater administrative expense for plans and possibly reduced benefits for plan members.

This is not an academic or theoretical issue. So that the Court may appreciate the complexity and confusion that patchwork state regulation would cause, here is a sample of state processing deadlines. While the below-listed statutes do not apply to self-funded plans, they illustrate the widely-divergent regulation that such plans could become subject to in the absence of ERISA preemption. In the following states, electronic claims (the most common kind) must be paid, rejected, or deemed incomplete (with missing information requested) within—

- **15 days**
    - Hawaii (Haw. Rev. Stat. § 431:13-108)

  - New Hampshire (N.H. Rev. Stat. Ann. §§ 415:6-h, 415:18-k, 420-A:17-d, and 420-J:8-a)
  - North Dakota (N.D. Cent. Code § 26.1-36-37.1)
- **20 days**
  - Florida (for 95% of claims) (Fla. Stat. § 627.613)
  - South Carolina (20 business days) (S.C. Code Ann. § 38-59-230, et seq.)
- **21 days**
  - Tennessee (for 90% of claims) (Tenn. Code Ann. § 56-7-109)
- **25 days**
  - Louisiana (La. Rev. Stat. § 22:250.31, et seq.)
  - Mississippi (Miss. Code Ann. § 83-9-5(1)(h))
- **40 days**
  - Virginia (but 30 days to request additional information) (Va. Code Ann. § 38.2-3407.15)
- **45 days**
  - Oklahoma (but 30 days to request additional information) (Okla. Stat. tit. 36, § 1219(A)).

Congress enacted § 514(a) precisely to avoid the burden such inconsistent state regulation would impose. ERISA preempts state claim-processing regulations, including prompt pay laws, in order to preserve the Act's nationally uniform claims-administration scheme and the efficiency and cost-savings that that scheme makes possible. Methodist's arguments, if adopted, would destroy uniformity and the benefits that flow from it.

C. Section 514(a) also preempts the Chapter 1301 prompt pay provisions to the extent they are applied to TPAs acting for self-funded plans.

Appellant's argument in the court below that ERISA does not preempt prompt pay statutes as applied to TPAs is contrary to Fifth Circuit case law. In *NGS American*, this Court held that § 514(a) preempts a prompt pay provision to the extent it is "applied to third-party administrators of ERISA-governed insurance plans in their capacity as third party-administrators of ERISA-governed insurance plans." 998 F.2d at 300.[24] *NGS* dealt with a different prompt pay provision, Texas Insurance Code art. 21.07-6, which, among other things, required TPAs to adjudicate claims within 60 days of receipt.[25] *NGS* nonetheless controls here, given the Court's reasoning that "art. 21.07-6 imposes significant burdens on administrators of ERISA-governed employee benefit plans. It is these burdens of complying with conflicting state regulations that Congress sought to eliminate by enacting ERISA." *Id*. at 300. The prompt pay provisions at issue are even more burden-

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[24] Although this quote references "insurance plans," the opinion makes clear that the plan in question was self-funded. "Masco established a Self-Funded Employee Benefit Plan … to provide medical and other benefits to its employees." *NGS Am.*, 998 F.2d at 297.

[25] Texas Insurance Code art. 21.07-6, Section 18 (re-codified at TEX. INS. CODE § 4151.111) provided:

> The administrator shall adjudicate the claims not later than the 60th day after the date on which valid proof of loss is received by the administrator. The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement.

some than art. 21.07-6 was.

IV. Section 514(a) preempts the Chapter 1301 prompt pay provisions for another reason: the penalties they impose are so excessive as to interfere with nationally uniform claims administration and affect the relationship among the ERISA parties.

As discussed above, § 514(a) preempts *all* prompt pay provisions that apply, or are construed to apply, to self-funded plans. Without detracting from that fundamental principle, *amici* do, however, note an additional factual basis for § 514(a) preemption—namely, the penalties imposed by Chapter 1301 are so excessive that they meet both prongs of the *Bank of Louisiana* "relates to" test.

A. "Billed charges" greatly exceed contracted-for rates, the market value of the provider's services, and any compensatory damages the provider may incur because of late-payment.

Texas Insurance Code § 1301.103 generally provides that an "insurer" (as statutorily defined) must, within 30 days of receiving a claim electronically (the most common way a claim is transmitted), either pay the claim or notify the provider that the claim is rejected and state why. Section 1301.103 provides for the following tiered late penalties, which apply even if a claim is later determined not to be covered:

- For claims not completely paid or rejected on or before the 30-day pay-or-reject deadline, the insurer owes a penalty of 50% of the difference between *billed charges* and the amount of any underpayment, up to a cap of $100,000;[26] or

[26] TEX. INS. CODE § 1301.137(a).

- For claims paid or rejected on or after the 46th day but before the 91st day after the 30-day deadline, the insurer owes a penalty of 100% of the difference between *billed charges* and the amount of any underpayment, up to a cap of $200,000;[27] or
- For claims not paid or rejected before the 91st day after the 30-day deadline, the insurer owes the penalty specified immediately above and, in addition, 18% annual interest calculated from the 30-day pay-or-reject deadline.[28]

To fully appreciate just how excessive and arbitrary these penalties are, one must understand the meaning of "billed charges," a principal variable in the Texas late-payment penalty formula. Simply put, "billed charges" are non-negotiated, non-market-based rates that a provider unilaterally sets solely for billing purposes, even though it has contracted for payment at different rates and on different fee arrangements. The use of *pro forma* "billed charges" is an odd artifact left over from the days before managed care, when providers really did expect to collect the charges they billed.

"Billed charges" are based on chargemaster rates. Every hospital has a "chargemaster," a comprehensive list of all procedures and goods offered by the hospital, with a price assigned to each.[29] The provider bills everyone at its

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[27] TEX. INS. CODE § 1301.137(b).

[28] TEX. INS. CODE § 1301.137(c).

[29] Christopher Weaver, *Want to Know What a Hospital Charges? Good Luck*, Kaiser Health News (June 29, 2010), http://khn.org/news/hospital-prices/.

chargemaster rates, regardless of whether it has agreed to other rates or fee structures—which is virtually always the case.

Chargemaster rates do not represent an agreement between a hypothetical willing provider and willing payor. Indeed, they are not even what a willing provider *expects* to receive, much less what it requires as a condition for providing services. Negotiated rates and arrangements are typically less than half of chargemaster rates—often significantly less. "In 2004, the overall ratio of gross to net revenues was 2.57, which means that for every $100 the hospital actually collected from all sources, it initially charged $257."[30] "[T]he totals reflected on a hospital's itemized bill bear neither a specific relationship to the actual value of the goods and services received nor to the amounts actually paid on behalf of patients by the various insurers that the hospital deals with."[31] "[Hospitals] can set them at

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[30] Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, Health Affairs (May 2007), http://content.healthaffairs.org/content/26/3/780.full.

[31] George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care ACT, Governmental Insurers, Private Insurers and Uninsured Patients*, 65 Baylor L. Rev. 426, 470-71 (2013).

any level they want. There are no market constraints."[32] With no grounding in the market, billed charges "vary wildly."[33]

Thus, billed charges have no relation to contracted-for rates, the market value of the provider's services, or the injury the provider sustains (i.e., lost interest) because of late-payment. To impose such costs on an ERISA plan or the administrator of an ERISA plan would not only be unfair, it would invariably undermine the goal of nationally-uniform claim processing and affect the relationship among the ERISA parties.

B. The penalties specified by Chapter 1301 would interfere with nationally uniform claim processing standards.

As noted, state prompt pay laws are preempted in general. It is especially relevant in this case, however, that the Chapter 1301 prompt pay provisions are the only state prompt pay laws that calculate penalties based on provider billed charges. Such penalties are so excessive and arbitrary[34] that they could well interfere with nationally uniform claim-processing standards by introducing claim eval-

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[32] Elizabeth Rosenthal, *As Hospital Prices Soar, A Single Stitch Tops $500*, N.Y. Times, Dec. 2, 2012, http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?hp (quoting health economist Glenn Melnick).

[33] Erin Brown, *Irrational Hospital Pricing* (Houston Journal of Health Law & Policy (2014), https://www.law.uh.edu/hjhlp/Issues/Vol_14/Brown.pdf.

[34] Not only are billed charges themselves arbitrary, they cause Chapter 1301 late-payment penalties to apply non-uniformly. Penalties for the exact same late-payment scenario will differ in dollar amount from provider to provider based on each provider's chargemaster rates.

uation practices that differ depending on the state in which the particular claim originates. For Texas claims, a TPA—to avoid incurring such large penalties for itself or its customer—could facilitate a quick coverage determination by erring on the side of determining that coverage exists.[35] Such inconsistent incentive structures would defeat ERISA's goal of national uniformity and "would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." *FMC*, 498 U.S. at 60.

In addition, application of such excessive penalties to self-funded plans would likely cause such plans to bear the added expense of paying claims that a more deliberate determination would have revealed were not covered. That in turn would affect plan members.

C. The Prompt Payment Provisions' penalties would create tension between the plan and the plan administrator, adversely affecting the ERISA relationship.

Unsurprisingly, the second prong of the "relates to" test is also met. These arbitrary and excessive penalties would invariably create tension between the plan and the plan administrator, straining the ERISA relationship. As noted, for Texas claims, the plan administrator could be motivated to make a quick and possibly less-thorough coverage determination; the plan sponsor, on the other

[35] A TPA would more likely err on the side of determining that coverage exists than that it does not exist. Incorrect "no coverage" determinations would spawn disputes with plan members and providers, which TPAs are motivated to avoid.

hand, would want a more deliberate analysis that would assure non-covered claims would not be paid. Such differing motivations could significantly degrade the ERISA relationship.

CONCLUSION

Accordingly, the Court should affirm the district court's judgment because the Chapter 1301 prompt pay provisions, by their clear language, do not apply to self-funded employee benefit plans, and, even if they did, they would be preempted by ERISA.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 27, 2015, an electronic copy of the foregoing Brief of *Amici Curiae* America's Health Insurance Plans, the Chamber of Commerce of the United States, and the American Benefits Council was filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service on all parties will be accomplished by the appellate CM/ECF system.

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CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 29(C)(5)

No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparing or submitting the brief; and no person, other than *Amici*, their members or counsel, contributed money intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(c)(5).

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

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 28.1(e)(2)(A) because it contains 6,827 words, as determined by the word-count function of Microsoft Word 2010, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and Fifth Circuit Rule 32.2.

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman font.

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