A Mountain or a Molehill
The Scope of Texas’ Prompt Payment Statutes and Other Provider/Payor Issues

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• **Texas Prompt Payment of Claims Statute**
  • Pending Appeals

• **Network Provider Agreements**
  • “Any Willing Provider” Laws
  • Modification
  • Termination
Texas Prompt Payment of Claims

• Chapter 843, Subchapter J
  • Claims to HMOs
  • Deadlines for action on “clean” claims
  • Penalties for violations
    • 1-45 days past due: 50% Underpaid Amount or (Billed-Contracted) up to $100,000
    • 46-90 days past due: 100% Underpaid Amount or (Billed-Contracted) up to $200,000
    • 91+ days past due: additional 18% interest
    • Attorneys’ fees
• Chapter 1301, Subchapter C
  • Preferred Provider Benefit Plans
  • Deadlines for action on “clean” claims
  • Penalties for violations
    • 1-45 days past due: 50% Underpaid Amount or (Billed-Contracted) up to $100,000
    • 46-90 days past due: 100% Underpaid Amount or (Billed-Contracted) up to $200,000
    • 91+ days past due: additional 18% interest
    • Attorneys’ fees
Texas Prompt Payment of Claims

• Chapter 1301 - Scope
  • § 1301.0041
    • “Except as otherwise provided by this chapter, this chapter applies to each preferred provider benefit plan in which an insurer provides, through the insurer’s health insurance policy, for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider.”
  • § 1301.109
    • Applies to a “person, including a [PBM], with whom an insurer contracts to (1) process or pay claims . . . .”
Texas Prompt Payment of Claims

• **Does TPPA apply to a self-funded plan?**

  • *Aetna Life Ins. Co. v. Methodist Hospitals of Dallas*

  • *Health Care Service Corp. v. Methodist Hospitals of Dallas*
Texas Prompt Payment of Claims

- >200 Employees
  - 81% covered by self-funded plans
- < 200 Employees
  - 15% covered by self-funded plans
- 200-1000 Employees
  - 55% covered by self-funded plans
- >5000 Employees
  - 91% covered by self-funded plans

Kaiser Family Foundation, Employer Health Benefits: 2014 Annual Survey
• ALIC: TPA for self-funded plans
• MHD/THR claim for $10 million in penalties
• Declaratory Judgment filed by ALIC
  • TPPA does not apply to self-funded plans
  • Preempted by ERISA
• Pending state court litigation filed by MHD/THR
• Judge Lynn (March 2015)
  • Summary judgment/dismissal motions
  • Deference to state court decision on TPPA’s application to self-funded plans
  • Preemption
    • Express
    • Conflict
• **Judge Lynn (March 2015)**
  - Express Preemption
    - “Relates to”
      - Addresses an area of exclusive federal concern
        - Uniform plan regulation
        - *America’s Health Ins. Plans v. Hudgens*
        - *Lone Star OB/GYN Assocs. v. Aetna*
      - Increased cost of administration not enough
    - Affects the relationship among traditional ERISA entities
      - No claim on behalf of plan beneficiaries
  - **Conflict Preemption: providers v. beneficiaries**
Aetna/Methodist Hospitals: Appeal

• **Fifth Circuit**

  • **Aetna**
    • Self-funded plans are not insurers or policies
    • Prior codification inapplicable to self-funded plans
    • TDI has denied application of TPPA to self-insurers
    • Reliance on state court decision inappropriate
      • Potential certification to Texas Supreme Court
    • **Express preemption under ERISA**
      • Regulates how and how much ERISA fiduciaries pay
      • No effect on benefits insured has access to or population
    • **Conflict preemption under ERISA**
      • ERISA’s claim processing regulation and exclusive remedy provision
Aetna/Methodist Hospitals: Appeal

• Fifth Circuit

  • MHD
    • Aetna is an “insurer”
    • Contracts with the self-funded plan and providers constitute an “insurance policy”
    • Legislative history proves application to self-funded plans
    • No formal administrative construction from TDI
    • Preemption
      • Relation to provider contract, not beneficiaries
      • No complete preemption under LoneStar
      • No regulation of claims processing/payment amounts
      • Hudgens statute broader than TPPA
      • ERISA provisions govern “beneficiary” claims
Aetna/Methodist Hospitals: Appeal

• **Fifth Circuit**
  
  • **Amici Curiae**
    • U.S. Chamber of Commerce
      • Predictability and uniformity in plan regulation
    • Americas Health Insurance Plans
      • Statutory terms inapplicable to self-funded plans
      • Avoid patchwork of state regulation
      • “Billed rate” penalty basis
      • Tension between plan and administrator
  
  • Burden for TPAs already administering multi-state employer plans
  • Compliance with most restrictive statutory guidance
• **HCSC: BCBSTX**
  - Insurer for BCBSTX plans
  - TPA for other plans
    - Self-insured plans
    - State government plans
    - BlueCard plans
  - Federal Employee Program

• **Declaratory Judgment**
  - TPPA does not apply to non-BCBSTX plans
  - Preemption under ERISA
  - State/federal plans exempt or preempted
• **Judge Boyle (Jan. 2015)**
  
  - Limited to § 1301 – plans in which an “insurer” provides payment “through the insurer’s health insurance policy”
  - “Insurer”
    - “Life, health, and accident insurance company, health and accident 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.”
  - “Health insurance policy”
    - “Group or individual insurance policy, certificate or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness”
• **HCSC**
  - TPA is not an “insurer” for self-funded & BlueCard plans

• **MHD**
  - Provider agreement qualifies as a “health insurance policy”
  - “Specific” penalty provisions an exception to “general” application clause
  - Legislative history/intent: no exception for self-funded plans
  - HCSC is a stop-loss “insurer”
• **Judge Boyle (Jan. 2015)**
  - Provider agreement not a “health insurance policy”
  - No conflict between “general” application provision and “specific” penalty clauses
  - No express exception is needed to eliminate insurers acting as TPAs; text unambiguous
  - “Stop-loss” insurance insufficient
  - Did not reach preemption for self-funded/BlueCard plans
  - TPPA preempted as to FEHBA plans
• Judge Boyle (Aug. 2015)
  • Motion for reconsideration
  • *Toranto v. Blue Cross & Blue Shield of Texas*
    • Prohibition against “insurer” policies with anti-assignment provisions
    • TPA qualified as “insurer” as defined
  • Different definition of “insurer”
  • Refused to consider new arguments associating provider and TPA agreements
HCSC/Methodist Hospitals: Appeal

- Fifth Circuit
  - MHD
    - TPPA enacted to avoid protracted delays
    - HSCS is an insurer providing payment through policy
    - Contracts are “health insurance policies” providing benefits for medical/surgical expenses
    - Legislative history confirms interpretation
    - TDI website not binding administrative construction
    - FEHBA preemption
      - No change in plan terms/enforcement
      - Liability independent of plan coverage
HCSC/Methodist Hospitals: Appeal

• Fifth Circuit
  • HCSC – Brief 10/20
    • Self-Funded Plans
      • Statutory interpretation
      • Preemption
        • Express
        • Conflict
    • BlueCard Plans
    • Federal Employee Plans
• **Amici Curiae**
  
  • HCSC is one “insurer” for all BlueCard plans
  • § 1301.109, 138 applies to TPAs contracting with “insurers”
  • Self-funded plan qualifies as an “insurer”
    • Corporation authorized to engage in business involving the payment of money in event of loss resulting from sickness or ill health
    • Authorized to issue/deliver contracts providing benefits for medical expenses incurred because of an accident or sickness
    • *Harris County Hosp. Dist. v. Alief Indep. Sch. Dist.*
HCSC/Methodist Hospitals: Appeal

• Amici Curiae
  • Preemption
    • “Deemer” clause irrelevant absent express “relating to” preemption
    • No “exclusive federal concern”
      • Right to payment v. rate of payment
      • Not a dispute between traditional ERISA entities
  • Must have incentive for payors to respond to providers
Pending Fifth Circuit Appeals

• **Key Practice Points**
  - Self-funded plans
    - Contract terms governing deadlines/penalties
  - ERISA preemption
    - Providers v. beneficiaries distinction
    - Any contractual claim opposite self-funded plan?
Provider/Payor Issues: AWP Laws

- **Access to Provider Networks**
  - Providers:
    - “Any willing providers” laws by jurisdiction
    - Tex. Ins. Code 21.52B
    - Consider preemption
  - Payors:
    - Consider contractual terms
Provider/Payor Issues: Modification

• Modification of Provider Agreements
  • Unilateral amendment rights
  • Enforceability
  • Requirement of consent/consideration?
• Case Study
  • Billing format?
  • Billing rates?
Provider/Payor Issues: Termination

- Termination of Provider Agreements
  - “Without cause”