UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

HEALTH CARE SERVICE CORP.,	§	
	§	
Plaintiff/Counterclaim Defendant,	§	
	§	
v.	§	**CIVIL ACTION NO. 3:13-CV-4946-B**
	§	
METHODIST HOSPITALS OF DALLAS d/b/a METHODIST HEALTH SYSTEM,	§	
	§	
Defendant/Counterclaimant.	§	

MEMORANDUM OPINION AND ORDER

Before the Court is a Motion for Summary Judgment (doc. 18), filed by Health Care Services Corporation on May 15, 2014. Having considered the Motion and the filings in this case, the Court finds that the Motion should be and hereby is **GRANTED**.

I.

BACKGROUND[1]

A. *Factual Background*

This case arises out of a dispute between a company that insures and administers health plans and a medical services provider concerning the application of the Texas Prompt Pay Act (the "TPPA") to the payment of certain claims. Tex. Ins. Code §§ 843.336 *et seq.*, 1301.101 *et seq.* Plaintiff and Counterclaim Defendant, Health Care Services Corporation ("HCSC"), is an Illinois

[1] The Court draws its factual account from the parties' pleadings, summary judgment briefs, and evidentiary submissions. Unless characterized as a contention by one of the parties, these facts are undisputed.

mutual legal reserve company that operates in Texas as Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation ("BCBSTX"). Doc. 1, Compl. for Decl. Relief ("Compl.") 1; Doc. 19, HCSC Summ. J. Br. ("HCSC Br.") 5; Ex. A, Decl. of Donald Donahue ("Donahue Decl."), App. 3, ¶¶ 3–4. Defendant and Counterclaimant, Methodist Hospitals of Dallas d/b/a Methodist Health System ("Methodist"), is a medical services provider that has a written Preferred Provider Organization contract ("PPO Agreement") with HCSC, according to which Methodist agrees to provide medical services to patients who have health plans that are insured or administered by HCSC. Compl. 1.

BCBSTX has the following different roles depending upon the function it is providing to the various plans it serves. HCSC Br. 6; Donahue Decl., App. 5, ¶ 11.

(1) as an insurer for plans underwritten by BCBSTX ("BCBSTX Insured Plans");

(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, so that BCBSTX does not bear the risk of the cost of health care under the plan ("Non-BCBSTX Insured Plans"); and

(3) in servicing federal employees in the state of Texas, pursuant to the Federal Employee Health Benefit Program ("FEHBP"), under the Blue Cross and Blue Shield Service Benefit Plan, known colloquially as the Federal Employee Program. HCSC Br 6. Donahue Decl., App 5–6, ¶¶ 11–14; Ex. B, Declaration of Kenneth D. Shuler ("Shuler Decl."), App. 90, ¶ 3.

HCSC asserts, and Methodist does not dispute, that the claims at issue in this litigation relate only to the second and third categories of plans listed above: (1) where BCBSTX acts only as an administrator and not as an insurer, and therefore neither bears the risk of the cost of health care

under the plan nor provides the benefit plan pursuant to which claims are submitted; and (2) where BCBSTX provides services under the Federal Employee Program. HCSC Br. 6, 7; Donahue Decl. App. 6, ¶¶ 14–15. These plans, as well as the corresponding functions of BCBSTX, are described in greater detail as follows:

1. Non-BCBSTX Insured Plans

When acting as an administrator for plans under the second category listed above—Non-BCBSTX Insured Plans—HCSC processes claims, provides customer service, works with subscribers seeking access to a provider network with reduced health care rates, and provides medical necessity determinations. HCSC Br. 8; Donahue Decl. App. 6, ¶ 15. These Non-BCBSTX Insured Plans are comprised of the following three separate types of plans:

(a) Employer self-insured plans, which are administered by BCBSTX pursuant to an administrative-services agreement. 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. HCSC Br. 8; Donahue Decl. App. 5–6, ¶¶ 14–16.

(b) State government plans, which are also administered by BCBSTX pursuant to an administrative-services agreement. These state government plans are sponsored by state agencies and operate similarly to employer self-insured plans in that the relevant government entity—and not BCBSTX—provides the health benefit plan that covers medical services provided to the state government entity's employees. HCSC Br. 8; Donahue Decl., App. 6, ¶ 17.

(c) BlueCard plans, which involve services provided to members of other Blue Cross and Blue Shield plans located outside of Texas. HCSC Br. 6, 8; Donahue Decl. App. 6–7, ¶ 19. Claims under

this plan are made under the BlueCard program, which allows members of out-of-state plans access to Blue Cross and Blue Shield coverage when receiving medical services in states other than the state in which their plan is based. HCSC Br. 8; Ex. C, Decl. of Graham Williams ("Williams Decl."), App. 95, ¶ 4. 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. *Id.* at App. 95–96, ¶ 5. The claim information is then transmitted to the member's home plan (the Blue Cross and Blue Shield Plan of the particular state), which is located outside Texas, for it to determine if the member plan can receive benefits for the service under the terms of the relevant plan. *Id.* at App. 96, ¶ 5. The home plan makes the payment decision based on the member's policy and then returns the claim to BCBSTX. *Id.* BCBSTX pays the claim and is virtually simultaneously reimbursed by the home plan. *Id.* Therefore, when processing a BlueCard claim, BCBSTX does not bear the cost of reimbursement or the ultimate financial responsibility for paying the claim and accordingly, does not bear the financial risk of claims under those plans. *Id.* at ¶ 6. As a result, BCBSTX functions as an intermediary between the home plan and the provider. *Id.* at App. 97, ¶ 7.

2. Plans under the Federal Employee Program

The second broad category of claims at issue in this litigation arises under the Service Benefit Plan, also referred to as the Federal Employee Program, which was created pursuant to the Federal Employee Health Benefits Act ("FEHBA"). HCSC Br. 9; Shuler Decl., App. 90, ¶ 3. The FEHBA provides health benefits for federal employees and annuitants and their dependents. *See* 5 U.S.C. §§ 8901–8913. Congress vested the U.S. Office of Personnel Management with the discretion to establish insurance plans (sponsored by the government) with many different entities. HCSC Br. 9; 5 U.S.C. §§ 8901(7), 8902–03, 8913. The Federal Employee Program is one of these plans, and is

formed by a contract between the Office of Personnel Management and the Blue Cross and Blue Shield Association. *See* 5 U.S.C. § 8903(1); HCSC Br. 9; Shuler Decl. App. 90, ¶ 3. BCBSTX is a licensee of the Blue Cross and Blue Shield Association and is responsible for processing claims and providing customer service to the Federal Employee Program members in Texas. Shuler Decl. App. 90–91, ¶¶ 4–5.

B. Procedural Background

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. Compl. 1–2. In its Complaint, HCSC requests that the Court declare that the TPPA does not apply to claims arising out of the Non-BCBSTX Insured Plans because HCSC is not acting as an "insurer" issuing a "health insurance policy" with respect to these claims. *Id.* at 9. Instead, HCSC avers it is "merely administering or providing other similar services" while other entities retain financial responsibility for the plans. *Id.*

HCSC further claims it is entitled to a declaration that, even if the TPPA applies to plans for which HCSC is not the insurer, the TPPA does not apply to plans subject to ERISA because it is preempted by 29 U.S.C. § 1144(a). *Id.* Additionally, HCSC seeks a declaration that, even if the TPPA applies to plans for which HCSC is not the insurer, the TPPA does not apply to plans identified as self-funded state government plans because such plans are exempted from the TPPA. *Id.* Lastly, HCSC requests that the Court declare that "the TPPA does not apply to FEHBA-governed Plans because application of the TPPA to such plans is preempted by 5 U.S.C. § 8902(m)(1)." *Id.* Methodist submitted its Answer and Counterclaim (doc. 7) on January 13, 2014, seeking statutory penalties against HCSC under the TPPA.

HCSC filed the present Motion for Summary Judgment (doc. 18) on May 15, 2014. Methodist filed its Response (doc. 21) on June 5, 2014, and HCSC submitted its Reply (doc. 24) on June 19, 2014. The Motion is now ripe for the Court's review.

II.

LEGAL STANDARD

Under Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is appropriate when the pleadings and record evidence show that no genuine issue of material fact exists and that, as a matter of law, the movant is entitled to judgment. *Hart v. Hairston*, 343 F.3d 762, 764 (5th Cir. 2003). In a motion for summary judgment, the burden is on the movant to prove that no genuine issue of material fact exists. *Provident Life & Accident Ins. Co. v. Goel*, 274 F.3d 984, 991 (5th Cir. 2001). To determine whether a genuine issue exists for trial, the Court must view all of the evidence in the light most favorable to the non-movant, and the evidence must be sufficient such that a reasonable jury could return a verdict for the non-movant. *See Chaplin v. NationsCredit Corp.*, 307 F.3d 368, 371–72 (5th Cir. 2002).

When the party with the burden of proof is the movant, it must establish each element of its claim as a matter of law. *Fontenot v. Upjohn Co.*, 780 F.2d 1190, 1194 (5th Cir. 1986). If the non-movant bears the burden of proof at trial, the summary judgment movant need not support its motion with evidence negating the non-movant's case. *Latimer v. Smithkline & French Lab.*, 919 F.2d 301, 303 (5th Cir. 1990). Rather, the movant may satisfy its burden by pointing to the absence of evidence to support the non-movant's case. *Id.*; *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 (5th Cir. 1994).

Once the movant has met its burden, the non-movant must show that summary judgment

is not appropriate. *Little*, 37 F.3d at 1075 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986)). "This burden is not satisfied with some metaphysical doubt as to material facts, . . . by conclusory allegations, . . . by unsubstantiated assertions, or by only a scintilla of evidence." *Id.* (internal citations and quotations omitted). The non-moving party must "come forward with 'specific facts showing that there is a *genuine issue for trial*.'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (emphasis in original) (quoting Fed. R. Civ. P. 56(e)).

The district court does not have a duty to search the entire record to find evidence supporting the non-movant's opposition. *Jones v. Sheehan, Young, & Culp, P.C.*, 82 F.3d 1334, 1338 (5th Cir. 1996). Rather, the non-movant must "identify specific evidence in the record, and [] articulate the 'precise manner' in which that evidence support[s] [her] claim." *Bookman v. Shubzda*, 945 F. Supp. 999, 1004 (N.D. Tex. 1996) (quoting *Forsyth v. Barr*, 19 F.3d 1527, 1537 (5th Cir. 1994)).

III.

ANALYSIS

In its Motion for Summary Judgment, HCSC raises the following arguments: (1) the TPPA does not apply to plans for which BCBSTX is not the insurer; (2) even if the TPPA applied to self-insured plans, ERISA would preempt the TPPA's application to such plans; and (3) the FEHBA preempts the TPPA's application to Methodist's claims regarding Federal Employee Program enrollees. HCSC Br. 16–40. Not surprisingly, Methodist rejects these assertions and contends that the TPPA applies to all plans at issue. Doc. 22, Methodist Resp. Br. As explained in detail below, the Court **GRANTS** HCSC's Motion for Summary Judgment with respect to its claim that the TPPA does not apply to plans for which BCBSTX is not the insurer, which include self-insured employer

plans, state government plans, and out-of-state BlueCard plans. Accordingly, the Court need not determine whether self-insured plans are preempted by ERISA. The Court therefore reviews the parties' respective arguments on the remaining issues—(1) whether the TPPA applies to Non-BCBSTX Insured Plans and (2) whether the FEHBA preempts the TPPA's application to claims regarding Federal Employee Program enrollees.

As a preliminary matter, the Court notes that all of HCSC's arguments, as well as all of Methodist's related responses, pertain to whether the plans at issue come within the reach of the section of the TPPA that is incorporated into Chapter 1301 of the Texas Insurance Code, governing "Preferred Provider Benefit Plans." *See* Tex. Ins. Code §§ 1301.103, 1301.137. Accordingly, to the extent any claims or counterclaims exist under the part of the TPPA that is incorporated into Chapter 843 of the Texas Insurance Code, which governs "Health Maintenance Organizations," these claims are not at issue before the Court. *See id* §§ 843.338, 843.342.[2] Therefore, any reference to the TPPA specifically relates to the prompt payment provisions of Chapter 1301 of the Texas Insurance Code. *Id.* §§ 1301.103, 1301.137.

A. *The TPPA Does Not Apply to Non-BCBSTX Insured Plans*

HCSC argues that the prompt payment provisions of Chapter 1301 of the Texas Insurance Code do not apply to plans for which BCBSTX is not the insurer. HCSC Br. 16. These plans include self-insured employer plans, state government plans, and out-of-state BlueCard plans. *See* Donahue Decl. App. 5–7, ¶¶ 16–20. HCSC argues that, because it does not qualify as an "insurer" to a "health

[2] The Court observes, however, that the parties describe the contract between them as a preferred provider organization agreement (PPO Agreement) rather than as a contract relating to a health maintenance organization (which would fall within the scope of Chapter 843 governing Health Maintenance Organizations). *See* HCSC App. 104–293, PPO Agreement.

insurance policy" to BlueCard and self- and state government-funded health plans under the Applicability Section of Chapter 1301, the statute's prompt payment penalties do not apply to it with respect to claims arising under these plans. HCSC Br. 19–20.

Chapter 1301 of the Texas Insurance Code governs preferred provider benefit plans. Tex. Ins. Code § 1301.001 *et seq*. Subchapter C of the Chapter, Texas Insurance Code § 1301.101 *et seq.*, is titled "Prompt Payment of Claims" and requires that a physician or other health care provider submit a claim to an insurer within a proscribed period of time after medical services are provided. *Id.* § 1301.102(a). If the claim is "clean"—that is, if the provider has submitted the claim to the insurer on the appropriate form and with complete, legible, and accurate information—the insurer has 45 days (if the claim was submitted in a nonelectronic format) or 30 days (if the claim was submitted in an electronic format) to make a payment or otherwise notify the provider why the claim will not be paid. *Id.* §§ 1301.103, 1301.131. Failure to adhere to the provisions of Chapter 1301 results in penalties for the insurer, which increase in accordance with the extent of the insurer's delay in responding to claims. *Id.* § 1301.137. In addition, Chapter 1301 allows for the award of attorneys' fees and court costs for any physician or provider who recovers payment under the TPPA. *Id.* § 1301.108.

HCSC asserts, however, that the payment deadlines of the TPPA, like the rest of Chapter 1301 governing preferred provider benefit plans, are "expressly limited to instances where a clean claim is submitted to an 'insurer' pursuant to *the insurer's* 'health insurance policy.'" HCSC Br. 3 (citing Tex. Ins. Code § 1301.0041(a)) (emphasis added). HCSC contends that it does not qualify as such an insurer with respect to Non-BCBSTX Insured Plans, and it bases its argument on the language of Section 1301.0041 of Chapter 1301, titled "Applicability," which provides:

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

Tex. Ins. Code § 1301.0041(a); HCSC Br. 17 (emphasis added).

Pointing to the plain meaning of the statute and the definitions of the relevant terms used, HCSC explains that the prompt payment provisions of Chapter 1301 apply only when an entity is acting as an "insurer" that provides a "preferred provider benefit plan" through the same insurer's "health insurance policy," as opposed to when the entity is acting as an administrator for the plan. HCSC Br. 17–18. The terms used in Section 1301.0041(a) are, in turn, defined as follows. 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 policy is defined as "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.* § 1301.001(2). Lastly, a preferred provider benefit plan is "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." *Id.* § 1301.001(9).

Relying on these interrelated definitions, HCSC contends that Chapter 1301's prompt payment requirements apply only to insurers that issue their health insurance policies in Texas pursuant to a preferred provider organization ("PPO") plan, and that, as a result, it does not apply to entities that merely administer the plans through a health benefit plan that is not the entity's own

health insurance policy. HCSC Br. 19. HCSC offers as evidence the declaration of Donald Donahue, Senior Vice President of Service Delivery and Operations at HCSC's Chicago Headquarters, where he oversees HCSC's claims administration, as well as the declaration of Graham Williams, Director of InterPlan Business Solutions at HCSC's Chicago Headquarters, where he manages HCSC's relationship with various Blue Cross and Blue Shield Plans. Donahue Decl., App. 2–10, Williams Decl., App. 94–97. Based on these declarations, HCSC explains that it qualifies as a plan administrator—and not as an insurer—to BlueCard and self- or state government-funded plans, because it does not provide them any "health insurance policies." HCSC Br. 19; Donahue Decl., App. 4–7, ¶¶ 11–20; Williams Decl., App. 95–97, ¶ 3–7. Instead, HCSC maintains that it only "offers claims processing and other administrative services," and that "the funds used to cover the medical services rendered are paid by the party bearing the risk of loss—i.e., the employer or out-of-state insurer . . . or the government." HCSC Br. 19; Donahue Decl., App. 5–7, ¶¶ 14–19. Therefore, HCSC claims that it is not an "insurer" to a "health insurance policy" to BlueCard and self- and state government-funded employee health plans, and it maintains that Chapter 1301's Applicability Section thus excludes it from the Chapter's prompt payment provisions with respect to such plans. HCSC Br. 19–20.

In its Response, Methodist asserts ten reasons why HCSC misconstrues Section 1301.0041 in arguing that the TPPA does not apply to it when it functions as an administrator. Methodist Resp. Br. 3. These objections relate to the following overarching topics: (1) the text of the Applicability Section and the related definitions included in Chapter 1301; (2) the rules of statutory construction guiding the reading of Chapter 1301; and (3) the legislative intent behind Chapter 1301. In addition, Methodist raises the argument that the TPPA applies to HCSC because it functions as a "stop-loss

insurer" by virtue of its contract with Methodist. The Court reviews Methodist's contentions, as well as the corresponding arguments presented by HCSC in its Reply, in turn, below.

1. The Text of the Applicability Section and the Related Definitions in Chapter 1301

Methodist challenges HCSC's interpretation of the definition of "health insurance policy" used in Chapter 1301's Applicability Section, Texas Insurance Code § 1301.0041, and asserts that the definition of "health insurance policy" in Section 1301.001(2) should instead be read in the following way:

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

Methodist Resp. Br. 7 (quoting Tex. Ins. Code § 1301.001(2)). Therefore, Methodist contends, a health insurance policy is either: (1) a group or individual insurance policy; (2) a certificate; or (3) a contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness. *Id.* Methodist then argues that the last component of this definition pertains to contracts such as that between HCSC and Methodist, and that, as a result, HCSC's administration of plans under this contract provides benefits that fall within the meaning of Section 1301.001(2). *Id.* at 8. Methodist urges the Court to rely on the plain meaning of the word "benefit" found within this definition and notes that "whether HCSC acts as an administrator or as an insurer is irrelevant here, as under either scenario its contract with Methodist conveys the following benefits: (1) delivery of covered health care services by Methodist to HCSC's insureds; (2) administration of claims by HCSC; and (3) payments at an agreed-upon, reduced rate." *Id.* Methodist acknowledges that its contract with HCSC is "not 'insurance' as classically defined," but nonetheless asserts that HCSC is an "insurer [who] provides, through the insurer's health insurance policy, for the payment of a level

of coverage . . .” and therefore falls within the scope of the TPPA. *Id.*

In its Reply, HCSC takes issue with Methodist’s reading of Chapter 1301’s definition of a “health insurance policy,” noting that Methodist’s interpretation would lead to an absurd result, in which a “health insurance policy” would include *any* “certificate” and *any* “contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.” HCSC Reply 4–5. Instead, HCSC proposes that the inclusion of the initial worlds “group or individual health insurance” describes the subsequent forms that such insurance can take, and that the last phrase—“providing benefits for medical or surgical expenses incurred as a result of an accident of sickness”—relates to each of these forms of insurance. *Id.* at 5. Thus, a “health insurance policy” would encompass the following items:

> (1) a “group or individual insurance *policy* . . . providing benefits for medical or surgical expenses incurred as a result of an accident of sickness;”
> (2) a “group or individual insurance . . . *certificate* . . . providing benefits for medical or surgical expenses incurred as a result of an accident of sickness;”
> (3) a “group or individual insurance . . . *contract* providing benefits for medical or surgical expenses incurred as a result of an accident of sickness.

Id. (emphasis added).

HCSC also disputes Methodist’s argument that the PPO Agreement between them is a “contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.” *Id.* at 7 (quoting Methodist Resp. Br. 8). HCSC instead maintains that the PPO Agreement confers no medical benefits for any network members, but rather sets out the rate of reimbursement for services Methodist renders to patients. *Id.*; HCSC App. 104–293, PPO Agreement. Further supporting this contention, HCSC explains that “if any member were improperly

denied coverage for medical services, the member's rights to coverage would not arise under the PPO Agreement; they would arise under (and thus, the member would sue upon) the member's policy with their insurer." *Id.*

After review of the relevant statutory provisions and arguments, the Court finds HCSC's reading of the Applicability Section and the relevant definitions it incorporates to be persuasive. The Applicability Section outlines what entities are included in the scope of Chapter 1301, and it explicitly states that it applies to "each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy," for specified levels of payment. Tex. Ins. Code § 1301.0041. Methodist agrees that HCSC does not provide insurance "as classically defined" when it administered Non-BCBSTX Insured Plans, yet it argues that HCSC's PPO Agreement somehow qualifies as a health insurance policy. Methodist Resp. Br. 8. This argument is based on a convoluted reading of the definition of "health insurance policy," which the Court cannot adopt. As HCSC notes, Methodist's interpretation of the definition of "health insurance policy" would lead to an absurd result, as any certificate or contract issued by an insurer would qualify as a "health insurance policy," even if it is unrelated to insurance services. Moreover, this definition would be irrelevant and beyond the scope of this portion of the Insurance Code, as it would cast the reach of Chapter 1301 to any "certificate" and any "contract providing benefits for medical or surgical expenses incurred as a result of an accident of sickness" provided by an insurer.

2. The Rules of Statutory Construction Guiding the Reading of Chapter 1301

Methodist bases several of its arguments on a canon of statutory interpretation established by the Texas Code Construction Act, which provides that:

> (a) If a general provision conflicts with a special or local provision, the

> provisions shall be construed, if possible, so that effect is given to both.
> (b) If the conflict between the general provision and the special or local provision is irreconcilable, the special or local provision prevails as an exception to the general provision, unless the general provision is the later enactment and the manifest intent is that the general provision prevail.

Tex. Govt. Code § 311.026.

Methodist argues that HCSC focuses on the "general" provisions of the Applicability Section (Texas Insurance Code § 1301.0041) while ignoring the "specific" provisions of Section 1301.103, which establishes the deadlines insurers must follow in making claim determinations, and Section 1301.137, which outlines the penalties that result if these deadlines are violated. Methodist Resp. Br. 4. Based on this assertion, Methodist claims that the general provision should not trump the specific provisions, but that the specific provisions of Sections 1301.103 and 1301.137 should rather be read as "an exception to the general provision." *Id.* at 4–5 (quoting Tex. Govt. Code § 311.026(b)).

Methodist further contends that, because the Texas Legislature amended the Applicability Section to add the language "[e]xcept as otherwise specifically provided by this chapter," the specific provisions of the TPPA should trump the later-enacted general applicability language of Section 1301.0041(a). *Id.* at 5. Methodist also asserts that the Code Construction Act's exception for situations in which "the general provision is the later enactment and the manifest intent is that the general provision prevail" does not pertain to the Applicability Section because, even though it was enacted after the "specific" provisions that Methodist claims are controlling in this case, it is not a substantive provision. *Id.* Thus, Methodist insists that the specific provisions of Sections 1301.103 and 1301.137 must be given more weight than the Applicability Section. *Id.*

In its Reply, HCSC disputes Methodist's reliance on "extra-textual justifications for ignoring the Applicability Section's text." HCSC Reply 7. First, HCSC asserts that the Applicability Section is a gatekeeper of Chapter 1301 and that, by the plain meaning of its language, it defines the Chapter's scope and establishes which entities are subject to all of its provisions, including the prompt payment requirements of Section 1301.103 *et seq*. *Id.* at 8. HCSC thus explains that "when Section 1301.103 imposes a deadline on an 'insurer' for remitting payments upon the submission of a . . . 'clean-claim,' the Applicability Section identifies precisely what type of 'insurer' is subject to the deadline—one who 'provides' for preferred provider coverage 'through [its] health insurance policy.'" *Id.*

HCSC further questions the relevance of the canon of construction upon which Methodist relies, arguing that a code of statutory construction must "take a backseat when its application would conflict with the plain language of the statute." *Id.* (citing *Varity Corp. v. Howe*, 516 U.S. 489, 511 (1996) (declining to follow the canon of construction providing that "the specific governs the general" and finding that "[c]anons of construction . . . are simply rules of thumb which will sometimes help courts determine the meaning of legislation"); *Piazza v. Nueterra Healthcare Physical Therapy, LLC*, 719 F.3d 1253, 1267 (11th Cir. 2013) (stating that "[a]lthough specific statutory provisions often trump more general ones, this presumption is not an absolute rule," and noting that "the general/specific canon is simply an indication of statutory meaning that can be overcome by textual indications that point in the other direction.") (internal quotations and citations omitted)). Moreover, HCSC explains that this canon of construction applies only where there is a conflict between the general and the specific provisions, and that Methodist has failed to identify any such inconsistencies in Chapter 1301. *Id.* at 9 (citing Tex. Govt. Code § 311.026(b)).

Again, the Court finds Methodist's arguments unavailing in light of the plain meaning of the Applicability Section and the lack of conflict among the provisions of Chapter 1301. First, Methodist fails to observe that the portion of the Code Construction Act on which it relies is predicated on the existence of a "conflict between the general provision and the special or local provision" that is "irreconcilable." Tex. Govt. Code § 311.026(b). Neither has Methodist indicated such a conflict (much less an irreconcilable conflict), nor is the Court able to discern one.

Second, it is unclear whether the distinction between "general" and "specific" provisions is applicable to the sections of Chapter 1301 that Methodist discusses. As HCSC remarks, the Applicability Section is not merely a "general" section, but is rather the section that defines the scope of the entire Chapter 1301. *See* Tex. Ins. Code § 1301.0041 (stating that "this *chapter* applies to each preferred provider benefit plan . . .") (emphasis added). Though the "specific" Sections 1301.103 and 1301.137 establish the prompt payment deadlines and corresponding penalties for violations of those deadlines, they do not specifically target administrators such as HCSC. Had these sections indicated that they specifically apply to insurers acting in a purely administrative capacity, Methodist may have been able to draw the distinction between specific and general provisions, assert that a conflict exists between them, and argue that HCSC falls within the reach of Chapter 1301. However, such is not the case.

3. The Legislative Intent Behind Chapter 1301

Next, Methodist presents several arguments based on the Texas Legislature's intent with respect to Chapter 1301, as inferred from the legislative history of the TPPA and other statutes. First, Methodist claims that HCSC's interpretation of the Applicability Section would improperly create an exclusion in the statute, which Methodist insists the Legislature did not intend. Methodist Resp.

Br. 6. Methodist argues that if the Legislature had wished to exclude certain plans from the scope of Chapter 1301, it would have done so through the 2005 and 2011 amendments to the TPPA. *Id.* at 6–7. Methodist argues that the presence of other exceptions in Chapter 1301 indicates that, were the plans at issue to be similarly exempted, the statute would have contained a specific provision explicitly removing them from the reach of Chapter 1301. *Id.* (citing Tex. Ins. Code § 1301.002 (exempting dental care benefits); Tex. Ins. Code § 1301.0041(c) (exempting claims involving Medicaid and the child health plan program under Chapter 62 of the Health and Safety Code).

HCSC responds, however, that such an explicit exclusion was not necessary, as the plain language of the Applicability Section already clearly excludes the plans in question "by limiting Chapter 1301's scope to plans issued by an 'insurer' who 'provides' a 'health insurance policy.'" HCSC Reply 11 (citing Tex. Ins. Code. § 1301. 0041(a)).[3]

After review of the arguments and the construction of the Applicability Section, the Court finds that a specific and express exemption is not necessary in order for insurers acting as administrators to be excluded from the reach of Chapter 1301. Methodist's argument broadly assumes that any and all exceptions should be explicitly stated, and that any entities and claims not specifically exempted are therefore included in the scope of Chapter 1301. Such a reading of the statute comports neither with the plain meaning of its provisions nor with common sense. The Applicability Section provides that "[t]his chapter does not apply to: (1) the child health plan

[3] HCSC further notes that at the time of Chapter 1301's 2011 amendment, the Texas Department of Insurance ("TDI") had already issued a statement that the TPPA does not apply to entities that merely act as administrators for a particular plan. HCSC Reply 11. Thus, if the Legislature had found that to be incorrect or contrary to their initial intent, it could have corrected the statute so as to preclude the TDI's interpretation. However, the Court does not consider this assertion, as it decides the present dispute based on the plain meaning of the statute and does not reach the parties' arguments with respect to the pertinence of the TDI's statements.

program under Chapter 62, Health and Safety Code; or (2) a Medicaid managed care program under Chapter 533, Government Code." Tex. Ins. Code § 1301.0041(c). These exclusions are explicit because, had they not been made so, the programs they describe may have qualified as "preferred provider benefit plan[s] in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage . . ." under Subsection (a) of the Applicability Section. Nothing in the construction or meaning of the statute indicates that all plans not specifically excluded are included within its reach; indeed, the Applicability Section states that "[e]xcept as otherwise *specifically provided* by this chapter, this chapter *applies* to each preferred provider benefit plan" that satisfy certain criteria. *Id.* § 1301.0041(a) (emphasis added). This positive language establishes the general contours of Chapter 1301; the Chapter applies to those preferred provider benefit plans that meet the stated requirements of the Applicability Section, and it allows for the possibility that other exceptions or inclusions within Chapter 1301 otherwise limit or extend its scope. It does not, however, suggest that for an entity or plan to be excluded from the reach of Chapter 1301, it must have been specifically enumerated under a distinct provision of the statute.

Methodist further argues that the legislative history of the TPPA, as evidenced by certain comments made during its progression through the legislative process, reveals the legislature's intent in applying the statute to the plans at issue. Methodist Resp. Br. 11–12. Methodist points to statements made by the insurance industry's lobbyists with respect to the TPPA, introduced as Senate Bill 418 (S.B. 418), a bill "relating to the regulation and prompt payment of health care providers under certain health benefit plans; providing penalties," as well as remarks made by proponents and opponents of the statute. *Id.* at 11; Methodist Ex. 9, App. 50; S.B. 418, 78th Leg., Reg. Sess. (Tex. 2003). Methodist highlights several other comments that indicate S.B. 418 would

regulate the relationship between the insurer and the provider and that distinguish the statute's reach from the scope of ERISA. Methodist Resp. Br. 12; Methodist Ex. 12, App.147–48, S.B. 418 Analysis. Related to this argument, Methodist also notes that it would be illogical that "the Legislature intended to regulate late payments of claims by health maintenance organizations administering claims for self-funded plans, but not late payment of claims by preferred provider organizations involving the very same plan beneficiaries," as "there is no similar applicability section contained within Chapter 843 regarding HMOs." Methodist Resp. Br. 9.

With respect to Methodist's reliance on comments made during the legislative process shaping the TPPA, HCSC observes that Methodist elsewhere urges the Court to end its inquiry "with the text." HCSC Reply 15; Methodist Resp. Br. 14 (quoting *Asadi v. G.E. Energy (USA), L.L.C.*, 720 F.3d 620, 622 (5th Cir. 2013)). Methodist affirms that "[b]ecause the TPPA is unambiguous, the text of the statute is the exclusive evidence of legislative intent." *Id.* Even if this inconsistency in Methodist's arguments were to be completely ignored, the Court finds that Methodist's reliance on statements made by lobbyists and other commentators is of questionable relevance and significance. Methodist's focus on S.B. 418, which was enacted as the TPPA in 2003 and incorporated into Chapters 843 and 1301 of the Texas Insurance Code, is misplaced. Dissecting the implications of these provisions is not the key to resolving the present dispute, as the language of S.B. 418 is not at issue; rather, it is the Applicability Section and the definitions of the terms it references that are at issue and that must be discussed in conjunction with Chapter 1301's prompt payment provisions. By pointing to the legislative history of Chapter 1301's prompt payment and penalty provisions and by emphasizing that commentators speculated the TPPA would not infringe on ERISA, Methodist is in no way advancing its argument that insurers who do not provide benefits through their own

insurance plans are subject to Chapter 1301. Methodist's legislative arguments are therefore irrelevant and unpersuasive, especially in light of the unambiguous nature of the language in Chapter 1301.

By extension, the fact that the TPPA was incorporated in a different manner into two distinct Chapters of the Texas Insurance Code does not indicate that application of the prompt payment provisions in the context of Chapter 843, governing HMOs, must control the application of these provisions in the context of Chapter 1301, governing PPOs. The inclusion of the Applicability Section in Chapter 1301 may have different implications for this chapter, but such a difference does not indicate that the plain meaning and construction of the Chapter must be bent to resemble another portion of the Texas Insurance Code. As discussed more fully below, the Court "must take the Legislature at its word, respect its policy choices, and resist revising a statute under the guise of interpreting it." *Christus Health Gulf Coast v. Aetna, Inc.*, 397 S.W.3d 651, 654 (Tex. 2013) (citing *Entergy Gulf States, Inc. v. Summers*, 282 S.W.3d 433, 443 (Tex. 2009)).

4. Stop-Loss Insurance

Methodist next argues that when "HCSC provides to employer plans its stop-loss coverage together with its administration of their claims, it remains an insurer covered" by Chapter 1301. Methodist Resp. Br. 10–11. HCSC disagrees and notes that stop-loss insurance falls outside the scope of Chapter 1301 because it is not a "health insurance policy." HCSC Reply 13. Under Chapter 1301, 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*." Tex. Ins. Code § 1301.001(2) (emphasis added). HCSC explains that stop-loss insurance does not qualify as such a health insurance policy because it does not provide for "insurance against loss from sickness

or from bodily injury or death by accident or both." HCSC Reply 13 (quoting *Brown v. Granatelli*, 897 F.2d 1351, 1354 (5th Cir. 1990)). Rather, it is a policy "purchased by an employee benefit plan to insure that plan against catastrophic loss." *Id.* (quoting *Brown*, 897 F.2d at 1353). Based on the distinction between stop-loss insurance and accident and sickness insurance, as articulated by the court in *Brown*, the Court concludes that the stop-loss insurance discussed by Methodist is not sufficient to render HCSC an insurer who provides its own health insurance policy within the purview of Chapter 1301. *See Brown*, 897 F.2d at 1354 ("we are persuaded that under Texas law stop-loss insurance is not accident and sickness insurance.").

After considering the arguments and evidence presented with respect to the language and construction of Chapter 1301 of the Texas Insurance Code, the Court finds that the Chapter's Applicability Section is unambiguous and, based on its plain meaning, finds that it does not apply to plans which HCSC merely administers and for which BCBSTX does not provide its own health insurance policy. As the Texas Supreme Court has stated, "the truest manifestation of what lawmakers intended is what they enacted. This voted-on language is what constitutes the law, and when a statute's words are unambiguous and yield but one interpretation, 'the judge's inquiry is at an end.'" *Christus Health Gulf Coast*, 397 S.W.3d at 653–54 (quoting *Combs v. Roark Amusement & Vending, L.P.*, 422 S.W.3d 632, 635 (Tex. 2013)). Moreover, the Court "must take the Legislature at its word, respect its policy choices, and resist revising a statute under the guise of interpreting it." *Id.* at 654 (citing *Entergy Gulf States, Inc.*, 282 S.W.3d at 443).

Methodist's arguments based on unconventional readings of definitions, general rules of statutory construction, and comments made during the legislative process are irrelevant and fail to demonstrate that the language of Chapter 1301's Applicability Section and related definitions is

either ambiguous or in need of clarification. Accordingly, the Court's inquiry must end with the text. *See Christus Health Gulf Coast*, 397 S.W.3d at 653–54. Here, the Applicability Section unambiguously provides that Chapter 1301 "applies to each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider." Tex. Ins. Code. § 1301.0041(a). The prompt payment provisions of Chapter 1301 then outline the deadlines with which such insurers must comply. *Id.* §§ 1301.103, 1301.137. By the plain meaning of these provisions, a preferred provider benefit plan under which an entity is not an insurer who provides its own health insurance policy is not within the reach of Chapter 1301's prompt payment provisions. Moreover, based on the definitions of the terms "preferred provider benefit plan," "insurer," and "health insurance policy," incorporated into the Applicability Section, the Court finds that HCSC's PPO Agreement with Methodist does not qualify as a health insurance policy for employer self-insured plans, state government plans, and BlueCard plans, as HCSC merely administers these plans without providing insurance and bearing the risk of the cost of health care. In light of this finding, the Court need not address HCSC's remaining arguments with respect to the pertinence of statements made by the Texas Department of Insurance and regarding whether it is governed by another section of the Insurance Code. *See* HCSC Br. 2–23; Methodist Resp. Br. 12–17.

The declarations that HCSC submits in support of its assertions constitute sufficient summary judgment evidence to demonstrate that HCSC does not provide an insurance plan and does not carry the financial risk of loss for Non-BCBSTX Insured Plans, which include: (1) employer self-insured plans; (2) state government plans; and (3) BlueCard plans. Donahue Decl., App. 6–8; Williams Decl., App. 95–97. Based on this evidence and the arguments and conclusions discussed

above, the Court finds that HCSC has carried its burden in establishing that it is not liable under the Texas Insurance Code §§ 1301.103, 1301.137 for claims arising from these plans, and accordingly **GRANTS** HCSC's Motion for Summary Judgment with respect to this issue. The Court thus determines that it need not address the parties' remaining contentions with respect to these plans. *See* HCSC Br. 23–38; Methodist Resp. Br. 17–33.

B. The FEHBA Preempts the Application of the TPPA to Plans under the Federal Employee Program

HCSC argues that the FEHBA preempts the TPPA's application to Methodist's claims regarding federal government funded plans. HCSC Br. 38. As previously explained, the FEHBA provides health benefits for federal employees and annuitants and their dependents. *See* 5 U.S.C. §§ 8901–8913. Congress vested the U.S. Office of Personnel Management with the discretion to establish insurance plans (sponsored by the government) with many different entities. HCSC Br. 9; 5 U.S.C. §§ 8901(7), 8902–03, 8913. The Federal Employee Program is one of these plans, and is formed by a contract between the Office of Personnel Management and the Blue Cross and Blue Shield Association. *See* 5 U.S.C. § 8903(1); HCSC Br. 9; Shuler Decl. App. 90, ¶ 3. BCBSTX is a licensee of the Blue Cross and Blue Shield Association and is responsible for processing claims and providing customer service to the Federal Employee Program members in Texas. Shuler Decl. App. 90–91, ¶¶ 4–5.

Under the FEHBA, the government pays approximately 75% of the premiums for the plans, while the enrollees pay the remainder. HCSC Br. 10 (citing *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 684 (2006) (citing 5 U.S.C. § 8906(b))). The premiums are deposited into a special U.S. Treasury fund called the Employees Health Benefits Fund. 5 U.S.C. § 8909(a). BCBSTX draws directly against the fund to pay both for covered health care benefits and the costs

of administering the plan. HCSC Br. 10; 5 U.S.C. § 8909(a); 48 C.F.R. § 1632.170(b). At the end of the year, any balance in the Treasury fund that is associated with the Federal Employee Program is the property of the federal government, not BCBSTX. HCSC Br. 10. Specifically, any surplus in the Treasury fund is placed in the Plan's contingency reserves, which may be used, at OPM's discretion, to defray future rates, reduce future government and employee contributions, increase plan benefits, or provide refunds to the government and plan enrollees. HCSC Br. 10; *See* 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2).

The FEHBA's preemption clause provides that:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

The FEHBA preempts state law only when: (1) "the FEHBA contract terms at issue 'relate to the nature, provision, or extent of coverage benefits;'" and (2) the state law "relate[s] to health insurance or plans." *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 (2d Cir. 2005), *affirmed* 547 U.S. 677 (2006) (quoting 5 U.S.C. § 8902(m)(1)). As the Supreme Court has stated, the FEHBA's preemption clause "does not purport to render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans." *Empire HealthChoice Assurance, Inc.*, 547 U.S. at 698.

HCSC argues that both of the above requirements are satisfied because Methodist asserts its claims directly under the TPPA statute, rather than under a distinct obligation provided by a contract or provider agreement, and because Chapter 1301 pertains to the timing of payments with

respect to benefits and therefore "relates to health insurance or plans." HCSC Br. 40.

Methodist does not clearly explain why the TPPA provisions at issue do not "relate to health insurance or plans," but rather disputes the applicability of the cases on which HCSC relies, the most relevant of which is *Burkey v. Gov't Emps. Hosp. Ass'n.*, 983 F.2d 656 (5th Cir. 1993). Methodist Resp. Br. 33–39. In *Burkey*, a federal employee brought suit against the Government Employees Hospital Association ("GEHA") for failing to pay her son's medical expenses pursuant to a contractual agreement. *Burkey*, 983 F.2d at 657. The district court ruled in favor of the plaintiffs under Louisiana law and further awarded them recovery under a Louisiana statute authorizing damages and attorneys' fees for unreasonable delay in paying health and accident insurance claims. *Id.* (citing La. Rev. Stat. Ann. 22:657 (1992)). However, on appeal, the Fifth Circuit held that this statute's penalty provisions were inconsistent with and preempted by the FEHBA. *Id.* at 657–58. At the time of this decision, the FEHBA's preemption clause differed from the present version, in that it provided for preemption of state law "to the extent that such law or regulation is inconsistent with" contracts under the FEHBA. 5 U.S.C. § 8902(m)(1) (1994). Congress deleted this phrase in 1998, amending the FEHBA preemption clause so that "state law—whether consistent or inconsistent with federal plan provisions—is displaced on matters of 'coverage or benefits,'" thus widening the reach of the preemption clause. *Empire HealthChoice Assurance, Inc.*, 547 U.S. at 686.

The Fifth Circuit in *Burkey* held that, "[i]nsofar as [the plaintiffs'] claims for statutory delay damages necessarily refers to GEHA's plan to determine coverage and whether the proper claims handling process was followed, it refers to the plan, 'relates to' it and is therefore preempted." *Burkey*, 983 F.2d at 660. The court thus rejected the plaintiffs' argument that their request for statutory penalties related to remedies and not to the "nature or extent of coverage of benefits." The court

declined to recognize this distinction, noting that such claims "relate to" the plan and are thus preempted "as long as they have a connection with or refer to the plan." *Id.*

The court reiterated that "[t]he policy underlying § 8902(m)(1) is to ensure nationwide uniformity of the administration of FEHBA benefits." *Burkey*, 983 F.2d at 660 (citing *Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 925 (9th Cir. 1987)). Echoing this policy, the court held that "preemption is required because imposition of Louisiana's statutory penalties would invariably expand GEHA's obligations under the terms of its plan and would foster interstate conflicts in coverage." *Id.*

Methodist challenges the relevance of the *Burkey* decision, arguing that, unlike the *Burkey* plaintiffs, Methodist is seeking recovery from HCSC in the present case "on a contract between the two—a contract having nothing to do with the government plan itself, and a contract that does not even reference such government plan." Methodist Resp. Br. 34. As HCSC notes, however, this statement is inaccurate, as Methodist is not asserting any breach of contract claims pursuant to its PPO Agreement with BCBSTX, but is rather asserting its rights to statutory penalties under the provisions of the TPPA, whose application depends on how the claims are processed under the Federal Employee Program. HCSC Reply 24 (citing Methodist Answer and Counterclaim ¶ 56). In support, HCSC presents the declaration of Kenneth D. Shuler, Senior Director of the Federal Employee Program Department in HCSC's Service Delivery Operations, who oversees HCSC's handling of claims under the Federal Employee Program. Shuler Decl., App. 89–92. The declaration indicates that when a claim is submitted under the Federal Employee Program, the benefit determination is made under the Federal Employee Program Direct System, which then communicates the information to BCBSTX. *Id.* at App. 91, ¶ 7. BCBSTX then processes and pays

the claim according to the determination made by the Federal Employee Program Direct System. *Id.* Accordingly, a demand for penalties under the TPPA for claims paid through this mechanism necessarily relates to and depends upon the health insurance plan.

Methodist also contends that a critical distinction exists between a suit brought by a covered individual against a government plan, as in *Burkey*, and a suit brought by a health services provider against an entity processing a federal employees' benefit plan, as in the present case. Methodist Resp. Br. 36. In its Reply, HCSC demonstrates the irrelevance of this distinction, pointing to decisions from other district courts that held that the FEHBA's preemption clause applies to claims brought by medical providers just as it applies to claims brought by covered individuals. HCSC Reply 24; *see Lieberman v. Nat'l Postal Mail Handlers Union*, 819 F. Supp. 344, 349 (S.D.N.Y 1993) (holding that medical provider's equitable claims against administrator of federal health benefits plan were preempted by the FEHBA); *Ctr. for Restorative Breast Surgery, LLC v. Blue Cross Blue Shield of La.*, No. 06-9985, 2007 WL 1428717, at *27–29 (E.D. La. May 10, 2007) (concluding that medical provider's claim for FEHBA benefits was preempted). With respect to the issue of FEHBA preemption, the Court is likewise unable to discern a distinction between a suit brought by a medical provider and one brought by an enrollee, as in both instances, the plaintiffs seek to assert their interpretation of the extent of the defendants' obligations with respect to claims under a federal health benefits plan, and the defendants are asked to pay the claims or additional penalties pursuant to the federal health plan. That the provider is not an enrollee under a federal plan does not negate the fact that the claim at issue relates to the plan and "ha[s] a connection with or refer[s] to the

plan." *See Burkey*, 983 F.2d at 660.[4]

For the reasons stated above, the Court finds that HCSC has carried its burden in demonstrating that the determination of penalties due under the TPPA relates to plans created pursuant to the FEHBA and is therefore preempted under 5 U.S.C. § 8902(m)(1). Accordingly, the Court **GRANTS** summary judgment with respect to this issue.

IV.

CONCLUSION

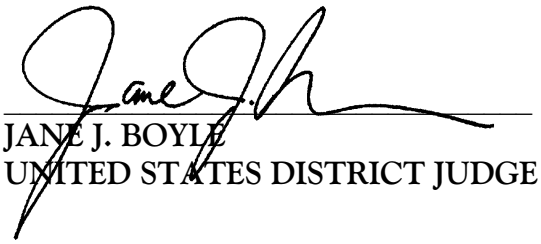
For the foregoing reasons, the Court **GRANTS** HCSC's Motion for Summary Judgment (doc. 18) with respect to its claim that the prompt payment provisions of Texas Insurance Code § 1301.101 *et seq.* do not apply to plans that are not insured by BCBSTX. The Court further **GRANTS** the Motion with respect to HCSC's claim that the TPPA does not apply to plans it processes under the Federal Employee Program.

The Court therefore declares that the prompt payment provisions of Texas Insurance Code § 1301.101 *et seq.* do not apply to HCSC with respect to plans that are not insured by BCBSTX, namely employer self-insured plans, state government funded plans, and BlueCard plans. The Court further declares that the TPPA does not apply to plans HCSC processes under the Federal Employee Program because application of the TPPA to such plans is preempted by 5 U.S.C. § 8902(m)(1).

[4] Methodist further argues that the Louisiana statute at issue in *Burkey* differed from the TPPA in that it did not allow health care providers (such as Methodist) to assert the rights of insured patients to collect penalties. Methodist Resp. Br. 35. However, the fact that the TPPA allows providers to make such claims does not indicate that it does not "relate to" a federal plan; rather, it undermines Methodist's argument that a claim by a provider cannot be preempted because it was not asserted by an enrollee.

SO ORDERED.

SIGNED: January 28, 2015.



JANE J. BOYLE
UNITED STATES DISTRICT JUDGE