IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT
CASE NO. 13-10349-FF

RALPH T. HUDGENS, IN HIS OFFICIAL CAPACITY AS GEORGIA INSURANCE AND SAFETY FIRE COMMISSIONER

Defendant/Appellant

v.

AMERICA'S HEALTH INSURANCE PLANS

Plaintiff/Appellee

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND MEDICAL ASSOCIATION OF GEORGIA IN SUPPORT OF APPELLANT SUPPORTING REVERSAL

On Appeal from the United States District Court
Northern District of Georgia
Case No. 1:12-CV-02978-WSD

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel certifies, pursuant to 11th Cir. R. 26.1-1, that the following is a full and complete list of the trial judges and all attorneys, persons, associations of persons, firms, partnerships, or corporations that have an interest in the outcome of this appeal.

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6. Duffey, William S., United States District Court Judge;
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CORPORATE DISCLOSURE STATEMENT

Neither the American Medical Association nor the Medical Association of Georgia has any parent corporations or public stockholders.

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INTEREST OF AMICI CURIAE[1]

The American Medical Association ("AMA") and the Medical Association of Georgia ("MAG") submit this brief as *amici curiae* in support of Appellant Ralph T. Hudgens, Georgia's Insurance and Safety Fire Commissioner.[2]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all United States physicians, residents, and medical students are represented in the AMA's policy making process. The AMA seeks to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Georgia and throughout the Eleventh Circuit. The AMA has taken a leadership role on behalf of its members nationwide to establish an equitable set of procedures and relationships with the nation's health insurers and third-party administrators regarding issues affecting the economic aspects of health care and the practice of

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[1] Counsel certifies that all parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part. No counsel, party, or other person, other than *amici*, their members, or their counsel, contributed monetarily to this brief's preparation or submission. *See* Fed.R.App.P. 29.

[2] On October 12, 2012, *amici* moved to intervene in the district court proceedings and filed their proposed opposition to AHIP's preliminary injunction motion. (R.14, 17, 18) In its opinion, the court acknowledged *amici*'s motion and opposition but said they "remain[] pending." (R.46, pp.13-14, n.11&12) *Amici*'s motion is still undecided.

medicine. This has included working with the litigants in *In re Managed Care Litig.*, 135 F. Supp. 2d 1253 (S.D. Fla. 2001), which has been litigated throughout the Eleventh Circuit, and which addressed prompt payment issues like those regulated by Sections 4 through 6 of the Insurance Delivery Enhancement Act of 2011 ("IDEA" or "HB 167").

MAG is a professional association representing over 7,000 physicians, residents, and medical students in the State of Georgia. Founded in 1849, MAG is the leading advocate in Georgia for the medical profession. Its physician members represent every medical specialty in every practice setting. MAG's mission is to enhance patient care and public health by advancing the art and science of medicine and by representing physicians and patients in the policy making process. MAG was a plaintiff in the *Managed Care Litigation* and advocated for IDEA's passage.

The AMA and MAG also represent the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and private, voluntary, nonprofit medical societies of each state, plus the District of Columbia. It represents the viewpoint of organized medicine in the courts in accordance with the AMA's policies and objectives.

STATEMENT OF ISSUES

1. Did the district court err by holding that IDEA Sections 4 and 6, which regulate third-party administrators ("TPAs"), "relate to" employee benefit plans regulated by Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) ("ERISA")?

2. Did the district court err by holding, *sub silentio*, that IDEA Sections 4 and 6, are preempted under ERISA's "deemer clause," 29 U.S.C. §1144(b)(2)(B), insofar as they regulate TPAs of self-funded plans?

STATEMENT OF THE CASE

Most Americans receive health benefits through their employers. (R.4, p.5) Employers often subsidize those benefits through plans that may be regulated by ERISA. *Id.* Employee health benefit plans can be categorized by their funding. Generally, there are insured plans, for which an employer purchases a health insurance policy that covers its employees; and there are self-funded plans, where the employer bears the risk of paying employees' medical claims itself, often out of general assets. (*Id.*, pp.5-6) As Appellee America's Health Insurance Plans ("AHIP") stated, with a self-funded plan, the employer (plan sponsor) usually hires a TPA, often an insurance company that also sells insurance to insured plans, to:

> process claims under the plan (paid for by the plan sponsor) and to perform other plan administration services. . . . [T]he administrator applies the terms of the plan as developed by the plan sponsor to meet its needs and those of its covered employees and dependents. The self-funded plan [or typically the plan sponsor] retains the financial responsibility to pay claims made under the plan.

Id. AHIP's members are both TPAs, processing claims for self-funded plans, and health insurers. (*Id.*, p.3; R.1, ¶11) In fact, as AHIP's counsel told the court, to his knowledge, *all* AHIP's TPA members are also health insurers. (R.44, 14:22-15:6).

In 1999, Georgia enacted the Prompt Pay Act ("Act"), which requires traditional insurers of employee health benefit plans to either pay a provider's claim, or give notice why a claim would not be paid, within 15 working days. *See*

O.C.G.A. §33-24-59.5(b)(1). The Act did not regulate self-funded plans or TPAs that processed claims for those plans.

By 2011, the Act regulated only about 35% of Georgia's health benefits market because the market increasingly favored self-funded plans.[3] This meant that TPAs for those plans had no deadline to pay a physician or provide notice that a claim would not be paid. (R.14-3, ¶19)

Faced with this industry shift, in April 2011, the Georgia Legislature overwhelmingly enacted IDEA, which expands to TPAs the Act's prompt pay requirements already applicable to insurers. IDEA Section 4 expands the definition of "administrator," defined under the Act as any entity that collects charges, fees, or premiums, processes claims, provides underwriting or precertification and preauthorization of hospitalizations or medical treatments on behalf of any insurer, O.C.G.A. §33-23-100(a)(1),[4] to apply more generally, including to TPAs for self-funded plans, O.C.G.A. § 33-23-100(b)(12), and

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[3] This mirrors the national trend since shortly after ERISA's passage. In 1979, 11% of medical plan participants in medium or large private companies received benefits through self-funded plans. *See* Albert E. Schwenk, "Trends in Health Insurance Costs," at 2, COMPENSATION AND WORKING CONDITIONS (Spring 1999), *online at* http://www.bls.gov/opub/cwc/archive.htm. By 2012, this had increased to 60% overall (93% of the largest employers are self-funded). (R.18-2, Ex. C).

[4] An "administrator" under the Georgia Act, before and after IDEA, differs markedly from the ERISA fiduciary called the "plan administrator." *Compare* O.C.G.A. §33-23-100(a)(1) with 29 U.S.C. §1002(16)(A). Indeed, AHIP acknowledges that its members are not ERISA fiduciary "plan administrators." *See* Section I.A, *infra*.

subjects all "administrators" to the Act's requirements. *Id.* § 33-23-100(f). IDEA exempts from its prompt payment requirements situations where an administrator cannot pay a claim because the self-insured plan is not properly funded. *Id.*

IDEA Section 5 broadens the definition of "insurer" to include self-funded plans. *Id.*, § 33-24-59.5(a)(2), (3). It lengthens the time period for processing non-electronic claims from 15 to 30 working days and reduces the interest payable on late claims. *Id.*, §33-24-59.5(b)(1), (c).[5] And it potentially subjects an insurer to a penalty from the Commissioner if the insurer processes less than 95% of all claims promptly. *Id.*, §33-24-59.5(d).

IDEA Section 6 is new and more narrowly focused than Section 5, applying the same obligations to "administrators" that previously applied just to "insurers." *Id.*, §33-24-59.14(b)(1). Unlike Section 5, Section 6 does not define "insurer" to include a self-funded plan. *Id.*, §33-24-59.14(a)(6).[6] It requires payment by an

[5] Fifteen working days for electronic claims is not unusual. The pre-IDEA Act established the fifteen-day time limit, and other states have similar deadlines. *See* Haw. Rev. Stat. §431:13-108 (15 calendar days); N.H. Rev. Stat. Ann. §§415:18-k, 415:6-h (same); N.D. Cent. Code §26.1-36-37.1 (15 business days).

[6] The district court noted this important difference but then mistakenly concluded that the sections were still "identical" and did not examine it further because "neither party" argued that Sections 5 and 6 differed. (R.46, pp.30-31 & n.22) *Amici*'s papers, however, did raise this distinction. (R.18-1, pp.16, 20) Contrary to the court's assumption, a self-funded plan does not fall within Section 6's definition of "insurer" because it has been expressly deleted from Section 5's definition of "insurer." *Id.* (citing O.C.G.A. §33-24-59.14(a)(6)). To ignore this omission when interpreting Section 6 reads out the distinction between these two

"administrator" (not a self-funded plan) to a medical "facility" or "provider" and requires payment of a claim within 15 or 30 working days, or an explanation why the claim was not paid, including if there is other information needed to process the claim. *Id.*, §33-24-59.14(b)(1). Once any information needed has been received, the "administrator" then has 15 or 30 working days to process and pay the claim or explain its denial. *Id.* Section 6 also requires the "administrator" to pay interest on late claims and authorizes the Commissioner to penalize the "administrator" if it processes less than 95% of claims promptly. *Id.*, §33-24-59.14(c), (d). IDEA Sections 4 through 6 were to take effect January 1, 2013.

In August, 2012, fifteen months after IDEA's passage, AHIP sued on behalf of its insurer/TPA members (not on behalf of self-funded plans), claiming that ERISA preempts IDEA. (R.1) AHIP obtained a preliminary injunction, preventing IDEA Sections 4 through 6 from taking effect because the court concluded that ERISA §514(a) preempted those provisions. (R.46, p.50)

The district court awarded this extraordinary relief, without record evidence showing how IDEA would be enforced, whether it would be enforced against a self-funded ERISA plan, or how it concretely impacted any such plan or TPA, because it concluded that IDEA Sections 4 through 6 had a "connection with" and

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sections and disregards the court's obligation not to "treat statutory terms as surplusage." *Duncan v. Walker*, 533 U.S. 167, 174 (2001).

therefore "relate to" ERISA-regulated employee benefit plans. (*Id.*, p.39). The court then concluded that, although IDEA fell within ERISA's insurance savings provision, (*id.*, p.41), it was not saved from preemption because IDEA ran afoul of ERISA's "deemer" clause, which prohibits state regulation from deeming self-funded plans to be "insurance companies." (*Id.*, pp.42-44). Therefore, Sections 4 through 6 were preempted. The court's analysis did not distinguish between applying IDEA to self-funded plans and applying it to TPAs that provide services to those plans.

The district court erred in concluding, particularly on this barren record, that IDEA, especially Sections 4 and 6, must be preempted from applying both to self-funded plans and TPAs that process claims for those plans, thereby requiring entry of a preliminary injunction.

SUMMARY OF ARGUMENT

Can states regulate TPAs that perform administrative tasks for employee benefit plans, or are those TPAs treated the same as plans by ERISA's preemption provision? This case views that question from multiple perspectives. First, from a statutory interpretation perspective, two issues arise that require this Court to wade into the "morass" of ERISA preemption, *Morstein v. National Ins. Services, Inc.*, 93 F.3d 715, 718 & n.7 (11th Cir. 1996) (en banc): (a) the often-litigated question of the breadth of "relates to" in ERISA's preemption provision, 29 U.S.C.

§1144(a); and (b) the interpretation of ERISA's "deemer" clause, 29 U.S.C. §1144(b)(2)(B), which has been little-discussed by the Supreme Court in twenty years. *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990). Second, from a state sovereignty perspective, can Georgia regulate at the intersection of health care and insurance – each of which "historically has been a matter of local concern," *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) ("*Travelers*") – or must a statute passed overwhelmingly by the Georgia Legislature be preempted when even AHIP concedes that nothing in ERISA regulates the specific conduct IDEA addresses? (R.44, 63:20-64:20). Finally, can Georgia regulate the independent, contractual relationship between medical providers and insurance companies, acting as TPAs, when those insurer/TPAs slow-pay physicians for their contractually-rendered services so those TPAs can pocket the float on those payments,[7] or does ERISA treat state regulation of insurer/TPAs the same as direct regulation of a benefit plan?

From all these perspectives, ERISA does not preempt IDEA, particularly Sections 4 and 6, at least as applied to TPAs. *Amici* therefore urge this Court to

[7] Perhaps because the district court reached its decision before discovery, it mistakenly concluded that plans "earn income on the unpaid funds" and so benefit from withholding payment to providers. (R.46, p.39 n.26) Discovery would show that typically it is *the insurer/TPAs* that benefit because they receive funds promptly from the plans but then retain those funds rather than pay providers. IDEA Section 4 does not apply to situations where the self-funded plan has not provided funds to the TPA. *See* O.C.G.A. §33-23-100(f).

reverse the preliminary injunction order and either conclude that IDEA Sections 4 through 6 are not preempted by ERISA, as applied to TPAs, or remand to the district court to conduct the discovery needed to provide the context to address the ERISA preemption issues properly.

ARGUMENT

I. ERISA §514(a) Does Not Preempt IDEA Sections 4 and 6, As Applied To TPAs, Because Such Regulation Does Not "Relate To" Employee Benefit Plans.

To avoid the "morass" of ERISA preemption jurisprudence, *Morstein*, 93 F.3d at 718 & n.7, it is important to understand the entities ERISA regulates and how ERISA §514's various components interact. One must also remember the Supreme Court's doctrinal shift enunciated in *Travelers* narrowing the breadth of ERISA §514 preemption.

A. ERISA does not regulate TPAs, medical professionals, or the relationship between them.

ERISA's "overall intent" is "to promote the interests of employees and their beneficiaries in employee benefit plans." *Morstein*, 93 F.3d at 718. The principal "ERISA entities" ERISA regulates "are the employer, the plan, the plan fiduciaries, and the beneficiaries under the plan." *Id.* at 722. ERISA, and ERISA preemption, focuses on the "relationship between the principal ERISA entities." *Lordmann Enterp., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994); *Morstein*, 93 F.3d at 722 ("when a state law claim brought against a non-ERISA

entity does not affect relations among principal ERISA entities as such," no preemption).[8]

Obviously, an "employee benefit plan" and a fiduciary with discretionary authority acting on the plan's behalf are different. *Compare* 29 U.S.C. §1002(3) *with id.*, §1002(16)(A). Plan fiduciaries are entities that exercise discretionary authority on behalf of an ERISA plan. *Id.*, §1002(21)(A); *Cotton v. Massachusetts Mutual Life Ins. Co.*, 402 F.3d 1267, 1277 (11th Cir. 2005). This includes the plan sponsor, often the employer, that funds the plan. 29 U.S.C. §1002(16)(B). It also includes the ERISA "plan administrator," again, often the employer, that exercises discretionary authority over the plan. *Id.*, §§1002(16)(A), (21)(A)(iii).

A TPA for a self-funded plan is qualitatively different than the plan itself and also different than an ERISA "plan administrator." Typically, as this case demonstrates, TPAs are insurance companies performing the same administrative services they provide when acting as insurers for insured plans. (R.44, 14:22-15:6); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 336 n.1 (2003) ("*KAHP*"). However, TPAs often blur the distinction between the plan, ERISA

[8] *See Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376 (5th Cir. 2011), *reinstated en banc*, 698 F.3d 229 (5th Cir. 2012), *cert. denied*, 2013 U.S. LEXIS 1850 (U.S. Feb. 25, 2013) ("whether the claims affect an aspect of a *relationship* that is comprehensively regulated by ERISA" determines preemption); *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692, 698 (6th Cir. 2005) (same); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1053 (9th Cir. 1999) (same).

"plan administrator," and TPA to assert ERISA preemption to avoid state insurance regulation, as this case demonstrates. Close examination of ERISA's language and jurisprudence will avoid this inappropriate outcome.

The "plan administrator" retains discretionary authority over the plan, but the TPA handles various administrative functions. *See Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1194-95 (11th Cir. 2007), *aff'd in relevant part*, 506 F.3d 1316 (11th Cir. 2007), *adhered to*, 546 F.3d 1353 (11th Cir. 2008).[9] AHIP acknowledged that, when a plan sponsor "retain[s] the financial risk of coverage" by creating a "self-funded" plan," the plan administrator often "contract[s] with a [TPA] solely to handle aspects of plan administration, such as claims processing." (R.4, pp. 5-6) The TPA "applies the terms of the plan as developed by the plan sponsor to meet its needs and those of its covered employees and dependents." *Id.* at 6. The self-funded plan or plan sponsor "retains the financial responsibility to pay claims made under the plan." *Id.* Department of Labor regulations, and this Circuit's case law, underscore that "claims processing" does not make a TPA an ERISA fiduciary. *See* 29 C.F.R. §2509.75-8, D-2 ("processing of claims," "calculation of benefits," and other TPA "ministerial activities" do not render an entity an ERISA fiduciary); *Baker v. Big Star Div. of Grand Union Co.*, 893 F.2d

[9] TPAs routinely assert this distinction to avoid liabilities imposed on an ERISA "plan administrator." *See id.*; *Rohan v. UnitedHealthcare Ins. Co.*, 881 F. Supp. 2d 1356 (N.D. Fla. 2012).

288, 290 (11th Cir. 1989) ("[A] plan administrator who merely performs claims processing, investigatory, and record keeping duties is not a fiduciary.").[10] As *Baker* explains, when an employer simply "'rent[s]' the claims processing department of [an insurance company] to review claims and determine the amount payable 'in accordance with the terms and conditions of [a benefit plan]," that entity does not become an ERISA fiduciary. *Id.*

Because TPAs are not "ERISA entities" or fiduciaries, "ERISA does not regulate the duties of non-fiduciary plan administrators." *Id.* at 289; *Howard v. Parisian*, 807 F.2d 1560, 1564 (11th Cir. 1987); *Terry*, 145 F.3d at 35; *Pharmaceutical Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 305 (1st Cir. 2005) (ERISA does not "regulate or afford remedies against entities that provide services to plans."). AHIP's members are not self-funded plans; they are TPAs that "process claims and otherwise administer the ERISA plans the Prompt Pay Amendment is designed to regulate." (R.4, p.3; R.1, ¶11) Therefore, AHIP's members are not fiduciaries of ERISA self-funded plans and are not regulated by

[10] *See also id.* ("An insurance company does not become an ERISA 'fiduciary' simply by performing administrative functions and claims processing within a framework of rules established by an employer."); *Terry v. Bayer Corp.*, 145 F.3d 28, 35 (1st Cir. 1998); *Klosterman v. Western Gen. Mgmt.*, 32 F.3d 1119, 1124-1125 (7th Cir. 1994); *Kyle Rys. v. Pacific Admin. Servs.*, 990 F.2d 513, 516 (9th Cir. 1993).

ERISA.[11]

ERISA also does not regulate medical providers. "[H]ealth care providers [we]re not parties to the ERISA 'bargain'" between health benefit plans and their participants. *Lordmann*, 32 F.3d at 1533 (internal citation omitted). In fact, "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661; *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000). So, "ERISA does not preempt enforcement of contracts that specify who pays how much to whom for medical care." *Central States, Southeast & Southwest Areas Health and Welfare Fund v. Pathology Labs. Of Arkansas*, 71 F.3d 1251, 1253, 1254 (7th Cir. 1995).

IDEA Sections 4 and 6 regulate the contractual relationship between these two types of *non-ERISA-regulated entities*. Most physicians have "Provider Agreements" with various insurers/TPAs (including AHIP members) to participate in their provider networks. (R.14-3, ¶¶29-30) These contracts create the rights and obligations between insurer/TPAs and providers regarding each other, including how providers submit claims to the insurer/TPA, and how the insurer/TPA pays

[11] This may be why TPAs are not discussed in ERISA's statutory text or legislative history. *See* LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, Pub. L. 93-406, prepared by the Subcomm. On Labor of the Comm. On Labor and Public Welfare, U.S. Senate (April 1976) (Volumes 1 through 3).

those claims. *Id.* ERISA simply does not regulate the contractual relationship between these entities. *See Borrero v. United Healthcare of New York*, 610 F.3d 1296, 1302 (11th Cir. 2010) (claims "made by providers against insurers . . . challenging the 'rate of payment' pursuant to the provider-insurer agreement . . . . [do] not necessarily implicate an ERISA plan."); *Blue Cross of Cal.*, 187 F.3d at 1050 (physicians' claims, "which arise from the terms of their provider agreements and could not be asserted by their patient-assignors, are not claims for benefits under the terms of ERISA plans").[12]

The district court did not address ERISA preemption analysis's focus on only preempting statutes that impinge on the relationship *between* ERISA-regulated entities. *Id.*; *Morstein*, 93 F.3d at 722. Instead, the court, without citation, simply noted that *Baker* did not "hold that ERISA cannot preempt a state law regulating non-fiduciary TPAs," and then reoriented its analysis to address "not whether the State of Georgia can impose the [Act's] requirements on TPAs

[12] *See, e.g., Lone Star OB/GYN Associates v. Aetna Health Inc.*, 579 F.3d 525, 530 (5th Cir. 2009) ("[a] claim that implicates the rate of payment as set out in the Provider Agreement, rather than the right to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA."); *Pascack Valley Hospital, Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 402 (3d Cir. 2004). ERISA also does not regulate this relationship when it arises from tort law. *See, e.g., Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1346-47 (11th Cir. 2009) ("*CSDA*"); *Access Mediquip*, 662 F.3d at 385-86; *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1010-11 (9th Cir. 1995).

but whether the State can regulate the function governed by the [Act] as applied to self-funded plans." (R.46, p.29, n.21) (emphasis added) Thereafter, the opinion did not address IDEA's regulation of TPAs or the *relationship* between TPAs and providers. As discussed *infra*, by reorienting the analysis and ignoring IDEA's attempt to regulate the *relationship* between providers and TPAs, separate and apart from self-funded plans, the court erred.[13]

B. ERISA's Default Assumption Is No Preemption.

This Court has noted previously that the Supreme Court's view of ERISA §514 preemption has narrowed over time. Early Supreme Court cases had a "broad interpretation" of §514 which preempts state laws insofar as they "*relate to* any [ERISA-governed] employee benefit plan." *Morstein*, 93 F.3d at 720; 29 U.S.C. §1144(a). However, in *Travelers*, the Supreme Court "turned the tide on the expansion of the preemption doctrine" and began limiting ERISA's preemptive scope. *Id.* at 721; *Whitt v. Sherman Int'l Corp.*, 147 F.3d 1325, 1333 (11th Cir. 1998) (noting "sea change" begun in *Travelers*). *Travelers* "unequivocally concluded" that the "starting presumption" in ERISA preemption cases, like other cases, is "that Congress [did] not intend to supplant state law." *DeBuono v. NYSA-*

[13] By ignoring ERISA's preemption only of state laws which comprehensively regulate the relationship between the principal ERISA entities, the district court contradicted this Court's analysis in *CSDA*, *Morstein* and *Lordmann* and settled doctrine in at least four other Circuits (Third, Fifth, Sixth, and Ninth). *See* fn. 8 and 12.

ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 813 (1997). Section 514 did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by [ERISA]," *California Div. of Labor Stds. Enforcement v. Dillingham Constr*, 519 U.S. 316, 331 (1997), unless that was the "clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655. In particular, ERISA does not preempt "traditional state regulation" that is "quite remote from the areas with which ERISA is expressly concerned – 'reporting, disclosure, fiduciary responsibility, and the like.'" *Dillingham*, 519 U.S. at 330 (quotation omitted). Therefore, "relates to" should not be read "to extend to the furthest stretch of indeterminacy." *Travelers*, 514 U.S. at 655.

Instead, a court must examine "the objectives of [ERISA]" when deciding if ERISA preempts state law. *Id.* at 656. "[C]ost uniformity was almost certainly not an object of pre-emption." *Id.* at 662. So, it is not enough for a law to have an "indirect economic influence" on ERISA plans, *id.* at 661, or even a "'direct' impact." *DeBuono*, 520 U.S. at 816. After all, any state law "that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by [ERISA]." *Id.*

C. IDEA's Regulation of TPAs Does Not "Relate To" ERISA-Regulated Health Plans.

Because the provider-insurer/TPA relationship that IDEA regulates is not one ERISA regulates, and because the starting point for preemption analysis is that ERISA does not supplant state law, IDEA Sections 4 and 6 do not "relate to" employee benefit plans insofar as they regulate TPAs.[14]

A state law "relates to" an employee benefit plan "if it has a connection with or reference to" it. *Travelers*, 514 U.S. at 656. Even pre-*Travelers*, some state actions affected plans "in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983). Examining ERISA's objectives helps identify what it preempts. *Travelers*, 514 U.S. at 654, 656. "[C]ost uniformity," *id.* at 662, regulating health care, *id.* at 661, and regulating insurance, 29 U.S.C. §1144(b)(A), were <u>*not*</u> among ERISA's objectives.

The district court properly concluded that IDEA fails the "reference to" test because it makes the Act more general and function "irrespective of the existence of an ERISA plan." (R.46, p.40 n.27) (citing *Dillingham*). However, the court incorrectly concluded that IDEA Sections 4 and 6 have an impermissible

[14] *Amici*'s focus on Sections 4 and 6 does not imply agreement with the district court's conclusion that ERISA preempts Section 5. Moreover, preempting Section 5 does not invalidate Sections 4 and 6. *See* O.C.G.A. §1-1-3 (invalidating one portion of statute "shall not affect" remainder of statute).

"connection with" ERISA plans because they allegedly require ERISA plans to process and pay provider claims, or send notices denying those claims, within 15 or 30 days. (R.46, p.37) The court's analysis misapprehended both what an impermissible "connection" with ERISA plans is and what IDEA requires, particularly regarding TPAs.

First, as discussed *supra*, ERISA preemption analysis examines whether a state law "affect[s] relations among principal ERISA entities as such." *Morstein*, 93 F.3d at 722. The TPA-provider relationship (which Section 6 regulates), and even plan-provider relationship (addressed in Section 5), are not relationships "among principal ERISA entities."[15] That is why, even pre-*Travelers*, this Court concluded that "state law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the Act."[16] *Lordmann*, 32 F.3d at 1533. Other courts concur that state claims against, or laws that impact, entities performing contract-based tasks for plans do not "relate to" ERISA. *See, e.g.*, *Rowe*, 429 F.3d at 301-05; *In re Managed Care Litig.*, 2011 U.S. Dist. LEXIS 46877, *45-46 (S.D. Fla. 2011) (contract claims against insurer based on provider agreements not preempted).

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[15] *See also* fn. 8, *supra*.

[16] Only when a provider asserts a state-law claim against an insurer as the assignee of a plan participant's claim does ERISA preemption arise. *CSDA*, 591 F.3d at 1347. AHIP has not argued, and cannot argue, that IDEA simply regulates payments to providers based on assigned claims.

Second, even the district court's interpretation showed that IDEA Sections 4 and 6 have "too tenuous, remote, or peripheral" a connection to ERISA plans to "relate to" them. *Shaw*, 463 U.S. at 100. The district court said that the time limit for plans, and their TPAs, to make eligibility determinations and pay or deny claims "compel[s] certain action – 'prompt' benefit determinations and payments – by plans and their administrators" that potentially "interferes with nationally uniform administration of ERISA plans." (R.46, p.37) But the district court's own analysis showed this is inadequate. After acknowledging that, when a statute "alters the incentives, but does not dictate the choices, facing ERISA plans," there is no impermissible connection to those plans, *id.* at p.37 (quoting *Dillingham*), the court then admitted that IDEA is not even "'alter[ing] the incentives' for ERISA plans." *Id.* And while noting that the tax statute in *DeBuono* lacked an impermissible "connection" because it "affected the cost of an available benefit scheme (*i.e.*, the operation of a hospital), but it did not require or prohibit any particular benefit scheme, specific type of benefits, or methods of calculating benefits," *id.* at 36, the district court did not find that IDEA does <u>*any*</u> of these things.

The district court relied heavily on *Egelhoff*, but that case has nothing to do with regulating TPAs or even health plans. *Id.* at 33-36. The district court concluded that IDEA "govern[s] the payment of plan benefits, which is a 'central

matter of plan administration.'" *Id.* at 35 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001)). However, in *Egelhoff*, the Washington statute bound administrators "to a particular choice of rules for determining beneficiary status" that contradicted ERISA's beneficiary designation rules, which required them to rely on the plan's documents. *Egelhoff*, 532 U.S. at 148 (citing conflicts with 29 U.S.C. §§1102(b)(4), 1104(a)(1)(D), and 1002(8)). It also interfered with "nationally uniform plan administration" because it prevented administrators from relying on plan documents to determine the proper beneficiary. *Id.* at 148.

IDEA does none of this. It does not establish beneficiary designation rules that contradict ERISA or require administrators to rely on state law when deciding claims. Instead, IDEA is like statutes that impose "some burdens" on TPAs, insurers, or even plans, but do not "relate to" plans. *See, e.g.*, *DeBuono*, 520 U.S. at 815; *Louisiana Health Serv. & Indem. Co. v. Rapides Healthcare System*, 461 F.3d 529, 539 (5th Cir. 2006) (statute required insurers to honor assignments from plan participants to hospitals);[17] *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 653 (7th Cir. 1995) (statute imposed tax on health insurance sales, even when insurance purchased for ERISA plan); *Self-Insurance Institute of America, Inc. v. Snyder*,

[17] The *Rapides* court found persuasive that insurers already complied with the statute for non-ERISA plans, so insurers already had some mechanism for compliance. *Id.* Here, insurer/TPAs, when acting as insurers, have been governed by the Act since 1999.

2012 U.S. Dist. LEXIS 124405 (E.D. Mich. Aug. 31, 2012) (statute imposed tax payable by TPAs/insurers on all claims paid).

The district court worried that IDEA's time limit might cause benefit determinations to vary between states, but it acknowledged that the time limit did not conflict with ERISA's claims-processing requirements. (R.46, p.45, n.29). Moreover, establishing a uniform time-limit for responding to benefit claims is hardly one of ERISA's objectives. "[S]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381 (2002) (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)).

Third, the district court misinterpreted IDEA, especially Section 6, which does not require that *all* eligibility determinations be made and claims paid within 15 or 30 working days. *Compare* R.46, p.37. (Furthermore, *amici* believe that discovery would demonstrate that most determinations are made, and the funds paid to the TPA, within that timeframe.). Instead, Section 6 permits the insurer/TPA to identify, in writing, any additional "documents or other information needed to process the claim." O.C.G.A. §33-24-59.14(b)(1). Only after all the information needed to process the claim has been received does the time period for benefit determinations begin. *Id.*

Moreover, Section 6 only regulates the TPA's payments to the physician. *Id.* Interest or penalties are paid by the insurer/TPA, not the plan, regardless of whether the insurer/TPA is processing claims as a TPA or insurer. *Id.*, §§6(c)-(e). Finally, to avoid imposing any "prompt payment" obligation on a self-funded plan, Section 4(f) provides a safe harbor for the TPA to ensure that interest and penalties are not incurred if the self-funded plan has not provided funds to pay the claim. O.C.G.A. §33-23-100(f). IDEA Section 6's intent is to ensure that, once the benefit determination has been made and the TPA receives funds to pay the claim, the insurer/TPA actually pays the provider.

Therefore, IDEA Sections 4 and 6, at least insofar as they regulate TPAs, do not "relate to" ERISA-regulated plans and should not be preempted by ERISA §514(a).

II. IDEA Also Is Saved From Preemption And Is Not Affected By The "Deemer" Clause, Particularly Regarding TPAs.

Even if IDEA Sections 4 and 6 "relate to" ERISA-regulated self-funded plans, they are not preempted because they "regulate insurance" and, insofar as they regulate TPAs, do not "deem" employee benefit plans to be "insurance companies." 29 U.S.C. §1144(b)(2)(A), (B). The district court correctly employed *KAHP*'s "insurance savings clause" analysis, but failed to distinguish between IDEA's application to self-funded plans and the TPAs that process claims for those plans, and so failed to follow the rationale of *FMC Corp.*

A. IDEA "Regulates Insurance" So It Is Saved By The Savings Clause.

The court concluded correctly that IDEA "regulates insurance" and so, initially at least, is "saved" from preemption. (R.46, p.41-42) (citing 29 U.S.C. §1144(b)(2)(A)) Indeed, a statute regulating entities like Aetna Insurance, Cigna Health and Life Insurance Company and members of America's *Health Insurance* Plans can hardly be otherwise. A statute "regulates insurance" if it (1) is "specifically directed toward entities engaged in insurance," and (2) "substantially affect[s] the risk pooling arrangement between the insurer and insured." *KAHP*, 538 U.S. at 341-42. According to the Supreme Court, self-funded plans and those entities that "provide only administrative services to self-insured plans" "bring them[selves] within the activity of insurance" for the savings clause. *Id.* at 336 n.1.[18] The district court correctly concluded that IDEA substantially affects the risk pooling arrangement between insurer and insured. (R.46, p.40-41) For the district court's reasons, and because requiring TPAs to pay providers' claims, rather than hold funds indefinitely, "alter[s] the scope of permissible bargains"

[18] Regarding non-risk-bearing entities, like HMOs (or TPAs), the Supreme Court said: "[N]on-insuring HMOs would be administering self-insured plans, which . . . suffices to bring them within the activity of insurance for purposes of §1144(b)(2)(A)." *Id.*

between insurer and insured, IDEA falls squarely within the savings clause. *KAHP*, 538 U.S. at 338-39.

B. IDEA's Regulation of TPAs Is Not Affected By The Deemer Clause.

The district court erred, however, by concluding that imposing "the requirements [of IDEA Sections 4 through 6] is prohibited under the Deemer Clause," at least with respect to TPAs. (R.46, p.44)[19] By ignoring the critical difference between regulating plans and regulating TPAs in concluding that the deemer clause prohibits state regulation of TPAs for self-funded plans, the district court has created a regulatory vacuum for TPAs because ERISA does not substantively regulate TPAs.

The "deemer" clause states: "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an . . . insurer. . . for purposes of any [State law] purporting to regulate insurance companies." 29 U.S.C. §1144(b)(2)(B). The textual language compels the conclusion that the clause only prohibits an "employee benefit plan" (or trust) from being "deemed to be an . . . insurer." *Id.* It is not directed at, and does not protect from regulation,

[19] The opinion focuses exclusively on IDEA's regulation of plans, and not TPAs, but it nonetheless applies to "ERISA-regulated self-funded health plans and the administrators of them." (R.46, p.50).

TPAs or other entities (like insurers) that provide services to those plans.[20]

The district court's "straightforward" application of the deemer clause was erroneously overbroad as applied to TPAs. (R.46, p.44). *FMC Corp.* highlights this. *FMC Corp.* only prohibited the Pennsylvania anti-subrogation statute's application to a plan. The *FMC Corp.* opinion emphasized that "[s]tate laws that directly regulate insurance companies are 'saved' but do not reach *self-funded employee benefit plans* because the *plans* may not be deemed to be insurance companies." *FMC Corp.*, 498 U.S. at 61 (emphasis added).

The Supreme Court also explained that, while a State cannot regulate a plan directly, it *can* regulate entities, like insurers, that contract with a plan without running afoul of the deemer clause. *Id.* ("The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer."). According to the Court, "[b]y recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the 'business of insurance.'" *Id.* at 63.

[20] ERISA's legislative history "contains no explanation whatsoever of the reason for enacting the deemer clause." *FMC Corp.*, 498 U.S. at 69 (Stevens, J., dissenting).

IDEA, particularly Section 6, makes this distinction, focusing only on the insurer/TPAs and not plans themselves. Section 6 requires the TPA to process and pay the provider's claim. It requires the insurer/TPA, not the plan, to pay any potential interest. And it requires the insurer/TPA, to meet the prompt payment threshold or potentially incur penalties. *FMC Corp.* allows a state to focus on regulating insurance companies, including insurers that perform administrative services as TPAs, as Section 6 does, without preemption. Differentiating between regulating the plan and the TPA for that plan upholds "Congress' clear intent to exempt from direct state insurance regulation ERISA *employee benefit plans*." *Id.* at 65.

Other Supreme Court cases shed additional light on the deemer clause. In *Metropolitan Life*, the Court upheld a Massachusetts mandated benefit statute as applied against insurers of plans. Massachusetts never enforced the statute against plans themselves, *Metropolitan Life*, 471 U.S. at 735, n.14, but the Court permitted application of the statute to insurers because the deemer clause "exempt[ed] from the saving clause laws regulating [insurance] that apply directly to benefit plans." *Id.* at 741. By allowing insured plans to be "open to indirect regulation" while self-funded plans were not, the Court "merely g[a]ve life" to the distinction created by the deemer clause. *Id.* at 747. The Court's rationale derived from the

"presumption . . . against pre-emption" and the refusal to limit "federal statutes in order to enlarge their pre-emptive scope." *Id.* at 741.

In *Rush Prudential*, the Court again applied a statute to administrative service providers (*i.e.*, non-risk-bearing HMOs) but not directly to self-funded plans. The Court concluded that the Illinois statute "would not be 'saved' as an insurance law to the extent it applied to self-funded plans. This fact, however, does not bear on Rush's challenge to the law as one that is targeted toward non-risk-bearing organizations." *Rush Prudential*, 536 U.S. at 371 n.6. This analysis again differentiates between regulating non-risk-bearing organizations, like TPAs or other administrative service providers, and regulating a plan. Only state laws directed at the latter entity are preempted under the deemer clause. As the *Rush Prudential* Court noted, nothing "stand[s] in the way of applying the savings clause . . . [to] a contractor that provides only administrative services for a self-funded plan." *Id.* at 371.

Finally, in *KAHP*, the Court again concluded that the savings clause protected state regulation of TPA-like entities (HMOs that "provide only administrative services to self-insured plans") from preemption while noting that regulating self-insured plans would be preempted under the deemer clause. *KAHP*, 538 U.S. at 336, n.1.

The district court opinion did not differentiate between Section 6's

regulation of TPAs (but not plans) and Section 5 (which includes plans). Thus, the order foreclosed appropriate state regulation of TPAs. When properly construed, however, IDEA, particularly Sections 4 and 6, regulates insurance and should not be preempted under the deemer clause.

III. ERISA § 502(a) And Ordinary Conflict Preemption Do Not Apply.

The district court did not reach AHIP's alternative argument that ERISA §502(a) preempted IDEA; however, it does not.[21] (R.46, p.45) ERISA §502(a) preemption is "narrower" than ERISA §514 preemption, *Cotton*, 402 F.3d at 1281, and "provides the exclusive cause of action for the recovery of benefits governed by an ERISA plan." *Id.* Complete preemption exists only when a plaintiff "[1] could have brought his claim under §502(a); and [2] . . . no other legal duty supports the plaintiff's claim. *CSDA*, 591 F.3d at 1345 (citing *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 210 (2004)).

As the district court correctly noted, ERISA §502(a) preemption cannot apply because "this case presents a direct challenge to the validity of a state law, not a state law claim alleged to be preempted by ERISA." (R.46, p.45-46 n.30) The *Davila* test demonstrates this. The Commissioner cannot assert an ERISA §502(a) claim against an insurer/TPA. Neither can providers. *Borrero*, 610 F.3d

[21] The nomenclature differentiating §514 and §502(a) preemption sometimes varies between courts. This Court has called §514 preemption "conflict preemption" and §502(a) preemption "complete preemption," so that terminology is used here. *CSDA*, 591 F.3d at 1343-45.

at 1301-02 (physician cannot bring claim). Moreover, providers have another "legal duty," established by their Provider Agreements, that supports any claim against insurer/TPAs. *CSDA*, 591 F.3d at 1346-17; *Blue Cross of Cal.*, 187 F.3d at 1050.[22]

Finally, AHIP's assertion that, under ordinary "conflict preemption" principles, IDEA conflicts with ERISA's claims-processing regulations, 29 C.F.R. §2560-503-1, fails for three reasons. First, those regulations govern "claims for benefits by participants and beneficiaries," not physicians pursuant to provider agreements. *See* 29 C.F.R. §2560-503-1(a). Second, they instruct an ERISA plan to process benefits claims in a particular way, emphasizing the denial and appeal of a participant/beneficiary's claim. *Id.*, §2560-503-1(g), (h). Section 6, and even Section 5, establishes the time a TPA has to process a provider's claim for payment, when there is no dispute about right to payment and the claim has been funded by the self-funded plan. *See* IDEA §§5(b)(1), 6(b)(1). Finally, the district court correctly noted that it is certainly possible to comply with the regulations and IDEA, so IDEA does not "actually conflict[] with federal law" or "stand[] as an obstacle" to Congress's objectives. *See* (R.46, p.45 & n.29); *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

[22] *See* fn. 12, *supra*.

CONCLUSION

Amici respectfully request that this Court reverse the district court's preliminary injunction order and conclude that IDEA is not preempted, at least as applied to TPAs, or remand the case for further proceedings.

Respectfully submitted,

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I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,991 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2003 with 14 point Times New Roman font.

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