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United States District Court,
S.D. Texas, Houston Division.

ACS PRIMARY CARE PHYSICIANS SOUTHWEST, P.A., et al., Plaintiffs,

v.

UNITEDHEALTHCARE INSURANCE COMPANY, et al., Defendants.

CIVIL ACTION NO. 4:20-CV-01282
|
Signed 01/22/2021

Attorneys and Law Firms

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ORDER

Andrew S. Hanen, United States District Judge

***1** Pending before the Court is a motion to dismiss filed by Defendants UnitedHealthcare Insurance Company and UnitedHealthcare of Texas, Inc. (collectively, the "Defendants") (Doc. No. 13), and a request for clarification by Plaintiffs ACS Primary Care Physicians Southwest, P.A., Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medical Associates, P.A., Central Texas Emergency Associates, P.A., Emergency Associates of Central Texas, P.A., and Emergency Services of Texas, P.A. (collectively, the "Plaintiffs") (Doc. No. 40). Plaintiffs filed a response to Defendants' motion. (Doc. No. 25). Defendants replied. (Doc. No. 27). Defendants also filed a response to Plaintiffs' request for clarification (Doc. No. 41), and the Court heard oral argument on both motions. Finally, Plaintiffs filed a motion for leave to file submit supplemental authority (Doc. No. 52), to which Defendants replied (Doc. No. 55). After careful consideration of the arguments, the briefing, and applicable law, this Court **GRANTS** Plaintiffs' motion for leave to file, **DENIES** their motion to clarify, and **GRANTS** in part and **DENIES** in part the Defendants' Motion to Dismiss.

I. Background

Plaintiffs are emergency care physician groups in Texas, and Defendants are health care insurance companies. Unlike some other physicians, emergency care providers are obligated by law to serve all those who require emergent care. As a result of this duty, Plaintiffs are protected by Texas laws that require health care insurers to compensate nonpreferred and non-network emergency medical providers at usual and customary rates. The protective statutes relevant to Plaintiffs' claims govern health maintenance organizations ("HMO"), exclusive provider organizations, ("EPO"), and preferred provider organizations ("PPO"). The statutes include Tex. Ins. Code §§ 1271.155(a) (applicable to HMO plans), 1301.0053(a) (applicable EPO plans), and 1301.155(b) (applicable to PPO plans) (collectively, the "emergency care statutes").

Based upon the pleadings, Plaintiffs have provided emergency medical services to patients enrolled in Defendants' various health care plans from January 2016 through the present. The parties agree that the Plaintiffs should have been compensated for the services rendered to plan members and for the most part agree that Defendants have already paid benefits to Plaintiffs for these services. Due to the fact that Plaintiffs did not participate in Defendants' provider network, however, there were no written contracts between the parties and consequently no explicitly agreed-upon rates. Plaintiffs allege that the reimbursement levels were "paid at unacceptably low rates," that were below the "usual and customary rate" required by statute. (Doc. No. 9 at 6–7).

II. Procedural History

Plaintiffs sued Defendants in the 190th Judicial District Court of Harris County, Texas "to collect damages from Insurance Companies for Insurance Companies' failure to comply with Texas law and to compel Insurance Companies to pay Plaintiff[s] the usual and customary rate for the emergency services that Plaintiff[s] provided to Insurance Companies' Members." (Doc. No. 1-6 at 12). Plaintiffs pleaded three causes of action in their Original Petition: (1) violations of

the Texas Insurance Code; (2) breach of contract implied in fact; and (3) *quantum meruit.* (*Id.* at 12–14). Defendants removed the case to federal court on the basis that Plaintiffs' claims were completely preempted by the Employment Retirement Income Security Act ("ERISA"). (Doc. No. 1 at 3). Subsequently, Plaintiffs amended their pleadings and moved to remand. (Doc. Nos. 9 & 10). Defendants also filed, following Plaintiffs' amended complaint, a motion to dismiss (Doc. No. 13), to which Plaintiffs responded (Doc. No. 25), and Defendants replied (Doc. No. 27). This Court denied Plaintiffs' motion to remand, because it found that Plaintiffs' claims under the Texas Insurance Code, Section 1301.155(b) ("the PPO statute") from January 2016 through December 31, 2019, including the common law claims involving PPO plans, were completely preempted by ERISA. (Doc. No. 38 at 16). Following this Court's order, the Plaintiffs filed a request for clarification (Doc. No. 40), to which Defendants replied (Doc. No. 41). The Court then heard oral argument on the motion to dismiss and request for clarification.[1] Before the Court, therefore, remains Defendants' motion to dismiss, Plaintiffs' request for clarification, and Plaintiffs' motion for leave to file supplemental authority (Doc. No. 52).

III. Legal Standard

***2** A party may file a motion to dismiss claims against it for "failure to state a claim upon which relief may be granted." Fed. R. Civ. P. 12(b)(6). To defeat a motion under Rule 12(b)(6), a plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 663, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009) (citing *Twombly*, 550 U.S. at 556, 127 S.Ct. 1955). "Where a complaint pleads facts that are 'merely consistent with' a defendant's liability, it 'stops short of the line between possibility and plausibility of entitlement to relief.' " *Id.* (quoting *Twombly*, 550 U.S. at 557, 127 S.Ct. 1955). In reviewing a Rule 12(b)(6) motion, the court must accept all well-pleaded facts in the complaint as true and view them in the light most favorable to the plaintiff. *Sonnier v. State Farm Mut. Auto. Ins. Co.*, 509 F.3d 673, 675 (5th Cir. 2007). The Court is not bound to accept factual assumptions or legal conclusions as true, and only a complaint that states a plausible claim for relief survives a motion to dismiss. *Iqbal*, 556 U.S. at 678-79, 129 S.Ct. 1937. When there are well-pleaded factual allegations, the court assumes their veracity and then determines whether they plausibly give rise to an entitlement to relief. *Id.*

IV. Analysis

A. Plaintiffs' Request for Clarification

As an initial matter, the Court is unpersuaded by the argument in Plaintiffs' request for clarification that the Court should reconsider its holding that Plaintiffs' common law claims pertaining to the PPO statute from January 2016 through December 31, 2019 were completely preempted by ERISA. The Court held that claims for reimbursement under the PPO statute were completely preempted because prior to 2020, the statute imposed a duty on the insurer only to pay "at the preferred level of benefits," which would require an interpretation of the ERISA plan. The "at the usual and customary rate or at an agreed rate" language upon which Plaintiffs rely to take their claims outside of ERISA was not effective in the PPO statute until January 1, 2020, and thus does not apply to any PPO-related claims in this case from January 2016 through December 31, 2019. (Doc. No. 38 at 15).

Plaintiffs now argue that the Texas Administrative Code, Section 3.3708 established a price term outside of the ERISA plans throughout the relevant period, even though the PPO statute itself did not.[2] (Doc. No. 40 at 4). Plaintiffs point to the fact that § 3.3708(b) used the "usual and customary" language before the PPO statute allegedly codified it. The Court, however, agrees with Defendants' position, expressed during oral argument, that the clear text of Section 3.3701 of the Texas Administrative Code prevents the regulation from governing the PPO statute:

> (d) These sections [of the Administrative Code] *do not create a private cause of action* for damages or *create a standard of care, obligation, or duty that provides a basis for a private cause of action.* These sections do not abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available.

Tex. Admin. Code § 3.3701(d) (emphasis added). The regulation's own directive against deriving from it a "standard of care, obligation, or duty" strongly counsels against lifting the text of § 3.3708 and dropping it into a statute in order to impose an extra obligation upon insurers. Moreover, the Administrative Code itself specifically states that it does not create a private cause of action. Tex. Amin. Code § 3.3701(d).

This could not be clearer. Furthermore, Plaintiffs have not demonstrated why the Court should assume a regulation should trump the plain words of the statute in the first place. The Supreme Court of Texas has clearly stated that "clear text equals controlling text," and "[o]ur aversion to extratextual impulses is less prudish than prudent: If it is not necessary to depart, it is necessary not to depart." *Bankdirect Capital Fin., LLC v. Plasma Fab, LLC*, 519 S.W.3d 76, 85 (Tex. 2017). In this regard, Plaintiffs have not shown that the prior PPO statute was not clear, nor have they demonstrated why a regulation should control over a very specific statute. For the foregoing reasons, the Court will not reconsider its previous order on complete preemption and it denies the "request" for clarification insofar as its goal is for this Court to change its decision on the Motion to Remand.

B. The Motion to Dismiss

***3** Defendants asserted five theories upon which to grant relief in their motion to dismiss. (Doc. No. 13). First, Defendants argued that Plaintiffs' claims were completely preempted by ERISA pursuant to 29 U.S.C. § 1132(a). (*Id.* at 11). This Court addressed complete preemption in its Order on Remand, in which it determined that only the Plaintiffs' claims pursuant to the PPO statute from January 2016 through December 31, 2019 were completely preempted. (Doc. No. 38 at 17). Since Plaintiffs declined to amend their complaint, those claims pursuant to the PPO statute have effectively been dismissed. *See Quality Infusion Care Inc. v. Humana Health Plan of Texas Inc., 290* F.App'x 671, 682 (5th Cir. 2008). Second, Defendants asserted that Plaintiffs' claims are expressly preempted under ERISA's conflict preemption provision, 29 U.S.C. § 1144(a). (Doc. No. 13 at 13). Third, Defendants argued that the emergency care statutes do not create a private cause of action under which relief may be sought. (*Id.* at 14). Fourth, Defendants argued that Plaintiffs failed to state a claim for an implied-in-fact contract. (*Id.* at 16). Finally, Defendants argued that Plaintiffs failed to state a claim for relief for *quantum meruit*. (*Id.* at 17). The Court will take each argument in turn and, for the most part, in reverse order.

1. Implied-in-Fact Contract

Plaintiffs allege that Defendants breached an implied-in-fact contract with the Plaintiffs to reimburse claims submitted by Plaintiffs at the usual and customary rate for services rendered to plan members. (Doc. No. 9 at 8-9). Under Texas law, an implied contract is like an express contract. *Haws & Garrett Gen. Contractors, Inc. v. Gorbett Bros. Welding Co.*, 480 S.W.2d 607, 608-09 (Tex. 1972). Like express contracts, there "must be shown the element of mutual agreement which, in the case of an implied contract, is inferred from the circumstances." *Id.* In implied contracts, "the meeting of the minds of the parties [is] implied from and evidenced by their conduct and course of dealing." *Id.; see also Ishin Speed Sport, Inc. v. Rutherford*, 933 S.W.2d 343, 348 (Tex. App.—Fort Worth 1996, no writ) ("dealings ... may result in an implied contract *where the facts show* that the minds of the parties met on the terms of the contract without any legally expressed agreement") (emphasis added).

Plaintiffs contend that they have set out the elements of an enforceable contract. They point to the following allegations from their complaint in support of this contention:

> Plaintiff Doctors and Insurance Companies have impliedly demonstrated their mutual assent to an agreement requiring the Insurance Companies to reimburse the Plaintiff Doctors at a usual customary rate for emergency medical services rendered to the Insurance Companies' Members and requiring the Plaintiff Doctors to accept reimbursement at a usual and customary rate as payment in full.

(Doc. No. 9 at 5). The only other facts pleaded to support the above conclusory statement are that Plaintiffs "have provided emergency medical services to thousands of Insurance Companies' Members," and the Insurance Companies "have dramatically decreased the reimbursements to Plaintiff Doctors for services provided to certain of their Members." (*Id.* at 6). In other words, Plaintiffs alleged that they provided services for plan members and received inadequate reimbursement from Defendants.

Defendants argue, and this Court agrees, that Plaintiffs' allegations are wholly conclusory and bereft of facts that demonstrate a meeting of the minds. They have not alleged any facts to show that either the "circumstances" or the "conduct" of the parties implies an inference of mutual assent to contract. *See Haws*, 480 S.W.2d at 609; *Ishin*, 933 S.W.2d at 348. In fact, Plaintiffs have not pointed to any facts surrounding the alleged agreement, and have instead alleged only naked conclusions which cannot substitute for factual allegations necessary to survive a motion to dismiss. *See Twombly*, 550 U.S. at 555, 127 S.Ct. 1955. Due to the bare fact pleadings, Plaintiffs failed to state a claim for breach of implied-in-fact contract.

2. *Quantum Meruit* Claim

***4** Plaintiffs have also pleaded a claim for recovery under *quantum meruit*. Texas law sets out the elements of *quantum meruit* as follows: (1) valuable services were rendered or materials furnished; (2) to or for the person sought to be charged; (3) which services and materials were accepted by the person sought to be charged and were used and enjoyed by him; and (4) the person sought to be charged was reasonably notified that the plaintiff performing such services or furnishing such materials expected to be paid by the person sought to be charged. *Vortt Expl. v. Chevron*, 787 S.W.2d 942, 944 (Tex. 1990).

Plaintiffs contend that they have adequately pleaded a claim for *quantum meruit* by pleading: (1) Plaintiffs rendered valuable services to Defendants' members; (2) Defendants received and enjoyed the benefit of having its healthcare obligations to its members discharged, and its members received the benefit of care; (3) Defendants were reasonably aware that Plaintiffs would expect payment because of the obligation imposed by the Texas Insurance Code and in their implied-in-fact contract. (Doc. No. 9 at 9). Plaintiffs argue that because Defendants underpaid Plaintiffs despite accepting the benefits, they are entitled to recovery of the difference between what they were paid, and the reasonable value of the services rendered.

Defendants disagree on two points. First, Defendants argue that Plaintiffs have failed to adequately plead the middle two prongs of the *quantum meruit* claim: that Defendants were the "person[s] sought to be charged" who also "accepted ... and enjoyed" the services rendered.[3] *Vortt*, 787 S.W.2d at 944. Defendants argue that patient plan members, not Defendants, are the "persons sought to be charged," because they received the benefit of Plaintiffs' services. (Doc. No. 13 at 18). Second, Defendants assert that an express contract bars *quantum meruit* recovery. (*Id.*). The Court acknowledges that there is conflicting case law as to whether the indirect benefit that an insurer or health plan receives from a plan member's receipt of medical services is enough to support a quantum meruit claim. *Compare Encompass Office Sols., Inc. v. Ingenix, Inc.*, 775 F.Supp.2d 938, 966 (E.D. Tex. 2011) ("Even if [Insurer] received some benefit as a result of [Provider] providing medical services to its insureds, a proposition the court finds dubious, [Provider's] services were rendered to and for its patients.") *with El Paso Healthcare Sys., Ltd. v. Molina Healthcare of N.M., Inc.*, 683 F.Supp.2d 454, 461 (W.D. Tex. 2010) ("While it is true that the immediate beneficiaries of the medical services were the patients, and not [Insurer], that company *did* receive the benefit of having its obligations to its plan members ... discharged.").

The Court agrees with the courts that have found a provider cannot state a claim for *quantum meruit* under similar facts. Plaintiffs allege that they conferred a benefit to the Defendants because they discharged Defendants' "duty to provide for its members' care," but Defendants' duty is to *reimburse* members. (Doc. No. 25 at 19). It is counterintuitive to assert that services provided to an insured are also provided to its insurer. Instead of a benefit, the insurer gets a ripened obligation to pay money to the insured, which is hardly a benefit. *See Ingenix*, 775 F.Supp.2d at 966 n.11; *see also Mid-Town Surgical Ctr., LLP v. Blue Cross Blue Shield of Tex., Inc.*, No. CIV. A. H-11-2086, 2012 WL 1252512, at *3 (S.D. Tex. Apr. 11, 2012) (holding that an insurer of patients/administrator of plans has no recovery in *quantum meruit* because the benefit exchanged is between the providers and the patients).

***5** Furthermore, the Court finds that the express contract bar comes into play because there is a contract that precludes the claim for *quantum meruit*. *Pepi Corp. v. Galliford*, 254 S.W.3d 457, 460 (Tex. App.—Houston [1st Dist.] 2007, pet. denied) (observing no claim for *quantum meruit* may lie where there is an existing contract covering the subject matter). As stated above, there are no express contracts between Plaintiffs and Defendant; however, the healthcare plans are express contracts between the Defendants and their insureds which bear directly on Plaintiffs' claims. The plans' terms define the method of reimbursement that Defendants agreed to provide to its members (or their physicians) upon obtaining out-of-network services. (Doc. No. 13 at 18). Without these plans, Plaintiffs would have no basis to sue Defendants at all.[4] *See Christus Health v. Quality Infusion Care*, 359 S.W.3d 719, 724 (Tex. App.—Houston [1st Dist.] 2011, no pet.) ("[Provider] cannot avoid the express contract bar to its quantum meruit claim on the ground that [Insurer] did not designate [Provider] as an approved network provider or otherwise treat [Provider] as a party to the medical plan for purposes of providing those services."). Thus, the Court finds that the claim for *quantum meruit* must also fail as a result of the express-contract bar.

3. Statutory Claims

Under Texas law, a statute creates a private cause of action "only when a legislative intent to do so appears in the statute as written." *Brown v. De La Cruz*, 156 S.W.3d 560, 567 (Tex.

2004). When a private cause of action is alleged to derive from a statutory provision, courts must ascertain the drafters' intent. *See Atl. Cas. Ins. Co. v. PrimeLending*, No. 3:15-CV-1476-D, 2016 WL 1322235, at *4, 2016 U.S. Dist. LEXIS 45780, at *12 (N.D. Tex. Apr. 5, 2016) (citing *Brown*, 156 S.W.3d at 563); *see also Witkowski v. Brian, Fooshee & Yonge Props.*, 181 S.W.3d 824, 831 (Tex. App.—Austin 2005, no pet.) ("We apply a 'strict rule of construction' to statutory enforcement schemes and imply causes of action only when the drafters' intent is clearly expressed from the language as written."). In addressing an unsettled question of state law, a federal court must predict how the state high court would rule. *McCaig v. Wells Fargo Bank (Tex.), N.A.*, 788 F.3d 463, 472 (5th Cir. 2015).

Defendants accurately argue that the emergency care statutes do not expressly provide a private cause of action to sue for damages. (Doc. No. 13 at 15). They further argue that there is no evidence of legislative intent to create an implied private cause of action and correctly allege that the only precedent cited to this Court to squarely consider the question of whether the emergency care statutes provide a private cause of action held that they did not. (*Id.*); *see Apollo MedFlight, LLC v. BlueCross BlueShield of Texas*, No. 2:18-cv-166-Z-BR, 2019 WL 4894263 at *3 (N.D. Tex. Oct. 4, 2019).

Plaintiffs concede, as they must, that the emergency care statutes lack an express private right of action. Instead, they argue that the Code impliedly creates a private cause of action because it confers upon a limited class of parties the entitlement to compensation at a defined rate. (Doc. No. 25 at 8). Plaintiffs cite Texas law to argue that as a rule, a statute that confers an entitlement to compensation upon a limited class of parties reflects a legislative intent that entitled parties may enforce the statute through private litigation. (*Id.* at 15).[5] In addition, Plaintiffs bolster their statutory-construction argument with the "Mandatory Binding Arbitration" provision of the Insurance Code, effective as of January 1, 2020. Plaintiffs contend that the enactment of this provision, that requires out-of-network providers and plan administrators to arbitrate before filing suit for an out-of-network claim, obviously means the Texas Legislature, the author of the Code in question, assumes private parties *can* file suit.

***6** The two most recent decisions on point are *Apollo MedFlight*, 2019 WL 4894263 and *Angelina Emergency Medicine Ass. P.A. v. Healthcare Service Corporation*, 2020 WL 7259222 (N.D. Tex. Dec. 10, 2020). Both cases followed what is unquestionably the general rule in Texas that "statutes create a private cause of action 'only where a legislative intent to do so appears in the statute as written.' " *Angelina*, 2020 WL 7259222 at *6 (quoting *Brown*, 156 S.W.3d at 567) (and citing the analysis of the statutes in question done by the court in *Apollo*, 2019 WL 4894263 at *3). This Court is certainly in agreement with their analysis of Texas law and agrees with their conclusions as far as they go, but neither court offers an explanation of the effect of the "Mandatory Binding Arbitration" provision, § 1467.085, which applies to the emergency care statutes at issue here. But for this provision, the Court might agree with the reasoning and conclusions reached in both cases.

The Court finds that a fair and practical reading of the "Mandatory Binding Arbitration" provision from the Texas Insurance Code indicates that the Texas Legislature interprets the emergency care statutes to create a private cause of action. First, prior to September 2019, the Insurance Code authorized certain claims dispute resolution procedures as non-exhaustive alternatives for healthcare providers to resolve coverage disputes. The controlling law between June 2009 and September 2019 was § 1467.004, which states:

> The remedies provided by this chapter are *in addition to* any other defense, remedy, or procedure provided by law, including the common law.

Tex. Ins. Code Ann. § 1467.004. (emphasis added). This provision by itself, of course, does not state that plaintiffs can file suit under the emergency care statutes. Nevertheless, in September 2019, the Texas Legislature enacted the "Mandatory Binding Arbitration" process in an amendment to Chapter 1467, that must be completed *before providers can file suit* to compel payment. The amendment sets out a mandatory scheme to arbitrate claims submitted by out-of-network providers like Plaintiffs. *See* § Tex. Ins. Code § 1467.083(a) ("[A]n arbitrator may determine ... the reasonable amount for the health care or medical services ... provided to the enrollee by an out-of-network provider."). Critically, Section 1467.085 of the Texas Insurance Code provides:

> *Notwithstanding Section 1467.004, an out-of-network provider or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue* of the amount to be paid in the out-of-network claim dispute.

Tex. Ins. Code Ann. § 1467.085 (emphasis added).

This provision confirms that the Texas Legislature intended for the emergency care statutes to create a private cause of action. By requiring arbitration before out-of-network providers "file suit" for out-of-network claims "*[n]otwithstanding Section 1467.004*," the Texas Legislature clearly interprets Section 1467.004 as authorizing such suits. *Id.* (emphasis added). If there were no implied cause of action prior to this amendment, the language of Section 1467.004 —that the remedies are "in addition" to any other remedy provided by law—and the wording of Section 1467.085 to the effect that a health care provider "may not file suit for an out-of-network claim *subject to this chapter*," would be superfluous. *See Spradlin v. Jim Walter Homes, Inc.*, 34 S.W.3d 578, 580 (Tex. 2000) ("We give effect to all the words of a statute and do not treat any statutory language as surplusage if possible.") (cleaned up). Stated another way, the Texas Legislature was acknowledging that it was restricting Section 1467.004 by mandating arbitration before any lawsuits were filed.[6]

***7** Second, Chapter 1467 clearly incorporates the emergency care statutes. Section 1467.002 states that Chapter 1467 applies to:

> (1) a health benefit plan offered by a health maintenance organization *operating* under Chapter 843;
>
> (2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and
>
> (3) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

Tex. Ins. Code Ann. § 1467.002 (emphasis added). The emergency care statutes fall within those parameters: the HMO statute is "operating" under Chapter 843, because that chapter authorizes and oversees HMO plans, and the EPO and PPO statutes are found in Chapter 1301. In other words, the applicable provisions in this case are "subject to" the arbitration provision. If the healthcare providers had no right to file suit, this provision would be a nullity.[7] Whenever possible, "statutes should be construed so as not to be in conflict with each other." *Araya v. McLelland*, 525 F.2d 1194, 1196 (5th Cir. 1976) (citing *Morton v. Mancari*, 417 U.S. 535, 551, 94 S.Ct. 2474, 41 L.Ed.2d 290 (1974)). *See* Ron Beal, *The Art of Statutory Construction: Texas Style*, 64 Baylor L. Rev. 339, 415 (2012) ("[L]egislative enactment covering a subject dealt with in an older law, but not expressly repealing that law, should be harmonized whenever possible with its predecessor in such a manner as to give effect to both."). *See, e.g., Tex. Indus. Energy Consumers v. CenterPoint Energy Houston Elec., LLC*, 324 S.W.3d 95, 107 (Tex. 2010); *Standard v. Sadler*, 383 S.W.2d 391, 395 (Tex. 1964).

Additionally, the language of the emergency care statutes unambiguously identifies a limited class of parties (out-of-network providers) to receive compensation for an actual loss (the usual and customary or preferred rate) from another party (insurers or health maintenance organizations).[8] The Supreme Court of Texas has indicated that when statutes are not penalties, identity actual loss, and identity the persons to receive payment, they may create an implied cause of action. *See Brown*, 156 S.W.3d at 565 (discussing characteristics of statutes that provide a private right of action); *City of Beaumont v. Bouillion*, 896 S.W.2d 143, 149 (Tex. 1995) (finding the takings provision of the Texas Constitution necessarily implied a private right of action held by persons entitled to the compensation). The emergency care statutes appear to satisfy that criteria. The Court also notes that private claims under the Texas Insurance Code survived both a summary judgment motion in this district and a motion to dismiss in the Western District of Texas. *Emergency Health Ctr. at Willowbrook, L.L.C. v. UnitedHealthcare of Tex., Inc.*, 892 F.Supp.2d 847, 857 (S.D. Tex. 2012); *Gilmour for Grantor Trusts of Victory Parent Co., LLC v. Aetna Health, Inc.*, SA-17-CV-00510-FB, 2018 WL 1887296, at *14 (W.D. Tex. Jan. 19, 2018).

***8** Thus, it appears to the Court that a private cause of action was intended in the emergency care statutes.[9]

4. ERISA Express Preemption

Finally, the Court turns to ERISA preemption. ERISA's express (also known as conflict) preemption clause, 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. A state law relates to an ERISA plan "if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001). To determine whether a state law has an impermissible connection with an ERISA plan, courts consider ERISA objectives "as a guide to the scope of the state law that Congress understood would survive." *California Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997). ERISA is "primarily concerned with preempting laws that require providers to structure

benefit plans in particular ways, such as requiring payment of specific benefits, or by binding plan administrators to specific rules for determining beneficiary status." *Rutledge v. Pharm. Care Mgmt. Ass'n*, —— U.S. ——, 141 S. Ct. 474, 480, —— L.Ed.2d —— (2020). To paraphrase those considerations, courts ask whether a state law "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320, 136 S.Ct. 936, 194 L.Ed.2d 20 (2016). A law "refers" to ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation." *Id.* at 319–320, 117 S.Ct. 832.[10]

***9** As a preliminary matter, the Court notes that after its rulings above, the only viable claims remaining are the violations of the Texas Insurance Code (the emergency care statutes). At oral argument, Plaintiffs urged that they were "not suing under assignments here ... [but] are suing under the basis that is provided under Texas law under the HMO statutes and the other statutes ..." (Doc. No. 50 at 34). More specifically, Plaintiffs argued that "there's a separate obligation that United owes directly to the medical providers under the statute .... [t]hat would not be in any way affected by the existence of the plan itself and any obligations under the plan." (*Id.* at 27). Without being tethered to an assignment of benefits or a contract claim, the Plaintiffs are suing purely under the HMO, EPO, and PPO statutes.[11]

This Court is bound by the recent Supreme Court ruling in *Rutledge v. Pharm. Care Mgmt. Ass'n*, —— U.S. ——, 141 S. Ct. 474, —— L.Ed.2d —— (2020). The facts in *Rutledge* present a comparable situation to the one in this case. Therefore, its recent holding, if not outcome determinative, is certainly instructive. In *Rutledge*, the Supreme Court held that an Arkansas law governing the conduct of pharmacy benefit mangers ("PBMs") was not expressly preempted by ERISA. *Rutledge*, 141 S. Ct. at 478. PBMs are intermediaries between prescription-drug plans and the pharmacies that those plans' beneficiaries use. When a beneficiary wishes to fill a prescription from a pharmacy, the PBM instructs the pharmacy as to the beneficiary's coverage and copayment. The PBM in turn reimburses the pharmacy, and the drug plan reimburses the PBM. In response to PBMs setting reimbursement rates too low to cover pharmacy costs, Arkansas passed a state law that required PBMs to reimburse pharmacies at a price equal to or higher than the pharmacy's wholesale cost by (1) imposing requirements on PBMs regarding their maximum allowable cost ("MAC") lists, which set the reimbursement rates to pharmacies; (2) prescribing administrative appeal procedures for pharmacies; and (3) enabling pharmacies to decline to dispense if the transaction will incur a loss. *Id.* at 479. This is quite similar to Texas' requirement that emergency room doctors get paid at a "usual and customary rate."

In reaching the conclusion that the state law was not preempted, the Supreme Court first determined that the law is not impermissibly connected to ERISA. It noted that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." *Id.* at 480. The Supreme Court relied on its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), and reiterated that ERISA "does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Id. See Travelers*, 514 U.S. at 662, 115 S.Ct. 1671 ("[C]ost uniformity was almost certainly not an object of pre-emption."). The Court concluded that the Arkansas law is just a form of cost regulation, and therefore is not "impermissibly" connected to an ERISA plan.[12]

***10** The Supreme Court also held that the Arkansas statute does not "refer" to ERISA. The Court determined that the state law does not act "exclusively" on ERISA, because it applies to all PBMs regardless of whether they "manage an ERISA plan." *Id.* at 481. The Court similarly decided that ERISA plans are not "essential" to the state law because the state law does not depend on the existence of ERISA plans—it governs PBMs "whether or not the plans they service fall within ERISA's coverage." *Id.* In sum, the Supreme Court found that the state law did not "require plan administrators to structure their benefit plans in any particular manner, or ... lead to anything more than potential operational inefficiencies," and was therefore not preempted by ERISA. *Id.* at 482.

The emergency care statutes before this Court are analogous to the Arkansas law considered in *Rutledge.* In fact, they are probably less intrusive than the Arkansas PBM law, because they require only that an HMO, EPO, or PPO issuer reimburse at a "usual and customary" rate. Unlike the PBM law, the emergency care statutes do not provide for an appeals procedure or enable emergency care physicians to decline to treat the patient. *See* Tex. Ins. Co. §§ 1271.155(a),

1301.0053(a) and 1301.155(b). This Court can find no legally meaningful distinction, for purposes of express ERISA preemption, between an Arkansas law that regulates the rate at which PBMs reimburse pharmacies, and the Texas emergency care statutes, which regulate the rate at which insurers and insurance plan administrators reimburse emergency care physicians. In terms of "impermissible connection," the statutes are alike because neither the Arkansas law nor the Texas emergency care statutes impose a "scheme of substantive coverage." *Rutledge*, 141 S. Ct. at 480. As stated above, the emergency care statutes merely impose a rate regulation on insurers and insurance plan issuers. Likewise, none of the statutes "refers" to ERISA because each statute encompasses non-ERISA plans. Nothing in the emergency care statutes places requirements on an ERISA plan as opposed to a Medicaid, Medicare, military, marketplace or other plan. *See id.* at 481 n.1; *see also* Tex. Ins. Co. §§ 1271.155(a), 1301.0053(a) and 1301.155(b). In other words, the emergency care statutes, like the Arkansas PBM law, apply to insurance plans and issuers regardless of whether they are tethered to an ERISA plan.

Plaintiffs and Defendants both agree that the emergency care statutes regulate the rate of reimbursements. (Doc. No. 25 at 12; Doc. No. 48 at 5). Plaintiffs have argued that their claims under the statutes are not preempted because ERISA does not preempt state regulation of the reimbursement *rates*. (Doc. No 25 at 12; Doc. No. 50 at 74). Defendants previously argued that there is no precedent supporting the notion that a rate regulation should be treated any differently than a regulation of the *right* to benefits for purposes of ERISA. (Doc. No. 48 at 8; Doc. No. 50 at 80). With the recent decision in *Rutledge*, however, Defendants' argument is somewhat undercut. The Supreme Court has now explicitly stated that "ERISA *does not pre-empt state rate regulations that merely increase costs* or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Rutledge*, 141 S. Ct at 480 (emphasis added). The emergency care statutes do not force plans to adopt any scheme at all. The Court, guided by the *Rutledge* decision, finds that the emergency care statutes equate to cost regulation that does not bear an impermissible connection with or reference to ERISA, and are therefore not preempted.

V. Conclusion

This Court has found that Plaintiffs have a cause of action under the emergency care statutes largely because of the language of the "Mandatory Binding Arbitration" provision, which applies to health benefit claims submitted by out-of-network providers for medical services rendered on or after January 1, 2020. Tex. Ins. Code Ann. § 1467.081. Plaintiffs' Amended Complaint alleges that the insurance companies paid them at unacceptably low rates from January 2016 "*through the present.*" (Doc. No. 9. at 6) (emphasis added). Accordingly, any disputes in this case over claims for reimbursement that were filed after January 1, 2020 are subject to arbitration, despite Plaintiffs' statement that "[t]his action does not seek recovery for underpayment of any claim for reimbursement subject to mandatory arbitration." (Doc. No. 9 at 6 n.3). Unless the Plaintiffs file a formal stipulation that they are no longer seeking to enforce claims arising after January 1, 2020, when the mandatory arbitration provision took effect, this Court will stay the case while those claims undergo arbitration. Plaintiffs have thirty (30) days from the date of this order to file such a stipulation.

***11** This opinion may be the first opinion in this Circuit to implement the *Rutledge* decision. Moreover, it clearly reaches a conclusion as to the existence of a private cause of action which is at odds with at least two recent district court opinions. That being the case, the Court will entertain a request to certify this matter for an interlocutory appeal if that request is made by February 5, 2021. *See* 28 U.S.C. § 1292(b).

For the foregoing reasons, the Court **GRANTS** in part the Motion to Dismiss (Doc. No. 13) as to the PPO claims from January 1, 2016 through December 31, 2019, the implied-in-fact contract claims, and the *quantum meruit* claims, and **DENIES** in part the Defendants' Motion to Dismiss as to the statutory claims. To the extent this order clarifies the Court's previous order, the Plaintiffs' Request for Clarification (Doc. No. 40) is also granted. To the extent that request can be read as a renewed motion to remand, it is denied. The Plaintiffs' Motion for Leave to File (Doc. No. 52) is granted.

All Citations

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Footnotes

1 Plaintiffs' "request for clarification" is essentially a motion to rehear its arguments on the motion to remand.

2 The relevant provision of 28 Tex. Admin. Code § 3.3708(b) provides that:

> (b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:
>
> (1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan ....

28 Tex. Admin. Code § 3.3708(b).

3 The Court also questions whether the Plaintiffs have alleged facts to satisfy the fourth prong: that Defendants were *reasonably notified* that Plaintiffs, in performing such services, expected to be paid by Defendant. As Plaintiffs conceded at oral argument, Defendants do not become aware of the services rendered until a claim is submitted i.e., until after the services are rendered. By definition, the "emergency" services rendered are emergent and unpredictable, thereby for the most part precluding reasonable notice to Defendants until after-the-fact. It appears to the Court that due to the nature of the services, the Defendants would rarely be reasonably notified.

4 Additionally, without the express contractual healthcare plans between the defendants and their insureds, Plaintiffs would not know which insurer or administrator to sue for *quantum meruit.*

5 *City of Beaumont v. Bouillion.* 896 S.W.2d 143 (Tex. 1995); *Brown v. De La Cruz*, 156 S.W.3d 560 (Tex. 2004); *see also Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1194–98 (Fla. 4th DCA 2006) (Florida state court applying similar reasoning to an analogous Florida emergency care statute, Fla. Stat. § 641.514(5)).

6 In fact, the new scheme limits the right to sue only to judicial review of the arbitrator's decision based on a "substantial evidence standard." Tex. Ins. Code Ann. § 1467.089. Accordingly, this case may be one of the first and perhaps the last of its kind, because the claims at issue arose between 2016 and 2019, in the time between the enactment of § 1467.004 and § 1467.085. Practically speaking, the claims arose during the window of time when out-of-network providers were authorized to file suit under the emergency care statutes, but did not have to first go through arbitration, only to be later limited to judicial review of the arbitrator's decision.

7 Section 1467.084 states that mandatory arbitration of out-of-network claims is available to health benefit claims for (A) emergency care; (B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider; (c) an out-of-network laboratory service; or (D) an out-of-network diagnostic imaging service. *See* Tex. Ins. Code § 1467.084. In support of its finding an implied private right of action, this Court highlights that emergency care is specifically enumerated and accounted for by the provision.

8 The current emergency care statutes provide, in relevant part:

— § 1271.155(a) – HMO plans:

"A[n] [HMO] *shall pay* for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate."

Tex. Ins. Code § 1271.155(a) (emphasis added).

— § 1301.0053 – EPO plans:

"If a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in an [EPO], the issuer of the plan *shall reimburse* the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services."

Tex. Ins. Code § 1301.0053(a) (emphasis added).

— § 1301.155 – PPO plans:

"If an insured cannot reasonably reach a preferred provider, an insurer *shall provide reimbursement* for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider ..."

Tex. Ins. Code § 1301.0055(b) (emphasis added).

9 The Magistrate Judge's Memorandum, which was not adopted by the court, in *Apollo MedFlight, LLC v. BlueCross BlueShield of Tex.*, No. 2:18-CV-0166-D-BR, 2019 WL 2539272, 2019 U.S. Dist. LEXIS 106205 (N.D. Tex. Apr. 12, 2019), recommended that private causes of actions for violations of emergency care statutes should survive a motion for dismiss after a thorough analysis of the statutory scheme, including Texas and federal law, and other court opinions discussing the emergency care statutes. This Court, acknowledging the complexity of these statutes, respectfully disagrees with the District Court's thoughtful decision not to adopt that recommendation. *Apollo MedFlight, LLC v. BlueCross BlueShield of Tex.*, 2019 WL 4894263, at *, 2019 U.S. Dist. LEXIS 172927, at *7 (N.D. Tex. October 4, 2019).

10 The Fifth Circuit iteration of the express preemption test requires that a defendant pleading express pre-emption under ERISA prove: "(1) the state law claims address an area of exclusive federal concern, such as the right to receive benefits

under the terms of an ERISA plan; and (2) the claims directly affect the relationships among traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 382 (5th Cir. 2011) (quoting *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 245 (5th Cir. 1990)). Obviously, the Court here must follow the dictates in *Rutledge.* Nevertheless, this Court is not convinced that the result would be any different should it be based solely on the existing Fifth Circuit precedent.

11 *See supra* note 8.

12 The Supreme Court's ruling in *Rutledge* is strikingly similar to the Fifth Circuit's complete preemption rule articulated in *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525 (5th Cir. 2009). In the context of complete preemption, the Fifth Circuit held that when a claim implicates the *rate* of payment in a contract, rather than the *right* to payment under terms of a plan, it is not completely preempted. *Id.* at 530–31. It would not be surprising if the Fifth Circuit interpreted *Rutledge* as requiring the application of its rule distinguishing a rate of payment from a right to payment to apply with equal force to complete preemption (ERISA § 502) and conflict preemption (ERISA § 514).

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