Case No. 05-19-01583-CV

IN THE FIFTH DISTRICT COURT OF APPEALS

DALLAS MEDICAL CENTER, ET AL.,
Appellants,

v.

MOLINA HEALTHCARE OF TEXAS, INC.,
Appellee.

On Appeal from Cause No. DC-18-06920
193rd Judicial District Court, Dallas County, Texas

Brief of Amicus Curiae

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STATEMENT OF INTEREST AND CONCERN

The Texas Hospital Association ("THA"), a non-party, writes as *amicus curiae* to alert the Court of the importance of permitting a hospital to file suit against a health insurance carrier for the underpayment of emergency claims and to encourage this Court to reverse the decision of the district court to dismiss this cause of action for lack of subject matter jurisdiction. The Texas Hospital Association does not have a direct financial interest in this case and is solely responsible for payment of fees for preparation of this brief.[1] THA, as a representative of over 450 Texas hospitals, is vitally interested in and concerned about the matters before this Court, which will affect the delivery of care and treatment to individuals, and the operations and financial viability of Texas hospitals. There are approximately 640 general and special hospitals in Texas that provide a wide array of health care services to the communities they serve, and hospital emergency room admissions total over 11.6 million per year.

[1] *See* Tex. R. App. Proc. 11(c) (2020).

SUMMARY OF THE ARGUMENT

Hospitals operate under a unique legal obligation to screen and stabilize every patient who comes to an emergency department, regardless of whether the patient has insurance or the ability to pay for care. Hospitals are generally not paid prior to providing care or immediately thereafter. Instead, hospitals file requests for reimbursement from patients and their health insurance companies (if the patient has insurance) well after the care is provided. A health insurance carrier may have a contractual relationship with a hospital with agreed upon terms of reimbursement or no direct contractual relationship with a hospital—where reimbursement is less predictable. Unlike for scheduled procedures, patients often have no choice of where they receive emergency care. Even when patients do have a choice, the Legislature and state agencies have recognized that patients should be able to receive care at the closest emergency department. The State of Texas has developed important minimum payment protections for hospitals who do not have the benefit of a contract with a health insurance carrier, commonly referred to as out-of-network hospitals. It is paramount for out-of-network hospitals to have a meaningful legal recourse to hold health insurance carriers accountable for underpayment. Unfortunately, the trial court in this case failed to consider the legal and public policy ramifications for denying Appellant its legal recourse.

The provision and payment of health care involves a carefully calibrated relationship between the patient, the health insurance carrier and the health care provider. Patients purchase health insurance to protect themselves from much of the cost of medical care, and they pay monthly premiums to their health insurers to ensure they have access to certain health care services; health insurers arrange for their members to receive those health care services, typically by entering into contracts with health care providers who agree to accept pre-negotiated, discounted rates of payment from the insurer in return for receiving the benefits of "in-network" status; and health care providers render medical care to the insurers' members and then seek reimbursement for those services from the insurer.

To encourage their members to choose an in-network provider, insurers often cover only a portion of the cost of out-of-network services and require the member to pay the "balance bill"—the difference between what the provider charged for the service and what the insurer paid—if the member chooses to receive the services from an out-of-network provider. However, in an emergency situation, the patient often does not have the time or wherewithal to choose between an in-network or out-of-network hospital. Instead, the patient typically goes (or is taken) to the closest hospital. At the same time, hospitals with emergency departments are legally required to provide every patient seeking emergency care with certain medical screening and stabilization services, without regard to the patient's insurance, ability

to pay or the provider's network status. As a result, patients sometimes seek emergency care from an out-of-network hospital, and the hospital provides emergency care to the patient even though the hospital does not have a contract with the patient's insurer. If the patient's insurer refuses to pay for some or all of those out-of-network emergency services, hospitals are forced to choose between billing the patient to recover all or part of the balance (which can be a significant amount of money) or to write off legitimate charges (which, over time and in the aggregate, can have a significant impact on a hospital's financial viability and ability to continue providing services). For these reasons, the Texas Legislature passed a series of laws aimed at protecting patients who receive out-of-network emergency care—and the health care providers who render it—from the full burden of "balance billing" by imposing minimum payment requirements on insurers for out-of-network emergency care.

Those laws, including Tex. Ins. Code § 1271.155 and Tex. Admin Code § 353.4, were passed: (1) to protect patients who need emergency care —and who have already paid for emergency care coverage by paying premiums to their insurers—from incurring significant medical bills; and (2) to ensure that safety net hospitals and other critically needed health care providers are fairly reimbursed for the emergency services they are legally required to provide. Moreover, those laws evidence a clear legislative policy to ensure that patients are not placed in the middle

of billing and payment disputes between hospitals and insurers, and that those disputes are instead resolved directly between the hospitals and the insurer. They do so by shifting financial responsibility for out-of-network emergency services from the patient to the insurer and by expressly mandating that the insurer (not the patient) pay the provider for those emergency services. Under these circumstances, it would contravene the Legislature's intent and upset the balance of the health care infrastructure to give insurers carte blanche to reimburse hospitals whatever amount the insurers choose and to deny hospitals judicial recourse to challenge the insurer's reimbursement determination. Indeed, had the Legislature believed that an insurer's unilateral reimbursement determination was always appropriate and not subject to judicial review, there would have been no need to enact the emergency care laws or to include a legally-mandated rate in them. Nevertheless, the Appellee contends that health care providers have no right to enforce the emergency care laws against insurers and must instead bill and try to collect from the patient directly to obtain payment for out-of-network emergency services. That position directly contradicts what the Legislature worked to accomplish with the various protections included in the emergency care laws, all of which are intended to protect patients and providers, *not* insurers. With the Texas Hospital Association's support, the Texas Legislature recently confirmed its intent to protect patients—and rejected Molina's assertion that out-of-network providers should be required to seek payment from their patients—

by passing Senate Bill 1264, 86th R.S., and amending Tex. Ins. Code § 1271.155 to expressly prohibit out-of-network providers from "balance billing" patients starting January 1, 2020. S.B 1264 will prevent balance billing going forward; however, it does not apply to services rendered before January 1, 2020, including all the services at issue in this case. The Appellee contends that out-of-network providers are *required* to seek payment from their patients for all such services.

An insurer should be held accountable for its legally and contractually obligated payment, and a patient should not be dragged into a dispute with a provider over whether the amount an insurer paid to the provider for services was appropriate. The Appellee's assertion—and the trial court's implicit conclusion—that the Texas Legislature intended to allow insurers to unilaterally dictate the appropriate amount of reimbursement for emergency services and to deny providers any judicial recourse to challenge those determinations under any theory is illogical, contrary to the text and purpose of the emergency care laws and damaging to patients and health care providers in Texas. It should therefore be rejected.

In addition to the public policy arguments, the Appellant raised a variety of valid legal theories for why the district court has subject matter jurisdiction over this case. These include: (1) the existence of a contractual relationship established by an assignment of benefits from patients to the Appellant; (2) enforcing Texas Insurance Code Section 1271.155's requirement for health insurance carriers to pay out-of-

network health care providers "at the usual and customary rate" and Texas Administrative Code Section 353.4's mandate to reimburse out-of-network health care providers at "the Medicaid [Fee for Service] rate in effect on the date of service less five percent"; and (3) recognizing an equitable remedy for underpayment.

ARGUMENT

I. An assignment of benefits creates a contractual relationship between a health insurance carrier and an out-of-network provider, and a court has subject matter jurisdiction to determine whether that contract is breached.

An assignment of benefits creates a contractual relationship between a health insurance carrier and an out-of-network provider. An assignment of benefits allows the assignee to "stand[] in the shoes" of the assignor. *Sw. Bell Tel. Co. v. Mktg. on Hold Inc.*, 308 S.W.3d 909, 916 (Tex. 2010). A patient enrolled in an insurance plan enters into a contractual relationship with the insurance carrier. A patient may assign the benefit of a particular claim or encounter to a hospital. Thus, an assignment of health insurance benefits from an enrolled patient to a hospital creates a contractual relationship between the insurance carrier and the hospital. *See, e.g.*, *Tex. Gen. Hosp. LP v. United HealthCare Serv.*, No. 3:15-CV-02096-M, 2016 WL 3541828, at *11 (D. Tex. June 28, 2016) (denying a motion to dismiss for a breach of contract claim based on an assignment of benefits to a hospital). If the insurance carrier fails to meet its payment obligations to the assignor patient, then an assignee hospital should be permitted to pursue a claim for breach of contract. A court has subject-matter jurisdiction to adjudicate a claim for breach of contract. *See Lewis v. Foxworth*, No. 05-06-00452-CV, 2007 WL 499649, at *2 (Tex. App.—Dallas Feb. 16, 2007, no pet.) ("The Dallas district court has jurisdiction to determine a breach of contract case.").

There is established case law permitting out-of-network hospitals to bring causes of action against out-of-network insurers for breach of contract based on an assignment of benefits. In *Texas General Hospital*, an out-of-network hospital sued an insurer for underpayment based on, among other theories, breach of contract. 2016 WL 3541828, at *1–*2. As a condition of providing care, the hospital required patients to execute an assignment of benefits form. *Id.* at *3. The court found that the plaintiffs "adequately identif[ied] the contract terms" and denied the insurer's motion to dismiss. *Id.* at *11. Similarly, in *Grand Parkway Surgery Ctr., LLC v. Health Care Serv. Corp*, the plaintiff, an out-of-network provider, brought suit against an insurance carrier for underpayment based on breach of contract and other claims. No. H-15-0297, 2015 WL 3756492, at *1 (D. Tex. June 16, 2015). The defendant moved to dismiss the plaintiff's breach of contract claim, alleging that the plans contained anti-assignment clauses. *Id.* at *1. The court found that there was no requirement for the plaintiff to attach proof of the assignments of benefits to establish standing. *Id.* at *2. The court also found that the anti-assignment clause was relevant, but not sufficient to grant a motion to dismiss. *Id.* Accordingly, the court denied the defendant's motion to dismiss. *Id.* THA urges this Court to follow precedent and reverse the district court's finding that it lacked subject matter jurisdiction over Appellant's breach of contract claims.

II. Hospitals have a valid cause of action to enforce the Texas Insurance Code's requirement to pay out-of-network hospitals at the usual and customary rate and the Texas Administrative Code's requirement for Medicaid managed care organizations to reimburse out-of-network health care providers for medically necessary emergency care at the required minimum rate.

Although chapter 1271, Texas Insurance Code, and chapter 353, Texas Administrative Code, do not include express causes of action, there is an implied cause of action inherent to the statute which is the only avenue to meaningful enforcement of the law. The Texas Hospital Association directs the Court to pages 41 through 57 of Appellant's brief, which provide a thorough overview of why a private cause of action exists. Appellant's Br. 10. There is a clear statutory mandate for commercial insurance: "A health maintenance organization 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). For Medicaid managed care, "An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services." 1 Tex. Admin. Code § 353.4(c)(1). For emergency services performed by out-of-network providers, an "MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount." 1 Tex. Admin. Code § 353.4(e)(2)(A).

Neither the Texas Insurance Code nor the Administrative Code includes a clear enforcement mechanism for violations. The Texas Hospital Association urges

this Court to consider the devastating public policy implications that would occur if hospitals could not enforce claims for underpayment in Texas courts. Payers would be permitted to underpay hospitals at will—even in clear violation of Texas law—and hospitals would have no way to challenge them.

III. Absent recognizing other legal remedies, at the very least, a hospital is entitled to an equitable remedy for underpayment for emergency care based on unjust enrichment and quantum meruit.

"Quantum meruit 'is founded [on] the principle of unjust enrichment.'" *Christus Health v. Quality Infusion Care, Inc.*, 359 S.W.3d 719, 722 (Tex. App.—Houston [1st Dist.] 2011, no pet.) (quoting *Bashara v. Baptist Mem'l Hosp. Sys.*, 685 S.W.2d 307, 310 (Tex. 1985)). "Unjust enrichment is an implied-contract theory stating one should make restitution when it would be unjust to retain benefits received." *Id.* at 722–23. It is "based upon the promise implied by law to pay for beneficial services rendered and knowingly accepted." *Id.* at 723 (quoting *In re Kellogg Brown & Root, Inc.*, 166 S.W.3d 732, 740 (Tex. 2005)). If the enrollees of a health benefit plan receive emergency care from a provider who receives payment from the health benefit plan below the contemplated rate, then the health benefit plan is unjustly retaining a benefit at the provider's expense. "The measure of recovery for quantum meruit is the reasonable value of the services." *Hudson v. Cooper*, 162 S.W.3d 685, 688 (Tex. App.—Houston [14th Dist.] 2005, no pet.). The hospitals, in this case, are entitled to the benefit of the bargain. If this Court does not find

sufficient evidence of a contractual relationship between the Appellant and the Appellee by virtue of assignment or a private right of action through the enforcement of minimum payment standards, then the Appellant is still entitled to an equitable remedy.

CONCLUSION AND PRAYER

Based on the legal and policy arguments presented in this brief, Amicus Curiae respectfully requests that the Court fully consider the effect of this dispute on Texas hospitals and their ability to provide care to Texans and grant the relief requested by Appellants.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 52.3(j)

I certify that I have reviewed this Amicus Curiae Brief on behalf of the Texas Hospital Association and that I have concluded that every factual statement herein is supported by competent evidence.

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I hereby certify that this document complies with the typeface requirements of Tex. R. App. P. 9.4(e) because it has been prepared in a conventional typeface no smaller than 14-point for text and 12-point for footnotes. This document also complies with the word-count limitations of Tex. R. App. P. 9.4(i), because it contains 2,524 words, excluding any parts exempted by Tex. R. App. P. 9.4(i)(l).

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