IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 98-20940

CORPORATE HEALTH INSURANCE, INC.;
AETNA HEALTH PLANS OF TEXAS, INC.;
AETNA HEALTH PLANS OF NORTH TEXAS, INC.;
AETNA LIFE INSURANCE COMPANY,
Plaintiffs – Appellees – Cross-Appellants,

v.

THE TEXAS DEPARTMENT OF INSURANCE
Defendant – Cross-Appellee,
JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS
DEPARTMENT OF INSURANCE; JOHN CORNYN,
ATTORNEY GENERAL, STATE OF TEXAS
Defendants – Appellants – Cross-Appellees,

On Remand from the United States Supreme Court

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE TEXAS MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS JOSE MONTEMAYOR AND JOHN CORNYN

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SUPPLEMENTAL STATEMENT OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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American Medical Association/State Medical Society Litigation Center
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STATEMENT OF INTEREST

The American Medical Association ("AMA") and the Texas Medical Association ("TMA") submit this brief *amicus curiae* in support of appellants/cross-appellees Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas.[1] The AMA, an Illinois not-for-profit corporation founded in 1847, is the country's largest medical society. Its approximately 275,000 physicians practice in all fields of medical specialization in every state, including Texas. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

Amicus TMA, a Texas not-for-profit corporation, is an association of physicians who practice in the State of Texas. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Its approximately 36,000 members, representing more than 83% of all licensed physicians in Texas, practice in all fields of medical specialization. As an association of physicians and medical students, TMA is interested in and concerned with matters before this Court that affect the health of Texas citizens.

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[1] *Amici* file this brief as members of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

The members of the AMA and TMA seek to protect the integrity of the patient-physician relationship in order to provide quality medical care for patients. Their activities are intended to promote a health-care system in which all Americans have access to affordable medical care and in which treatment decisions are made by knowledgeable physicians who practice subject to traditional state regulation and the ethical values of the profession. In furtherance of these goals, the AMA has adopted the Principles of Medical Ethics, a set of "standards of conduct which define the essentials of honorable behavior for the physician." AMA, *Code of Medical Ethics* (2001)*, available at* http://www.ama-assn.org/ama/pub/category/2503.html. Under these principles, physicians are obligated to "regard responsibility to the patient as paramount" and "to seek change to those [legal] requirements which are contrary to the best interests of the patient." *Id*. (Principles VIII, III). In addition, the AMA has sought to protect state jurisdiction over regulation of the quality of medical care and medical-necessity determinations from preemption by federal law. *See* AMA, H-165.875, *Establishment of Liability of Managed Care Organizations, in Policies of the AMA House of Delegates ("AMA Policy")* (2001), *available at* http://www.ama-assn.org/ad-com/polfind/announce.htm (endorsing federal legislation to amend

ERISA expressly to provide that state regulation of quality of medical care and medical-necessity determinations are not preempted.).[2]

This case presents the question whether the independent review provisions of the Texas Health Care Liability Act (Act of May 22, 1997, ch. 163, 1997 Tex. Gen. Laws 317) (the "THCLA" or "Act") are preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). The independent review provisions of the THCLA are designed to ensure that patients enrolled in managed care organizations receive medically necessary health care. They do so by requiring managed care organizations to allow a neutral, independent review organization to resolve disputes between physicians, patients, and managed care organizations about the medical necessity of paticular treatment.

Specifically, the Act permits patients to seek review of an "adverse determination" before an independent review organization. An "adverse determination" is defined as "a determination by [an HMO] or a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." Tex. Ins. Code art.

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[2] The health policies of the AMA are established by the House of Delegates. These policies "are based on professional principles and scientific standards" and "represent the consensus viewpoints of many thousands of physicians gained through years of professional practice." AMA, *PolicyFinder: About AMA Policy*, *available at* http://www.ama-assn.org/ad-

20A.12A(a)(1). The THCLA authorizes the Commissioner of Insurance to certify and oversee independent review organizations to ensure, among other things, that such organizations consist of health care professionals who possess the requisite medical expertise to review medical necessity determinations and who are financially independent from insurers and HMOs. *See id.* art. 21.58C § 2. The Act requires a utilization review agent to "comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items or services for an enrollee." *Id.* art. 21.58A § 6A(3); *see also id.* art. 20A.12A(b) (directing HMOs to follow the rules applicable to utilization review agents).

Amici have concluded, based on substantial academic research and commentary and significant practical experience, that independent review laws such as the THCLA protect the integrity of the patient-physician relationship in the managed care context and serve the best interests of patients. *See* AMA, H-285.931, *The Critical Role of Physicians in Health Plans and Integrated Delivery Systems, in AMA Policy* (adopting policy that patients' health plans and integrated health-care delivery systems should "be able to appeal the medical necessity determination or coverage decision to an independent review organization"); *id.* H-285.998, *Managed Care,* in *AMA Policy* ¶ 5 (same); *id.* H-320.952, *External*

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com/polfind/announce.htm.

Grievance Review Procedures, in *AMA Policy* ¶ 3 (same); *id*. H-320.953, *Definitions of "Screening" and "Medical Necessity,"* in *AMA Policy* ("[u]sage of the term 'medical necessity' must be consistent between the medical profession and the insurance industry"). The need for independent review laws arises when the functions of insurer and health-care providers are merged, as they often are in managed care. In these circumstances, a significant risk arises that medical treatment decisions will be made, not by the patient's physician, but by a managed care administrator who will subordinate proper patient care to cost considerations. As a practical matter, an HMO's decision to deny coverage for a prescribed medical treatment often results in the patient being unable to afford, and thus having to forgo, necessary treatment. Independent review laws such as the THCLA diminish such risks.

For these reasons, the AMA and other medical societies have promoted independent review laws before state legislatures and the United States Congress. In addition, the AMA and other medical societies have defended such laws from assertions that they are preempted by ERISA. Indeed, the AMA and TMA participated in this case when it was last before this Court, and they filed an *amicus* brief in the Supreme Court in support of the subsequent petition for a writ of certiorari. The AMA also filed an *amicus* brief in *Rush Prudential HMO, Inc. v.*

Moran, 122 S. Ct. 2151 (2002), in which it argued that ERISA did not preempt Illinois' independent review law.

Amici have a strong and demonstrated interest in this case and other cases involving claims that ERISA preempts independent review of medical necessity decisions.[3]

SUMMARY OF ARGUMENT

The Supreme Court's decision in *Moran* compels the conclusion that ERISA does not preempt the independent review provisions of the THCLA. In *Moran*, the Supreme Court held that an Illinois independent review law did not impermissibly expand or supplement ERISA's exclusive enforcement scheme because, like the THCLA provisions at issue here, the Illinois law "provide[d] no new cause of action . . . and authorize[d] no new form of ultimate relief." *Moran*, 122 S. Ct. at 2167. In the course of reaching this conclusion, the Supreme Court considered and rejected the precise rationale that led this Court to rule that the independent review provisions of the THCLA are preempted under ERISA. The Supreme Court's holding is fully applicable, and completely dispositive, here.

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[3] *Amici* do not address whether the independent review provisions of the THCLA are preempted by the Federal Employees Health Benefits Act. That Act employs different preemption language than ERISA, and it applies only to federal employees. *Amici* note, however, that federal regulations do provide for independent review by the Office of Personnel Management ("OPM") of carrier coverage denials, and that, in conducting such review, OPM may obtain an advisory opinion from a physician. *See* 5 C.F.R. § 890.105. *Amici* further note that, like the independent

Indeed, there are no material differences between the Illinois and Texas laws that could possibly justify any departure from *Moran*'s holding.

ARGUMENT

I. The Supreme Court's Decision In *Moran* Compels The Conclusion That ERISA Does Not Preempt The Independent Review Provisions Of The THCLA.

In its original decision, this Court concluded that the independent review provisions of the Act regulate the business of insurance within the meaning of ERISA's preemption "savings clause." *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 537-39 (5th Cir.), *reh'g denied*, 220 F.3d 641 (5th Cir. 2000), *cert. granted, decision vacated and remanded* 122 S. Ct. 2617 (2002).[4] The Court found, however, that these provisions are preempted because they impermissibly supplement ERISA's exclusive civil enforcement scheme. *Id.* at 539. Specifically, this Court reasoned that the independent review provisions:

> establish a quasi-administrative procedure for the review of such denial and bind the ERISA plan to the decision of the independent review organization. This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan – the identical relief offered under § 1132(a)(1)(B)

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review that the THCLA mandates, OPM review is designed to address the risk that carriers will deny needed medical coverage in order to protect or promote their own financial interests.

[4] In reaching this conclusion, this Court found that these provisions regulate the business of insurance both as a "commonsense" matter and when viewed under the three McCarran-Ferguson "'guideposts.'" 215 F.3d at 537-38. The Supreme Court employed the same analysis to reach the same conclusions with respect to the Illinois law at issue in *Moran*. Accordingly, no re-consideration of this portion of the original decision is warranted.

> of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the savings clause.

Id.

In *Moran*, the Supreme Court considered and rejected the proposition that independent review laws expand or supplement ERISA's exclusive enforcement scheme. Like the provisions at issue here, the Illinois independent review law at issue in *Moran* requires an HMO to submit contested "medical necessity" decisions to an independent physician, and provides that such a physician's determination is binding on the HMO. Adopting the reasoning this Court employed in its original decision, the HMO argued in *Moran* that the Illinois law created an impermissible "'alternative remedy'" beyond those available under ERISA. The independent review procedure, the HMO claimed, "is a form of binding arbitration that allows an ERISA beneficiary to submit claims to a new decisionmaker to examine [the HMO's] determination *de novo*, supplanting judicial review under the 'arbitrary and capricious' standard ordinarily applied when discretionary plan interpretations are challenged." 122 S. Ct. at 2165-66.

The Supreme Court squarely rejected this argument. The Court explained that it has only twice found state laws preempted on the ground that they impermissibly supplement or supplant ERISA's exclusive enforcement scheme – in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), where the state law authorized recovery of damages that cannot be recovered under § 1132(a), and in

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990), where the state law "duplicated the elements of a claim available under ERISA, [but] converted the remedy from an equitable one under § 1132(a)(3) . . . into a legal one for money damages." *Moran*, 122 S. Ct. at 2166. The Court recognized, however, that, unlike the laws at issue in *Pilot Life* and *Ingersoll-Rand*, the Illinois independent review law "provides no new cause of action . . . and authorizes no new form of ultimate relief." *Id.* at 2167. Accordingly, the Court ruled that the Illinois law "does not involve the sort of additional claim or remedy exemplified in *Pilot Life* . . . and *Ingersoll-Rand*," and thus "does not fall within *Pilot Life*'s categorical preemption." *Id.*

In the course of reaching this conclusion, the Court made unmistakably clear that a state law does not conflict with ERISA's exclusive enforcement scheme because it creates a "quasi-administrative procedure" that allows plan members to "seek benefits due them under the terms of the plan" based on the "bind[ing]" decisions of an independent reviewer. *Corporate Health Ins., Inc.*, 215 F.3d at 539. The Supreme Court explained that:

> [w]hile independent review under [the Illinois law] may well settle the fate of a benefit claim under a particular contract, the state statute does not enlarge the claim beyond the benefits available in any action brought under § 1132(a). And although the reviewer's determination would presumably replace that of the HMO as to what is 'medically necessary' under [the plan] contract, the relief ultimately available

> would still be what ERISA authorizes in a suit for benefits under § 1132(a).

Moran, 122 S. Ct. at 2167 (footnote omitted). The Court concluded that the "quasi-administrative" procedure mandated under an independent review law most closely resembles "a practice (having nothing to do with arbitration) of obtaining another medical opinion." *Id.* at 2169. The Court described such a practice as "far removed from any notion of an enforcement scheme." *Id.*

The Supreme Court has thus flatly rejected the very reasoning this Court employed in ruling that the independent review provisions of the THCLA are preempted under ERISA. Under *Moran*, a state law regulating the business of insurance is saved from ERISA preemption unless the law provides a new cause of action or enlarges, supplements or supplants the ultimate relief available in a suit for benefits under § 1132(a). Because the independent review provisions of the THCLA do not run afoul of this proscription, and instead mandate a "second-opinion" practice, they are not preempted by ERISA.

II. There Are No Material Differences Between The Independent Review Provisions Of The THCLA And Illinois' Independent Review Law That Would Justify A Departure From *Moran*.

There are no material differences between the independent review provisions of the THCLA and the Illinois independent review law that would justify a departure from *Moran*'s clear holding. Both the Texas and Illinois laws

permit appeals of adverse medical necessity decisions to independent reviewers who possess relevant medical expertise.[5] Both laws provide that such appeals should be decided based on a review of the relevant medical records.[6] And both laws require insurers to abide by the independent reviewer's decision.[7] Most fundamentally, both laws make clear that the purpose of the independent review is to obtain an "independent *medical* judgment" concerning the necessity of a course or form of treatment. *Moran*, 122 S. Ct. at 2168 (emphasis added). The slight differences between the two laws are immaterial to any determination of whether ERISA preempts the independent review provisions of the THCLA.

A. The Scope of Independent Review Authorized by the THCLA Does Not Justify Any Deviation From *Moran*.

The THCLA permits appeals of decisions that medical treatments or services are not "medically necessary or are not appropriate," *see* Tex. Ins. Code art. 21.58A § 6A(1); *id.* art. 20A.12A(a)(1). Although its language is slightly different from that of the Illinois independent review law, the THCLA does not

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[5] *See* Tex. Ins. Code art. 21.58A § 6A(1) & art. 21.58C § 2(b)(3) & (d)(6) (appeals of adverse determinations assigned to independent reviewer certified under standards that ensure its "qualifications," "areas of expertise," and "independence."); 215 Ill. Comp. Stat. 125/4-10(a) (appeals of medical necessity decisions to physician who is unaffiliated with HMO and holds same class of license as patient's primary care physician).

[6] *See Moran*, 122 S. Ct. at 2168-69 (referring to review conducted under Illinois law); Tex. Ins. Code art. 21.58A § 6A(2) (requiring submission to independent review organization of relevant medical records, the names of health care providers who may have relevant medical records, documents and information submitted by physician or patient in the internal appeal, and any documents used by the plan in denying the appeal).

[7] Tex. Ins. Code art. 21.58A § 6A(3); 215 Ill. Comp. Stat. 125/4-10(a).

expand the scope of independent review beyond medical necessity determinations. Rather, the phrase "or . . . appropriate" in the THCLA simply refers to a particular aspect of medical necessity decisions. *See Norfolk & Western Ry. v. American Train Dispatchers Ass'n*, 499 U.S. 117, 129 (1991) ("when a general term follows a specific one, the general term should be understood as a reference to subjects akin to the one with specific enumeration.").

In disagreeing with a treating physician's judgment that a proposed course of treatment is medically necessary, an HMO may sometimes take the position that various factors, such as the patient's age or general health, make the particular course of treatment not "appropriate" under the circumstances. The THCLA's reference to treatments deemed "not appropriate" simply permits independent review of medical necessity decisions based on these types of judgments. *Cf. Moran*, 122 S. Ct. at 2168 (noting that determinations of whether coverage is "medically necessary" "'cannot be untangled from physicians' judgments about *reasonable* medical treatment") (quoting *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000) (emphasis added)); *id.* at 2171 ("regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of *reasonable* medical care") (emphasis added). Indeed, in its rehearing decision, this Court recognized that the THCLA authorizes a "second opinion on medical necessity," and substitutes the "medical

judgment of a third party physician for the HMO's . . . judgment as to medical necessity." *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 220 F.3d 641, 644, 645 (5th Cir. 2000), *cert granted, decision vacated and remanded*, 122 S. Ct. 2617 (2002).

Thus, like the Illinois independent review law, the THCLA does not confer on independent review organizations "a free-ranging power to construe contract terms." *Moran*, 122 S. Ct. at 2168. Rather, it confines review to medical necessity judgments, including such judgments that turn on the "appropriateness" of a particular course of treatment. In making such medical necessity judgments, moreover, the independent review organization does not "hold the kind of conventional evidentiary hearing common in arbitration, but simply receive[s] medical records submitted by the parties, and ultimately [comes] to a professional judgment of [its] own." *Id.* at 2168-69. Like the Illinois law in *Moran*, therefore, the independent review provisions of the THCLA "mandate [a] second-opinion practice in order to ensure sound medical judgments," *id.* at 2169.

In this way, the THCLA achieves the central purpose of all independent review statutes – ensuring that persons enrolled in managed care programs receive medically-necessary health care. Geraldine Dallek & Karen Pollitz, *External Review of Health Plan Decisions: An Update* 1 (Kaiser Family

Foundation May 2000). As the AMA has stated, "medical necessity decisions are ultimately medical decisions and should continue to be treated as such. [They] must always be made in accordance with those generally accepted standards of medical practice that a prudent physician would follow when treating a patient." *Employer Health Plan Accountability: Do Plan Participants Have Adequate Protections?: Hearing Before the House Subcomm. on Employer-Employee Relations, House Comm. on Educ. and the Workforce*, 106th Cong. 130 (1999) (statement of Timothy T. Flaherty, M.D. American Medical Association). Independent external review helps ensure "that doctors will be reviewing doctor decisions." 147 Cong. Rec. H5204 (daily ed., Aug. 2, 2001) (statement of Rep. Johnson). Further, as the AMA has testified, "a definition of medical necessity that is determined *by physicians* is one of the most critical factors in the review process." Susan Hershberg Adelman, M.D., AMA, *Statement to the Department of Labor Re: Proposed Claims Procedure Regulations* 3 (Feb. 17, 1999) (emphasis added, emphasis in original deleted); *see also Moran*, 122 S. Ct. at 2168 ("determinations of coverage 'cannot be untangled from *physicians'* judgments about reasonable medical treatment.'") (quoting *Pegram v. Herdrich*, 530 U.S. at 229) (emphasis added).

In all events, there is simply no basis for concluding, in the context of this facial challenge, that the slightly different language of the THCLA's

independent review provision justifies a finding of preemption under ERISA. Under *Moran*, such a finding would be permissible only in a case in which (1) the THCLA was found to mandate coverage simply because an indepenent review organization determined that the medical treatment at issue was "appropriate," though not medically necessary, and (2) the plan did not provide coverage for all "medically appropriate" treatment. This case involves no actual coverage denial, no actual plan language, and, most importantly, no actual application of the statute that establishes that it authorizes an independent review of the "appropriateness" of medical treatment without regard to whether the treatment is medically necessary. Nor has the Commissioner of Insurance issued any regulations establishing that the THCLA has such a scope. Accordingly, there is no basis for finding that the THCLA authorizes any form of independent review beyond the form of independent review that the Supreme Court upheld in *Moran*.

B. The Procedural Requirements of the THCLA Do Not Justify Any Deviation From *Moran*.

Similarly, none of the procedural differences between the Texas and Illinois laws justifies a finding of preemption in this case. Under the Illinios law, the affected parties jointly select the independent reviewer. *See* 215 Ill. Comp. Stat. 125/4-10(a). By contrast, under the THCLA, appeals are assigned to

independent review organizations. *See* Tex. Ins. Code art. 21.58A § 6A(1). The THCLA also sets forth standards and rules that independent review organizations must satisfy in order to be certified to conduct such reviews, *see id*. art. 21.58C, whereas the Illinois law does not provide for certification and regulation of independent reviewers. Nothing in the Supreme Court's decision, however, suggests that the manner in which an independent reviewer is chosen or certified has any material bearing on the preemption analysis. *See Moran*, 122 S. Ct. at 2167 n.11 ("we do not believe that the mere fact that state independent review laws are likely to entail different procedures will impose burdens on plan administration that would threaten the object of 29 U.S.C. § 1132(a)").

Indeed, because these regulations govern independent review organizations – not ERISA plans themselves, or even HMOs – the regulations impose "no special burden of compliance upon an ERISA plan." *Id.* And these regulations plainly are not so "elaborate" or "onerous," *id.*, that any compliance costs that may be passed on to ERISA plans can be said to undermine § 1132(a). Indeed, this Court has already correctly concluded that these provisions are not preempted by § 1132(a) of ERISA. *See Corporate Health Ins., Inc.*, 215 F.3d at 537 n.42.

Finally, no deviation from the Supreme Court's holding in *Moran* can be justified on the ground that, unlike the Illinois independent review law, the THCLA contains a number of standards and procedural requirements that govern the *internal* appeals process that must be exhausted before any external review by an independent review organization takes place.[8] Because *Moran* holds that external, independent review does not impermissibly supplement or supplant ERISA's exclusive enforcement scheme, it follows *a fortiori* that any procedural prerequisites to external review likewise do not supplement or supplant that exclusive scheme. Nor is there any basis for finding, particularly in the context of this facial challenge, that these procedures are so "elaborate" or "onerous," *Moran*, 122 S. Ct. at 2167 n.11, that any compliance costs that may be passed on to ERISA plans can be said to undermine § 1132(a).[9]

* * *

[8] *See* Tex. Ins. Code art. 21.58A § 3 (standards for certification of utilization review agents); § 4 (standards for utilization review); § 5 (notice of determinations by utilization review agents); § 6 (appeal of adverse determination by utilization review agent).

[9] Similarly, there is no basis for finding that § 1133 of ERISA preempts the internal review provisions of the Act. The Court has never held that § 1133 has the same preemptive force as § 1132(a) such that it can override the express savings clause for state insurance regulation, and for good reason – § 1133 does not set forth an *exclusive* set of review procedures, but merely establishes a *floor* for such review processes. *See Moran*, 122 S. Ct. at 2170 n.16 (§ 1133 "merely requires that plans provide internal appeals of benefit claims."); 29 U.S.C. § 1133 (requiring plans to provide notice and the opportunity for internal review of denied claims); 29 C.F.R. pt. 2560 (setting forth the minimum requirements for benefit claims procedures for employee benefit plans); *see also UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 377 (1999) ("[b]y allowing a longer period to file than the *minimum* filing terms mandated by federal law, the [state rule] complements rather than contradicts ERISA and the regulations").

In short, the independent review provisions of the THCLA are, in all material respects, indistinguishable from the Illinois law at issue in *Moran*. Accordingly, the appellees/cross-appellants cannot evade *Moran*'s holding based on any minor differences between the two laws. Instead, it is clear that *Moran* governs this Court's re-consideration of its prior decision, and mandates the determination that ERISA does not preempt the independent review provisions of the THCLA.

CONCLUSION

For the foregoing reasons, the Court should re-instate its original decision insofar as it held that ERISA does not preempt the anti-retaliation and anti-indemnification provisions of the THCLA, and should reverse the lower court's judgment that ERISA preempts the independent review provisions of that Act.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the Brief Of The American Medical Association And The Texas Medical Association As Amici Curiae In Support Of Appellants Jose Montemayor And John Cornyn, along with an electronic version in WordPerfect format, was served on August 27, 2002, to the following counsel of record:

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