IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

NO. 01-10831

ROBERT ROARK, INDIVIDUALLY AND
ON BEHALF OF THE ESTATE OF GWEN
ROARK, DECEASED,

Plaintiffs-Appellants,

v.

HUMANA, INC.; HUMANA HEALTH PLAN OF TEXAS, INC.,
D/B/A HUMANA HEALTH PLAN OF TEXAS (DALLAS),
HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO),
HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI),
AND HUMANA HMO TEXAS, INC.,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Texas, Dallas Division

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND TEXAS MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS' PETITION FOR REHEARING *EN BANC*

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CERTIFICATE OF INTERESTED PERSONS

In accordance with Fifth Circuit Rule 28.2.1, 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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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

CASES

STATUTES

STATEMENT OF INTEREST

The American Medical Association ("AMA") and the Texas Medical Association ("TMA") submit this brief as *amici curiae* in support of Appellants' Petition for Rehearing *En Banc*.[1] *Amici*'s more than 300,000 physicians practice in all fields of medical specialization, in Texas and around the nation. *Amici* seek to protect the integrity of the patient-physician relationship in order to provide quality medical care for patients. Central to that goal is maintaining the integrity of medical treatment decisions. That integrity is at risk when HMOs, which often commingle their insurer and health-care provider functions, make medical treatment decisions. In these cases, there is a significant risk that such decisions will be made, not by a patient's physician, but by an HMO administrator who may subordinate proper patient care to cost considerations. Requiring HMOs to follow the medical profession's standards of care when making these decisions reduces that risk and bolsters the integrity of the decision-making process.

The panel's decision threatens to insulate an HMO's medical treatment decisions from adherence to ordinary standards of medical care, thereby placing patients at risk and threatening the integrity of the medical treatment decision. When HMOs usurp the right to make medical treatment decisions, they must also adhere to the state's regulation of the appropriate standard of medical care. *Amici*

[1] *Amici* are part of the AMA/State Medical Society Litigation Center ("Litigation Center"), which is a coalition of medical societies that represents the views of organized medicine in the courts.

have a strong interest in any case involving claims that the Employee Retirement Income Security Act, 29 U.S.C. §1001 *et seq.* ("ERISA") preempts such state regulation of medical necessity decisions.

ARGUMENT

This case is about the integrity of the medical treatment decision-making process. The panel's conclusion that the Roarks' THCLA[2] claims are preempted by ERISA §514 (29 U.S.C. §1144), *see Roark v. Humana, Inc.*, 2002 U.S. App. LEXIS 19139, *35 (5th Cir. Sept. 17, 2002), threatens to allow ERISA to subvert that process despite the Supreme Court's repeated emphasis that the regulation of medical treatment decisions should remain the province of state law.[3]

The panel felt "bound" to follow this court's previous decision in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). *Id.* at *41-42. In doing so, the court failed to follow the Supreme Court's decisions since *Corcoran*, which expressly narrow the scope of ERISA §514 preemption and acknowledge that ERISA does not preempt state regulation of those who make health care treatment decisions. *Amici* submit that the entire Fifth Circuit must revisit this area in light of the Supreme Court's recent guidance on the

[2] The Texas Health Care Liability Act ("THCLA") states that "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." Tex. Civ. Prac. & Rem. Code §88.002(a) (2002).

[3] This decision may impact Louisiana patients as well as Texas patients because that state has a statute similar to the THCLA. *See* La. R.S. 22:3085(D).

patient-physician relationship and the scope of ERISA preemption. *Amici* urge this court to vacate the panel decision, grant rehearing *en banc*, and reverse the district court's order denying remand of the Roarks' THCLA claims to state court. In doing so, the court should overturn *Corcoran* and hold that ERISA §514 does not preempt the Roarks' THCLA claims asserting liability directly against their HMO.

Resolving Appellants' appeal *en banc* will harmonize this court's case law with the evolving scope of ERISA preemption in the Supreme Court and internally. *See Corporate Health Ins., Inc. v. Texas*, 215 F.3d 526 (5th Cir. 2000), *vacated on other grounds by Montemayor v. Corporate Health Ins.*, 122 S. Ct. 2617 (2002). It will also properly cabin ERISA's application and ensure that HMOs abide by the same standards as physicians when making medical treatment decisions.

I. The Supreme Court Has Narrowed the Scope of ERISA §514 Preemption Since *Corcoran*.

The *Corcoran* court believed that "even attenuated and indirect effects on an ERISA plan are enough to bring a statute within §514 preemption." *Roark*, 2002 U.S. App. LEXIS 19139 at *37. However, the Supreme Court has now made clear that "ERISA was not meant to consume everything in its path." *Hook v. Morrison Milling Co.*, 38 F.3d 776, 786 (5th Cir. 1994). ERISA's "relates to" inquiry does not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by the Federal Act." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 331 (1997).

A court must examine "the objectives of [ERISA] as a guide to the scope of the state law that Congress understood would survive." *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). It is not enough for a state law simply to have an indirect or sometimes even a direct, economic impact on an ERISA plan. *See, e.g., id.* at 661 (statute which had an "indirect economic influence" on ERISA plans by imposing additional costs on commercial insurers and HMOs which contract with them did not "relate to" an ERISA plan). "[A]ny state . . . law[] that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 (1997). A THCLA claim against an HMO may indirectly increase benefit costs for covered employees, but codifying Texas's malpractice standard does not conflict with ERISA's goal of "safeguard[ing] . . . the establishment, operation, and administration of employee benefit plans." 29 U.S.C. §1001(a).

II. The Supreme Court Has Made Clear that ERISA Does Not Preempt State Regulation of the Patient-Physician Relationship.

The disconnect between ERISA's objectives and Texas's regulation of medical treatment decisions is underscored when one examines how the Supreme Court has treated state health care regulation in ERISA cases since *Corcoran*. *Corcoran* recognized that an HMO (and its related entities) "makes medical

decisions as part and parcel of its mandate to decide what benefits are available under [an ERISA] plan." *Corcoran*, 965 F.2d at 1332. Nonetheless, the court felt that ERISA preempted review of those medical treatment decisions according to state malpractice law, even if those decisions could be egregiously wrong.

After *Corcoran*, however, the Supreme Court has repeatedly concluded that ERISA leaves medical treatment decisions to traditional state regulation in order to ensure the integrity of those decisions. The THCLA's regulation of such decisions therefore is not preempted by ERISA.

Beginning in *Travelers*, the Court stressed that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. The Court specifically identified state "quality standards" for hospital services as regulations that had too indirect an impact on ERISA plans to be preempted by ERISA §514. *Id.* at 660.

In *Pegram v. Herdrich*, 530 U.S. 211 (2000), the Court held that ERISA's fiduciary standards did not govern a physician's medical treatment decisions. Whether or not a patient requires immediate attention for appendicitis (the situation in *Pegram*) or whether or not home treatment is "medically necessary" to safeguard a patient's wound from potential infection (the situation here) are among the "countless medical administrative decisions" where "[t]he eligibility decision

and the treatment decision [a]re inextricably mixed." *Id.* at 229. In these situations, "the physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible medical setting." *Id.* at 232. (The "mixed" nature of the decision remains even if a non-physician HMO employee makes the decision.).

The Court recognized that applying ERISA to these "mixed" decisions "require[s] reference to standards of reasonable and customary medical practice" which is "the traditional standard of the common law." *Id.* at 235. Creating an "ERISA standard of reasonable medical skill" would thus "be a prescription for preemption of state malpractice law." *Id.* at 236. The Court concluded that ERISA was not enacted "in order to federalize malpractice litigation." *Id.* A contrary result, the Court believed, would lead to "unheard-of" results. *Id.* at 237.

Finally, last term in *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002), the Court held that a state statute intended to protect patients from HMOs that ignore the "medical necessity" decision of a primary care physician and failed to involve an independent physician was not preempted by ERISA. *Id.* at 2171. The Illinois statute was enacted "to ensure sound medical judgments" and therefore was "far removed" from the goals of ERISA's enforcement scheme. *Id.* at 2169. Since these decisions are "probably inseparable" from "quintessentially state-law standards of reasonable medical care," they are not preempted by ERISA "without

clear manifestation of congressional purpose." *Id.* at 2167. In addition, because "it is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations, ... [the statute's] indirect economic effects are not enough to preempt state regulation even outside of the insurance context." *Id.* at 2167 n.11.

The THCLA provision at issue here is precisely the type of state regulation of HMO medical treatment decisions the Court has clearly avoided allowing ERISA to preempt. The law "simply codifies Texas's already-existing standards regarding medical care . . . . [which] are at the heart of Texas's regulatory power." *Corporate Health*, 215 F.3d at 535. ERISA did not alter Texas's power to regulate medical care, nor should the standard of care a patient receives vary depending on whether an HMO or a physician makes the medical treatment decision or whether the theory is direct or vicarious liability. *See, e.g.*, *id.* ("A suit for medical malpractice against a doctor is not preempted by ERISA simply because those services were arranged by an HMO and paid for by an ERISA plan.").

This court has recognized recently that "Congress [never] intended for ERISA to supplant [the THCLA's] regulation of the quality of medical practice." *Id.* It held that ERISA does not preempt a THCLA vicarious liability claim against an HMO for physician malpractice. *Id.* There is no principled distinction between holding an HMO vicariously liable when its physician fails to adhere to ordinary standards of medical care and this case, which seeks to hold an HMO directly

liable for failing to follow those same standards. The *en banc* court should affirm that ERISA does not preempt THCLA claims against HMOs for direct liability.

CONCLUSION

Accountability under state law is needed to ensure that HMOs "operate within the broad compass of sound medicine" when they make medical treatment decisions. *Id.* The court should vacate the panel decision, grant rehearing *en banc*, and reverse the district court's order denying remand of the Roarks' THCLA claims. In doing so, the court should overturn *Corcoran* and hold that ERISA does not preempt the Roarks' THCLA claims.

Dated: October 7, 2002 Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 7th day of October, 2002, a true and complete copy of the BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND TEXAS MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS' PETITION FOR REHEARING *EN BANC* was served, along with an electronic version in Word 2000 format, by depositing it in the United States mail, first class postage prepaid, to the following counsel of record:

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