NO. 02-1826

IN THE
SUPREME COURT OF THE UNITED STATES

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

Petitioner,

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.,

Respondents.

On Petition For A Writ of Certiorari to the United States Court of
Appeals
for the Fifth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND TEXAS MEDICAL ASSOCIATION AS *AMICI CURIAE* SUPPORTING PETITIONER

Attorneys for Amici Curiae

Mark E. Rust
Counsel of Record
Barnes & Thornburg
One North Wacker Street
44th Floor
Chicago, IL 60603
(312) 357-1313
Attorneys for Amici Curiae

(Additional Counsel Listed on Inside Cover)

JON N. EKDAHL
LEONARD A. NELSON
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
(312) 464-5059
Counsel for Amicus
American Medical Association

DONALD P. WILCOX
TEXAS MEDICAL ASSOCIATION
401 W. 15th Street
Austin, TX 78701
(512) 370-1300
Counsel for Amicus
Texas Medical Association

BRIAN E. CASEY
BARNES & THORNBURG
100 North Michigan Street, Suite 600
South Bend, IN 46601
(574) 233-1171

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and the Texas Medical Association ("TMA") submit this brief as *amici curiae* in support of Robert Roark's Petition for *Writ of Certiorari*.[1]

The AMA is the largest professional association of physicians in the United States. Its more than 250,000 members practice in all fields of medical specialization, in Texas and in every other state of the nation. The objects of the AMA are to promote the science and art of medicine and the betterment of public health. The TMA, with 38,000 members, is the largest professional association of physicians in Texas. TMA's purposes are to organize the medical profession, advance the practice of medicine within Texas, and improve the public health of Texans.

Amici appear not only on their own behalves but as representatives of the Litigation Center of the American Medical Association and the State Medical Societies ("the Litigation Center"). The Litigation Center is a coalition of the AMA and the state medical societies of every state, plus the Medical Society of the District of Columbia. It was established to concentrate the resources of its members and represent the views of organized medicine in the courts. The Litigation Center represents the interests of physicians and of patients before all governmental bodies, including the United States Congress and the legislatures of the 50 states and the District of Columbia. The members of the

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part. The Litigation Center, described more fully in the text, provided the funding for this brief. Pursuant to Rule 37.2, the parties have consented to the filing of this brief. The parties' letters of consent have been lodged with the Clerk of this Court.

Litigation Center are the principal advocates for physicians and their patients in the United States.

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 situations, there is a significant risk that medical treatment decisions will be made, not by a patient's physician, but by an HMO employee 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 medical decision-making process.

In *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), the Fifth Circuit held that the Employee Retirement Income Security Act, 29 U.S.C. §1001 *et seq.* ("ERISA") preempts a Texas state law medical negligence claim arising from an HMO's medical treatment decision. The court's decision insulates HMOs from adherence to ordinary standards of medical care, places patients at risk, and threatens to compromise medical treatment decisions. The "perverse incentives for HMO's" under such a scheme can lead to "potentially serious mistakes" and tragic, unremedied consequences for patients, as Mr. Roark's case shows all too clearly. *Id.* at 315, 313. 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* have a strong interest in any case involving claims that ERISA preempts such state regulation of medical necessity decisions.

REASONS WHY THE PETITION SHOULD BE GRANTED

The Fifth Circuit's decision conflicts with this Court's recent opinions narrowing the breadth of ERISA preemption and squarely contradicts a recent decision by the United States Court of Appeals for the Second Circuit on the same important matter.[2] Numerous other federal circuits have divided on this issue, both actually and in principle, and decisions from a number of state courts conflict as well. Laws similar to the Texas statute at issue here have been passed in nine other states. Several more state courts of last resort permit such claims as a matter of common law. As a result, this issue will continue to arise throughout the country, absent guidance from this Court. Finally, the United States has advocated to this Court previously that this is an issue of national importance which should be addressed.

This issue affects the health care coverage of tens of millions of Americans. The conflict in the lower courts creates uncertainty, inconsistency and inefficiency in the judicial branches of the state and federal governments. These are reasons enough to grant Mr. Roark's petition.

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[2] That case, *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), has also prompted a petition for writ of certiorari, which was filed on July 11, 2003. That petition highlights the importance of the question presented by Mr. Roark. *Amici* believe that this case is a more appropriate vehicle for addressing the issues presented in these petitions in part because the Texas legislature has clearly created a statutory right of action. Petitions have also been filed in *Roark*'s companion cases in the Fifth Circuit, *Cigna Healthcare of Texas v. Calad*, No. 03-83, and *Aetna Health Inc. v. Davila*, No. 02-1845, which also construe the Texas statute at issue here but which were decided solely on ERISA §502(a)(1)(B) "complete preemption" grounds.

There is, though, an additional reason for Supreme Court review. HMO tort liability has been strenuously debated during the latest presidential election, in Congress, and in the state legislatures. No consensus has been reached, *except the consensus that the scope of ERISA preemption should be clarified.*

Until *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (Pa. 1998), *vacated and remanded*, 530 U.S. 1241 (2000) ("*Pappas I*"), and, more significantly, *Pegram v. Herdrich,* 530 U.S. 211 (2000), it was generally assumed that HMO tort liability was primarily a question for Congress. Now, it appears to be an issue for the state legislatures. However, unless the Supreme Court decides the matter definitively, the proper forum for legislative action remains uncertain.

Under the present state of the law, state legislatures that might deem it beneficial, on the merits, to impose HMO tort liability confront an unfortunate dilemma. They can pass a law that may be invalid -- inherently an undesirable outcome. Alternatively, they can, because of the uncertainty, act against their own consciences and refuse to consider such a law -- also an undesirable outcome. If, as recent case law suggests, HMO tort liability is a matter for state decision, then the issue should be addressed in the state legislatures, without concern that political capital and energy may be expended on a pointless or even invalid exercise.

Amici suggest, therefore, that the Court grant this petition to bring some much-needed clarity to this area of the law. Such clarity will not only benefit the judicial functions of government -- it will also benefit the legislative functions.

I. THE FIFTH CIRCUIT'S DECISION CONFLICTS WITH THIS COURT'S DECISIONS REGARDING STATES' TRADITIONAL AUTHORITY TO REGULATE HEALTH CARE.

This case is about the integrity of the medical treatment decision-making process. The Fifth Circuit's conclusion that Mr. Roark's THCLA[3] claim is preempted by ERISA §514 (29 U.S.C. §1144), threatens to allow ERISA to subvert that process despite this Court's repeated emphasis that regulation of medical treatment decisions should remain the province of state law.

In its decision, the Fifth Circuit felt "bound" to follow its now outdated opinion in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). *Roark*, 307 F.3d at 315. The Fifth Circuit in *Corcoran* had believed mistakenly that "even attenuated and indirect effects on an ERISA plan are enough to bring a statute within §514 preemption." *Id.* at 314. Because 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," the *Corcoran* court reached the "troubling" conclusion that ERISA preempted review of those medical treatment decisions according to

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[3] The relevant section of 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) (2003).

state malpractice law, even if those decisions could be "serious mistake[s]." *Corcoran*, 965 F.2d at 1332, 1338.

Since then, however, this Court has made clear that ERISA §514 preemption does not sweep so broadly. This Court's subsequent decisions have expressly narrowed the scope of ERISA §514 preemption and acknowledged that ERISA does not preempt state regulation of those who make health care treatment decisions. Now it is clear that ERISA's starting point -- whether a state law "relate[s] to any employee benefit plan," 29 U.S.C. §1144(a) -- does not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by [ERISA]." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 331 (1997).

In 1995, this Court set forth the rationale to employ when deciding whether ERISA preempts a state law because that law "relate[s] to" an employee benefit plan. 29 U.S.C. §1144(a). 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 sufficient for a state law simply to have an indirect or sometimes even a direct, economic impact on an ERISA plan. *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). This follows ineluctably from *Travelers*, where this 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. "There is not so much as a hint in ERISA's legislative history or anywhere else that Congress intended to squelch . . . state efforts" to regulate the practice of medicine when it enacted ERISA. *Id.* at 665. In fact, this Court specifically identified state "quality standards" for medical services as regulations that fall outside ERISA §514 preemption. *Id.* at 660.

More recently in *Pegram v. Herdrich*, 530 U.S. 211 (2000), this Court held that ERISA's fiduciary standards do not govern a physician's medical treatment decisions. Whether a patient requires immediate attention for appendicitis (the situation in *Pegram*) or whether home treatment is "medically necessary" to safeguard a patient's wound from potential infection (the situation here) are simply two of 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.).

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. This Court concluded that ERISA was not enacted "in order to federalize malpractice litigation." *Id.* A contrary result – which is essentially the Fifth Circuit's decision -- would lead to "unheard-of" results and raise a "puzzling issue of preemption." *Id.* at 236-37. In reaching this decision, this Court reiterated that, "[i]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.*

Finally, in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), this Court held that an Illinois statute intended to protect patients from HMOs that ignore the "medical necessity" decision of a primary care physician and fail to involve an independent physician is not preempted by ERISA. *Id.* at 387. The Illinois statute was enacted "to ensure sound medical judgments" and therefore is "far removed" from the goals of ERISA's enforcement scheme. *Id.* at 383. Since these decisions are "probably inseparable" from "quintessentially state-law standards of reasonable medical care," they are not preempted by ERISA absent clear congressional intent. *Id.* at 387. Though the opinion rested ultimately on ERISA's insurance savings clause, this Court also reasoned that 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 381 n.11.

The THCLA provision at issue here is precisely the type of state regulation of HMO medical treatment decisions that should not be preempted. It goes without saying that the provision is not directed at an employee benefit plan, since an HMO is generally not an ERISA plan. *Pegram*, 530 U.S. at 223;

Kentucky Assn. of Health Plans v. Miller, 123 S. Ct. 1471, 1476 n.1 (2003) (distinguishing HMO from an ERISA plan). Rather, the law "simply codifies Texas's already-existing standards regarding medical care . . . . [which] are at the heart of Texas's regulatory power." *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir. 2000), *vacated on other grounds sub nom.*, *Montemayor v. Corporate Health Ins. Co.*, 536 U.S. 935 (2002), *reinstated as modified*, 314 F.3d 784 (5th Cir. 2002).[4] ERISA did not alter Texas's power to regulate medical care, and the standard of care a patient receives should be the same, regardless of whether an HMO or a physician makes the medical treatment decision. *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."). In *Roark*, the Fifth Circuit failed to follow this Court's admonition that ERISA does not preempt health care regulation "without clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237. Because the Fifth Circuit strayed so far from this Court's recent pronouncements on the scope of ERISA preemption over

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[4] In *Corporate Health*, the Fifth Circuit decided both that a THCLA claim brought under a vicarious liability theory was not preempted, 215 F.3d at 534-35, and that the THCLA's independent review provision was preempted. *Id.* at 539. This Court vacated the Fifth Circuit's opinion and remanded for consideration in light of *Rush Prudential HMO* which concluded that independent review provisions are not preempted. 536 U.S. 935 (2002). After remand, the Fifth Circuit followed *Rush Prudential HMO* and concluded that the THCLA's independent review provision was not preempted when applied to insured plans. 314 F.3d at 786. With that modification, the court reinstated its prior opinion. *Id.*

state regulation of the practice of medicine, the petition should be granted.

II. LOWER COURTS HAVE REACHED DEEPLY CONFLICTING CONCLUSIONS REGARDING THE SCOPE OF ERISA'S PREEMPTION OF STATE REGULATION OF THE PATIENT-PHYSICIAN RELATIONSHIP.

Since this Court decided *Pegram*, lower courts have reached widely divergent conclusions regarding the extent to which ERISA preempts state regulation of the patient-physician relationship when HMOs are involved. The number of analytical fault lines when addressing this issue and the depth of those fractures reflect an urgent need for this Court's guidance.

The Second Circuit's recent decision in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), conflicts most directly with *Roark*'s conclusion that ERISA §514(a) preempts a direct liability claim against an HMO. The Second Circuit, in a split decision, held that "a state law malpractice action, if based on a 'mixed eligibility and treatment decisions,' is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a specific patient's symptoms." *Id.* at 102. Unlike the Fifth Circuit, the Second Circuit reasoned that "the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component." *Id.* at 103. It recognized that to segregate the two distinct parts of these types of medical decisions would be a daunting task for a reviewing court because "it would likely often be difficult to delve into physicians' minds to examine their decisions, which are frequently executed in very brief time periods and under tremendous pressures, to determine what part of them is medical and what part is administrative." *Id.* at 105. Contradicting *Roark*, the *Cicio* court rejected the premise

that these inextricably "mixed" decisions need not conform with state medical malpractice standards because of ERISA preemption. The court concluded instead that "Section 514 preemption does not obtain with regard to those claims predicated on the violation of a state tort law by failure to meet state-law defined standard of care in diagnosis or recommending treatment" of a "patient's constellation of symptoms." *Id.* at 103-04. *Cf. Land v. CIGNA Healthcare of Florida*, 2003 U.S. App. LEXIS 15080, *20-21 (11th Cir. July 30, 2003) (concluding that medical malpractice claim challenging HMO's mixed eligibility and treatment decision is not completely preempted by ERISA §502(a)(1)(b)).

Both the Pennsylvania and Florida Supreme Courts have reached the same conclusion regarding direct claims of medical malpractice against HMOs. *See Pappas v. Asbel*, 564 Pa. 407, 420, 768 A.2d 1089 (2001), *cert. denied sub nom. U.S. Healthcare Systems of Penn., Inc. v. Pennsylvania Hosp. Ins. Co.*, 536 U.S. 938 (2002) ("*Pappas II*") (determining that HMO's decision "was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law, as *Travelers* teaches, is not preempted by ERISA."); *Villazon v. Prudential Health Care Plan, Inc.*, 843 So.2d 842, 848 (Fla. 2003) ("state law causes of action against HMOs based upon allegations of direct and vicarious liability for negligence in the provision of medical services to member patients" not preempted by ERISA); *see also Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994) (direct liability medical negligence claims against HMO not preempted).

In a slightly different factual context, the Ninth Circuit has determined that "ERISA also does not preempt the claim for negligent medical advice. . . ." *Bui v. AT&T*, 310 F.3d 1143, 1146 (9th Cir. 2002); *id.* at 1146, n.2 ("Medical

malpractice is one traditional field of state regulation that several circuits have concluded Congress did not intend to preempt. . . . ERISA's preemption clause, 29 USC §1144, does not preempt actions involving allegations of negligence in the provision of medical care, even if the patient procures the care through an ERISA plan.").[5]

Other courts have taken a slightly different approach. Perhaps seeking to avoid the potentially egregious result in *Corcoran*, they have permitted medical negligence claims to proceed against HMOs under vicarious liability or apparent authority theories. *See, e.g., Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995) (vicarious liability claim not preempted); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Lupo v. Human Affairs Int'l. Inc.*, 28 F.3d 269 (2d Cir. 1994); *Hinterlong v. Baldwin*, 308 Ill. App. 3d 441, 452, 720 N.E.2d 315 (Ill. App. 1999) (medical malpractice claim against HMO based on vicarious liability did not relate to plan and was not preempted by ERISA).[6]

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[5] Analytically, these decisions mirror the "chorus" of appellate decisions finding that ERISA does not preempt professional malpractice claims against other types of non-fiduciaries. *See, e.g., Gerosa v. Savasta & Co. Inc.*, 329 F.3d 317, 323 (2d Cir. 2003) ("ERISA does not preempt 'run-of-the-mill' state-law professional negligence claims against non-fiduciaries."); *see also LeBlanc v. Cahill*, 153 F.3d 134, 138 (4th Cir. 1998); *Arizona State Carpenter's Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Painters of Philadelphia Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146, 1153 (3d Cir. 1989). There is certainly nothing in ERISA's language, purpose, or legislative history to suggest that medical malpractice should be singled out from other types of professional malpractice claims for ERISA preemption.

[6] Of course, other appellate courts have concluded that ERISA preempts vicarious liability claims as well. *See, e.g., Danca v. Private Health Care Plan, Inc.*, 185 F.3d 1 (1st Cir. 1999)

In fact, even the Fifth Circuit has permitted a medical negligence claim under the same THCLA provision at issue here to proceed against an HMO under a narrow vicarious liability theory based on negligent arrangement of a physician's services. *Corporate Health*, 215 F.3d at 535 ("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."); *id.* ("Congress [never] intended for ERISA to supplant [the THCLA's] regulation of the quality of medical practice."). There should be no distinction between holding an HMO vicariously liable when its physician fails to adhere to ordinary standards of medical care and holding an HMO directly liable for failing to follow those same standards. *Cf. Roark*, 307 F.3d at 310-11 (holding that companion plaintiffs Calad and Davila's claims were not completely preempted under ERISA § 502(a)(1)(B) and remanding THCLA claim to state court).

The Third Circuit has its own formulation of this issue, distinguishing between preempted "quantity of care" claims and non-preempted "quality of care" claims, which are essentially medical malpractice claims. *See, e.g.*, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 279 (3d Cir. 2001) (distinction between quality and quantity of benefits claim applies both to ERISA §514(a) cases and §502(a) cases); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999) (distinction between "an HMO's role in 'arranging for medical treatment' rather than its role as a plan administrator determining what benefits are appropriate."); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350,

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(vicarious liability claim preempted); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (same); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (same).

356 (3rd Cir. 1995) (vicarious liability claim not preempted under ERISA §502(a) because plaintiff sought to hold

"HMOs liable for their role as the arrangers of their decedents' medical treatment").

Finally, the Maryland Court of Appeals has looked to the absence of a traditional physician-patient relationship to conclude that a medical negligence claim against an HMO's utilization review physician is preempted. *Eid v. Duke*, 373 Md. 2, 816 A.2d 844 (2003).

However the issue is defined, the interrelationship between ERISA preemption and the application of state-law medical malpractice standards to an HMO's medical necessity decisions continues to confound litigants and produce contradictory decisions from both state and federal courts. This Court's guidance is sorely needed to provide direction in this increasingly muddled corner of ERISA jurisprudence.

III. NUMEROUS STATES HAVE ENACTED SIMILAR STATUTES MAKING FURTHER DISUNIFORMITIES AND CONFLICTS INEVITABLE.

At least nine other states now -- Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, and Washington -- have enacted statutes similar to the Texas statute, imposing a duty of ordinary care on managed care organizations when making medical necessity decisions. *See* A.R.S. §20-3153; Cal. Civ. Code §3428; O.C.G.A. §51-1-48(a); La. R.S. §22:3085(D); 24-A M.R.S. §4313; N.J. Stat. §2A:53A-33(a); N.C. Gen. Stat. §90-21.51(a); 36 Okl. St. §6593(A); Rev. Code Wash. §48.43.545. Other states, such as Pennsylvania, Florida, and Illinois, appear to permit state common law medical negligence claims (either directly or vicariously) against

HMOs for medical necessity decisions. *See Villazon*, 843 So.2d at 848; *Pappas II*, 564 Pa. at 420; *Hinterlong*, 308 Ill. App. 3d at 452 (vicarious liability). This issue therefore will inevitably create additional conflicts and disuniformities in courts throughout the country without this Court's guidance on this important issue.

IV. THE UNITED STATES HAS STRESSED THAT THIS ISSUE HAS "NATIONWIDE IMPORTANCE" AND WARRANTS PLENARY REVIEW.

Finally, the United States itself has confirmed that this issue has national importance and deserves plenary review. Moreover, since *Pegram*, the Government's position has argued that medical negligence actions against HMOs should be governed by state law and not preempted by ERISA.

The Solicitor General asserted that an issue similar to the one Petitioner now raises merits this Court's review in his analysis of the petition for *writ of certiorari* in *Pappas I*. *See* Brief for the United States as *Amicus Curiae* in *United States Healthcare Sys. Of Pa., Inc. v. Pennsylvania Hosp. Ins. Co.*, No. 98-1836 ("*Pappas I* Brief"). There, the Solicitor General asserted that "questions regarding the scope of negligence claims against HMOs are currently of great nationwide importance," *id.* at 6, and "[t]he profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise." *Id.* at 18.[7] Because

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[7] The question presented in *Pappas I* was whether ERISA § 514(a) "preempt[s] state law claims arising from a health maintenance organization's negligence in denying a claim for benefits under an ERISA-governed health plan." *Id.* (Question Presented).

Pegram was pending, the Solicitor General suggested holding the *Pappas I* petition, and, if *Pegram* failed to clearly resolve the issue, "the Court should grant plenary review in [*Pappas I*] to ensure uniform interpretation of the extent to which ERISA beneficiaries may bring state-law negligence claims against HMOs." *Id.* at 20.[8]

On the merits, the United States has advocated that ERISA does not preempt state medical negligence actions against HMOs. In *Pegram*, the United States argued that a plaintiff does not state an ERISA breach of fiduciary duty claim by contesting an HMO employee-owner physician's "treatment" decisions. *See* Brief For the United States as *Amicus Curiae* Supporting Petitioners in *Pegram v. Herdrich*, No. 98-1949 at 8 ("*Pegram* Brief"). Deciding otherwise, the Solicitor General warned, would mean that "traditional state regulation of the practice of medicine – along with traditional state-law malpractice and professional licensing regulations – would necessarily be preempted insofar as they applied to ERISA plans. In *Travelers* and subsequent cases, this Court has rejected that overly expansive view of ERISA's scope, and it should do so again here." *Id.* at 9.

The United States explained that reading ERISA preemption broadly "threaten[s] to carve out an enormous hole in traditional state regulation of the practice of medicine" because "the practice of medicine by HMOs – would necessarily 'relate to' ERISA plans and would be preempted under [ERISA]." *Id.* at 13 (citing appellate

[8] More recently, the Solicitor General stated that *Pegram*'s effect on the scope of ERISA preemption with respect to "the scope of permissible state-law suits against HMOs arising out of [] medical necessity decisions" was an issue of "very broad significance." Brief for the United States as *Amicus Curiae* in *Montemayor v. Corporate Health Ins.* and *Rush Prudential HMO v. Moran*, Nos. 00-665 and 00-1021, at 18 & n.6.

courts that have "correctly held that state laws governing the practice of medicine by HMOs are not preempted by ERISA.”).

The Solicitor General reiterated this position to this Court in *Pappas I* when he argued that an "HMO is subject to suit under state law for negligence in performing its medical duties." *Pappas I* Brief at 10. After remand, the United States argued to the Pennsylvania Supreme Court that “ERISA does not preempt state law that applies to the HMO's medical treatment decisions, even though they are . . . 'mixed' treatment and eligibility decisions." *Amicus* Brief of the Department of Labor in *Pennsylvania Hosp. Ins. Co. v. United States Healthcare Sys. of Pa.*, No. 0098 E.D. Appeal Docket 1996 (“*Pappas II* Brief”) at 9; *id.* at 10-11 ("*Pegram* holds that 'treatment' decisions and 'mixed' treatment and eligibility decisions by physician employees of an HMO are governed by state malpractice standards and not ERISA fiduciary standards.”). According to the Government, ERISA § 514(a) preemption of state malpractice standards would allow an HMO to “escape responsibility as an ERISA fiduciary for its 'mixed eligibility decisions,' as *Pegram* holds, and also avoid state malpractice law," leaving a "a gap in protection as courts have recognized." *Pappas II* Brief at 13 (citing *Corcoran*, 965 F.2d at 1333) (footnote omitted). Thus, the United States concluded that, if an HMO makes a "'mixed' treatment and eligibility decision, . . . ERISA does not preempt a state negligence action challenging that decision." *Id.* at 11-12.[9]

The Government's prior positions make clear that the issue here has broad, national significance and may well

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[9] The Pennsylvania Supreme Court concurred substantively with the United States, concluding that the HMO’s decision "was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law, as *Travelers* teaches, is not preempted by ERISA." *Pappas II*, 564 P. at 420 n.6.

have been wrongly decided by the Fifth Circuit. *Amici* therefore respectfully suggest that the Court address this issue squarely by granting Mr. Roark's petition.

CONCLUSION

For all of the foregoing reasons, the petition should be granted.

Respectfully submitted,

MARK E. RUST *
Counsel of Record
BARNES & THORNBURG
One N. Wacker Street
44th Floor
Chicago, IL 60603
(312) 357-1313

BRIAN E. CASEY
BARNES & THORNBURG
100 North Michigan Street, Suite 600
South Bend, IN 46601
(574) 233-1171

JON N. EKDAHL
LEONARD A. NELSON
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
(312) 464-5059

Counsel for Amicus
American Medical Association

DONALD P. WILCOX
TEXAS MEDICAL ASSOCIATION
401 W. 15th Street
Austin, TX 78701
(512) 370-1300

Counsel for Amicus
Texas Medical Association

Attorneys for Amici Curiae

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