Casenote

**ERISA'S PREEMPTION RULING PREVENTS A PATIENT FROM SUING AN HMO UNDER STATE MALPRACTICE LAW: AFTER AETNA HEALTH, INC. V. DAVILA WHO WILL GRANT THE WORKING MIDDLE CLASS A MEANINGFUL RIGHT TO BE HEARD?**

L. Darnell Weeden†

The *Davila* decision

created law that makes ERISA a sword in the hands of insurance companies against their vulnerable insured. Because ERISA was written with pensions and employee retirement plans in mind . . . the act was never intended to apply to health insurance. The court has put a square peg in a round hole to try to fit claims against insurance companies into a scheme created for pension and employee retirement plans.¹

The issue to be addressed is whether the Employment Retirement Security Act (ERISA) preempts state law claims against a Health Maintenance Organization (HMO) for its failure to meet ordinary standards of medical care in its mixed eligibility and treatment decisions.² One of the sundry messages of *Pegram v. Herdrich*³ is that an HMO's mixed

---

† Professor, Thurgood Marshall School of Law, Texas Southern University; B.A., J.D., University of Mississippi. I would like to thank Marva O. Coward, Public Services Coordinator at Thurgood Marshall School of Law Library for her research help; and Simeon O. Coker, Research Assistant at Thurgood Marshall School of Law, Class of 2005, for his valuable comments concerning earlier drafts of this article.

1. Correy E. Stephenson, Malpractice Claims Against HMOs Preempted By ERISA, LAW, WKLY. USA, July 5, 2004, at 1.
2. Corporate Health Ins., Inc. v. Texas Dept. of Ins., 215 F.3d 526 (5th Cir. 2000).
eligibility and treatment decisions are neither preempted by ERISA nor covered by federal common law and are subject to the state law malpractice claims, according to the Fifth Circuit. The Fifth Circuit apparently believes that a state could protect a patient’s right to sue an HMO in state court for a failure to meet the ordinary standards of medical care in a mixed eligibility and treatment decision. On June 21, 2004, the United States Supreme Court reversed the Fifth Circuit in its Aetna Health, Inc. v. Davila (hereinafter Davila I) decision by holding that ERISA preempts the state law malpractice claim against an HMO because the HMO’s decision to deny treatment presented a question of eligibility or administration and not an issue of treatment.

Part I of this article will analyze preemption and the right to sue an HMO for medical malpractice under state law with a discussion of relevant lower court opinions including Roark v. Humana, Inc. (hereinafter Roark I), Davila v. Aetna (hereinafter Davila I), Calad v. Cigna Healthcare, and Corporate Health Insurance. Part II of this article will discuss the rationale of United States Court of Appeal decision in Roark v. Humana, Inc. (hereinafter Roark II). Part III of this article will critique the United States Supreme Court’s ruling in Aetna v. Davila (hereinafter Davila II).

I. PREEMPTION AND THE RIGHT TO SUE AN HMO FOR MEDICAL MALPRACTICE UNDER STATE LAW

On May 25, 2001, when the issue of suing an HMO for medical malpractice in state court was presented below at the federal trial court level in Roark I, Judge Fitzwater of the Northern District of Texas issued an “amazing” memorandum opinion. The federal trial court’s holding can

4. Corporate Health Ins., 215 F.3d 526 (5th Cir. 2000).
5. Roark v. Humana, Inc., 307 F.3d 298, 310–11 (5th Cir. 2002). “The Supreme Court has declined to decide whether § 502(a)(1)(B) displaces a medical malpractice claim involving ‘mixed decisions’... and this circuit has not yet confronted the question. We now conclude that § 502(a)(1)(B) does not preempt Calad’s and Davila’s THCLA claims.” Id. at 308 (citing Pegram, 530 U.S. at 229, n.9).
7. Id.
12. 307 F.3d 298, 305 (5th Cir. 2002).
be characterized as ‘amazing’ because real world logic and practical experience support the conclusion that the plaintiffs’ complaints about not receiving reasonable health care treatments were caused in fact by Humana HMO’s pattern and practice and course of conduct. However, neither good public policy nor congressional intent supports Judge Fitzwater’s conclusion that a pattern and practice of negligent conduct under state law by a provider of health care benefits is preempted by ERISA’s civil enforcement provisions.

In a recent article, David L. Trueman provides an excellent one-paragraph description of what he refers to as basic ERISA principles. ERISA is a far-reaching law approved in 1974 to look after beneficiaries’ pension plans; nevertheless, ERISA also contains provisions about welfare benefit plans. ERISA’s welfare benefit provisions have been construed to have an effect on health benefits plans. Two ERISA sections have an impact on claims aligned with employer sponsored health care plans. First, section 502(a) of the Act involves making decisions about employee benefits while giving federal courts total jurisdiction concerning claims about the denial of benefits. In the past, courts construed section 502(a) to require state law tort claimants asserting an HMO’s unreasonable refusal of medical treatment to litigate the controversy under federal jurisdiction. When the denial of the of health care benefit reaches the federal court, section 514 has been used as an effective general preemption tool to defend state law claims brought by plaintiffs with the end result habitually being a dismissal of the plaintiffs cause of action.

Judge Fitzwater’s application of section 514’s general preemption rationale to dismiss the plaintiffs’ state medical malpractice claims with little regard for the HMO’s adverse impact on medical treatment seems to represent a continuing misreading of congressional intent regarding the applicability of federal preemption to State law claims that relate to an employee health benefit plan. Judge Fitzwater’s ERISA preemption

15. Id.
16. 29 U.S.C.A. § 1132(a) (2004). “A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .” Id. § 1132.
18. Id.
19. Id.
20. Id. (citing 29 U.S.C. § 1132(a) (2000)).
21. Id.
22. Id. (citing 29 U.S.C. § 1144 (2000)).
rationale for state medical malpractice issues involving real questions of treatment and only pre-textual issues of eligibility was admittedly endorsed by all nine members of the Supreme Court in Davila II. It is unfortunate that the Supreme Court in Davila II rejected the suggestion it made four years earlier in Pegram v. Herdrich that the HMOs involved in ERISA plans could be held liable for state law negligence and avoid issues of preemption when the question involves real quality of treatment issues rather than issues of eligibility.

In theory, one could support the contention made by Trueman that the Supreme Court's rationale articulated in Pegram v. Herdrich may have possibly "paved the way for a new line of ERISA jurisprudence, narrowing ERISA preemption by identifying a new category for utilization decisions which could avoid preemption."24

Although Trueman successfully asserts that Pegram v. Herdrich could have been the vehicle for the Supreme Court to avoid virtually wholesale preemption of most state law claims involving ERISA medical treatment claim, his view that the Court would use the case to avoid unintended preemption of medical treatment issues is too optimistic.25 After analyzing the rationale of Pegram v. Herdrich, it was simply not convincing that the Court would construe ERISA's general preemption provision in a manner that would allow states to grant patients a bill of rights in the absence of an express mandate from Congress to do so.26

Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] and not exempt under section 4(b) [29 U.S.C. § 1003(b)]. This section shall take effect on January 1, 1975.

24. Trueman, supra note 17, at 434.

In Pegram, the Supreme Court started down the path of eliminating preemption for claims alleging injuries resulting from wrongful denials or delays of treatment but only when a patient's symptoms are included in the process of making a pre-certification or utilization review determination. Although Pegram examined fiduciary duties owed to ERISA plan beneficiaries, the Court fashioned an opinion that extended well beyond the fiduciary duty issue into the arena of utilization review and medical determinations of requests for treatment.

Id. at 434–35.

25. L. Darnell Weeden, An HMO Does Not Owe An ERISA Fiduciary Duty To Its Employee Beneficiaries: After Pegram V. Herdrich, Who Will Speak For The Working Class?, 23 W. NEW ENG. L. REV. 381. (2002). "[T]he purpose of this Article is to demonstrate that Congress should amend ERISA to allow plan beneficiaries/patients to assert medical malpractice claims and breaches of both fiduciary duty and contract against both doctors and HMOs in the managed care industry." Id. at 387.
26. Id. at 387–88.
After considering the allegations presented below, Judge Fitzwater concluded that the plaintiffs' complaint implicated the administration of benefits rather than the quality of medical treatment. The position taken by Judge Fitzwater should be rejected because it is clear that the ERISA health benefit preemption rationale is used by HMOs as a clear pretext for the HMO's primary goal of actually controlling the quality of medical treatment a patient receives while allowing HMOs to escape accountability for their conduct impacting treatment. Considering the facts as alleged by the plaintiffs in Roark I, it would likely upset the American public to learn of Roark I's holding that the plaintiffs merely suffered from an inconvenient administrative benefits process rather than experienced life-endangering second-class medical treatment from their HMOs.

In Roark I, the plaintiffs sued Humana in state court under the Texas Health Care Liability Act [hereinafter THCLA] to dispute the coverage for medical care Mrs. Roark received because of a spider bite. The lower court in Roark I mischaracterizes the substance and heart and soul of the complaint as an issue of coverage rather than a complaint about the inferior quality of treatment she received after the administrative coverage issue had been resolved. Humana successfully had the Roarks' lawsuit removed from state to federal court under a theory of ERISA preemption; subsequently the federal trial court denied Mr. and Mrs. Roark's request to remand their claim to state court because of ERISA preemption.

Roark I illustrates how a misapplication of the ERISA preemption principle denies a state the opportunity to exercise its reserved police powers under the Tenth Amendment to protect the health and safety of its citizens from corporations or citizens who would render meaningless the right to adequate medical treatment from an HMO. If the Tenth Amendment means anything, it means that Congress may not preclude the states from providing their citizens with effective patient rights against HMOs and others in the managed care industry who may substantially undermine the quality of health care treatment a citizen receives. "There is an historic right to state sovereignty over public health and the Justices have begun to recognize the very intense local interest of states in

30. Id.
31. U.S. CONST. amend. X. ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.")
protecting their citizens from wrongful delivery of health care." In spite of the strong and compassionate state interest in insuring first quality medical treatment for its citizens, the Supreme Court's *Davila II* opinion denies a state the right to use its reserve powers to protect the health of its patients/citizens because the Court has revived its expansive construction of ERISA preemption.  

In an excellent article, Professor Larry J. Pittman argues that when an HMO provides health care coverage as an insurer to employees under an employer-sponsored health care plan, ERISA's saving clause, which saves state regulation of insurance from ERISA preemption, applies. Professor Pittman makes the logical and coherent case that applying the Supreme Court’s canons of statutory construction to ERISA’s express preemption clause precludes a finding that ERISA’s 1132(a)’s civil enforcement provisions “preempt[s] a state law regulation that satisfies the savings clause.” He effectively suggests that ERISA’s savings clause is designed to promote federalism by giving the states the ability to regulate insurance

---

32. Lorraine Schmall and Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims For Patients’ Rights*, 42 BRANDEIS L. J. 529, 530 (2004). “Three decades of scholarship and creative lawyering calling for either a narrower interpretation of federal preemption of state law and claims under ERISA or for the creation of meaningful remedies under a federal common law has fairly gone unanswered.” Id. (citations omitted).

33. Id. at 541. “In the first generation of preemption decisions, the United States Supreme Court described ERISA’s preemption decisions as having ‘a broad scope,’ an ‘expansive reach,’ as being ‘broadly worded,’ and ‘conspicuous for its breadth.’” Id. (citing Metro Life Ins. Co. v. Mass., 471 U.S. 724, 739 (1985); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138 (1990); FMC Corp v. Holiday, 498 U.S. 52, 58 (1990)).


A further deconstruction of ERISA’s preemption clause’s language shows that a saving clause-protected state law escapes ERISA’s preemption even when the state law conflicts with one of ERISA’s substantive provisions. For example, when the preemption clause’s language speaks of preemption of state laws, it does so regarding certain “provisions of this subchapter” superseding state laws. Importantly, the “provisions of this subchapter” language refers to Subchapter I of ERISA, which includes ERISA’s “fiduciary responsibility” provisions in §§ 1101-1114 and ERISA’s “administration and enforcement” provisions in §§ 1131-1147, which includes § 1132(a) of ERISA’s civil enforcement provisions.

When the second phrase of ERISA’s preemption clause is read in conjunction with the first phrase, the meaning of ERISA’s preemption clause is that certain sections of ERISA will preempt state laws except when such state laws regulate insurance under ERISA’s saving clause.

Id. (citations omitted).

35. Id. at 614.
where necessary to ensure an insured’s right to a mandated benefits or a mechanism to protect those benefits. Questions concerning the quality of eligible treatments are clearly not administrative matters for an HMO acting as an insurer to cover an eligible service. When decisions about the quality of an ERISA claimant’s medical treatment are made by an HMO, an issue of state insurance regulation is presented and should not be preempted under Professor Pittman’s savings clause federalism rationale. Professor Pittman asserts that a proper understanding of congressional intent and federalism allows a state to award compensatory damages even “when [section] 1132(a) of ERISA’s civil enforcement provisions does not allow such damages.”

A very expansive look at ERISA’s savings clause as advancing federalism should also allow state insurance laws to award punitive damages in medical malpractice claims against HMOs when deemed reasonably necessary by state officials to protect the quality of medical treatment decisions made by HMOs contrary to the advice of an ERISA insured patient’s official. In Roark I, the trial court’s assertion that the complaint is not really directed at medical treatment is not consistent with the experience of many patients who have received second class medical treatment because of an HMO’s aggressive denial of the specific medical treatment recommended by the primary care physician. One should apply a Justice Holmes truism to properly analyze the medical treatment issue presented in the Roark case. Holmes’ pronouncement that “the life of the law has not been logic: it has been experience” supports the conclusion that ERISA’s preemption rationale has been used by HMOs to provide patients with second class medical treatment.

Under common law, state medical malpractice claims generally focus on whether the quality of healthcare conforms to community standards. Although administrative denials of a certain quantity or type of health care clearly impacts a patient’s health, courts are inconsistent, but typically adverse to finding an employee-patient’s rights to such redress under state common law.

If an employee wants to bring a claim against the physician or the managed health care organization, the employee must consider whether the claim will fall under state law, or whether the state cause of action will be preempted by

---

36. Id. at 599–603.
37. Id.
38. Id. at 602.
39. Id. at 602–603.
41. See Schmall & Stephens, supra note 32, at 538.
42. OLIVER WENDELL HOLMES, THE COMMON LAW 1 (1881).
43. Schmall & Stephens, supra note 32, at 531–32.
is absolutely correct in asserting that "separating the existence of benefits from their quality makes little sense if a given level of quality is a deliberately designed component, and not merely an accidental byproduct, of an insurance benefit package." Professor Sage states that several lower courts have used their experience in the ERISA preemption quality of health care battles to recognize the substantial clinical impact that health care plans operated by HMOs have on the quality of a patient's health care. Because of the potential adverse impact HMOs have on medical decisions, these courts have avoided dismissing a patient's substandard treatment claim under a rigid application of ERISA's preemption logic to employer-sponsored health care plans. The practical effect of the Supreme Court's decision in Davila II, which approved the trial court's holding in Roark I, is a return to what Professor Sage appropriately describes as a general understanding that insurers were basically immune from tort liability prior to the Supreme Court's 1995 decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.

In granting the defendant's request to dismiss the plaintiff's compliant at the federal trial court level, the judge in Davila I provides some instructive insights about the adverse impact of the preemption doctrine on

---

ERISA. Because state law may offer employees greater protections than ERISA, broad federal preemption of state law under ERISA is also a part of the problem for an employee seeking protection against employer discharges and other acts that interfere with her rights to benefits. Rather than wait for Congress to amend a complicated tax and labor statute, plaintiffs can begin to look toward resolution in state common and statutory law.

Id. (citations omitted).

45. Id.
46. Id. at 614.

"Preemption"—the extent to which federal ERISA law protects defendants from suit under state law—matters greatly to the medical necessity debate. For the vast majority of privately insured Americans who might choose to file lawsuits, ERISA is the main difference between a dismissal and a generous award or settlement. Before 1995, ERISA preemption was interpreted broadly, essentially immunizing insurers from tort liability under state law and shielding self-funded plans from state regulation.

Id.

47. Id. at 616 ("[C]ourts have used these doctrinal devices, which allow them to emphasize the clinical influence of health plans and downplay managerial considerations, to achieve rough justice for injured patients.").
the issue of medical care for employee patients and their families. Although Judge Means’ analysis in Davila I somewhat disregards public policy and congressional intent for ERISA preemption of health care plans, the judge does a first-rate job of describing the remedies available to a patient concerning the quality of medical services under the complete preemption theory as well as the conflict preemption theory.49

The facts in Davila I are stated in a straightforward manner by the plaintiff and are not challenged by the defendant.50 The plaintiff seeking proper medical treatment argues that the defendants, who oversee healthcare benefits claims for the plaintiff and his coworkers, negligently and wrongfully dispensed inferior medicine to the patient in the course of requiring the patient to utilize a specific prescription-drug formulary.51 In particular the plaintiff finds fault with the defendant’s decision not to cover the Vioxx drug prescribed by his doctor for the plaintiff’s arthritis pain. The defendant declined to pay for the medication. The defendant’s negative response to the plaintiff’s request for Vioxx was consistent with its prescription drug formulary. The defendant’s prescription drug plan grew out of a utilization review lineup.52 Under this utilization review lineup, Vioxx would not be made available “unless the insured has a contraindication, intolerance, allergy to or a documented adequate trial of at least two... formulary [non-steroidal anti-inflammatory drugs].”53 As a result of the defendants’ drug formulary plan, the plaintiff’s doctor prescribed naprosyn for his arthritis pain. The plaintiff’s complaint alleges that he suffered bleeding ulcers because he was forced to take naprosyn and that he almost experienced a naprosyn-related heart attack. The plaintiff states that as a result of this condition, he was hospitalized as a critical care patient for a number of days.54 It should come as no surprise that the plaintiff believes that the plaintiff’s critical illness was caused by taking the naprosyn because plaintiff’s doctor wanted to prescribe the drug Vioxx for his arthritis rather than naprosyn. Stephanie Reinhart correctly concludes that HMOs have “virtually destroyed the doctor-patient relationship by forcing patients to see particular doctors and forcing doctors to perform particular procedures.”55 Reinhart appropriately suggests that ERISA

50. Id. at *1.
51. Id.
52. Id.
53. Id. (citation omitted).
54. Id.
preemption gives HMOs financial incentive to gamble with the health of patient employees.\(^{56}\)

After suffering through second-rate medical treatment by the defendants, the plaintiff filed suit against them in a Texas state court alleging a claim under the THCLA alleging that the defendant managed care providers violated the act by carelessly engaging in medical malpractice.\(^{57}\) The defendants responded to the plaintiff's claim by removing this case to a federal district court. The defendants argue that federal-question jurisdiction is present because the plaintiff's state-law tort cause of action is completely preempted by the ERISA. Defendants additionally contended that plaintiff's state-law claim should be dismissed because the plaintiff may only declare his claim under ERISA.

Davila, the plaintiff, requested the federal court to remand the case to state court because ERISA does not completely preempt his state law malpractice claim. Davila stresses that federal-question jurisdiction does not exist when a state law claim is not completely preempted and removal of his state law malpractice claim to federal court is improper.\(^{58}\) Since the defendants are the removing parties they possess the burden of resolving whether a federal court has jurisdiction over plaintiff's state law tort claim.\(^{59}\) The issue of whether federal jurisdiction exists on a given claim is generally decided by applying the "well-pleaded complaint rule."\(^{60}\) Under the well-pleaded complaint rule "federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint; a federal defense does not confer subject-matter jurisdiction."\(^{61}\) In Davila I, the federal district court conceded that the plaintiff's state law tort claim did not assert a federal claim on its face.\(^{62}\)

Although many doctors may be stuck with HMO rules, independent review statutes will allow patients to advocate for themselves the way doctors once advocated for them ... Independent review statutes are exactly the kind of "contracting regulations" needed to counterbalance the cost control measures that are at the heart of HMO plans. They give patients an additional safeguard when dealing with HMO administrators that allows them to feel like they have some control over their own healthcare.

\(^{56}\) Id. at 131–32.
\(^{57}\) Id. at 127–44.
\(^{59}\) Id.
\(^{60}\) Id. (citing Carpenter v. Wichita Falls Indep. Sch. Dist., 44 F.3d 362, 365 (5th Cir. 1995)).
\(^{61}\) Id. (citing Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 9–10 (1983).
\(^{62}\) Id. (quoting In re U.S. Healthcare, Inc., 193 F.3d 151, 160 (3d Cir. 1999)).
The defendants in Davila I insisted that removal is appropriate since federal-question jurisdiction is present under the complete preemption doctrine. The complete preemption doctrine is exempted from the well-pleaded complaint rule. The complete preemption rule applies when Congress has so completely preempted a specific field that any civil complaint bringing up this particular topic as a claim is inevitably federal in character. When the plaintiff’s state law claim is completely preempted, a federal question exists no matter how the plaintiff formulates the claim. Once a federal question is established, the right to remove a case from state court to federal court is appropriate. In litigation involving ERISA, complete preemption arises as soon as a state-law claim is appropriately inside the scope of the civil-enforcement provisions of section 502 of ERISA. ERISA’s civil-enforcement provision creates a federal claim each time an ERISA plan participant or beneficiary attempts to enforce or clarify plan rights.

In Davila I, the plaintiff appropriately asserts that his cause of action disputes the quality of care he was given as a consequence of defendants’ involvement with its formulary treatment scheme. When a plaintiff “attacks decisions made about his medical treatment, his claim does not fall under [section] 502 of ERISA and thus is not completely preempted.” In contrast, a claim declaring that an HMO turned down specifically requested medical services or treatment on the ground that they were not provided for under the plan obviously is one concerning the proper administration of

---

63. Id. at *2 (citing Giles v. NYLCare Health Plans, Inc., 172 F.3d 332, 336–37 (5th Cir.1999)).
64. Id.
65. Id.
67. Id. (citing 29 U.S.C. § 1132(a)(1)(B)). “ERISA also contains a second type of preemption known as ‘ordinary’ or ‘conflict’ preemption. Section 514 of ERISA provides that ERISA’s provisions ‘supersede any and all State common laws insofar as they may now or hereafter relate to any employee benefit plan.’” Id. (citing 29 U.S.C. § 1144(a)).

Although section 514’s ‘conflict’ preemption has been broadly construed, it nevertheless is defensive in nature and therefore provides no basis for removal jurisdiction under the well-pleaded-complaint rule. Giles, 172 F.3d at 337. Thus, “when the doctrine of complete preemption does not apply, but the plaintiff’s state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding § 514(a) preemption. Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 355 (3d Cir. 1995). Rather, it must remand to state court, and that court will resolve the section 514(a) preemption issue.

Id.
69. Id.
benefits and completely preempted under ERISA.\textsuperscript{70} The \textit{Davila I} Court correctly stated the issue as whether the plaintiff's cause of action contests the administration of or eligibility for benefits under ERISA's civil enforcement provisions and is completely preempted or whether the plaintiff is actually challenging the quality of the medical treatment he received which is not covered by complete preemption doctrine and could be covered under a state law cause of action under ERISA's conflict preemption theory.\textsuperscript{71}

It was most unfortunate for Judge Means to describe Davila's attempt to challenge the second-rate medical treatment he was receiving because of Aetna's utilization of a formulary scheme as simply a peppering of his cause of action "with quality-of-care and medical-treatment allegations."\textsuperscript{72} While ignoring the reality of Davila's effort to seek the medical treatment recommended by his doctor, Judge Means unfortunately misconstrues Davila's medical malpractice treatment claim as a cause of action involving the administration of health care benefits covered under an ERISA plan.\textsuperscript{73}

Despite Judge Means' ruling, Davila's disagreement with the defendants' devotion to its prescription drug formulary, regardless of his doctor's recommendation, is a quality of health care issue.\textsuperscript{74} When a plaintiff's cause of action alleges that the defendants decline to provide coverage for the drug recommended by his doctor, and as an alternative is required to first try a less-expensive drug with a history of causing side effects, the plaintiff properly raises an issue of medical treatment and not the false issue of eligibility of benefits. Davila makes reality-check argument that defendants' formulary policies are the functional equivalent to an unacceptable practice of medicine. Judge Means' conclusion—that Davila is simply disputing the defendants' decision concerning which specific drugs are covered by the plan and the status of that coverage—is out of touch with real-world medical treatments experienced by Davila and other middle class patients.\textsuperscript{75}

Judge Means' conclusion that Davila's cause of action against defendants relates to their administration of benefits covered by the plan instead of the quality of health care he received is not supported by the practical effect of being denied a course of treatment recommended by Davila's doctor.\textsuperscript{76} To conclude that Davila's state-law medical malpractice claim is completely preempted by ERISA because he was not concerned

\textsuperscript{70. Id.}  
\textsuperscript{71. Id.}  
\textsuperscript{72. Id. at 3.}  
\textsuperscript{73. Id.}  
\textsuperscript{74. Id.}  
\textsuperscript{75. Id.}  
\textsuperscript{76. Id.}
about the quality of medical treatment he was receiving under federal-question jurisdiction law defies legal logic and ignores the common experience of working-class employees struggling to receive first-rate medical care from employer-sponsored managed care plans.  

In Calad v. Cigna Healthcare, two plaintiffs in concert filed a state-court negligence cause of action against their health maintenance organizations (HMOs) alleging certain violations of the liability provisions of the Texas Health Care Liability Act (THCLA). Both plaintiffs allege that each HMO’s medical necessity evaluation wrongfully obstructed the recommendations of their treating physicians and that they endured damages because of the obstacles imposed by the defendants. Plaintiff Calad objects to the medical necessity determination concerning the duration of her hospital stay following surgery while plaintiff Thorn contests the delayed authorization of his surgery following an injury in an accident.

In Calad, the federal district court addressed the controlling impact of federal question removal for claims that may come within the scope of ERISA’s civil enforcement provisions under section 502(a). The Calad court reflected on the role CIGNA played in processing Calad’s requests for medical services under Section 502(a) preemption. All the litigants agree that Calad’s health care was made available through CIGNA under a plan covered by ERISA and sponsored by her husband’s employer. Calad asserts that section 502(a)’s complete preemption rationale cannot apply to her state-law cause of action under THCLA because she is filing a lawsuit against the HMO and not the ERISA plan. CIGNA (the HMO) executes numerous administrative functions for the plan as well as give utilization review services and make benefit decisions. The federal trial court rejected Calad’s argument and held that ERISA’s section 502(a) civil enforcement preemption scheme applies to claims against ERISA plans and to claims against administrators of ERISA plans including the HMOs that supply utilization review. Utilization review is a cost containment practice used by HMOs to resolve the issue of whether medical services are

77. See id.
79. Id.
80. Id. at *2-7. “Thorn receives his health insurance through his employer, the Azle Independent School District. The ERISA statute makes clear that the complete preemption provisions ‘shall not apply to any employee benefit plan if such plan is a governmental plan’... ERISA, therefore, does not preempt Thorn’s claims against Aetna.” Id. at *6 (quoting 29 U.S.C. § 1003(b)(1)) (citation omitted).
81. Id. at *6.
82. Id.
83. Id.
appropriate or necessary.\textsuperscript{84} The trial court appropriately described the HMO's involvement in the utilization review process as central to plaintiffs Calad's and Thorn's claims in this case.\textsuperscript{85}

Judge Sanders raised the quality of care issue in \textit{Calad}, but he reached the wrong conclusion on the issue of complete ERISA preemption under section 502(a)'s civil enforcement provisions. The proper issue before Judge Sanders concerning quality of care is not properly considered a completely preempted federal claim when the utilization review process is the functional equivalent of a medical treatment decision.\textsuperscript{86} The plain language of THCLA\textsuperscript{87} clearly demonstrates a legislative intent to treat the utilization review process as a health care treatment decision when medical services are actually provided and a decision in the process affects the quality of the treatment given to patients like Calad.\textsuperscript{88} In considering the facts surrounding the so-called medical service decision rendered in \textit{Calad} one should remember Justice Holmes' wise suggestion that the life of legal justice is not abstract logic but the real experience of people.\textsuperscript{89}

Starting with a Justice Holmes "common experience" perspective as one observes Calad's encounter with her HMO, one should ask whether the HMO merely denied her additional time in the hospital because of a lack of eligibility for coverage or whether the HMO made second-class quality of care decisions under the thin guise of conducting a utilization review. Calad's lawsuit seeks compensation under THCLA and not under her ERISA plan.\textsuperscript{90} Calad contends that at some stage while reviewing the pre-authorization and coverage procedures, she was advised by Cigna that it would approve only one day of hospitalization after her planned surgery (a vaginal hysterectomy). On the second day following her surgery, a hospital discharge nurse on behalf of a Cigna purportedly told Calad's treating medical doctor (Dr. Estrada) that Calad must be released if she did not demonstrate obvious hemorrhaging, fever or high blood pressure. If Calad


\textsuperscript{86} Contra id. at *3-4.

\textsuperscript{87} Id. at *4 n.2 ("Specifically, an HMO or other managed care entity has a duty to exercise ordinary care when making 'health care treatment decisions' and is liable for damages for harm proximately caused to an insured or enrollee by the entity's breach of that duty.") (citing TEX. CIV. PRAC. & REM. CODE § 88.002(a)).

\textsuperscript{88} See id. at *1.

\textsuperscript{89} HOLMES, \textit{supra} note 42.

\textsuperscript{90} Calad, 2001 WL 705776, at *3.
failed to show any of these observable symptoms, she could lengthen her hospital stay only by agreeing to assume the cost. It is important to understand that the medical necessity determination for extending patient Calad’s stay was predetermined by Cigna’s HMO rather than the considered medical determination of her treating physician Dr. Estrada. Calad could not pass Cigna’s medical necessity criteria for a longer hospital stay and she could not afford to personally pay for any additional time at the hospital. This situation strongly suggests that Cigna’s medical necessity criteria is consciously indifferent to the case-by-case medical necessity determination of Calad’s treating physician, Dr. Estrada, and to her health, safety, and welfare as a patient.

In the Calad decision, Judge Sanders was blinded by ERISA preemption labels that categorize negligent quality of medical treatment decisions made by HMOs under the ever-present self-serving utilization review process as determinations about administration of medical benefits rather than quality of health care. Judge Sanders’ analysis falls short because it fails to acknowledge that the ERISA civil enforcement complete preemption battle is really not primarily about the fact that the HMO’s medical necessity decision impacted Calad’s care, this ERISA preemption battle for patient employees is really about the fact that medical necessity determination is no longer made in the first instance by the treating medical doctor of the insured. Unlike the view taken by Judge Sanders, when a decision regarding the amount and type of services under a plan is functionally indistinguishable from one concerning the quality of medical treatment covered under the plan, both logic and experience dictate that it be treated as a medical treatment decision that escapes the complete preemption doctrine of ERISA’s civil enforcement provisions under section 502. Prior to the Supreme Court’s 2004 decision in Davila a lively controversy existed among the states about whether utilization review constituted the practice of medicine. The Supreme Court’s recent

91. Id.
92. Id.
93. Id. at *5.
94. See id.
95. See id. “[T]he Court concludes that Calad’s claim brought under THCLA is, at bottom, not about quality of care but rather about her HMO’s coverage determination and administration of her benefits. The Court therefore holds that Calad’s claims against CIGNA are completely preempted and were properly removed under federal question jurisdiction . . . .” Id. at *6.
decision Davila unfortunately creates a reasonable argument that utilization review determinations are not the functional equivalent of engaging in the practice of medicine.\(^98\)

Judge Gilmore, in *Corporate Health Insurance v. Texas Department of Insurance*, demonstrated the wisdom of experience and compassionate logic in finding no ERISA preemption where the Texas Health Care Liability Act’s (THCLA) provisions hold that managed care entities are liable for substandard health care treatment decisions.\(^99\) In 1998, Judge Gilmore appropriately rejected the arguments of health plans and insurers that ERISA’s federal preemption rationale applied to the THCLA’s substandard medical treatment decisions made through utilization review.\(^100\) Although Judge Gilmore’s holding that the use of the utilization review process to make medical decisions about the quality of treatment received under an ERISA plan is properly viewed as presenting a medical treatment determination under the THCLA, it has apparently been rejected by the Supreme Court’s mischaracterization of similar facts in Davila as involving medical eligibility questions. Judge Gilmore’s rationale for treating utilization review as a medical decision deserves to be recognized for objectively describing how the utilization review process is used to make medical decisions about the quality of a person’s health care.\(^101\)

Judge Gilmore conceded that the Fifth Circuit’s decision in *Corcoran v. United HealthCare, Inc.*\(^102\) held that a Louisiana negligence lawsuit for the wrongful death of an unborn baby was preempted by ERISA, while expressing why the Fifth Circuit’s ERISA preemption rationale used in Corcoran should not apply to the utilization review process involving medical treatment decisions.\(^103\)

The ugly consequence of the impact of an expansive ERISA preemption rationale on the lives of real people is demonstrated by the facts of the Corcoran case as discussed by Judge Gilmore in *Corporate Health Insurance*.\(^104\) In Corcoran, United Healthcare, the provider of utilization review services to an ERISA employee benefit plan, concluded that Mrs. Corcoran’s hospitalization throughout the closing months of her pregnancy was not necessary in spite of her doctors’ frequent and recurring recommendations for complete bed rest.\(^105\) While rejecting her doctor’s

---

98. *See Davila, 124 S. Ct. at 2502* (holding that, because Aetna’s coverage decisions were purely eligibility decisions, Davila’s causes of action fell within the scope of, and thus were completely preempted by, ERISA).
99. *Id. at 615–20.
100. *Id.*
101. *Id.*
102. *965 F.2d 1321 (5th Cir. 1992).*
103. *Corporate Health Insurance, 12 F. Supp. 2d at 614–16.*
104. *Id. at 614–15.*
105. *Id. at 614–15 (citations omitted).*
recommendations, United merely approved ten hours per day of nursing care at home for Mrs. Corcoran. During the period the nurse was not on duty the fetus became distressed and died. As a result, the Corcorans sued for wrongful death contending that their unborn baby died because of the negligent medical treatment decisions made by United. In Corcoran, United tried to ignore the fact it had made a medical treatment decision in rejecting Mrs. Corcoran’s doctor’s advice for bed rest; United also stated under ERISA preemption that the Corcorans could not sue under state tort law to redress their child’s death because the death was a result of dispute about what benefits are due under an ERISA plan. Judge Gilmore pointed out that in Corcoran, the Fifth Circuit determined that United, in its role as a provider of utilization review services, made medical decisions while deciding the type of treatment available to Mrs. Corcoran under ERISA plan benefits.

The Fifth Circuit in Corcoran had the intellectual integrity to properly characterize United’s conduct in its utilization review process as making medical decisions about available ERISA benefits. However, the court reached a flawed conclusion by holding that ERISA’s preemption of state law medical negligence claims that applied to medical treatment decisions left injured individuals like Mrs. Corcoran without an adequate remedy in negligence. Judge Gilmore distinguished Corporate Health Insurance, the case before her, from the Corcoran opinion in that a denial of a medical treatment benefit in Corcoran is preempted by ERISA while a claim about the quality of a benefit actually received is not preempted under ERISA.

The plaintiffs in Corcoran filed suit against their HMO regarding a medical decision made in relation to the denial of certain plan benefits. In this case, a suit brought under the Act would relate to the quality of benefits received from a managed care entity when benefits are actually provided, not denied. The Act clearly states that a “health care treatment decision” is “a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan’s insureds or enrollees.” Thus, Corcoran is factually distinguishable from the instant case.
Corporate Insurance is that a total denial of the health care treatment may suggest that the rejection was based on a theory of eligibility under ERISA's civil enforcement provisions. Judge Gilmore believes that the ERISA preemption rationale should only apply to those situations like Corcoran where the ERISA patient is totally denied physician-recommended medical treatment in the utilization review process. When the utilization review process actually practices poor medicine by approving substandard medical care for a patient counter to the recommendation of that patient's physician, as was the case in Corporate Health Insurance, Judge Gilmore, unlike the Supreme Court in Davila II, would not apply ERISA preemption because a medical treatment decision has actually been made.

On appeal, the Fifth Circuit properly upheld Judge Gilmore's determination that the terms of the THCLA makes HMOs liable for negligent use of the utilization review process in making medical treatment decisions. Judge Higginbotham's opinion for the Fifth Circuit, stating that an HMO should be liable for rendering poor quality health care after deciding that the patient is eligible to receive the service, was unfortunately overruled by the rationale of the Supreme Court in Davila. However, it is beneficial to discuss Judge Higginbotham's treatment of HMO liability issues because his analysis is well-reasoned and supported by the way in which the utilization review process has been used to limit the quality of health care received by patients.

More than thirty years ago, in response to rising costs for medical services to employees, Congress approved changes in providing medical services and limiting the liability of HMO under ERISA. Congress apparently believed that an HMO acting as an intermediary between doctor and patient on issues of medical services and payment would lower health care costs. According to a recent newspaper report, Aetna Health Inc. and Cigna Healthcare of Texas, the defendants in the Supreme Court's Davila II opinion, applauded the Davila II decision. Aetna and Cigna said that they approved the opinion's use of ERISA preemption to keep patients from receiving damages under state tort law because the Supreme

112. Id.
113. Id.
114. Id.
115. Corporate Health Ins., Inc. v. Texas Dept. of Ins., 215 F.3d 526, 534–35 (5th Cir. 2000) (hereinafter, Corporate Health Insurance II).
116. Id. at 530.
118. See Corporate Health Insurance II, 215 F.3d at 531 (summarizing the origin and growth of HMOs).
119. Patty Reinert, Court Ruling Favors HMOs; Patients Can't Seek Damages at State Level, HOUS. CHRON., June 22, 2004, at A1.
Court’s ruling in the case holds employers’ health care costs down. The insurers, Aetna and Cigna, made their unsupported allegations that the Supreme Court’s decision in Davila guaranteed that workers will keep on obtaining affordable insurance through their jobs. “Yet insurance premiums rose [eleven] percent in 2001, [thirteen] percent in 2002 and [fourteen] percent in 2003, according to the Henry J. Kaiser Family Foundation, and companies have asked workers to shoulder much of the higher costs with more ‘out of pocket’ payments.” The preemptive reach of ERISA has been used on a consistent basis by the managed care industry to create a federal enterprise that denies the state its traditional police power to protect its patients by “regulating the new field of managed health care” without remotely meeting the congressional goal of reducing rising health care costs to either the employer or employees. Judge Higginbotham in Corporate Health Insurance demonstrated proper experience and logic by characterizing the issue as the ability of a state to regulate the quality of health care services received by its citizens by requiring that a duty of reasonable care be exercised by health care providers under ERISA plans. As noted by Judge Higginbotham, the state of Texas properly exercised its health care police powers by adopting a law providing the “health care treatment decision” with a very specific definition. Under Texas law, any decision after medical services are made available that affects the quality of the treatment provided to the plan’s insured or enrollees is a medical treatment decision.

Before the Fifth Circuit, Aetna unsuccessfully contended that the liability provisions in the THCLA related to an ERISA plan and also involved plan administration. Aetna argued as an abstract proposition that an assertion that medical services were negligently offered certainly challenges the provider’s coverage decisions under an ERISA plan. Texas asserted before Judge Higginbotham that the THCLA was not like the difficult genre of cases challenging medical care and services that were not provided because, under the THCLA, a provider did not have a duty to provide treatment not covered by a plan. The Fifth Circuit rejected Aetna’s argument and adopted Texas’s interpretation of the THCLA.

120. Id.
121. Id.
122. Id.
123. Corporate Health Insurance, 215 F.3d at 531.
124. Reinert, supra note 119.
125. Corporate Health Insurance, 215 F.3d at 531.
126. Id. at 534 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(5) (1999)).
127. Id.
128. Id.
129. Id.
130. Id.
because the law imposed liability for a restricted universe of claims. The Fifth Circuit specifically held that the THCLA did not include claims based on a managed care entity's rejection of coverage for a medical service suggested by the treating doctor. The THCLA permits lawsuits alleging that a treating doctor was negligent in distributing medical services. Also, the THCLA enforces vicarious liability against managed care entities for the negligence of a medical care provider. Judge Higginbotham stated that the THCLA's vicarious liability provision did not "refer to" the managed care provider's responsibility as an ERISA plan administrator so as to invoke ERISA preemption. Judge Higginbotham's legal experience indicated that HMOs and managed care organizations (MCOs) usually carry out the two independent jobs of health care insurer and medical care provider. A managed care entity is capable of supplying administrative support for an insurance plan which might include making eligibility or coverage determinations. Simultaneously, a managed care entity is able to act as a controller and provider of medical treatment.

While state efforts to police an entity in its role as plan administrator are generally preempted, managed care providers maneuver in a traditional sphere of state police power when they act as health care providers. ERISA does not insulate physicians from professional accountability to their state licensing agency, given the responsibility to enforce standards concerning medical decisions. Judge Higginbotham has taken the logical approach that accountability is essential to ensure that ERISA plans operate inside the broad scope of sound medicine. Unlike the Supreme Court in Davila II, Judge Higginbotham properly concluded that Congress could not have logically intended for ERISA preemption to supplant Texas' regulation of the quality of medical practice in order to avoid some unsubstantiated indirect cost on ERISA plans.

131. Id.
132. Id.
133. Id.
134. Id. at 535.
136. Id.
137. Id.
138. Id. (citing Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987)).
139. Id.
140. Id. at 534–35.
141. Id.
142. Id. at 535.
II. An Analysis of the Fifth Circuit’s Holding and Rationale in Roark II Reveals That the Court Used Sound Legal Reasoning and Public Policy Considerations to Exclude an Opportunistic and Perverse Use of ERISA’s Preemption

In Roark v. Humana, Judge Jerry Smith of the Fifth Circuit merged four cases on appeal from multiple federal district courts below in order to judge common issues of law. Ruby Calad, Walter Thorn, Juan Davila, and Gwen Roark each filed a lawsuit against their HMOs alleging negligence under the THCLA. The four plaintiffs claim that that their doctors’ recommended courses of treatment were negligently rejected by the HMOs. The plaintiffs’ state law claims under THCLA were removed to federal court by the defendants under an ERISA preemption theory because the plaintiffs’ health care plans were sponsored by their employers. Judge Smith discussed ERISA’s two categories of preemption—complete preemption and conflict preemption—before properly deciding that because complete preemption did not apply to Calad’s and Davila’s claims, the federal district court was required to remand their respective THCLA negligent medical treatment cases to state court. The federal appeals court also accepted Calad’s and Davila’s assertions that complete preemption did not apply under these facts because the HMOs did not render their negligent treatment determinations as fiduciaries of an ERISA plan.

Concerning Roark II, the Fifth Circuit stated that the Supreme Court’s complete preemption holding in Pegram did not allow an ERISA patient to make an HMO vicariously liable for a doctor’s medical treatment decisions. Although the issue of whether ERISA’s complete preemption rationale precluded a patient from making an HMO liable because of its negligent conduct was not decided in Pegram, the Fifth Circuit believed that the Pegram court’s categorization of three types of determinations made by HMOs applied to the issue of HMO liability for its own negligence under the THCLA. The three categories of HMO evaluations as discussed in Pegram are eligibility evaluations, treatment evaluations, and mixed eligibility and treatment evaluations. Eligibility evaluations are based on an ERISA plan’s coverage of a specific circumstance or medical course of action for treatment of a condition. The Fifth Circuit

143. 307 F.3d 298 (5th Cir. 2002).
144. Id. at 302.
145. Id. at 305.
146. Id. at 306.
147. Id. at 307.
148. Id.
149. Id.
150. Id.
cited Pegram for the rather obvious proposition that pure eligibility decisions about whether an appendectomy is a covered condition is very uncommon.151 A traditional treatment evaluation requires an HMO to select the method for diagnosing and dealing with or handling a patient’s condition.152 As explained by the Court in Pegram, mixed eligibility and treatment evaluations made by HMOs are widespread and invoke the question of which treatment option produces enough superior results to satisfy the medical necessity obligation.153 Claims involving mixed eligibility and treatment decisions are not covered by ERISA’s civil enforcement provisions.154 The Fifth Circuit logically asserted, based on its judicial experience, that both Davila’s and Calad’s lawsuits against their respective HMOs clearly involved mixed eligibility and treatment evaluations.155 The Roark II decision properly applied Pegram’s definition of mixed treatment decisions to the facts of Davila’s and Calad’s claims to conclude that their HMOs were making medical treatment decisions rather than resolving the question of whether a patient under an ERISA plan was eligible to receive medical services.156 In basic terms, the legal dispute among the parties before the federal appellate court in Roark did not present a pure coverage or eligibility decision, as Cigna did not challenge the fact that its ERISA plan covered hospital stays following a hysterectomy, and Aetna did not contend its plan excludes a variety of arthritis drugs.157

The Fifth Circuit properly characterized the issue presented before it as a mixed eligibility treatment decision under the rationale of Pegram because the facts raise “when and how” medical necessity concerns about whether Calad was provided adequate treatment (a sufficient number of days in the hospital) and whether the HMO recommended the right medicine for Davila—naprosyn instead of the Vioxx recommended by his primary care physician.158 The Fifth Circuit held that the Pegram decision required it to abandon its prior conclusion that the denial of medical treatment by a doctor raised a quality of care determination that avoided ERISA preemption, but the same denial of treatment by an HMO is a coverage or eligibility decision preempted by ERISA.159 Following the recommendation of the Supreme Court in Pegram, the Fifth Circuit in Roark II looked to the substance of the decision made by Davila’s and

151. Id.
152. Id.
153. Id.
154. Id.
155. See id.
156. Id.
157. Id.
158. Id. at 302–03.
159. Id. at 308 n.11.
Calad’s HMOs—not their identities as HMOs—and concluded that because the HMOs were making mixed eligibility decisions, their conduct was not preempted by ERISA’s civil enforcement provisions.\textsuperscript{160} Unlike the Supreme Court’s holding in \textit{Davila II}, the Fifth Circuit in \textit{Roark} refused to prematurely abandon Pegram’s suggestion that mixed eligibility medical treatment decisions are predominately quality of health care treatment decisions escaping ERISA preemption and subject to traditional state tort law claims.\textsuperscript{161}

In \textit{Roark II}, the Fifth Circuit acknowledges that section 502(a)(1)(B) permits a beneficiary under the plan to file a civil lawsuit to enforce his or her claims for benefits provided by the plan.\textsuperscript{162} The Fifth Circuit’s logic and judicial experience appropriately recognized that Calad’s and Davila’s claims alleging medical malpractice by an HMO under the THCLA was not an ERISA civil enforcement breach of contract claim.\textsuperscript{163} Unlike the Supreme Court in \textit{Davila II}, the appellate court in \textit{Roark II} held that Calad and Davila did not allege breach of contract claims; they assert tort claims under state tort law. Calad and Davila had not filed a lawsuit against their plan administrator and they had not contested his interpretation of an ERISA plan.\textsuperscript{164}

The Fifth Circuit agreed with the conclusion that ERISA does not make available a medical malpractice cause of action against a negligent HMO. When ERISA’s conflict preemption under section 514 or its complete preemption under section 502 forbids a state from granting malpractice tort remedies, a patient will not have any tort remedy against an HMO for serious negligent misconduct.\textsuperscript{165} The Fifth Circuit in \textit{Roark II}, unlike the Supreme Court in \textit{Davila II}, properly rejected Cigna’s and Aetna’s arguments that Congress intended section 502(a)(1)(B)’s federal contract reimbursement claim to be the only remedy available against an HMO that has negligently made a mixed eligibility treatment decision about the quality of health care an ERISA patient/employee receives.\textsuperscript{166} As a matter of implicit public policy and a sense of fairness and justice, the Fifth Circuit was troubled by the fact that ERISA’s conflict and complete preemption rationale could be used to completely deny state tort relief to deserving plaintiffs suffering because of an HMO’s negligence in making a mixed treatment decision.\textsuperscript{167}

In \textit{Roark II}, the court appropriately observed that states may not

\textsuperscript{160} Id. at 308.
\textsuperscript{161} Id. at 308 n.11.
\textsuperscript{162} Id. at 308–09.
\textsuperscript{163} Id. at 309.
\textsuperscript{164} Id.
\textsuperscript{165} Id.
\textsuperscript{166} Id. at 310.
\textsuperscript{167} Id.
replicate the claims provided by under ERISA’s section 502(a).\textsuperscript{168} Complete preemption is properly implicated when state law claims are clones of ERISA’s contract claims.\textsuperscript{169} The Roark II court correctly concluded that a THCLA tort law claim sounding in negligence simply does not provide an action for collecting benefits under a contract theory and therefore it is not preempted by ERISA’s complete preemption rationale.\textsuperscript{170} In the Roark II opinion, the Fifth Circuit Court cited Pegram for the proposition that ERISA is not a proper vehicle to preempt a state malpractice claim under its tort law.\textsuperscript{171} The Fifth Circuit was correct in asserting that it did not believe Congress intended to create a federal common law of medical malpractice.\textsuperscript{172} Under the rationale of its Davila II decision, the Supreme Court destroyed state common law negligence medical malpractice claims against HMOs for ERISA claimants seeking medical assistance under a mixed eligibility decision without creating a malpractice corollary under the federal common law. By mischaracterizing the mixed eligibility determination in Davila II as a pure eligibility decision, the Supreme Court has given ERISA preemption such an expansive role that HMOs are now able to escape both federal and common law claims of medical malpractice for its de facto medical treatment determination.

The facts presented in the 2002 Roark II opinion\textsuperscript{173} are the same as those presented in the Corcoran decision, as discussed in Part I above. Essentially, Mrs. Corcoran filed a lawsuit against her HMO claiming that its negligent denial of adequate treatment was the proximate cause of her baby’s wrongful death.\textsuperscript{174} In Corcoran, the Fifth Circuit appropriately rejected the HMO’s bold assertion that not one aspect of its conduct involved medical decisions; the court also refused to accept Mrs. Corcoran’s argument that not a single aspect of the HMO’s conduct concerned a benefit determination.\textsuperscript{175} HMOs make benefit decisions in the course of deciding whether benefits are available under an ERISA plan.\textsuperscript{176} “[F]rom this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination.”\textsuperscript{177} The Fifth Circuit grudgingly decided that the Corcorans’ claim was preempted under ERISA’s section 514

\textsuperscript{168} Id. at 310–11.  
\textsuperscript{169} Id. at 311.  
\textsuperscript{170} Id.  
\textsuperscript{171} Roark, 307 F.3d at 311 (citing Pegram v. Herdrich, 530 U.S. 211, 236–37 (2000)).  
\textsuperscript{172} Id.  
\textsuperscript{173} Id. at 313.  
\textsuperscript{174} Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992).  
\textsuperscript{175} Id. at 1332.  
\textsuperscript{176} Id.  
\textsuperscript{177} Id.
conflict preemption rationale.\textsuperscript{178} In Roark II, the Fifth Circuit recalled that at the time of the Corcoran decision (1992), the court acknowledged the harm its decision would cause to future ERISA employee patients and their beneficiaries. "ERISA provided no cause of action for medical malpractice; if ERISA also preempted all state medical malpractice claims, patients such as the Corcorans would be left with no remedy for potentially serious mistakes. But, we were bound by Supreme Court precedent, which at that time articulated an expansive view of ERISA preemption."\textsuperscript{179} Because the Supreme Court, in the Davila II opinion, elected to return to its expansive view of preemption, the Court has in effect adopted the untenable position "that one of Congress’s goals in passing ERISA was to shift medical judgments from doctors to plan administrators."\textsuperscript{180}

\section*{III. A Basic Review of the United States Supreme Court's Logic in Davila II}

While writing an opinion for a unanimous Supreme Court in Davila II, Justice Thomas mischaracterizes the nature of the plaintiff’s allegations in the litigation as presenting a simple challenge to their HMOs negligent handling of coverage decisions under the THCLA.\textsuperscript{181} The plaintiffs’ lawsuit is properly understood as contending that the defendant HMOs breached their duty to exercise due care in the handling of mixed eligibility and treatment decisions in violation of the THCLA.\textsuperscript{182} Juan Davila and Ruby Calad, respondents, filed independent lawsuits in Texas state court against Aetna Health Inc. and CIGNA Healthcare of Texas, Inc., petitioners, under THCLA § 88.002(a).\textsuperscript{183} Davila and Calad contend that petitioners’ denial of coverage for medical services recommended by their primary care doctors violated their “duty to exercise ordinary care when making health care treatment decisions,” and that these decisions to deny treatment “proximately caused” their injuries.\textsuperscript{184} Petitioners successfully removed the cases to federal district courts on the legal theory of complete preemption under ERISA section 502(a)(1)(B)’s claim for benefits.\textsuperscript{185} Since the respondents declined to amend their complaints to bring appropriate ERISA claims, the respective district courts dismissed the complaints with prejudice.\textsuperscript{186}

\begin{itemize}
  \item \textsuperscript{178} \textit{Id.}
  \item \textsuperscript{179} \textit{Roark}, 307 F.3d at 313–14.
  \item \textsuperscript{180} \textit{Id.} at 315.
  \item \textsuperscript{181} Aetna v. Davila, 124 S. Ct. 2488, 2492 (2004).
  \item \textsuperscript{182} See \textit{id.} at 2493.
  \item \textsuperscript{183} \textit{Id.}
  \item \textsuperscript{184} \textit{Id.} (internal quotation marks omitted).
  \item \textsuperscript{185} \textit{Id.}
  \item \textsuperscript{186} \textit{Id.}
\end{itemize}
Both Davila and Calad appealed the federal district courts' refusals to remand their cases to state court. The Fifth Circuit combined their cases with several others presenting comparable ERISA preemption issues. The Fifth Circuit acknowledged that state causes of action that "duplicate[] or fall[] within the scope of an ERISA [section] 502(a) remedy" are entirely preempted and consequently are removable to federal court.

Once it considered the causes of action available under section 502(a), the Fifth Circuit decided that respondents' claims raised issues under ERISA section 502(a)(1)(B), which permits a cause of action for the retrieval of an incorrect refusal of benefits, and section 502(a)(2), which permits lawsuits challenging a plan fiduciary for a violation of a fiduciary duty under an ERISA plan.

In Davila II, the Supreme Court rejected the plaintiff's allegations that the HMOs breached their duty to follow the ordinary standard of reasonable care while making mixed eligibility and treatment decisions about the quality of health care employee patients receive in violation of the THCLA. The Court in Davila II, in defiance of its analysis in Pegram, fails to properly classify the HMOs conduct as presenting an incidental issue of coverage and predominant issue of treatment under its Pegram mix eligibility and treatment logic because the Court wants to make it clear that ERISA has an expansive preemptive reach under either its conflict prong or complete preemption prong. The Supreme Court's decision in Davila II to expand the role of ERISA in the field of health care has virtually allowed the Court to abandon its earlier statements in Pegram that HMOs typically make the following three kinds of decisions; (a) pure treatment, (b) pure eligibility and (c) mixed eligibility treatment. If the Supreme Court can conclude that the facts of the plaintiffs' case in Davila II creates a pure eligibility determination under its Pegram criteria for determining the type of decision made by an HMO, the Court has for all intents and purposes collapsed its mixed eligibility and pure treatment decisions into the fold of a pure eligibility decision at the discretion of the HMO decision maker. Under the Supreme Court's Davila II logic, when an HMO actually makes a treatment decision that is a substantial factor in increasing the risk of harm to an ERISA patient, it can avoid liability under a state's negligence law by simply engaging in the pretext that its

---

187. Id.
188. Id.
189. Id. (citing Roark v. Humana, Inc., 307 F.3d 298, 305 (5th Cir. 2002) (internal citations omitted)).
190. Id. at 2493–94.
191. Id. at 2488.
192. Id. at 2495.
193. Id. at 2495–96.
194. Id.
predominantly quality of treatment determination is an incidental by product of its patient/employee adverse coverage decision.

In order to decide whether Davila’s and Calad’s claims came “within the scope” of ERISA section 502(a)(1)(B), Justice Thomas concluded it was necessary to consider the statute on which their allegations of negligence are based (the THCLA) as well as the ERISA plan documents. Davila contends that Aetna makes available health coverage through his employer’s health benefits plan. Davila furthermore states that after his primary care physician prescribed Vioxx, Aetna rejected the doctor’s advice and decided not to pay for it. According to Justice Thomas’ characterization of the facts, “the only action complained of was Aetna’s refusal to approve payment for Davila’s Vioxx prescription.” Davila challenged Aetna’s refusal to pay for the Vioxx prescription most likely because that action was the functional equivalent of a mixed eligibility treatment decision under the standard for the types of decisions made by HMOs established by the Court in its Pegram decision. Justice Thomas improperly concluded that “the only relationship Aetna had with Davila was its partial administration of Davila’s employer’s benefit plan.” Aetna had a dual relationship with Davila in its partial administration of the plan by making eligibility determinations; Aetna also had a utilization review medical treatment determination role under the mixed eligibility treatment standard approved in Pegram.

In the same way, Calad asserts that she has ERISA beneficiary health plan coverage from CIGNA through her husband’s employer. Justice Thomas concedes that Calad was advised by CIGNA, at the time of her admittance at the hospital for major surgery, that it would authorize a stay for one day only. Calad contends that CIGNA’s agent—a discharge nurse—declined to authorize more than one day despite the advice and recommendation of the doctor treating her. It defies medical reality for the Supreme Court to superficially conclude that “Calad contests only CIGNA’s decision to refuse coverage for her hospital stay” without at least acknowledging that Calad is challenging CIGNA’s right under ERISA to use an incidental or ministerial coverage question to undermine the quality of medical treatment decisions made by her treating physician. Similar to the Davila’s case, the real connection between Calad and CIGNA is CIGNA’s ability to apply the incidental administrative aspects

195. Id. at 2496.
196. Id.
197. Id.
198. Id.
199. Id.
200. Id. at 2496–97.
201. Id. at 2497.
202. Id.
of Calad’s ERISA-regulated benefit plan to dominate and control the reasonable quality of medical treatment Calad fails to receive.203

Speaking for a unanimous Court, Justice Thomas amazingly states “[i]t is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans.”204 Both respondents, Davila and Calad, were actually complaining about a denial of ordinary reasonable medical treatment once their respective HMOs, Aetna and CIGNA, made incidental coverage decisions. The HMOs made predominantly medical treatment decisions to provide their ERISA claimants with inferior health care to increase profits rather than lower the cost of health care. The Supreme Court’s advice to working middle-class families who have been refused the benefit of reasonable medical treatment recommended by their primary care doctor to pay “for the treatment themselves and then [seek] reimbursement through a [section] 502(a)(1)(B) action, or [seek] a preliminary injunction”205 is remarkably unimpressive and not practical for many middle class families struggling to make ends meet. Most middle class American ERISA plan patients cannot afford to pay for expensive medical treatment services denied by the HMO and for the cost of hiring a lawyer to fight their ERISA treatment claims in federal court while seeking reimbursement remedies because an HMO made an improper medical treatment decision.

Even if one concedes that the requirements of the THCLA in the context of both Davila and Calad’s claims are not independent of ERISA or the plan terms, the THCLA escapes ERISA preemption when the Court properly applies the substance of its mixed eligibility treatment rationale as articulated by the Court in Pegram. In Pegram, the Court stated that mixed treatment eligibility decisions made by HMOs were not preempted by ERISA. “The THCLA does impose a duty on managed care entities to ‘exercise ordinary care when making health care treatment decisions,’ and makes them liable for damages proximately caused by failures to abide by that duty.”206 In Davila II, a managed care entity did not correctly conclude “that, under the terms of the relevant plan, a particular treatment was not covered.”207 In Davila II the managed care entity provided made a mixed eligibility treatment decision under Pegram that was the proximate cause of any injuries arising from that determination. An HMO’s negligent making of the mixed eligibility treatment decision under the terms of the plan itself could be the proximate cause of an ERISA’s beneficiary’s injuries permitted to escape ERISA preemption under Pegram’s mixed eligibility

203. Contra id.
204. Id. at 2497.
206. Id. at 2497 (quoting TEX. CIV. PRAC. & REM. CODE § 88.002(a)).
207. Id.
treatment decision standard for HMOs.

Justice Thomas used a hypothetical example—a plan explicitly excluding from coverage the cost of surgery for an appendectomy—to support his conclusion that it is the plan itself, not the HMO that administered the ERISA plan, that denies the person eligibility coverage. Justice Thomas’ appendectomy hypothetical does not apply to the facts of the Davila II case because the ERISA plan itself does not explicitly exempt an HMO from its duty to use reasonable care when making a mixed eligibility treatment decision at the sole discretion of the HMO health care provider. The appendectomy hypothetical used by Justice Thomas would only apply to Justice Thomas’ exclusionary ERISA coverage rationale if Davila’s plan explicitly excluded drug prescriptions and Calad’s ERISA plan explicitly excluded hospital stays for any surgeries performed.

In the Davila II opinion, the Supreme Court concluded that Davila and Calad sued to remedy the wrongful denial of benefits guaranteed under ERISA-regulated plans; that they were not trying to deal with any violations of legal rights beyond the scope of ERISA. The Supreme Court held that because both Davila’s and Calad’s state causes of action came “within the scope of” ERISA section 502(a)(1)(B), they were completely preempted and removable to federal district court. "The limited remedies available under ERISA are an inherent part of the ‘careful balancing’ between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans."

In Davila II, the Supreme Court gave the Pegram mixed eligibility treatment decision an extremely narrow application that unnecessarily interferes with a state’s Tenth Amendment reserve power to regulate in the field of health care when Congress has been silent about ERISA preemption. In its narrowest sense, the Davila II Court unfortunately appears to suggest that it is when the physician making the eligibility determination for an HMO is also allowed to make the treatment decision for an HMO that Pegram’s mixed treatment eligibility decision rule applies. In Davila II, the Supreme Court missed a golden opportunity to expand the definition of ERISA’s mixed eligibility treatment determination to include any decision made by an agent or employee of an HMO where the predominantly medical determinations are an intricate and controlling

208. Id. at 2498 n.3.
209. See id.
210. Id.
211. Id. at 2498.
212. Id.
213. Id. at 2499 (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)).
214. Id. at 2501.
215. Id.
product of an HMO routine ministerial administrative function.\footnote{Id. at 2501-02.} 

IV. CONCLUSION

In their concurring opinion, Justice Ginsburg and Justice Breyer correctly characterized the current ERISA preemption regimes in the field of health care as unjust and tangled. However, Justice Ginsberg's suggestion that the Supreme Court's decision in \textit{Davila II} is consistent with either logic, experience of the states in the field of health care, or the Supreme Court's prior cases governing the scope of ERISA preemption is arguably improper.\footnote{See Thomas R. McLean & Edward P. Richards, \textit{Health Care's \textquotedblleft Thirty Years War	extquotedblright}: \textit{The Origins and Dissolution of Managed Care}, 60 N.Y.U. ANN. SURV. AM. L. 283, 316-17 (2004) (discussing how patients, plaintiffs' lawyers, and state regulators have been pushing the courts to rethink ERISA preemption, as ERISA MCOs and HMOs have become more and more ruthless in their cost-cutting strategies).} For the reasons previously articulated in the analysis of the Fifth Circuit's opinion in \textit{Roark II}, I contend that the Fifth Circuit's analysis is more consistent with prior cases controlling the scope of ERISA preemption than that of a unanimous Supreme Court in \textit{Davila II}. In my opinion Justices Ginsburg and Breyer could have voted to affirm the reasoning of the Fifth Circuit in \textit{Roark II} rather than simply recommend that Congress and the Supreme Court revisit the unjust effect on patient-employees of the current ERISA preemption regime.\footnote{Aetna U.S. Healthcare, Inc. v. Davila, 124 S. Ct. at 2503 (Ginsburg, J., concurring).} It is unfortunate that Justices Ginsburg and Breyer did not write dissenting opinions in \textit{Davila II} defending the necessary and appropriate analysis taken by the Fifth Circuit to limit the scope of ERISA preemption in those cases like \textit{Davila II} which, according to the Fifth Circuit, are truly cases of mixed eligibility and treatment decisions.\footnote{Id. at 2501-02. (citations omitted).}

Justice Ginsburg acknowledges that the Supreme Court has joined together "an encompassing interpretation of ERISA's preemptive force with a cramped construction of the 'equitable relief allowable under [section] 502(a)(3),'' to create a "regulatory vacuum" that in effect denies ERISA plan beneficiaries any tort damages against HMOs for medical malpractice.\footnote{Id. at 2501-02.} Under this regulatory vacuum, Justice Ginsburg observes, "virtually all state law remedies are preempted but very few federal substitutes are provided."\footnote{Id. at 2501-02.} In the next case with facts and issues similar to \textit{Davila II}, Justices Ginsburg and Breyer should lead the way in persuading the Supreme Court to adopt the position taken by the Fifth Circuit in \textit{Roark II} as a necessary first step toward reversing a "series of the
Court's decisions [which have] yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief." Congress should adopt a Patients' Bill of Rights (PBR) Law to wipe out the vast regulatory vacuum created by ERISA's conflict and complete preemption rationales that leave patients without any adequate legal remedy when an HMO's conduct is proximate. It is my sincere hope that one day Congress will enact meaningful PBR legislation to protect all Americans from the bottom-line oriented eligibility and treatment decisions made by big business HMOs and other greedy corporate actors in the managed care industry.

222. *Id.*

[T]he original defense of a federal PBR has been undermined by the subsequent evolution of the case law of the U.S. Supreme Court. That case law today construes ERISA section 514 as generally permitting state regulation of HMOs and similar medical care providers, both statutorily and via malpractice liability rules, even when such providers service employers' medical plans. Thus, there is no longer a regulatory gap and no need for federal legislation in the form of a PBR to fill the void.

*Id.* at 443–44.