

01-10905

No. 01-10905

In The
United States Court of Appeals
For The Fifth Circuit

JUAN DAVILA,

Plaintiff - Appellant,

v.

AETNA U.S. HEALTHCARE INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.,

Defendants - Appellees.

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

BRIEF OF APPELLEES
AETNA U.S. HEALTHCARE INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

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U.S. COURT OF APPEALS

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HEALTHCARE INC. and AETNA U.S.
HEALTHCARE OF NORTH TEXAS INC.

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ATTORNEYS FOR AETNA U.S.
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HEALTHCARE OF NORTH TEXAS INC.

CERTIFICATE OF INTERESTED PERSONS

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

Defendants - Appellees

Aetna U.S. Healthcare Inc.
Aetna U.S. Healthcare of North Texas Inc.
(collectively "Aetna")
Aetna Inc. (remote, publicly traded parent corporation)

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 - A. When an ERISA claims administrator, independent from the Participant’s treating physician, makes a utilization review determination, is that decision a benefit determination as this Court held in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992)?
 - B. Are state law remedies for allegedly mishandled claims for benefits completely preempted under *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987)?
- II. Did the District Court correctly dismiss the Appellant’s claim under FED. R. CIV. P. 12(b)(6)?
 - A. Was dismissal of Davila’s claims under the Texas Health Care Liability Act proper given that this Court has already excluded such claims from the “limited universe of events” covered by the Act?

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STATEMENT OF ISSUES

- I. Is an ERISA Participant's lawsuit complaining that the claims administrator mishandled a claim for benefits completely preempted by ERISA?
 - A. When an ERISA claims administrator, independent from the Participant's treating physician, makes a utilization review determination, is that decision a benefit determination as this Court held in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992)?
 - B. Are state law remedies for allegedly mishandled claims for benefits completely preempted under *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987)?
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 - A. Was dismissal of Davila's claims under the Texas Health Care Liability Act proper given that this Court has already excluded such claims from the "limited universe of events" covered by the Act?

STATEMENT REGARDING ORAL ARGUMENT

Oral argument is not appropriate when the dispositive issue or issues have been authoritatively decided. *See* FED. R. APP. P. 34(a)(2); *see also* 5TH CIR. R. 34.2. Likewise, one panel of this Circuit is without power or authority to overrule the precedents of a prior panel. *See Ford v. Cimarron Ins. Co.*, 230 F.3d 828, 832 (5th Cir. 2000) (“We are a ‘strict *stare decisis* court. [Thus], . . . one panel of this court cannot disregard, much less overrule, the decision of a prior panel”). Under these standards, the Appellant’s brief shows on its face that this is not an oral argument case.

According to Davila, “[t]he only thing standing in the way” of his approach to ERISA preemption is [*Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992)]¹—the authoritative precedent of this Court. No aspect of *Corcoran* is subject to legitimate question.²

Nearly fifteen years ago, the Supreme Court held that Congress intended “ERISA § 502(a) to be the exclusive vehicle for actions by ERISA-plan participants [like Davila] asserting improper processing of a claim for

¹ App. Br. at 51.

² And, only the *en banc* Court would have the power to raise such questions in any event.

benefits.” *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). The Court has never even distinguished *Pilot Life*, let alone retreated from its holding. To the contrary, the Supreme Court recently reaffirmed (in an opinion *not* cited in the Appellant’s Brief) that benefit determinations are “an area of core ERISA concern.” *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001).

Consistent with those basic and long-standing propositions, this Court has never questioned *Corcoran*’s continuing vitality. Just the opposite, this Court continues to cite *Corcoran* with approval, and did so as recently as December.³ Most importantly, this Court has already considered and *specifically rejected* the Appellant’s principal argument that “*Pegram v. Herdrich* cast doubt on . . . this court’s prior decision in *Corcoran v. United Healthcare, Inc.*” *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 220 F.3d 641, 643 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000). Said the court, “we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise.” *Id.* at 643-44.

³ See *McCall v. Burlington N./Santa Fe Co.*, 237 F.3d 506, 512 (5th Cir. 2000), *cert. denied*, 2001 WL 690391 (Oct. 1, 2001).

This Court is not alone in recognizing *Corcoran's* continuing vitality. *Corcoran's* reasoning has been widely followed in other Circuits, and more of those decisions were rendered after the Appellant's so-called "Travelers Trilogy" than before it.⁴ Indeed, the Third Circuit followed *Corcoran* as recently as March of this year. *Pryzbowski*, 245 F.3d at 278.

Because this Court has authoritatively decided the issues presented here and because a panel of this Court cannot revisit the *Corcoran* decision, Aetna respectfully submits that oral argument is not necessary. Instead, this cause could appropriately be placed on the summary disposition calendar.⁵

⁴ **Post-Travelers:** See *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 278 (3d Cir. 2001); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073 (8th Cir. 2000) (per curiam); *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), cert. denied, 528 U.S. 1189 (2000); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 6-7 (1st Cir. 1999); *Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1007-08 (9th Cir. 1998), cert. denied, 528 U.S. 870 (1999); *Parrino v. FHP, Inc.*, 146 F.3d 699, 704-05 & n.3 (9th Cir. 1998); *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196, 199-200 (1st Cir. 1997); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1494 (7th Cir. 1996); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273 (10th Cir. 1996); **Pre-Travelers:** *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (per curiam); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993).

⁵ Aetna likewise believes that oral argument is not necessary in any of the related cases appealed by Davila's counsel (Case Nos. 01-10831, 01-10891 & 01-10943) because the legal issues are the same. If, however, the Court wishes to hear argument, this case gives the optimal presentation. There are no additional parties beyond the ERISA claims administrator and the ERISA participant, and the dispositive issue was decided in a 12(b)(6) ruling on undisputed facts. Aetna's counsel likewise has broad experience before this Court with ERISA and managed care issues, enabling them to address managed care and preemption issues beyond the confines of the facts in this case to the extent necessary. Representative appeals include *Corporate Health Insurance, Inc. v. Texas Department of*

I. INTRODUCTION

*“The report of my death was an exaggeration.”*⁶

The Appellant boldly claims that the entire federal judiciary (including this Court) has been incorrectly reading ERISA’s preemption clause and misapplying its exclusive remedies for nearly thirty years—that is, until the Supreme Court caused an alleged “seismic shift”⁷ in ERISA jurisprudence with *Travelers*⁸ and later with *Pegram*.⁹ If the case law is any indication, Appellant’s counsel is the only one who felt the earth move; nevertheless, the Appellant bravely asserts that ERISA preemption is dead. Moreover, he purports to bring a claim under a state statute that this Court says provides no cause of action for utilization review and benefit determinations.¹⁰

Insurance, 215 F.3d 526 (5th Cir.), *on reh’g*, 220 F.3d 641 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *Ehlmann v. Kaiser Foundation Health Plan of Texas*, 198 F.3d 552 (5th Cir. 2000); *Rhorer v. Raytheon Engineers & Constructors, Inc.*, 181 F.3d 634 (5th Cir. 1999); *Texas Medical Association v. Aetna Life Insurance Co.*, 80 F.3d 153 (5th Cir. 1996).

⁶ Mark Twain, Note to London Correspondent of the NEW YORK JOURNAL (June 1, 1897).

⁷ App. Br. at 9.

⁸ *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

⁹ *Pegram v. Herdrich*, 530 U.S. 211 (2000).

¹⁰ *See infra* § V.C.2.

“Exaggeration” understates the Appellant’s attack on controlling law contrary to his position.

In addition to the law review “authority” and supposed legislative history contained in the Appellant’s Brief, the actual case law on which Appellant relies in charging into the teeth of preemption is decidedly illusory:

- The Appellant *acts* as if the Supreme Court signaled some wholesale retreat from the preemption of benefit determinations beginning with the so-called “*Travelers* Trilogy.” In reality, more federal appellate courts have applied *Corcoran* after *Travelers* than before it.
- The Appellant *acts* as if this Court bolstered his position in *Corporate Health Insurance*. In fact, this Court *expressly* reaffirmed *Corcoran v. United HealthCare*, and *expressly* held that state remedies for adverse utilization review determinations are preempted by ERISA § 502(a).
- The Appellant *acts* as if the Supreme Court decided this question in *Pegram v. Herdrich*. In reality, the court expressly and specifically *disclaimed* any intent to decide preemption and this Court has already considered and rejected Davila’s “*Pegram* preemption” argument.

Just last year, the Fifth Circuit reaffirmed that *Corcoran v. United HealthCare* is still good law. Adverse utilization review (“medical necessity”) decisions are benefits determinations, and all causes of action for that conduct *must* be brought under ERISA § 502(a). Every state remedy for that conduct

is an alternate enforcement mechanism, *i.e.*, completely preempted. Under this Court's precedent, only the narrow claim raising an HMO's vicarious liability for the malpractice of a *treating physician* (not at issue here) can escape preemption. *See generally Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir.), *on reh'g*, 220 F.3d 641, 643 & n.6 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665).

II. STATEMENT OF THE CASE

A. Nature Of The Case

This is an action brought by an ERISA participant (Juan Davila) complaining that Aetna, a Claims Administrator for an ERISA plan, incorrectly administered a claim for prescription drug benefits under an ERISA plan.¹¹

B. Course Of Proceedings And Disposition Below

Davila sued Aetna in Texas state court complaining of personal injuries arising from Aetna's alleged actions as claims administrator for the ERISA plan from which Davila receives health care benefits.¹² This Court has

¹¹ 1R4; 1R14 ("Juan Davila . . . obtained his . . . health coverage through his employer, Monitronics"); 1R12 ("[D]espite the recommendations and protests of his treating physician, Aetna refused to provide Vioxx").

¹² 1R2 - 3, 11 - 21.

previously held that the Texas Health Care Liability Act (“the Act”) applies only to claims of vicarious liability arising from the alleged malpractice of a treating physician.¹³ Nevertheless, Davila purported to allege direct liability claims under the Act against Aetna arising from Aetna’s purported refusal to fill a prescription recommended by Davila’s treating physician.¹⁴

Aetna removed Mr. Davila’s claim to the United States District Court for the Northern District of Texas, Fort Worth Division, contending that Davila’s claims arise under federal law because they are completely preempted by ERISA.¹⁵ Davila moved to remand the claims to state court and specifically disclaimed any desire to amend to state a claim under ERISA.¹⁶ Aetna responded,¹⁷ and likewise moved to dismiss under FED. R. CIV. P. 12(b)(6) on

¹³ See *infra* § V.C.2.

¹⁴ 1R2 - 3.

¹⁵ 1R1 - 6.

¹⁶ 1R70; 2R322 (“If this Court denies Plaintiff’s Motion to Remand, it should also dismiss this case *sua sponte* in order to permit this matter to be immediately appealed since Plaintiff *will not* be amending to add ERISA claims for denied benefits”) (emphasis in original).

¹⁷ 1R198 - 228.

the ground that the Act provides no cause of action for adverse utilization review decisions.¹⁸

The District Court, Judge Means presiding, denied Davila's motion to remand and granted Aetna's Motion to Dismiss.¹⁹ This appeal followed.

III. STATEMENT OF FACTS

A. Davila Is A Participant In An ERISA Plan

The Appellant's Brief contains a great many unsupported factual allegations having no bearing on the outcome of this dispute. Some were never even alleged by Davila below. The reality is that Davila has conceded all the material facts necessary to establish complete preemption.

The first material concession is Davila's status as a participant in an ERISA plan.²⁰ Davila conceded that he receives his health care benefits through the plan provided by his employer, Monitronics ("the Monitronics Plan").²¹ Likewise, Davila did not dispute the allegation in Aetna's Notice of

¹⁸ 2R309.

¹⁹ 3R623 - 630.

²⁰ See 29 U.S.C. § 1002(7) (1999) (defining "participant").

²¹ 1R85 ("Juan Davila obtained his Aetna HMO health coverage through his employer, Monitronics").

Removal that the Monitronics Plan is maintained “pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1001, *et seq.*”²²

B. Davila Complained That Aetna Mishandled His Claim For ERISA Benefits

The second material concession is that this ERISA participant’s claim arises from the supposedly improper processing of a claim for benefits. Davila did not dispute the allegation in Aetna’s Notice of Removal that “Aetna U.S. Healthcare of North Texas, Inc. . . . provides various administrative services to the Monitronics Plan, including making claims determinations as to claims for benefits for . . . prescription drugs.”²³ Davila’s current argument, that Aetna’s decision was not made by “any ERISA plan administrator”²⁴ is both newly advanced and insupportable. The plan documents in the record establish Aetna’s sole role as claims administrator for

²² 1R2. Beyond the mere allegation, Aetna proved the existence of an ERISA plan. *See generally* 2R252 - 298.

²³ 1R2. Aetna U.S. Healthcare Inc., the other entity sued by Davila, had nothing to do with his health care plan.

²⁴ App. Br. at 11.

the Monitronics Plan and the independent contractor status of Davila's treating physician.

For example, both the Group Agreement and the Certificate of Coverage establish that Aetna has discretion to make coverage decisions under the terms of the Monitronics Plan, including precertification of coverage based upon criterion of medical necessity.²⁵ The Monitronics Plan likewise provides that treatment decisions are solely within the province of the Aetna member

²⁵ The Group Agreement provides:

HMO has complete authority to review all claims for Covered Benefits under this Group Agreement. In exercising such responsibility, HMO shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this Group Agreement. HMO shall be deemed to have properly exercised such authority unless HMO abuses its discretion by acting arbitrarily and capriciously.

2R260 (emphasis of defined terms in original). The Certificate of Coverage provides:

A Member shall be entitled to the Covered Benefits as specified below, in accordance with the terms and conditions of this Certificate. Unless specifically stated otherwise, in order for benefits to be covered, they must be Medically Necessary. For the purposes of coverage, HMO may determine whether any benefit provided under the Certificate is Medically Necessary, and HMO has the option to only authorize coverage for a Covered Benefit performed by a particular Provider.

2R269 (emphasis of defined terms in original).

and his or her treating physician, regardless of Aetna's coverage determination.

The Group Agreement provides:

Participating Providers are solely responsible for any health services rendered to their **Member** patients. HMO makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital or other Participating Provider.**²⁶

Similarly, the front page of the Certificate of Coverage provides:

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

* * *

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.²⁷

The Group Agreement between Monitronics as Plan Administrator and Aetna U.S. Healthcare of North Texas Inc. explicitly sets out the independent contractor status of the network of providers who provide care for Aetna members:

²⁶ 2R259 (emphasis of defined terms in original).

²⁷ 2R263 (emphasis in original).

INDEPENDENT CONTRACTOR RELATIONSHIPS

A. Between Participating Providers and HMO

The relationship between HMO and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of HMO nor is HMO an agent or employee of any Participating Provider.²⁸

The Certificate of Coverage submitted in opposition to remand likewise established the independence of the treating physicians from Aetna:

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.²⁹

It is only in this context that Davila claims that Aetna countermanded his doctor or “[told] his doctor what drugs he must prescribe”³⁰ when Aetna would not “fill” (*i.e., cover*) a prescription even though he was allegedly entitled to it under the terms of the Monitronics Plan.³¹ Davila claimed that

²⁸ 2R259 (emphasis of defined terms and headings in original).

²⁹ 2R263 (emphasis in original).

³⁰ App. Br. at 16.

³¹ 1R86 (“Dr. Joseph Lopez, Juan’s primary care physician, prescribed Vioxx When Juan tried to fill the prescription, however, he was informed that his insurer, Aetna HMO, would not fill it, *even though Vioxx is on the Aetna formulary*”); 1R86 (“Despite Dr. Lopez’s protests, Aetna’s decision to refuse his prescription for Vioxx was final”).

Aetna's decision was undertaken to contain costs in association with the Monitronics Plan³² and that, as a result of Aetna's decision, he had been damaged.³³

C. Davila Tried To Avoid ERISA's Exclusive Remedies

After being "informed that his insurer, Aetna HMO, would not fill"³⁴ the Vioxx prescription, Davila as a plan participant could have disputed the entitlement to benefits under 29 U.S.C. § 1132(a)(1) (1999), either by paying for the prescription and disputing coverage later or by hiring counsel to seek an injunction (and attorneys' fees) to force Aetna to mend the supposed error of its ways. Instead, after harm had allegedly occurred, Davila attempted to supplement ERISA's exclusive remedies by bringing a personal injury claim under the Texas Health Care Liability Act, a statute that the Fifth Circuit has already held has no application under these facts. Thus, the District Court

³² 1R86 (alleging that Aetna's decision was made "[i]n order to save its shareholders money").

³³ 1R87 ("As a result of Aetna's delaying the prescription of Vioxx, and forcing on Juan Davila the cheaper but inappropriate naprosyn, Juan will not be able to take any other pain medication for his arthritis-related pain which has to be absorbed through the stomach, including aspirin").

³⁴ 1R86.

correctly held that his claim was completely preempted, properly removed to federal court, and failed to state a claim upon which relief could be granted.³⁵

IV. SUMMARY OF THE ARGUMENT

Consistent with *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the crushing weight of authority from this circuit and all others holds that state law complaints about the denial or mishandling of claims for employee medical benefits are alternate enforcement mechanisms to ERISA § 502(a) and are thus completely preempted.³⁶ This Court so held in *Corcoran*, and neither the Supreme Court nor any federal appellate court has since held otherwise. To the contrary, this Court has recently reaffirmed *Corcoran* and all its underpinnings. Benefits administration activities, the area of core ERISA concern, is not impacted by *Travelers* and its progeny, nor is third party plan administration impacted by *Pegram*, which concerns only decisions made by treating physicians. In this case, Davila essentially asks a panel of this Court to revisit the decision of a prior panel, based upon no more than law

³⁵ 3R623-630.

³⁶ See *Rodriguez v. PacifiCare, Inc.*, 980 F.2d 1014, 1016 (5th Cir. 1993); *Corcoran*, 965 F.2d at 1324-25; see also *Pryzbowski*, 245 F.3d at 273; *Thompson*, 202 F.3d at 1073; *Hull*, 188 F.3d at 943; *Danca*, 185 F.3d at 6-7; *Parrino*, 146 F.3d at 704-05 & n.3; *Turner*, 127 F.3d at 199-200; *Jass*, 88 F.3d at 1494; *Cannon*, 77 F.3d at 1273; *Tolton*, 48 F.3d at 942; *Kuhl v.*, 999 F.2d at 302.

reviewers' suppositions about legislative history and his own dissatisfaction with the current state of the law. Appellant's arguments fail.

V. ARGUMENTS AND AUTHORITIES

A. Standard Of Review

The questions of complete preemption (*i.e.*, subject matter jurisdiction) and dismissal under 12(b)(6) are both questions of law that are reviewed *de novo* by this Court. *Shipp v. McMahon*, 234 F.3d 907, 911 (5th Cir. 2000), *cert. denied*, 121 S. Ct. 2193 (2001), (12(b)(6) ruling reviewed *de novo*); *Lockett v. Delta Airlines, Inc.*, 171 F.3d 295, 298 (5th Cir. 1999) (denial of motion to remand reviewed *de novo*). Even so, the law circumscribes Davila's efforts to manipulate the outcome of those decisions through artful pleading and word games. Conclusory allegations or legal conclusions masquerading as factual conclusions will not suffice to prevent a motion to dismiss under FED. R. CIV. P. 12(b)(6). *See Fernandez-Montes v. Allied Pilots Ass'n*, 987 F.2d 278, 284 (5th Cir. 1993).

B. Direct Action Utilization Review Disputes Are Completely Preempted No Matter What Artful Dodge Is Employed

Complete preemption authorizes removal to federal court even if the complaint is artfully pleaded to include solely state law claims for relief or if

the federal issue is initially raised solely as a defense. *Johnson v. Baylor Univ.*, 214 F.3d 630, 632 (5th Cir.), *cert. denied*, 531 U.S. 1012 (2000); *Heimann v. National Elevator Indus. Pension Fund*, 187 F.3d 493, 499 (5th Cir. 1999). Davila acts as if he can avoid complete preemption by refusing to plead for benefits and saying “mixed medical decision” or “quality of care” often enough. As applied to utilization review disputes, artful pleading like characterizing the refusal to pay for a benefit as “cancellation” of the treating physician’s directive or as “controlling” health care does not change the fact that Davila’s claims are based on how Aetna processed his claim for medical benefits. *See Corcoran*, 965 F.2d at 1332; *see also Hull*, 188 F.3d at 943; *Kuhl*, 999 F.2d at 300.

Thus, complete preemption is not determined by whether the plaintiff *pleaded a remedy* that could be granted under ERISA § 502(a).³⁷ The question, under binding authority in this circuit, is whether Davila, as a participant in

³⁷ That has never been the test for determining federal question jurisdiction. *See Steel Co. v. Citizens for a Better Env’t*, 523 U.S. 83, 89 (1998) (“It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction”); *Duke Power Co. v. Carolina Envtl. Study Group, Inc.*, 438 U.S. 59, 70 (1978) (“For purposes of determining [federal question jurisdiction] it is not necessary to decide whether appellees’ alleged cause of action . . . is in fact a cause of action ‘on which [appellees] could actually recover’”); *Bell v. Hood*, 327 U.S. 678, 682 (1946) (“Jurisdiction . . . is not defeated . . . by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover”).

an ERISA plan, *could have* pleaded a § 502(a) claim because the *conduct* of which he complains is governed by ERISA.³⁸

Heimann v. National Elevator Industry Pension Fund,³⁹ (notably absent from Davila's brief) establishes this truism beyond all doubt. Mr. and Mrs. Heimann sued for intentional infliction of emotional distress and tortious interference in state court because the International Union of Elevator Constructors, through its agent Ken Burkett, intentionally and maliciously represented that Mr. Heimann was engaging in disqualifying employment. *Id.* at 498 & 499. They did not sue for benefits in state court, because Mr. Heimann was pursuing those remedies in a separate federal action. *Id.* at 499. The defendants nevertheless removed the state court action, and this Court found that it was completely preempted. *Id.* at 499 & 504-05.

The Court noted that Mr. and Mrs. Heimann, as ERISA participants and beneficiaries, were persons authorized (like Davila) to maintain an action under ERISA § 502(a). *Id.* at 504. The Court likewise noted that the *conduct*

³⁸ See, e.g., *Corcoran*, 965 F.2d at 1325 n.5 ("Mrs. Corcoran could have (1) sued under ERISA, before entering the hospital, for a declaratory judgment that she was entitled to hospitalization benefits; or (2) gone into the hospital, incurred out-of-pocket expenses, and sued under ERISA for these expenses").

³⁹ 187 F.3d 493 (5th Cir. 1999).

of which the Heimanns complained was within the scope of ERISA § 502(a). *Id.* at 505. The Court *specifically rejected* the same argument Davila made below that complete preemption may be avoided simply by recharacterizing the claim as one not concerning benefits. *Id.* at 502 (“[N]ot only is § 502(a) the exclusive remedy for vindicating § 510-protected rights, but there is *no basis* in § 502(a)’s language for limiting ERISA actions to only those which seek ‘pension benefits’”) (quoting *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 145 (1990) (emphasis added)).⁴⁰

The *Heimann* analysis (ERISA participant complaining of conduct within the scope of § 502(a)) is not restricted to pension cases alone. Nearly fifteen years ago, the Supreme Court held that Congress intended “ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants [like Davila] asserting improper processing of a claim for benefits” and found that state claims for such conduct “would pose an obstacle to the purposes and objectives of Congress.” *Pilot Life*, 481 U.S. at 52. An impenetrable wall of

⁴⁰ See also *Anderson v. Elec. Data Sys. Corp.*, 11 F.3d 1311, 1315 & n.6 (5th Cir.), cert. denied, 513 U.S. 808 (1994) (finding complete preemption and rejecting a “benefits only” approach to determining the scope of § 502(a)). Significantly, the *Heimann* court *only* looked to see whether the Heimanns had pleaded an ERISA remedy when reviewing the district court’s 12(b)(6) ruling, *after* the court had determined that the case was completely preempted and properly removed. See *Heimann*, 187 F.3d at 508-511.

authority from this and other circuits has applied it where (as here) a participant like Davila complains of an adverse utilization review determination. This Court and its sister circuits have recognized that prospective utilization review of medical benefits is an ERISA benefits determination.⁴¹ This Court and its sister circuits have reached the same result, even when the managed care entity administering the plan refuses to authorize benefits for treatment recommended by the participant's treating

⁴¹ See *Thompson*, 202 F.3d at 1073 (upholding removal where precertification rejected for high dose chemotherapy and autologous bone marrow transplant); *Hull*, 188 F.3d at 941 (upholding removal where precertification rejected for thallium stress test); *Danca*, 185 F.3d at 3 (upholding removal where precertification rejected for inpatient psychiatric care); *Bast*, 150 F.3d at 1006 (finding preemption where precertification delayed for autologous bone marrow transplant); *Parrino*, 146 F.3d at 702 (upholding removal where "FHP initially refused to authorize payment for the therapy, claiming it was experimental and unnecessary"); *Turner*, 127 F.3d at 197 (upholding removal where "Transplant Committee . . . concluded . . . that the Duke program had as yet produced no adequate data suggesting a likelihood of success,"); *Jass*, 88 F.3d at 1485 (upholding removal where "Karen Margulis, an agent of PruCare, determined that [physical therapy] was not necessary"); *Cannon*, 77 F.3d at 1271 (upholding removal where "the insurers denied preauthorization for the ABMT"); *Tolton*, 48 F.3d at 940 (finding preemption where plaintiff did not receive requested substance abuse and psychiatric care); *Spain*, 11 F.3d at 131 (finding preemption where approval of autologous bone marrow transplant was delayed); *Kuhl*, 999 F.2d at 300 (upholding removal where "Lincoln National refused to precertify payment for the surgery"); *Rodriguez*, 980 F.2d at 1016 (upholding removal where "Rodriguez believed that the attention of an orthopedic specialist was needed, but was stymied in his efforts to obtain a referral letter from Heistand or Pacificare"); *Corcoran*, 965 F.2d at 1324-25 (upholding removal where "despite Dr. Collins's recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care").

physician.⁴² This Court and its sister circuits have reached the same conclusion even where the plaintiffs argue that their claims are “really” medical or did not complain that benefits were “denied.”⁴³ This Court and its

⁴² *Thompson*, 202 F.3d at 1073 (upholding removal where “[H]er treating physicians recommended that Gencare pre-certify a more aggressive treatment procedure”); *Hull*, 188 F.3d at 941 (upholding removal where “Dr. Delcau contacted Dr. Fallon . . . requesting authorization to administer a thallium stress test”); *Danca*, 185 F.3d at 3 (upholding removal where “Her physician recommended inpatient psychiatric care at McLean Hospital. . . . defendants denied precertification”); *Parrino*, 146 F.3d at 702 (upholding removal where “Loma Linda physicians . . . prescribed immediate proton beam therapy . . . [which] FHP initially refused to authorize”); *Turner*, 127 F.3d at 197 (upholding removal where “Charlotte Turner and Dr. Hochman asked Fallon to pay for her inclusion in the Duke program”); *Cannon*, 77 F.3d at 1271 (upholding removal where “Mrs. Cannon’s treating physician, . . . recommended she undergo an autologous bone marrow transplant”); *Kuhl*, 999 F.2d at 300 (upholding removal where “Dr. Levi concluded that Buddy Kuhl would have the best chance of survival if the surgery were performed at Barnes Hospital in St. Louis, Missouri”); *Corcoran*, 965 F.2d at 1324-25 (upholding removal where “despite Dr. Collins’s recommendation, United determined that hospitalization was not necessary”); *see also Bast*, 150 F.3d at 1005 (upholding preemption in federal court action where Prudential denied ABMT recommended by oncologist); *Jass*, 88 F.3d at 1484-85 (Upholding removal. There is no express indication that physical therapy was ordered by Jass’s physician, but presumably she did not prescribe it for herself); *Spain*, 11 F.3d at 131 (upholding preemption of wrongful death claim originally filed in federal court where defendant allegedly delayed approval of ABMT recommended by decedent’s physician).

⁴³ *Thompson*, 202 F.3d at 1074 (upholding removal of wrongful death damages claim); *Hull*, 188 F.3d at 943 (“[A]lthough Hull’s characterization of his claims sound in medical malpractice, the essence of his claim rests on the denial of benefits. As a Plan participant, *he could have brought* an action under section 502(a)”) (emphasis added); *Danca*, 185 F.3d at 6 (“We . . . find that . . . the allegations that defendants . . . failed to follow Danca’s physician’s recommendations . . . are alternative enforcement mechanisms under ERISA § 502(a) and therefore completely preempted”); *id.* at 5 n.4 (“The fact that ERISA does not provide the *remedy* plaintiffs seek is not relevant; all that matters is that the *claim* be within the scope of § 502(a)”) (emphasis in original); *Parrino*, 146 F.3d at 703-04 (finding that wrongful death claim falls within the scope of ERISA § 502(a) because “Parrino’s causes of action . . . are both predicated upon alleged defects in FHP’s procedures for processing health insurance claims”); *Turner*, 127 F.3d at 200 (upholding removal of wrongful death claim and noting that *only* “Congress is well equipped to revisit

sister circuits have upheld removal of such claims because the allegedly wrongful conduct falls within § 502(a) and any state law alternate enforcement mechanism is preempted even if the participant chooses not to seek the remedies provided by ERISA § 502(a).⁴⁴

the issue and alter the statutory language that now stands as a bar"); *Jass*, 88 F.3d at 1488 ("Jass argues . . . that she 'has not alleged a cause of action under any federal law nor has she sought damages or compensation under federal law. . . . While Jass presented her claim against Margulis as a state law negligence claim, '[w]e know that if [Plaintiff's] state law claim is within the scope of § 502(a) it is completely preempted regardless of how [s]he has characterized it"); *Cannon*, 77 F.3d at 1272 (upholding removal where "Mr. Cannon filed suit in Oklahoma state court to recover damages for the death of his wife"); *Kuhl*, 999 F.2d at 303 ("Artful pleading by characterizing . . . the same administrative decisions as 'malpractice' does not change the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claim for medical benefits"); *Corcoran*, 965 F.2d at 1324 (upholding removal even though "[Plaintiffs] sought damages for the lost love, society and affection of their unborn child . . . [and] the aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation"); see *Spain*, 11 F.3d at 131 (upholding preemption under *Pilot Life* because "[a]lthough Appellants do not seek benefits under the plan, their state common law cause of action seeks damages for the negligent administration of benefit claims").

⁴⁴ *Thompson*, 202 F.3d at 1074 ("In substance, Thompson now asserts a tort claim for damages on account of Gencare's allegedly wrongful benefits decisions as plan administrator. *Pilot Life*, *Hull*, and *Kuhl* make clear that claim is completely preempted by ERISA's remedies"); *Hull*, 188 F.3d at 943; *Danca*, 185 F.3d at 6; *Parrino*, 146 F.3d at 703-04; *Turner*, 127 F.3d at 200; *Jass*, 88 F.3d at 1488; *Cannon*, 77 F.3d at 1273 ("Mr. Cannon's initial claims . . . related to the improper processing of Mrs. Cannon's benefit claim for ABMT. Both the Supreme Court and this court have consistently held these type of claims are preempted by ERISA"); *Kuhl*, 999 F.2d at 303; *Corcoran*, 965 F.2d at 1332 ("The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA preempts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here").

For example, in *Corcoran*, 965 F.2d at 1322-23, Dr. Collins ordered Flo Corcoran to be “hospitalized so that he could monitor the fetus around the clock.” However, “[d]espite Dr. Collins’s recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care.” *Id.* at 1324-25. “[D]uring a period of time when no nurse was on duty, the fetus went into distress and died.” *Id.* Flo Corcoran and her husband, Wayne, did not sue for benefits under § 502(a). They filed a medical malpractice “wrongful death action in Louisiana state court” and “sought damages for the lost love, society and affection of their unborn child,” and “aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation.” *Id.* at 1324.⁴⁵

Notwithstanding the medical implications of the decision made by United, this Court found that “[utilization review] is a benefit determination nonetheless,” *i.e.*, within the scope of ERISA § 502(a). *Id.* at 1332. Thus, this Court held, “[t]he principle of *Pilot Life* that ERISA preempts state-law claims

⁴⁵ Indeed, the Corcorans conceded “that the defendants have fully paid any and all medical expenses that Mrs. Corcoran actually incurred that were covered by the plan, [meaning that] the plaintiffs have no remaining claims under ERISA.” *Id.* at 1325 n.5.

alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here." *Id.*

Similarly, in *Rodriguez*, the plaintiff sued the health maintenance organization and the primary care physician for failing to "provide prompt and adequate medical care." *Rodriguez*, 980 F.2d at 1016. Rejecting the Plaintiff's characterization of his own claim, this Court held that:

[plaintiff's] state law claims, at bottom, result from dissatisfaction over [the HMO's] handling of his medical claims. Consequently, his state law causes of action are sufficiently related to the employee benefit plan, in that they clearly have a "connection or reference to such a plan" to be pre-empted by ERISA.

Id. at 1017 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)).

Recent case law (and the record) likewise foreclose Davila's attempted shell-game of recharacterizing Aetna's payment decision as "controlling" medical care.⁴⁶ The unchallenged proof submitted in response to Davila's motion to remand established that Aetna had no authority to control care, but

⁴⁶ See *Hull*, 188 F.3d at 943 (quoting *Kuhl* and prohibiting plaintiff from recharacterizing MCE's refusal to pay for treatment as a cancellation of the prescribed treatment); see also *Thompson*, 202 F.3d at 1074 (claim that administrator "controlled" medical care by refusing to implement the treating physician's order is preempted under *Pilot Life*). Compare App. Br. at 16.

only to administer claims.⁴⁷ Davila cannot change the legal characterization of the benefit determination or the dispute by insisting that he complains of Aetna “making him” take naprosyn, not for denying Vioxx. Davila’s argument is roughly equivalent to an adolescent arguing, “I’m not complaining that you won’t let me stay out, I’m complaining that you set my curfew too early.” Neither argument has merit. If Davila’s view of the law were correct, Mrs. Corcoran could have avoided preemption if she had simply alleged that she was complaining that United Health Care forced her into home nursing care, not that it denied in-patient care.⁴⁸

Davila’s pleadings do not allow such word games to succeed in any event. Although Davila’s Petition attempted to morph and label his claim in the manner the artful pleading doctrine was intended to foreclose, it expressly pleaded that “[d]espite the recommendations and protests of his treating physician, Aetna *refused to provide* Vioxx . . .,” *i.e.*, denied a benefit.⁴⁹ This allegation is enough. *See Danca*, 185 F.3d at 6 (finding that plaintiff’s claims

⁴⁷ 2R259, 260, 263 & 269.

⁴⁸ *See Corcoran*, 965 F.2d at 1324 (“United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care”). It was preempted nonetheless.

⁴⁹ 1R12.

were an alternate enforcement mechanism because they alleged that the defendant “failed to follow Danca’s physician’s recommendations”); *see also Thompson*, 202 F.3d at 1073-74 (claim that administrator “controlled” medical care by refusing to “implement the treatment recommended by her physician” is preempted under *Pilot Life*).⁵⁰

Davila, like Flo Corcoran, may claim not to be seeking benefits and may indeed be characterizing his complaints as attacking the quality of medical care “actually provided.” All of these arguments, however, are unavailing because Davila is an ERISA participant complaining of conduct within the scope of ERISA § 502(a). All of the authorities governing removal jurisdiction would uphold removal and find preemption under facts as Davila alleges them:

⁵⁰ Tellingly, *Danca* and *Thompson* were both decided *after* the “seismic shift” that Davila claims has occurred.

The Plaintiff Does Not Seek Benefits-Preempted Anyway				
Case	HMO Failed To "Obey" M.D.	Removed from State Court?	Plaintiff Seeking Benefits?	Completely Preempted Anyway?
<i>Thompson v. Gencare Health Sys.</i>	Yes	Yes	No	Yes
<i>Hull v. Fallon</i>	Yes	Yes	No	Yes
<i>Danca v. Private Health Care Sys., Inc.</i>	Yes	Yes	No	Yes
<i>Parrino v. FHP, Inc.</i>	Yes	Yes	No	Yes
<i>Turner v. Fallon Community Health Plan, Inc.</i>	Yes	Yes	No	Yes
<i>Jass v. Prudential Health Care Plan, Inc.</i>	Yes	Yes	No	Yes
<i>Cannon v. Group Health Serv. of Okla., Inc.</i>	Yes	Yes	No	Yes
<i>Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.,</i>	Yes	Yes	No	Yes
<i>Corcoran v. United HealthCare, Inc.</i>	Yes	Yes	No	Yes
<i>Davila v. Aetna U.S. Healthcare, Inc.</i>	Yes	Yes	No	[Yes]

No case from this circuit holds that complete preemption may be avoided simply by refusing to plead relief that can be granted under ERISA § 502(a), and Davila has cited none.⁵¹ Indeed, Davila's core argument

⁵¹ Below, Davila mistakenly relied upon *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 337 (5th Cir. 1999) for such a proposition. In *Giles*, however, the underlying basis for the plaintiffs' complaint was not a refusal of coverage, but that "one of the doctors failed to diagnose Alex's heart defect." *Id.* at 335. After removal, Giles amended the complaint "dropping the breach of contract, misrepresentation, and breach of warranty claims" that she "*admitted* were preempted" before moving to remand. *Id.* (emphasis

contradicts *Heimann* from the Fifth Circuit and *Ingersoll-Rand* and *Pilot Life* from the Supreme Court and must, therefore, be rejected.

C. Davila's Efforts To Undermine Binding Precedent Are Futile

1. *Neither Pilot Life nor Corcoran have eroded with the passage of time*

Davila purports to advise the Court that times have changed and that the law no longer considers utilization review to be a benefit determination in the wake of *Pegram*. The cases say otherwise.

For example, as recently as March of this year, the Third Circuit upheld the removal and dismissal of utilization review claims against U.S. Healthcare.⁵² In so doing, the court cited *Corcoran* and the other supposedly "out-dated" authorities on which Aetna relies and noted that "suits against HMOs . . . for denial of benefits, even when the claim is couched in terms of

added). In that context, the Fifth Circuit panel intimated that a complaint seeking the "same relief" available under 502(a) was *sufficient* to create preemption. *Id.* at 337. However, the court *expressly* warned against reading its opinion as setting the outer boundaries of what was *necessary* to create complete preemption. *Id.* at 336 n.6 ("As in *McClelland*, we make no comment on the breadth of ERISA's complete preemption under § 502(a)").

⁵² See generally *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001).

common law negligence or breach of contract, have been held to be preempted by § 514(a).⁵³

Davila's attempted distinction of *Pryzbowski* as a claim involving only *delay* of precertification is a distinction without a difference.⁵⁴ The *Pryzbowski* court noted that "[a] claim alleging [as here] that an HMO *declined to approve* certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis."⁵⁵

Thus, if *Corcoran* has (as Davila contends) been "significantly undermined, if not destroyed altogether,"⁵⁶ all the federal appellate courts have yet to realize it. In fact, it is Davila, not the courts, who is out-of-step on this issue.

⁵³ *Pryzbowski*, 245 F.3d at 278 (citing *Bast*, 150 F.3d at 1007-08; *Tolton*, 48 F.3d at 941-43; *Spain*, 11 F.3d at 131-32; *Kuhl*, 999 F.2d at 302-03; *Corcoran*, 965 F.2d at 1331-34).

⁵⁴ Davila's pleadings would be unable to sustain such a distinction in any event. See 1R87 (complaining of Aetna's supposed "delaying the prescription of Vioxx")

⁵⁵ *Pryzbowski*, 245 F.3d at 273 (emphasis added). The case was removable because (like Davila and like Mr. and Mrs. Heimann), Mrs. Pryzbowski "could have" enforced the rights she was asserting with an action under ERISA § 502(a), but instead chose to wait and sue for damages under state law. *Id.* at 273-74.

⁵⁶ App. Br. at 12.

2. *Corporate Health does not bolster Davila's argument—it destroys it*

The heavy reliance Davila places on the Texas Health Care Liability Act (“the Act”) and *Corporate Health Insurance, Inc. v. Texas Department of Insurance*⁵⁷ does as much to undermine his argument as ignoring *Corcoran*, *Rodriguez*, and *Pilot Life*. Indeed, Davila’s boast that his claim survives because this Court “upheld” the liability provisions of the Act⁵⁸ does not tell the court “the rest of the story.”

In *Corporate Health*, this Court specifically held that the Act does not apply to the facts pleaded by Davila and recognized that Davila’s claim would be completely preempted by ERISA. This Court expressly held that the liability provisions of the Act were very narrow and applied only to a “limited universe of events,” *not* at issue here. *Id.* at 534. The Court found that the Act’s liability provisions provided only *vicarious* claims for a treating physician’s malpractice and were “rooted in general principles of state agency law.” *Id.* at 534 & 535. Said the Court:

⁵⁷ 215 F.3d 526 (5th Cir.), *on reh’g*, 220 F.3d 641 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665).

⁵⁸ See App. Br. at 24.

When the liability provisions are read together, they impose liability for a limited universe of events. The provisions *do not* encompass claims based on a managed care entity's denial of coverage for a medical service recommended by the treating physician: that dispute is one over coverage, specifically *excluded* by the Act. Rather, the Act would allow suit for claims that a treating physician was negligent in delivering medical services, and it imposes vicarious liability on managed care entities for that negligence.

Corporate Health, 215 F.3d at 534 (emphasis added).⁵⁹

The Court did more than hold that "adverse determination" claims like Davila's were outside the terms of the statute—it specifically recognized that such claims involve coverage disputes that are squarely preempted by ERISA. *Id.* (recognizing that "state efforts to regulate an entity in its capacity as plan

⁵⁹ Davila erroneously contends that the Court "recognized that the state could, without running afoul of ERISA, regulate and discipline HMO medical directors for making poor medical decisions as part of deciding medical necessity." App. Br. at 24-25. Like the Supreme Court in *Pegram*, the panel in *Corporate Health* drew a clear and consistent distinction between the supposed "medical malpractice" of HMO medical directors, which are actually coverage decisions preempted by ERISA, and the malpractice of *treating physicians*, which is regulated by state law. *Corporate Health*, 215 F.3d at 534-35 ("ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions"). No other reading of the quoted language can be harmonized with the Court's holding that the liability provisions of the Act escape preemption because those provisions apply only to vicarious liability claims arising from the malpractice of a *treating physician*. *Corporate Health*, 220 F.3d at 643 (harmonizing *Pegram* with this Court's holding that the Act only applies to "liability for physicians' malpractice . . . and the ensuring *vicarious* liability for the HMOs." (emphasis added)).

administrator are preempted” and that “ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan”); *Corporate Health*, 215 F.3d at 535 n.24 (“This distinction is consistent with *Corcoran’s* holding that medical decisions involving coverage determinations are preempted”). Even beyond the liability provisions, the Fifth Circuit held that state oversight of utilization review constituted an alternate enforcement mechanism—*i.e.*, laws within the scope of § 502(a) that are *completely* preempted.

As here, the state argued it was merely regulating the practice of medicine and insurance when it sought to create a state law remedy to redress adverse utilization review determinations about which Davila now complains. The Court rejected the arguments, saying:

“adverse determinations” include determinations by managed care entities as to coverage, not just negligent decisions by a physician. . . . [A]n attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA’s preemptive reach.

* * *

Here, the independent review provisions do not create a cause of action for the denial of benefits. They do, however, establish a quasi-administrative procedure for the review of such denial and bind the

ERISA plan to the decision of the independent review organization. This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under [ERISA § 502(a)(1)(B)]. As such, the independent review provisions conflict with ERISA’s exclusive remedy and cannot be saved by the saving clause.

Corporate Health, 215 F.3d at 537 & 539.

On rehearing, the Court correctly reaffirmed and bolstered its position. The state argued that it was merely regulating the practice of medicine or the business of insurance by reviewing medical necessity determinations. This Court, however, properly found that such a state regime conflicts with ERISA’s exclusive remedies and could not be saved. *Corporate Health*, 220 F.3d at 645 (“Because the IRO provisions here are plainly a state regime for reviewing benefit decisions . . . we have no occasion to decide whether that form of regulation could be saved”).

3. *Davila has not even pleaded a so-called “mixed” decision, and the Fifth Circuit has already rejected his Pegram preemption argument*

The core of Davila’s position is that all of Aetna’s authorities have been so substantially undermined that no court should follow them anymore. The authority Davila cites provides no support for such an extravagant claim.

For example, Davila relies heavily upon *Pegram v. Herdrich*, 530 U.S. 211 (2000). *Pegram*, however, neither mentioned nor overruled the preemption cases *from nearly every circuit* that are four-square consistent with *Pilot Life*, *Corcoran*, *Rodriguez*, and *Corporate Health*. Moreover, *Pegram* reveals on its face that it does not apply to the preemption of utilization review decisions made by third party administrators, and this Court has already considered and rejected the Appellant's *Pegram* preemption argument.

In *Pegram*, all of the claims arose through the HMO's alleged *vicarious* responsibility for a default by the *treating physicians that owned the HMO*.⁶⁰ The *treating physician* chose to delay diagnostic testing in order to use a participating provider rather than schedule an emergency test with a non-participating provider. *Id.* at 215. Here, however, Davila brings *direct liability* claims against Aetna (not a treating physician) for the identical type of coverage determinations that were found to be preempted in *Corcoran*. Here, unlike *Pegram*, the complaint focuses solely on the supposed decision

⁶⁰ *Pegram*, 530 U.S. at 226 ("What she does claim is that Carle, *acting through its physician owners*, breached its duty to act solely in the interest of beneficiaries by making decisions affecting medical treatment while influenced by the terms of the Carle HMO scheme") (emphasis added); *id.* at 231 ("[W]e think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians").

by the independent claims administrator not to cover the specific drug prescribed by the independent treating physician if more cost-effective options were appropriate.

Although Davila's Petition is intentionally vague on a great many things, it is clear on one matter: Davila is suing Aetna directly because of a decision that it made, not because of any "mixed eligibility and treatment determination" made by his treating physician. As such *Pegram* is particularly inapplicable, because "mixed eligibility *and treatment* determinations"⁶¹ (which Davila continually disguises as "mixed medical decisions" or "mixed medical necessity determinations" or simply "mixed decisions")⁶² are determinations made by *treating physicians*, not independent claims administrators for ERISA plans.

Moreover, *Pegram* was not even a preemption case, and Davila concedes as much.⁶³ In *Pegram*, the original claim challenging the incentives paid to treating physicians was removed to federal court, remand was denied, and

⁶¹ *Pegram*, 530 U.S. at 231.

⁶² *See, e.g.*, App. Br. at 12, 13, 20, 30

⁶³ *Pegram*, 530 U.S. at 229 n.9 ("[We have no] reason to discuss the interaction of such a [29 U.S.C. 1132(a)(1)(B)] claim with state law causes of action"); App. Br. at 25.

the plaintiff amended her pleadings to *expressly include* an ERISA claim. *Pegram*, 530 U.S. at 216 & n.2. Far from making a preemption holding, the court affirmed the 12(b)(6) ruling of the district court finding that ERISA provided no remedy for the conduct alleged. *Id.* at 217-18. Of course, it has long been recognized that the absence of a remedy in ERISA will not preclude a finding of preemption.⁶⁴ The court specifically disclaimed any intent to delineate the preemptive scope of a coverage dispute.⁶⁵

Indeed, Davila's "*Pegram* preemption" arguments have been rejected by this Court already. This Court's opinion on rehearing in *Corporate Health specifically rejected* the argument that "*Pegram v. Herdrich* cast doubt on . . . this court's prior decision in *Corcoran v. United Healthcare, Inc.*" *Corporate Health*, 220 F.3d at 643. Said the court, "we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held

⁶⁴ *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 979 (5th Cir. 1991) ("Even if [Davila] is correct that ERISA provides no adequate remedy, however, his state law claims would still be preempted"). Indeed, the Fifth Circuit has expressly held that one like Davila has no fiduciary duty claim where (as here) he could have brought a claim establishing his right to benefits. See *Rhorer v. Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 639 (5th Cir. 1999).

⁶⁵ *Pegram*, 530 U.S. at 229. n.9.

otherwise.” *Id.* at 643-44. Even further, “[i]t may be that state causes of action persist *only* for actions based in some part on malpractice committed by treating physicians. If so, state causes of actions [sic] against HMOs for the decisions of their utilization review agents would still be preempted, as *Corcoran* held.” *Id.* at 643 n.6 (emphasis added).

Failing to find aid in *Pegram*, Davila next urges the Court to consider the denial of certiorari in *In re U.S. Healthcare* as indicative of the Supreme Court’s substantive position.⁶⁶ Orders denying certiorari, of course, have no precedential value. The fallacy of arguing to the contrary is demonstrable: ERISA preemption was *also upheld* in a utilization review dispute and the high court denied certiorari in the same term and the *same reporter* in which *Pegram* appears.⁶⁷

The Supreme Court, however, was not wholly mute last term concerning the scope of ERISA preemption. The court summarily considered a case where the Pennsylvania Supreme Court had (like Davila) traced the “*Travelers Trilogy*” and had *erroneously* concluded that:

⁶⁶ App. Br. 29.

⁶⁷ See *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), *cert. denied*, 528 U.S. 1189 (2000).

[A]lthough . . . U.S. Supreme Court decisions from the 1980's and early 1990's support [U.S. Healthcare's] position that the preemption provision is to be read broadly, *Travelers* and its progeny have thrown the expansive holdings of those earlier cases into question.

Pappas v. Asbel, 724 A.2d 889, 893 (Pa. 1998). The state court had adopted the argument, urged here by Davila, that Aetna's actions were "intertwined" with medicine and could not be preempted. *Id.* The Supreme Court, however, summarily vacated and remanded *Pappas*. *United States Healthcare Sys., Inc. v. Pennsylvania Hosp. Ins. Co.*, 67 U.S.L.W. 3717 (June 19, 2000) (No. 98-1836).⁶⁸

4. *Davila's "Travelers Trilogy" sloganeering has been widely rejected in "medical necessity" disputes*

In the absence of cases, authorities, and precedents, Davila must again resort to slogans, trilogies, and so-called "trends" in the law. Yet, even Davila concedes that the cases making up the vaunted "*Travelers Trilogy*" are not complete preemption cases.⁶⁹ In fact, the issues presented are not similar to

⁶⁸ The Pennsylvania Supreme Court apparently did not take the hint from the high court, because the Pennsylvania court adhered to its original position on remand, and a petition for writ of certiorari is now pending. See *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), petition for cert. filed, 70 U.S.L.W. 3092 (August 1, 2001) (NO. 01-200). At this writing, the *Pappas* majority has only been distinguished or cited in dissent. Contrary to *Pappas*, recent federal authority recognizes the continuing preemption of direct action utilization review disputes. See *Pryzbowski*, 245 F.3d at 278.

⁶⁹ 1R92.

those here. Davila's claims are not like the neutral premium surcharge as in *Travelers*, the benign prevailing wage law as in *Dillingham*, or the gross receipts tax as in *De Buono*.⁷⁰ Davila's claims seek to recover damages allegedly arising from improper claims administration—an exclusively federal concern.

The reality is that *Travelers* had no effect in the courts on the preemption of utilization review disputes.⁷¹ Moreover, several courts specifically reject the notion that *Travelers* or its "Trilogy" has altered the preemption calculus for core ERISA functions such as utilization review. *See, e.g., Turner*, 127 F.3d at 199 ("[N]either of these cases involved a state's attempt to provide state remedies for what is in essence a plan administrator's refusal to pay allegedly promised benefits. It would be difficult to think of a state law that 'relates' more closely to an employee benefit plan than one that affords remedies for

⁷⁰ See generally *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

⁷¹ **Post-Travelers:** *See Thompson*, 202 F.3d at 1073; *Hull*, 188 F.3d at 943; *Danca*, 185 F.3d at 6-7; *Bast*, 150 F.3d at 1007-08; *Parrino*, 146 F.3d at 704-05 & n.3; *Turner*, 127 F.3d at 199-200; *Jass*, 88 F.3d at 1494; *Cannon*, 77 F.3d at 1273. **Pre-Travelers:** *Tolton*, 48 F.3d at 942; *Spain*, 11 F.3d at 131; *Kuhl*, 999 F.2d at 302; *Rodriguez*, 980 F.2d at 1017; *Corcoran*, 965 F.2d at 1328-29.

the breach of obligations under that plan"); *Parrino*, 146 F.3d at 705 n.3 (noting that the Supreme Court "has not . . . overturned its prior substantive holdings regarding the scope of ERISA preemption" and that its "more recent ERISA preemption cases had tenuous and peripheral connections to ERISA").

Indeed, the notion that *Travelers* denotes a "seismic shift" because the Supreme Court has suddenly rediscovered a presumption against preemption is simply wrong.⁷² The assumption that Congress did not intend to prohibit regulation by the States absent a clear manifestation of intent is not peculiar to *Travelers* and the "Trilogy"; rather, it is "black letter law" so well-established *prior* to *Travelers* as to defy comprehensive citation.⁷³ Indeed,

⁷² Equally fanciful is the notion that the so-called "new federalism" for such things as Gun Free School Zones or Violence Against Women (App. Br. at 39 - 41) has any application in the context of ERISA benefits administration. Even in the "Trilogy," the Supreme Court has forcefully declared Congress's intent that regulation of Employee Welfare Benefit Plans be "exclusively a federal concern." *Travelers*, 514 U.S. at 656.

⁷³ A mere sprinkling of the numerous, pre-*Travelers* Supreme Court authorities recognizing this principle includes: *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (ERISA preemption case); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981) (ERISA preemption case); *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 228 (1947); *Allen-Bradley Local No. 1111, United Electrical Workers of America v. Wisconsin Employment Relations Board*, 315 U.S. 740, 749 (1942) ("[T]his Court has long insisted that an 'intention of Congress to exclude states from exerting their police power must be clearly manifested' "); *Napier v. Atlantic Coast Line Railroad Co.*, 272 U.S. 605, 611 (1926); *Savage v. Jones*, 225 U.S. 501, 533 (1912) ("This principle has had abundant illustration."); *Sinnot v. Davenport*, 63 U.S. 227, 243 (1859).

Travelers itself cites to 1926 Supreme Court authority⁷⁴ and to one of the Supreme Court's earliest ERISA preemption cases⁷⁵ as sources for the Appellant's "newly-found" presumption against preemption. More to the point, the "Trilogy" cases cite the pre-*Travelers* Supreme Court precedents with approval, including those holding that ERISA's remedies are exclusive. *De Buono*, 520 U.S. at 815 & nn.13-15.

Thus, *Travelers* is a "limited" holding, not a wholesale abandonment of prior preemption law. See *CIGNA Healthplan, Inc. v. Louisiana ex rel. Ieyoub*, 82 F.3d 642, 649 (5th Cir. 1996). The Fifth Circuit has repeatedly rejected the notion that *Travelers* fundamentally alters the preemption calculus in a dispute between an ERISA plan participant and the managed care entity that administers the plan.⁷⁶ Moreover, the Supreme Court has again confirmed that benefits administration is a area of core ERISA concern—sufficient to

⁷⁴ See *Travelers*, 514 U.S. at 655 (citing *Napier v. Atlantic Coast Line R.R. Co.*, 272 U.S. 605, 611 (1926)).

⁷⁵ *Travelers*, 514 U.S. at 655 (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) ("We also must presume that Congress did not intend to pre-empt areas of traditional state regulation")).

⁷⁶ See *McNeil v. Time Ins. Co.*, 205 F.3d 179, 191 n.20 (5th Cir.), *cert. denied*, 121 S. Ct. 1189 (2000) ("We disagree with Mr. McNeil's argument that our inquiry on this issue has been fundamentally altered by the Supreme Court's decision in [*Travelers*]. The method of analysis we use today was well established before that decision, and it continues to be used today"); see also *CIGNA*, 82 F.3d at 649.

overcome supposed presumptions against preemption in areas of traditional state regulation. *See infra* § V.C.5.

5. *Preemption remains unchanged in the area of benefits administration—an area of exclusive federal concern*

A review of the Supreme Court authority in the area of benefit administration establishes, not surprisingly, that the court is decidedly free of the sloganeering and the Trilogy-speak contained in Davila's brief.

In *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001), the Supreme Court's most recent case on the topic, the court held that a Washington statute revoking (upon divorce) a beneficiary designation for a former spouse was preempted. In reaching its conclusion the court cited one of its earliest preemption authorities and used the same "relates to" and "connection with" analysis that Davila opines is "out-dated." *Id.* at 1327 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Indeed, while acknowledging that preemption is not limitless, the Court confirmed its repeated observation that ERISA's broadly worded preemption provision is "clearly expansive." *Id.* (citing *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992) (listing cases in which the court described ERISA pre-emption in broad terms)). The court found that the Washington statute was preempted because benefit determinations are

“an area of core ERISA concern,” and the Washington law, like Davila’s claim, bound the administrators to determine benefits according to state law rather than the terms of the plan. *Egelhoff*, 121 S. Ct. at 1327-28.

The court noted that “unlike generally applicable laws regulating ‘areas where ERISA has nothing to say’ . . . this statute governs the payment of benefits, a central matter of plan administration.” *Id.* at 1328. Where that “central matter” is concerned, ERISA’s goal of uniformity *for plans* “is impossible . . . if plans are subject to different legal obligations in different States.” *Id.* at 1328. Likewise, “[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of ‘minimiz[ing] the administrative and financial burden[s]’ on plan administrators—burdens ultimately borne by the beneficiaries.” *Id.* at 1329 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). In this area of core ERISA concern, “[d]iffering state regulations affecting an ERISA plan’s ‘system for processing claims and paying benefits’ impose ‘precisely the burden that ERISA pre-emption was intended to avoid.’” *Id.* (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)).

Like Davila, the *Egelhoff* respondents argued forcefully that their claim involved areas of “traditional state regulation.” The court agreed, but found preemption nevertheless:

There is indeed a presumption against pre-emption in areas of traditional state regulation such as family law. . . . But that presumption can be overcome where, as here, Congress has made clear its desire for pre-emption. Accordingly, we have not hesitated to find state family law pre-empted when it conflicts with ERISA or relates to ERISA plans.

Egelhoff, 121 S. Ct. at 1330; see also *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (“That the States traditionally regulated these areas would not alone immunize their efforts; ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation”).

Davila errs in arguing that his claim will only “indirectly affect” the incidental costs to his ERISA plan” like the laws in the “Trilogy.”⁷⁷ To the contrary, Davila’s claim directly impacts benefits administration like the law in *Egelhoff*. To allow the claim would countermand Aetna’s discretion to

⁷⁷ App. Br. at 23.

make benefits determinations under the terms of the plan,⁷⁸ it would subject Aetna, contrary to the intent of Congress, to remedies not contemplated by ERISA,⁷⁹ and it would punish Aetna with liability under *state* law because it complied with its *federal* duty to pay benefits only in conformity with the plan terms.⁸⁰ Seldom could an impact be more intrusive on federal prerogatives.

Whatever costume Davila's claim dons, Aetna's administration of benefits is key. Davila expressly pleads that if Aetna had precertified the requested Vioxx prescription, he would not have been damaged.⁸¹ He did not contest Aetna's pleading and proof that the Monitronics Plan is an ERISA plan, or Aetna's function in providing administrative services to the plan, including determination of coverage for prescription drugs. Because Aetna's decisions about whether an ERISA beneficiary is entitled to prescription drug benefits under the terms of an ERISA plan is an "area of core ERISA concern,"

⁷⁸ 2R260.

⁷⁹ *Pilot Life*, 481 U.S. at 52.

⁸⁰ 29 U.S.C. § 1104(a)(1)(D) (1999).

⁸¹ 1R87 (As a result of Aetna's delaying the prescription of Vioxx, and forcing on Juan Davila the cheaper but inappropriate naprosyn, Juan will not be able to take any other pain medication for his arthritis-related pain which has to be absorbed through the stomach, including aspirin").

the presumption against preemption is overcome and state laws contradicting ERISA (in this case the exclusive remedies of ERISA § 502(a)) are preempted.

6. *Neither the musings of law reviewers nor musty legislative history can aid Davila in the absence of law and precedent*

If decades of ERISA precedent have been overturned in a “seismic shift” to allow personal injury actions for utilization review decisions, would it be too much to ask Davila to cite *one* controlling federal appellate decision saying so? Apparently so, because he cannot do it.⁸² In the absence of precedent, Davila relies upon law reviewers’ regurgitations of legislative history. “Who else beside a law review deigns to ‘reverse’ the Supreme Court of the United States.”⁸³

⁸² The Plaintiff’s Third Circuit authorities certainly do not fill the bill. Not only do they fail to overcome binding authority from this circuit, they are factually inapplicable. One involves (unlike here) the attempted removal of a vicarious liability claim. See generally *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995). One involves a denial of treatment by the *treating physician*, with no allegation of a denial of coverage by the HMO and ERISA plan administrator. See *Lazorko v. Penn. Hosp.*, 237 F.3d 242, 246 (3d Cir. 2000), *cert. denied*, 121 S. Ct. 2552 (2001) (“Although [plaintiff] asked to be rehospitalized, Dr. Nicklin [the treating physician] denied her request”). In the last, the plaintiff managed to convince the court that no part of his claim arose from a coverage determination like an adverse utilization review decision. See generally *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 530 U.S. 1242 (2000). To the extent one attempts to read *In re U.S. Healthcare* as prohibiting removal of utilization review disputes, it is squarely contradicted by *Corcoran, Rodriguez, Corporate Health* from this Circuit, and now by *Pryzbowski* from the Third Circuit. See *supra* § V.C.1.

⁸³ Frank R. Strong, *The Iowa Law Review at Age Fifty*, 50 IOWA L. REV. 12, 13 (1964). See also Oliver Wendell Holmes, Jr. *attributed in* FREDERICK B. WIENER, *EFFECTIVE*

First, the notion that one must resort to legislative history or law review pieces for a nearly 30-year-old federal statute with over 2800 opinions addressing preemption⁸⁴ is highly suspect. It is especially questionable in the area of benefits administration where Congress's intent is so clear. It is improper to muddy the legal waters with legislative history when the statutory command is clear. *United States v. Gonzales*, 520 U.S. 1, 6 (1997).
no one thinks ERISA is clear
Likewise, courts "have no authority to enforce [a] principl[e] gleaned solely from legislative history that has no statutory reference point." *Shannon v. United States*, 512 U.S. 573, 584 (1994).

More than that, however, Davila's characterization of ERISA's legislative history, garnered mostly from academicians, is demonstrably wrong in two respects. First, it ignores the preemptive effect of ERISA's exclusive remedies. Davila wastes much effort supposedly demonstrating how ERISA § 514, the *conflict* preemption provision, was grafted into ERISA at the last minute.⁸⁵ The issue in this case, however, is *complete* preemption

APPELLATE ADVOCACY 130 (1950) ("I don't mind when the lads on the Law Review say I'm wrong, what I object to is when they say I'm right").

⁸⁴ *De Buono*, 520 U.S. at 809 n.1.

⁸⁵ App. Br. 36-37.

arising from ERISA's exclusive remedies in § 502(a). The Supreme Court has already parsed through the legislative history behind § 502(a) (with the help of the Solicitor General) and concluded that Congress intended the remedies to be exclusive. *Pilot Life*, 481 U.S. at 52-57. Second, Davila's approach to § 514 is erroneous. The Supreme Court has sifted that legislative history as well. The court concluded (contrary to Davila's argument) that Congress's rejection of a limited preemption provision substantively indicated that preemption is broader than the specific topics covered by ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 & nn.15 & 19 (1983).

If Davila's approach to ERISA's legislative history is incorrect, his invocation of the legislative history for the Federal HMO Act is *doubly* misguided. Even supposing that the statutory text of ERISA had any areas of doubt 30 years after its passage, resort to the legislative history of an altogether unrelated act is fatuous. *See Penn Mut. Life Ins. Co. v. Lederer*, 252 U.S. 523, 537-38 (1920). Moreover, the actual legislative history behind the Federal HMO Act demonstrates Congress's intent to exempt HMOs from state

interference disguised as insurance regulations⁸⁶—exactly what the State of Texas claimed it was doing in passing the Act under which Davila sues.

Davila quotes this Court as saying that ERISA preemption ought to be reevaluated given the advent of managed care, so that ERISA can “continue to serve its noble purpose of safeguarding the interests of employees.”⁸⁷ Davila, however, leaves out the most important part of the Court’s observation. This Court observed that its opinion was “faithful to Congress’s

⁸⁶ Only one year before it enacted ERISA, the 93d Congress enacted the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222 (codified as 42 U.S.C. § 300e, *et seq.* (1991)), to establish requirements for the administration and management of federally-qualified HMOs—a substantial legislative undertaking entirely inconsistent with the proposition that Congress understood the regulation of HMOs amounted to the type of traditional regulation of “insurance” that Congress intended to reserve to the States. As two commentators have observed: “The purpose of the 1973 Act was to *prevent* state laws from impeding the development of HMOs. In particular, Congress was concerned that local physicians’ political clout with state regulators would prevent HMOs from developing as a more efficient means of delivering quality health care.” Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 TORT & INS. L.J. 687, 734 n. 96 (2001). The Senate Report to the bill that was ultimately enacted states unequivocally that “[i]n the committee’s view HMO’s . . . should not be required to submit to regulations as an insurer of health care services Such requirements would be unduly restrictive, onerous, and not within the spirit of this legislation” Sen. Rep. No. 93-129 (1973), *reprinted in* 1973 U.S.C.A.A.N. 3033, 3058. Indeed, the Report identifies “applicable state insurance laws and regulations” as one of the “[p]rincipal state legal barriers . . . to the development of HMOs.” *See id.*; *see also Pegram*, 530 U.S. at 233 (“The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices.”). *See also Rush Prudential HMO Inc. v. Moran*, Brief of American Association of Health Plans, Inc., American Benefits Council, and Health Insurance Association of America, Inc. as Amici Curiae in Support of Petitioner, No. 00-1021, 2001 WL 1077919 (Sept. 10, 2001).

⁸⁷ App. Br. at 21 (quoting *Corcoran*, 965 F.2d at 1339 (sic)).

intent” and that the debate over whether the law *ought* to provide plaintiffs (and their attorneys) a monetary remedy for personal injuries are policy questions “allocat[ed] . . . to Congress, not the courts.” *Corcoran*, 965 F.2d at 1339. Congress is so engaged at this moment, and under our system, Davila’s invocation to this Court to usurp that function is improper.

7. *Aetna is not the plan-“Inconsequential”*

“Inconsequential (in’kɒnsi-kwen’shəl) *adj.*

1. Without consequence; lacking importance; petty.

2. Inconsequent. *-n.* A triviality.”⁸⁸

Davila’s willingness to argue into the very teeth of contrary precedent is most apparent when he argues that Aetna is not the ERISA plan.⁸⁹ The Fifth Circuit has heard the argument before and called it “inconsequential.” *CIGNA Healthplan, Inc. v. Louisiana*, 82 F.3d 642, 648 (5th Cir. 1996). Indeed, Davila’s current counsel tried the argument in *Corporate Health* but the district court called it “inconsequential.” *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 12 F. Supp. 2d 597, 610 (S.D. Tex. 1998). This Court found the argument to be of no moment in preempting the IRO procedures in *Corporate Health*. In this

⁸⁸ THE AMERICAN HERITAGE DICTIONARY 652 (1985).

⁸⁹ App. Br. at 14.

case, the District Court below was equally unimpressed. In fact, *nearly all* of the landmark ERISA preemption cases decided by this Court and the Supreme Court involve parties other than “the plan.” Davila’s argument thus falls of its own weight.

Preemption Outside “The Plan”

Case	Is Defendant “The Plan”?	Preempted Anyway?
<i>Pilot Life</i>	No--Plan Insurer	Yes
<i>Ingersoll-Rand</i>	No--Defendant Employer	Yes
<i>Corporate Health</i>	No--Plan Insurers & HMOs	Yes
<i>Corcoran</i>	No--UR Agent	Yes
<i>Rodriguez</i>	No--Plan Insurer	Yes
<i>TPA</i> ⁹⁰	No--Plan Insurer	Yes
<i>CIGNA</i>	No--HMO “for” the Plans	Yes
<i>Dowden</i> ⁹¹	No--Plan Insurer	Yes

“Inconsequential” is a multi-syllabic word for “does not matter,” and one wonders how many courts must say it before Davila’s counsel believes it. The mountain of removal cases in notes 41 through 43, as well as all the significant preemption cases from this circuit and the Supreme Court

⁹⁰ *Texas Pharmacy Ass’n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1036 (5th Cir. 1997).

⁹¹ *See Dowden v. Blue Cross & Blue Shield, Inc.* 126 F.3d 641, 642-43 (5th Cir. 1997).

demonstrate that ERISA preemption applies even if the plaintiff chooses not to join “the plan” as a defendant.

VI. CONCLUSION

“What has once been settled by a precedent will not be unsettled overnight, for certainty and uniformity are gains not lightly to be sacrificed.”

BENJAMIN NATHAN CARDOZO, *THE PARADOXES OF LEGAL SCIENCE* (1928).

Few things in the law are so certain and well-established: Aetna’s functions in regard to the Monitronics Plan are governed by Federal law alone. According to *Corcoran* (and all of its progeny), utilization review is a benefit determination. According to *Pilot Life* (and all of its progeny), there is only one remedy for a mishandled benefit determination: ERISA § 502(a). Any other claim alleging improper utilization review is an alternate enforcement mechanism, is completely preempted by ERISA § 502(a), and may be removed to federal court.

Supreme Court and Fifth Circuit precedents do not lose their binding force simply because a plaintiff is dissatisfied with their effect upon his claim. Far from being eroded, these authorities bind the decision of this Court. The precedential silly putty to which Davila was required to resort in arguing to

the contrary demonstrates on its face the impropriety of denying these defendants the federal forum and the judgment to which they are entitled under the law.

WHEREFORE, PREMISES CONSIDERED, Aetna respectfully requests that the Court affirm the judgment of the District Court and grant such other and further relief to which Aetna shall show itself entitled under the law.

Respectfully submitted:

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CERTIFICATE OF SERVICE

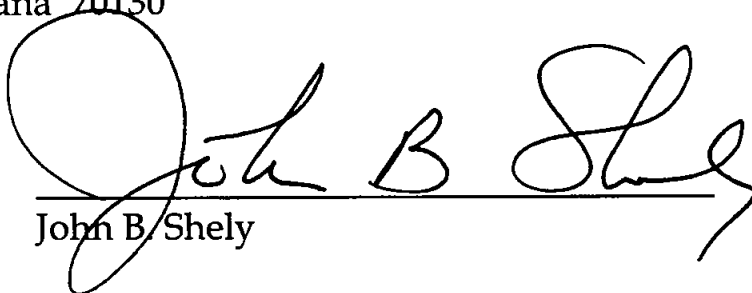
I hereby certify that on October 25th, 2001, two copies of the foregoing Appellant's Brief, in written form, and one copy in electronic computer readable form on a 3.5 inch disk in WordPerfect for Windows 9, labeled in accordance with 5TH CIR. R. 31.1, were served by Federal Express upon the following counsel of record:

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In addition, I hereby certify that on October 25th, 2001, seven copies of the foregoing brief, in written form, and one copy in electronic computer readable form on a 3.5-inch disk in WordPerfect for Windows 9, labeled in accordance with 5TH CIR. R. 31.1, were sent by Federal Express to the Clerk of the Fifth Circuit:

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CERTIFICATE OF COMPLIANCE

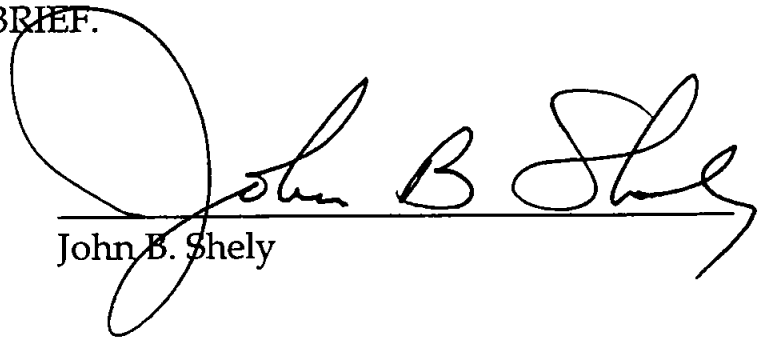
Pursuant to 5TH CIR. R. 32.2.7(c) (now 5TH CIR. R. 32.3 & FED. R. APP. P. 32(a)(7)(C)), the undersigned certifies this brief complies with the type-volume limitations of 5TH CIR. R. 32.2.7(b) (now FED. R. APP. P. 32(a)(7)(B)) and 5TH CIR. R. 32.3).

1. EXCLUSIVE OF THE EXEMPT PORTIONS IN 5TH CIR. R. 32.2.7(b)(3) (now 5TH CIR. R. 32.2 & FED. R. APP. P. 32(a)(7)(B)(iii)), THE BRIEF CONTAINS 11,628 words.

2. THE BRIEF HAS BEEN PREPARED in proportionally spaced typeface using WordPerfect 9 in Book Antiqua 14 pt.

3. THE UNDERSIGNED HAS PROVIDED AN ELECTRONIC VERSION OF THE BRIEF TO THE COURT AND OPPOSING COUNSEL.

4. THE UNDERSIGNED UNDERSTANDS A MATERIAL MISREPRESENTATION IN COMPLETING THIS CERTIFICATE, OR CIRCUMVENTION OF THE TYPE-VOLUME LIMITS IN 5TH CIR. R. 32.2.7 (now 5TH CIR. R. 32.2 & FED. R. APP. P. 32(a)(7)(B)), MAY RESULT IN THE COURT'S STRIKING THE BRIEF AND IMPOSING SANCTIONS AGAINST THE PERSON SIGNING THE BRIEF.



John B. Shely