

Chapter 37

Liability of Managed Care Organizations

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Our chapter in the sixth edition of this text contained a discussion and commentary on the exposure of managed care entities to liability arising out of claims revolving around medical care and treatment brought by HMO and PPO plan participants and beneficiaries. This writing is intended as an update and supplement to that chapter, and thus, will traverse the latest developments in this area of law.

ROARK v. HUMANA, INC.

The previous version of this text discussed the findings and implications of the Fifth Circuit case, *Roark v. Humana, Inc.*¹ In that case, the similar claims of four individuals were consolidated in order to effectively break down the question of federal preemption under the language of the Employee Retirement Income Security Act of 1974 (“ERISA”)² as it applied to issues of liability surrounding managed care entities and arrangements covered by that federal scheme.

Congress’s stated purpose behind the enactment of ERISA was to “protect . . . the interests of participants in employee benefit plans and their beneficiaries by outlining substantive regulatory requirements for employee benefit plans and to provide for appropriate remedies, sanctions, and ready access to the federal courts.”³ With this purpose in mind, the guidelines created by the ERISA scheme ensure that those charged with the duty of regulating applicable plans could rely on a uniform regulatory scheme to guide their efforts. ERISA includes extensive preemption provisions that are intended to ensure that employee benefit plan regulation remains a matter of exclusive federal concern.^{4,5} Therefore, issues arise when plaintiffs rely on claims that fall outside those specifically enumerated by ERISA, instead relying on common law or state statutory claims, and defendant managed care organizations attempt to remove these claims to federal courts.

Plaintiffs Calad and Davila each originally brought suit under the Texas Health Care Liability Act (“THCLA”).⁶

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Under §88.002 of THCLA, “a health maintenance organization . . . has the duty to exercise ordinary care when making healthcare treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.”⁷

Juan Davila was a participant, and Ruby Calad a beneficiary, in ERISA-regulated employee benefit plans. Davila and Calad each alleged, under the Texas statute, that defendants’ refusal to cover the requested services violated their “duty to exercise ordinary care when making health care treatment decisions,” and that these refusals proximately caused their resultant injuries.⁸

Mr. Davila’s difficulties with Aetna began when his treating physician prescribed Vioxx for his severe arthritis pain. Davila had previously had been a polio patient and, as a result, had a predisposition for digestive problems.⁹ Because of indications that Vioxx caused fewer incidents of negative digestive side effects than other medications, Davila’s physician recommended the drug. Aetna, however, mandated that in order for his pharmacy claim to eventually be covered, Davila would have to enter its “step program.” The program required that Davila first try two different, less expensive medications, and if and when he suffered a “detrimental reaction” to the medication or “failed to improve,” Aetna would reconsider his claim, more than likely allowing the Vioxx.¹⁰ Davila did not appeal or contest Aetna’s decision at the time. He did not purchase the medication with personal funds and seek reimbursement. Instead, he sought to comply with the “step program.”¹¹

After a few weeks of using one of the alternative pain relievers, Davila was taken to the emergency room. Doctors found that Davila was suffered from bleeding ulcers that had nearly caused him to have a heart attack. As a result, he required a massive transfusion and was in critical care for a period of 5 days.¹²

The facts of Ruby Calad’s case mirrored that of Davila’s. Calad was a beneficiary under a CIGNA Healthcare plan when she underwent a hysterectomy that included rectal, vaginal, and bladder repair.¹³ While Calad’s physician

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recommended an extended hospital stay, the CIGNA discharge nurse determined that Calad did not meet the requirements for such a stay, and Calad was discharged after the plan's standard one-day recovery period.¹⁴ After only a few days, Calad was forced back into the emergency room as a result of postsurgical complications.

Calad and Davila brought separate suits in the Texas State Court against the petitioners, alleging violations of standard of ordinary care laid out in THCLA (the Texas Healthcare Liability Act).¹⁵ The defendant HMOs petitioned to have the cases removed to federal courts, arguing that the plaintiff's causes of action fit within the scope of, and were therefore preempted by, ERISA §502(a). The district courts agreed with the defendants, and refused to remand the cases to state court. The plaintiffs both refused to amend their state claims to fall in line with ERISA's specified §502(a) remedies, and instead filed appeals of the district courts' refusals to remand with the Fifth Circuit. At the appellate level, Davila and Calad's cases were consolidated with the cases of plaintiffs Walter Thorn and Gwen Roark, who were claimants against their own managed care entities (but with distinguishable claims) in the case of *Roark v. Humana, Inc.*¹⁶

The Fifth Circuit found that Calad and Davila had complied with the "well-pleaded complaint rule," in pleading their claims in the state forum, but recognized that certain statutes carry such preemptive power as to remove them to the federal jurisprudence even in the face of adequate pleading.¹⁷ The Fifth Circuit noted that ERISA is one of these powerful statutes. After a base analysis, the *Roark* court found that the ability to preempt the claims of Calad and Davila would only possibly be found in two specific causes of action, found in ERISA §502(a)(2) and/or ERISA § 502(a)(1)(b).¹⁸

Roark: ERISA §502(a)(2)

The language of ERISA §502(a)(2) allows a plan participant or beneficiary to sue "for appropriate relief under section 1109 of this title." Section 1109(a) in turn provides:

*Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this sub-chapter shall be personally liable to make good to such plan losses to the plan resulting from each such breach.*¹⁹

The language under this ERISA remedy specifically grants an ERISA-covered plan participant or beneficiary a remedy against a plan fiduciary for a breach of fiduciary duty to the plan. In order to answer the question of whether the defendants were acting as fiduciaries when each had denied the respective plaintiff coverage, and therefore whether the resultant claims were targets for preemption under §502(a)(2), the court of appeals looked to *Pegram*²⁰ for answers.

In that case, the plaintiff, Cynthia Herdrich, was a patient of Dr. Pegram through her HMO.²¹ After early tests confirmed the appearance of a suspicious mass in the plaintiff's abdomen, Dr. Pegram stalled instead of ordering an immediate ultrasound. During the 8 days that Herdrich was waiting

for her ultrasound, her appendix ruptured, causing peritonitis.²² Herdrich attempted to sue her HMO in state court on a theory of vicarious liability for her doctor's erroneous decision-making, claiming fraud arising out of state law.

Upon the defendant's contention that the plaintiff's cause of action was preempted by ERISA, the court granted a motion removing Herdrich's case to federal court. Herdrich amended her complaint in attempts to place it under the scope of ERISA §502(a)(2). She alleged that provision of medical services under the terms of the defendant HMO organization, which entitled its physician owners for limited medical care, entailed an inherent or anticipatory breach of an ERISA fiduciary duty, because these terms created an incentive to make decisions in the physician's self, interest, rather than in the exclusive interests of plan participants (patients).²³ In the district court, the defendants moved to dismiss Herdrich's amended ERISA count for failure to state a claim upon which relief could be granted. This district court agreed and dismissed the case. The Seventh Circuit reversed, holding that the defendants were acting as fiduciaries when its physicians made the challenged decisions and, therefore, Herdrich's allegations were sufficient to state a claim. The Supreme Court, upon *certiorari*, reversed the Court of Appeals finding that there is no cause of action under §502(a)(2) that would permit a patient to hold his or her HMO vicariously liable for its physician's medical malpractice.

As mentioned above, §502(a)(2) is couched in terms of fiduciary duty. HMOs, as explained by the Supreme Court in *Pegram*, make three types of decisions—pure eligibility decisions ("simple yes-or-no questions, like whether appendicitis is a covered condition"²⁴), treatment decisions ("... choices about how to go about diagnosing and treating a patient's condition"²⁵), and what are known as "mixed eligibility" and treatment decisions (such as "whether one treatment option is so superior . . . and needed so promptly, that a decision to proceed would meet the medical necessity requirement"²⁶). Claims regarding the aforementioned mixed eligibility decisions (such as the decision that arguably resulted in Herdrich's injuries) were found in *Pegram* to not fall within the scope of §502(a)(2).²⁷ Even though there were differences between the two cases (Herdrich sued under a theory of HMO's vicarious liability for erroneous decision-making by plan doctors and Calad and Davila attacked their HMOs directly for their own erroneous decision-making), the *Roark* court found this distinction to be negligible. Using *Pegram* as controlling precedent, the Fifth Circuit held that Calad and Davila's claims could not be preempted by §502(a)(2).

Roark: ERISA §502(a)(1)(B)

As explained above, the Fifth Circuit had made the determination that plaintiffs' claims could only be preempted under two ERISA causes of action. The second was §502(a)(1)(B). Section 502(a)(1)(B) allows a plan participant or beneficiary to bring a civil action "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.”²⁸ This section creates a practical go-to for HMO participants in cases where it may be claimed that a covered managed care entity has failed to adhere to the terms of their policies and, therefore, wrongfully denied benefits. The difficulty in attempting to preempt under this section was apparent: the causes of action allowable under ERISA’s §502(a)(1)(B) are grounded in contract fundamentals, but Davila and Calad were seeking damages arising from tort liability. Instead of deciding issues of breach, interpretation, and inclusion or exclusion of services, Davila and Calad were attempting to invoke an “external, statutorily imposed duty of ordinary care.”²⁹

In its discussion of §502(a)(1)(B), the *Roark* court attempted to break through some conflicting interpretations of ERISA. In *Pilot Life Ins. Co. v. Dedeaux*,³⁰ the Supreme Court indicated that the remedies listed in §502(a)(1)(B) were exclusive; that being the case, the purpose of ERISA would be completely undermined if a potential plaintiff were able to utilize a remedy under state law that was purposely excluded under federal statute. The *Roark* court expressly noted that “ERISA provides no cause of action for medical malpractice claims against an HMO. . . . The result ERISA compels us to reach means that [plaintiffs] have no remedy, state or federal, for what might have been a serious mistake.”³¹ In light of *Pilot Life* as controlling precedent, it would seem that the Fifth Circuit’s proper course of action would have been to affirm the removal, refuse to remand, and endorse the dismissals of both Calad’s and Davila’s case as in *Pegram*. However, the Supreme Court’s discussion of *Ingersoll-Rand Co. v. McClendon*³² in *Rush Prudential HMO, Inc. v. Moran*³³ steered the Fifth Circuit in a completely opposite direction.

In *Rush Prudential*, the court reviewed its holding in *Ingersoll-Rand*, which involved a Texas statutory scheme that in all aspects duplicated an ERISA remedy, with the only difference being that the Texas scheme offered an action for damages where ERISA allowed only an equitable remedy. The Texas law was held to be preempted by ERISA as it was incompatible with the federal scheme. The *Roark* court translated this holding into a very simple rule: states may not duplicate causes of action listed in ERISA §502(a).³⁴ This rule seemed to limit preemption possibilities to near or exact duplication of state common law or statutory claims. Thus, as noted above, because ERISA offers no express remedies for breaches of the ordinary duty of care, the *Roark* court felt that the debated THCLA provision, unlike the statute in *Ingersoll-Rand*, did not create a duplicate cause and therefore should not have been preempted.³⁵ On this basis, the district court’s decisions regarding Calad and Davila’s claims were vacated and remanded.³⁶

AETNA HEALTH INC. v. DAVILA³⁷

The Supreme Court received the case on writs of certiorari in mid-2004 only on behalf of claimants Calad and Davila; *Roark*’s cause was disposed of before reaching the Supreme Court, and apparently did not find the Fifth Circuit’s reasoning to be very sound. In a unanimous opinion written

by Justice Thomas, the court disagreed with the Fifth Circuit, and held that both Calad and Davila’s causes of action fell within the scope of, and were therefore completely preempted by, §502(a)(1)(B). For that reason, the cases had been properly removed to district court.³⁸

The Supreme Court reviewed the two possible ERISA sections under which the Fifth Circuit had determined the plaintiffs’ causes of action could possibly fall. Thompson ratified the court of appeals conclusion concerning §502(a)(2); the claims asserted by the plaintiffs were “mixed eligibility and treatment decisions” and, thus, were not fiduciary in nature.³⁹ At the Supreme Court level, the defendants conceded that the plaintiff’s causes of action did not fit under this section for purposes of preemption, and for that reason, the discussion was limited to §502(a)(1)(B).⁴⁰

As stated above, the Fifth Circuit interpreted the holdings in *Ingersoll-Rand Co.*⁴¹ and *Rush Prudential* to stand for the proposition that complete preemption is limited to situations in which “States . . . duplicate the causes of action listed in ERISA §502(a).”⁴² The Supreme Court, however, used the language of *Pilot Life* to define ERISA’s preemption power in a much broader light.⁴³ As the court said in *Pilot Life*⁴⁴:

The detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in §502(a) of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.⁴⁵

As a result, the court placed massive preemption power on §502(a), stating, “[A]ny cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted.”⁴⁶ Of course, the language presented here was substantially more preemptively magnetic than the rule that *Roark* noted in *Pilot Life*.⁴⁷

In applying the preemption question to the cases of Calad and Davila, the court found that while the language of §502(a)(1)(B) seemed to cover only the contractual benefits of any underlying ERISA-covered plan, the fact that Calad and Davila claimed a tortious violation of the duty of ordinary care was merely artful pleading.⁴⁸ In both of the plaintiffs’ scenarios, their respective doctors made recommendations for treatment that were not covered by their HMOs. The Supreme Court explained that in the case of a denial of treatment, an HMO participant may have several options. These options include the possibility of seeking contemporaneous appeal of the denial of coverage

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or obtaining a preliminary injunction; as a third option, a patient can decide to undertake the expense of the treatment and then attempt to seek reimbursement for it later. If either plaintiff had taken advantage of any of these options, a claim may have been brought under the language of §502(a)(1)(B) to recover for benefits inappropriately denied. The court determined that “if an individual, at some point in time, could have brought his claim under ERISA §502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely preempted by ERISA §502(a)(1)(B).”⁴⁹

The circumstances surrounding the injuries incurred by the plaintiffs, according to the court, were merely a result of denials of coverage that may have been proper under the terms of each plan in question. Therefore, according to the court’s interpretation, the plaintiffs *could* have brought claims under §502(a)(1)(B), and might have avoided injury.

The court went on to say that, while THCLA does impose a duty on managed care entities to exercise ordinary care in making treatment decisions, and may allow damages where there is a breach of that duty, “. . . if a managed care entity had *correctly* concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity’s denial of coverage would not be a proximate cause of any injuries arising from the denial.”⁵⁰ On that basis, managed care entities are exculpated in cases where damages occur as a result of failing to authorize treatment that is not covered by the plan. There is simply no duty on the part of managed care entities to create a contractual obligation where none exists.⁵¹

Therefore, the court determined that the real meat of both plaintiffs’ claims was a search to rectify a wrongful denial of benefits promised under ERISA-regulated plans. As there was no legal duty independent of those plans invoked, as dictated by the rule above, the plaintiffs’ causes of action were found to be completely preempted by ERISA §502(a)(1)(B) and, hence, properly removed to federal district court.^{52,53}

With this holding, the distinction between “pure” eligibility claims versus “mixed” eligibility claims has been, for the purposes of ERISA preemption, erased from existence. Following *Davila*, situations in which a member of an ERISA-covered plan suffers harm due to an HMO’s decision that the treatment is not medically necessary (and hence, not covered by the plan), will not survive ERISA preemption. More importantly, as a result, plaintiff’s remedies will be limited to those found within the confines of ERISA, i.e., only the cost of the benefit denied.

IMPLICATIONS

The result of the holding in *Davila* has thus far proven to limit plaintiffs’ claims against managed care entities. Causes of action that might normally manifest as a result of a managed care entity’s negligent treatment decisions are preempted by the Supreme Court’s broad grant of ERISA preemption power and limitation of remedies. Texas’s THCLA and other statutory schemes with the same basic purpose of preventing negligent conduct by managed

care entities have been substantially weakened in their applicability.⁵⁴ The result to plaintiffs is detrimental; because ERISA remedies slide the possibility of extracontractual damages from the table, a plaintiff who has been injured as a result of a managed care entity’s negligence (in relation to an ERISA-covered plan) can never be made “whole.”

Parenthetically, Justice Ginsberg took the opportunity to discuss this important issue in her *Davila* concurrence. She noted that while the court had made the correct decision regarding the preemption, the holding left something of a “regulatory vacuum” in which virtually all state law remedies were preempted but plaintiffs were not left with any federal alternatives.⁵⁵ Ultimately, Ginsberg left the question of how a plaintiff can eventually remedially be “made whole” to legislators for future consideration.

SUBSEQUENT CASE LAW

Since *Davila*, the federal appellate courts have adopted the Supreme Court’s interpretation of ERISA preemption without much dissent. In *Cicio v. Does*,⁵⁶ the Second Circuit Court of Appeals followed the Supreme Court’s reasoning to the letter, determining that ERISA preemption extended to New York State medical malpractice claims against a managed care entity that failed to approve an experimental treatment request for a “tandem double transplant.” The Fifth Circuit’s decision in *Mayeux v. Louisiana Health Services Indemnity Co.*⁵⁷ mirrored the Second Circuit’s interpretation when it preempted a claim based on Blue Cross-Blue Shield’s failure to approve an experimental “High Dose Antibiotic Treatment” regimen.

While suits brought by participants of ERISA-covered plans have been forced to suffer the slings and arrows of preemption as a result of *Davila*, there still remain a few small categories of plaintiffs who may, theoretically, be able to find full relief by asserting common law or state statutory claims. Because certain types of plans are statutorily exempt from ERISA, including governmental plans (including plans sponsored by a state or local government for its own employees),⁵⁸ plans sponsored through a church,⁵⁹ or plans maintained solely for purposes of compliance with state workers’ compensation, unemployment compensation, or disability insurance laws⁶⁰, individuals may, under state or common law, sue these plans in order to recover damages that would otherwise have been limited by ERISA. This freedom to remain in state court also applies to suits brought by those who purchase their insurance plans individually, rather than as part of an employee benefit package.

Evidence that claims against a managed care entity may correctly continue to dwell in state court when brought by the appropriate plaintiff lies in the case of *Kotler v. PacifiCare of California*.⁶¹ Patient-plaintiff Steven Kotler, a freelance writer and presumed individual plan participant, brought actions alleging breach of contract and breach of the implied covenant of good faith and fair dealing against his HMO for “unreasonably delaying [the] authorization for necessary referral . . . to a specialist, and by ultimately referring him to an infectious disease specialist who saw

HMO patients only once a week.”⁶² The state appellate court reversed a finding of summary judgment in favor of the defendant HMO, noting that “[t]he obligations of contract—here, to provide plaintiff with medically necessary services of specialists, as authorized by the primary care physician—must be performed either at a time the contract specifies or *within a reasonable time*.”⁶³ After raising the existence of this extracontractual duty, the court found that “a triable issue existed as to whether or not [the defendant] had fulfilled its implied-in-law obligation.”⁶⁴ Seemingly, even in the face of *Davila*, an HMO is not completely invulnerable to bringing state claims. The *Kotler* decision marks the continued possibility of finding windows through which managed care entities can be targeted outside of ERISA.

Moreover, in order to reach the increasingly better-secured pockets of managed care entities, claims have become progressively more diverse and “imaginative.” One notable example has arisen as recently as February 2006 in Florida’s Seventh Judicial Circuit.⁶⁵ The plaintiff health plan participant⁶⁶ in that litigation alleged that his insurer retaliated against him (after the filing of an insurance fraud complaint with the State of Florida Department of Finance) when an agent/representative of the insurer called 911 emergency services to allegedly notify police that “[Plaintiff] was inside his home, armed with a gun, and threatening suicide!”⁶⁷ Following an altercation that left the plaintiff’s home surrounded by police and thoroughly searched by the same,⁶⁸ the plan participant and his wife filed a four-count complaint alleging (1) negligence; (2) breach of fiduciary duty; (3) outrageous conduct causing severe emotional distress; and (4) defamation.⁶⁹

Whether or not the plaintiffs’ claims will survive on the basis of these facts remains to be seen as of this writing, but it is known that the defendants are of the belief that no duty existed that would give rise to the asserted negligence.⁷⁰ Should the Florida court come to a contrary decision, it is undoubted that the impact of this case and others like it will be visible and controversial at the appellate level, and the answer to the question of “Can I sue my HMO?” will be further contorted and answerable in the positive only in increasingly particular situations.

FEDERAL LEGISLATION

The history of such legislation has been in “fits and starts.”⁷¹ Currently pending in Congress are S. 1012 and H.R. 2259. These two bills pertain to patients’ rights legislation, and would provide patients with the right to have adverse coverage decisions by health maintenance organizations reconsidered through a system of internal and external review. S. 1012 was referred to the Senate Finance Committee and H.R. 2259 to the subcommittees of the House Committees on Energy and Commerce, Education and the Workforce, and Ways and Means.⁷²

CONCLUSION

Up until the cases decided by the Supreme Court in *Calad* and *Davila*, it seemed reasonable to assert a cause of action

against a managed care entity, under ERISA, or not, for common law negligence arising out of the care or treatment of a plan enrollee. With the court’s pronouncements, it seems fairly certain, absent legislative intervention, that most allegations against a plan will be interpreted as administrative actions subject to ERISA and its damages “cap,” i.e., the loss of the benefit denied. The prognosis for legislative intervention, at the federal level, to amend the ERISA law to “trump” the holdings in *Calad* and *Davila* seems remote at best, particularly given the administration in office until at least the elections in 2008, and the emphasis in Congress on other issues. As of this writing as well, efforts continue to place restrictions on pursuing medical negligence claims at the federal level,⁷³ so efforts to expand, rather than limit, claims in the area of medical negligence are presently quite remote.

Endnotes

1. 307 F. 3d 298, 2002 U.S. App. LEXIS 19139, 29 Employee Benefits Cas. (BNA) 2612 (2002).
2. 29 U.S.C. §1001 et seq.
3. 542 U.S. 200 at 209, citing 29 U.S.C. §1001(b).
4. *Id.*, citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 532, 68 L. Ed. 402, 101 S.Ct. 1895 (1981).
5. See 29 U.S.C. §1144 (2000) (“the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”).
6. Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001–88.003.
7. *Id.* at §88.002.
8. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204, 124 S.Ct. 2488, 2492, 159 L. Ed. 2d 312, 324 (2004).
9. 307 F. 3d at 303.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Roark v. Humana, Inc.*, 307 F. 3d 298, 302, 2002 U.S. App. LEXIS 19139 at *2 (2002).
14. *Id.*
15. *Supra* note 6.
16. The Fifth Circuit consolidated the suits of Ruby Calad and Juan Davila with the suits of plaintiffs Walter Thorn and Gwen Roark, whose actions against their respective managed care organizations were parallel to the suits of Calad and Davila. The district court dismissals of the suits of Thorn and Roark were affirmed in the Fifth Circuit, and therefore their claims will not be considered or analyzed in this writing.
17. 307 F. 3d at 304.
18. 29 U.S.C. §1132(a).
19. 29 U.S.C. §1109(a).
20. *Pegram v. Herdrich*, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S.Ct. 2143 (2000).
21. *Id.* at 215.
22. *Id.*
23. *Id.* at 215–216.
24. *Pegram*, 530 U.S. at 228.
25. *Id.*
26. *Id.* at 228–229.
27. *Id.* at 231–232.

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28. 29 U.S.C. §1132(a)(1)(B).
29. 307 F. 3d at 310.
30. 481 U.S. 41, 95 L. Ed. 2d 39, 107 S.Ct. 1549 (1987).
31. 307 F. 3d at 309.
32. 498 U.S. 133, 112 L. Ed. 2d 474, 111 S.Ct. 478 (1990).
33. 536 U.S. 355, 153 L. Ed. 2d 375, 122 S.Ct. 2151 (2002).
34. 307 F. 3d at 311.
35. *Id.*
36. *Id.*
37. *Supra* note 8.
38. 542 U.S. at 204.
39. 542 U.S. at 206, citing 307 F. 3d at 307–308.
40. *Id.* at n. 1.
41. *Supra* note 32.
42. 307 F. 3d at 310–311.
43. “Nowhere in *Rush Prudential* did we suggest that the preemptive force of ERISA §502(a) is limited to a situation in which a state cause of action precisely duplicates a cause of action under ERISA §502(a).” 542 U.S. at 216.
44. *Supra* note 30.
45. 542 U.S. at 208–209, quoting *Pilot Life Ins. Co.*, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S.Ct. 1549 (quoting *Russell*, 473 U.S. at 146, 87 L. Ed. 2d 96, 105 S.Ct. 3085).
46. 542 U.S. at 209.
47. The Supreme Court also pointed out that the similarity between the language of ERISA §502(a)(1)(B) and the language of the Labor Management Relations Act, 1947 (LMRA). The LMRA was found to convert state causes of action into federal ones for the purposes of removal; LMRA’s similarity to ERISA lent ERISA the same level of preemption power. (*See Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557, 20 L. Ed. 2d 126, 88 S.Ct. 1235 (1968).)
48. 542 U.S. at 213.
49. *Id.* at 210.
50. *Id.*
51. *Id.*, citing THCLA §88.002(d).
52. *Id.* at 213.
53. The plaintiff/respondents other arguments, regarding the court’s interpretation of *Pegram* and state regulation of insurance, were similarly unsuccessful.
54. In addition to Texas’s THCLA, several other states have enacted managed care liability laws. These include Arizona, California, Georgia, Louisiana, Maine, New Jersey, Oklahoma, Washington, and West Virginia. *See* Ariz. Rev. Stat §20-3153; Cal. Civ. Code §3428(a); Ga. Code Ann. §51-1-48; La Rev. Stat. Ann. §22:3085; Me. Rev. Stat. Ann. tit. 24-A, §4313; N.J. Stat. Ann. 2A:53A-33; Okla. Stat. tit. 36 §6593; Tex. Civ. Prac. & Rem. Code §88.002; Wash. Rev. Code Ann. § 48.43.545; W. Va. Code Ann. §33-25c-7.
55. 542 U.S. at 222.
56. 385 F. 3d 156 (2004).
57. 376 F. 3d 420 (2004).
58. *See* 29 U.S.C. §1002(b)(1).
59. *See* 29 U.S.C. §1003(b)(2).
60. *See* 29 U.S.C. §1003(b)(3).
61. 126 Cal. App. 4th 950, 24 Cal. Rptr. 3d 447 (2005).
62. *Id.* at 954.
63. *Id.* at 956 (emphasis added).
64. *Id.*
65. This case is still in the trial phase and is therefore unpublished. It is docketed in the Volusia Circuit Court as 2005-32153 CICI *Charles Williams, et al v. Blue Cross/Blue Shield of Florida Insurance Company*.
66. The participant/insured’s wife is also listed as a plaintiff in the matter.
67. *Williams* Complaint at p. 2.
68. The complaint further specifically alleges that police searched the plaintiff’s “underwear drawers” and automobiles (*Williams* Complaint at p. 2).
69. As of the writing of this chapter, defendant’s motion to dismiss is pending before the Circuit Court of Volusia County.
70. The defendants have further denied the existence of a fiduciary relationship in the context at bar, and further argue the nonexistence of outrageous conduct that could give rise to an intentional infliction of emotional distress claim under Florida law.
71. *See* M. J Zaremski, ch. 36, *Liability of Managed Care Organizations* 391–393 in *Legal Medicine* 6th ed. (Mosby, 2004).
72. “Washington Letter” 29 42(1) American Bar Association (Jan. 2006).
73. Senator Frist intended to call up S. 354 for debate and passage in May 2006, for example. This bill would “cap” noneconomic damages in medical negligence cases. The prospects of passage, as of this writing, remained doubtful.