IN THE SUPREME COURT OF FLORIDA

CASE NUMBER SC01-1397
L.T. NUMBER: 3D00-1509

ROLANDO VILLAZON, as Personal Representative of the Estate of SUSAN COHEN VILLAZON, deceased,

Petitioner,

vs.

PRUDENTIAL HEALTH CARE PLAN, INC.,

Respondent.

ON PETITION FOR REVIEW OF A DECISION FROM THE THIRD DISTRICT COURT OF APPEAL

BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS AS AMICUS CURIAE

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Statement of Interest of the American Association of Health Plans

The American Association of Health Plans, Inc. ("AAHP") is the national association for the managed care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. AAHP has appeared as *amicus curiae* in a number of cases involving the managed care industry, including cases where issues under the Employee Retirement Income Security Act ("ERISA") and managed care plans are involved.

This case presents the important issue of whether the benefit design of an ERISA health plan can serve as a basis for establishing vicarious liability for the alleged negligence of independent contractor physicians who provide services to the plan participants. Such claims, if permitted to proceed, would potentially impose strict liability on the administrator of any plan whose terms of coverage include certain core managed care elements. These "core elements" include service benefits (the provision of benefits in the form of services from participating health care providers), the coordination of referrals by primary care physicians, and prior authorization and utilization review for covered health benefits. Administrators would be liable for negligent treatment by independent contractor physicians whether or not their implementation of these core elements of plan coverage led to the negligent treatment or adverse outcome at issue. Such a conclusion would erode certain ERISA plan managed care coverage

options with a corresponding rise in health benefit costs and reduction in choices for employer purchasers and plan participants alike. This outcome contravenes an important purpose of ERISA: to encourage the establishment and maintenance of employee benefit plans whose administration is governed by federal law rather than a multiplicity of state statutory and common laws. This Court should affirm ERISA's preemption of the Petitioner's vicarious liability claims in this case.

AAHP is familiar with the variety and complexity of various health benefit designs and their cost implications through the diversity of its member plans. AAHP also understands the relationship between federal preemption principles and state law liability claims and how they operate in the managed care plan context. AAHP believes that its input can be of assistance to the Court in resolving the issues in this case as the outcome will have a significant impact on the design and availability of health plan benefit options in Florida.

Statement of the Case and Facts

AAHP adopts the Statement of the Case and Facts as set forth in Respondent's Brief.

Summary of Argument

Based on the record, both lower courts in this case have properly determined that Petitioner's claims against Respondent are preempted by Section 514(a) of ERISA because the claims directly relate to plan structure and administration. Petitioner attempts to hold Respondent vicariously liable for the alleged malpractice of independent contractor physicians, and particularly a participating primary care physician, Dr. Sarnow, on the basis that Respondent had the right to control the physician. In support of these claims, Petitioner refers to and relies upon certain core benefit provisions of the employer's health

benefits plan as reflected in the terms and conditions of Dr. Sarnow's participation agreement with Respondent.

Petitioner has attempted to convert core elements of the health plan's coverage into indicia of a right of control by Respondent that renders it liable for every clinical judgment made by an independent contractor physician in his or her own office. Those elements include the coverage of non-emergency health care services furnished or arranged by participating providers, the provision of services by or upon the referral of the participant's chosen primary care physician, the entitlement to certain benefits based on prior authorization requirements, and the condition that the service or supply comport with certain utilization review requirements.

Fundamentally, Petitioner's cause of action is based on core managed care elements that are integral to the terms of coverage for the ERISA plan maintained by Ms. Villazon's employer and administered by Respondent. Under ERISA, Section 514(a) supersedes any and all state laws which relate to any employee benefit plan. This includes the state common law vicarious liability claims asserted by Petitioner, which specifically refer to and rely exclusively on the plan terms described above. Moreover, Petitioner's claims have a connection with the ERISA plan at issue because they would alter the structure of the current plan by expanding benefits through a quality outcome guarantee, and by altering the independent contractor relationships with participating physicians that were identified in the plan.

The fact that these basic terms of plan coverage were also reflected in Dr. Sarnow's primary care physician participation agreement underscores the nexus between plan benefit design and ERISA preemption principles. A service benefit plan, whose coverage is conditioned upon the plan participant's receipt or

authorization of services from participating physicians, can only be administered through contracts with physicians. In this case, all the terms of the physician agreement relied upon by Petitioner for Petitioner's vicarious liability claims are terms of the health benefits plan maintained by Ms. Villazon's employer.

To convert plan terms and their administration into strict liability for the clinical judgments of independent contractor physicians, regardless of circumstances, would severely limit the availability of benefit plans that provide managed care coverage. As such, a finding contrary to the lower courts' decisions would have a significant adverse effect on the cost and availability of employee health benefit plans in Florida.

In today's health care marketplace, with increased employment layoffs, an unrelenting rise in the cost of health care services, and an ever-increasing uninsured population, the consequences of such a judgment would be particularly detrimental. Employers and employees already are experiencing the brunt of rising health care costs as premiums rose by 11% from 2000 to 2001 after increasing over 8% from 1999 to 2000. *See* The Henry J. Kaiser Family Foundation, Employer Health Benefits, 2001 Annual Survey, Sept. 5, 2001, 12 ("Kaiser Survey"); *see also* Katherine Levit et al., *Inflation Spurs Health Spending in 2000*, Health Affairs, Jan./Feb. 2002, 178 (citing a rise in premiums of 6.8% in 1999 and 8.4% in 2000). Moreover, the return of health care hyperinflation takes a devastating toll as every one-percent increase in premium costs adds 300,000 more Americans to the ranks of the uninsured. *See* AAHP, *Health Plan Liability: What You Need to Know*, Mar. 2001, 5 (citing statistics by Lewin Group LLC, Feb. 1999).

A decision affirming the rulings of the lower courts in this case will not limit or diminish the remedies now available under Florida law for ERISA health

benefit plan participants who are injured by the negligent act or omission of any person. Such a decision will simply avert a new and unwarranted extension of malpractice liability to the employer sponsors, insurers and administrators of these ERISA plans based on nothing more than the terms of the plan coverage reflected in the provider contracts through which the plan is administered.

Standard of Review

As this case presents issues of law, the standard of review is *de novo*. *See Gemini Ventures of Tampa, Inc. v. Hamilton Engineering & Surveying, Inc.*, 784 So.2d 1179, 1180 (Fla. Dist. Ct. App. 2001); *Southwest Fl. Water Management Dist. v. Save the Manatee Club, Inc.*, 773 So.2d 594, 597 (Fla. Dist. Ct. App. 2000).

Argument

I. Petitioner's Claims Are Directed At Provisions of an ERISA Plan

In establishing employee health benefit plans, employers may select from a range of benefit designs and combinations. Under indemnity plans, those eligible for benefits can seek care from the provider of their choice and receive a fixed sum payment for health care expenses covered by the plan. *See* Kenneth R. Wing et al., The Law and American Health Care 79 (1998). Under service benefit plans, as is the case here, health care providers directly contract with the plan's insurer, administrator or sponsor to deliver the covered services to plan participants and beneficiaries. These contracting providers accept the plan's reimbursement as the total payment for health care services provided. *See* Peter R. Kongstvedt, The Essentials of Managed Health Care, Second Edition, 37, 554 (1997).

Over the last 30 years, variations on the service benefit plan model were developed to help control the escalating costs of health care. Plan benefits may be limited, except in case of an emergency, to covered services furnished by contracting providers. *See id.* at 542. This benefit design, which is characteristic of health maintenance organization or "HMO" plans, may also have the added feature of a participating primary care physician selected by the plan participant who is responsible for authorizing the use of covered health care services and making referrals to specialists. *See id.* at 39. Overall, HMO plans continue to provide a more affordable coverage option for employers and employees alike as the average monthly cost of family coverage under an HMO plan is about $100 less than conventional indemnity coverage. *See* Kaiser Survey at 13.

Other service benefit plans are more open and have different premium cost structures as a result. For example, under a Point of Service option or "POS" model, an HMO enrollee may obtain covered health care services from either a participating provider or a provider outside of the contracted network. In addition, preferred provider organization or "PPO" plans facilitate the choice of out-of-network providers as well. The use of an out-of-network provider in either a PPO or POS plan generally requires the plan participant to incur higher out-of-pocket costs. *See* Kongstvedt at 552. Some of these plans may require a participating primary care physician's referral for coverage of services provided by out-of-network providers, while others do not.[1]

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[1] According to the 2001 AAHP Dorland Directory Database, there were 1,030 managed care companies in 2001, representing 797 HMO products, 398 POS products and 795 PPO products.

For the employee health benefit plan at issue in this case, Valdes-Fauli, Cobb, and Petrey, P.A., (the "Employer") purchased HMO service benefit coverage limited to services obtained from participating providers, and including primary care physician referral, preauthorization and utilization review requirements for obtaining certain benefits.[2] Under *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000), the United States Supreme Court defined the term "plan" under ERISA as "a set of rules that define the rights of a beneficiary and provide for their enforcement," including rules governing the definition of benefits and the resolution of issues regarding entitlement to services. The Court specifically stated that "by setting out rules under which beneficiaries will be entitled to care," "the agreement between an HMO and an employer who pays the premiums may provide elements of [an ERISA] plan." *Id.*

Further guidance on what constitutes the elements of an ERISA health benefit plan is provided in the United States Department of Labor's ("DOL") regulations governing summary plan descriptions ("SPDs") that plan sponsors must provide to plan participants. SPDs serve as "the primary vehicle for informing participants and beneficiaries about their rights and benefits under the employee benefit plans in which they participate." Amendments to Summary Plan Description Regulations, 65 Fed. Reg. 70,228 (Nov. 21, 2000) (to be codified at 29 C.F.R. Part 2520) (hereinafter "DOL Regulations"). Specifically, the DOL Regulations require that SPDs provide information on the plan's benefit eligibility rules, **including whether and under what circumstances coverage is provided for out-of-network providers; provisions governing the use of network providers; any conditions or limits on the selection of primary**

[2] Neither Petitioner nor Respondent contests that Employer's employee health benefit plan was an ERISA plan. (R. Vol. II, 207-212, R. Vol. V, 1-48).

care providers or providers of specialty medical care; and provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. *See id*. at 70,241 (emphasis added).

For the Employer's health benefits plan, the provisions identified as elements of the plan in *Pegram* and the DOL Regulations are set forth in the PruCare Certificate of Coverage. This certificate is part of the agreement between Respondent and Employer, and it defines the plan's benefits as well as sets out the rules under which beneficiaries are entitled to those benefits. *See Pegram*, 530 U.S. at 223; DOL Regulations at 70,241. According to the PruCare Certificate of Coverage, the boundaries of the plan's benefit coverage are defined by the core managed care elements referenced above.

The record demonstrates that Petitioner seeks to establish the Respondent's "right to control" contracting primary care physicians and its consequent vicarious liability for their malpractice by referring to specific provisions of Dr. Sarnow's Primary Care Physician Agreement. Yet each contract term referred to by Petitioner as evidence of a "right to control" is or directly relates to a defining element of the plan's benefit design, that by necessity, must be reflected in the contracts with participating primary care physicians. According to Petitioner, requirements to use participating physicians in order to deliver covered health care services documents the Respondent's "right to control" a contracting physician. Yet the health benefit plan at issue is fundamentally structured as a service benefit plan where only services a participant obtains from or through participating providers are covered under the terms of the plan.

Similarly, Petitioner relies on provider contract provisions concerning the primary care physician's role as the "gatekeeper" for covered services through prior authorization requirements for certain medical services and referral authority for specialty care to establish the Respondent's right to control participating physicians. Yet the primary care gatekeeper feature is an essential element of the service benefit plan's design since self-referrals by plan participants to specialists typically increase costs and are not covered by the plan.

Finally, Petitioner attempts to characterize the Medical Director's administrative responsibilities in the referral process for an out-of-network specialist, the prior approval process for certain medical services, and the establishment of coverage rules based on utilization review requirements as indications of the Respondent's right to control a participating physician. The Medical Director's functions, however, are dictated by the terms of coverage under the plan, which require the use of participating physicians and coverage of needed medical services, both in and out-of-network.

Petitioner alleges no conduct whatsoever on the part of Respondent related to Petitioner's medical negligence claims. Petitioner's vicarious liability claims rely exclusively on the plan's terms of coverage and Respondent's arrangements for administering plan coverage in an effort to create an agency relationship between the Respondent and those providers who provided treatment.

II. Petitioner's Vicarious Liability Claims Relate to an ERISA Plan and Are Therefore Preempted

Section 514(a) of ERISA provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. §1144(a). State laws as referenced in

Section 514(a) include state common law causes of action such as the vicarious liability claims asserted in this case. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39 (1990) (examining a state common law claim regarding wrongful discharge). In *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), the Supreme Court explained that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97.

Under the "reference to" test, "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co.*, 498 U.S. at 139. In particular, the Supreme Court has ruled that in cases where an ERISA plan "is a critical factor in establishing liability" under a state cause of action, the state cause of action relates "to the essence of the [] *plan* itself" and is preempted under Section 514(a). *Id.* at 140; *see California Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325-28 (1997); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

In this case, the Employer's ERISA plan is the critical foundation upon which Petitioner relies in order to establish Respondent's liability. As described above, Petitioner's vicarious liability claims relate to the essence of that particular plan -- the provisions that define plan benefits and the rules governing plan

participants' entitlement to those benefits. As in *Ingersoll-Rand Co.*, Petitioner would have no cause of action in the absence of the Employer's ERISA plan, which established and governed the relationship between Respondent, participating physicians, and plan participants. *See* 498 U.S. at 140. Thus, Petitioner's claims inescapably "relate to" an ERISA plan and are preempted by Section 514(a).

Even if Petitioner's cause of action did not expressly refer to the essential terms of the Employer's ERISA plan, it would be preempted under Section 514(a) because of its "connection with" the plan. In determining "whether a state law has [a] forbidden connection" with an ERISA plan, Supreme Court precedent focuses both on "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and the nature of the state law's effect on ERISA plans. *Dillingham*, 519 U.S. at 325 (quotations and citations omitted).

The Court found that in formulating ERISA Section 514(a), Congress intended to prevent "the potential for conflict[s] in substantive law" that would require "the tailoring of plans . . . to the peculiarities of the law of " each state jurisdiction. *Ingersoll-Rand Co.*, 498 U.S. at 142. Thus, state laws that mandate the structure of ERISA health benefits plans or preclude the provision of a uniform interstate benefit package trigger ERISA preemption. *New York State*

Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658-60 (1995).

If successful, Petitioner's vicarious liability claims would add a new benefit to the Employer's plan by mandating that Respondent or any plan administrator serve as guarantor of the quality of the care provided by contracting physicians based merely on the existence of the core managed care elements of the plan. Thus, plan participants in Florida would be entitled to benefits that are "in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States" based on the plan administrator's expanded liability exposure for quality outcomes. *Travelers*, 514 U.S. at 657-58 (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990)). In addition, Petitioner's vicarious liability claims would alter the plan's terms that all participating providers furnishing covered services are independent contractors who are exclusively responsible for the patient-physician relationship by converting all participating physicians into actual agents of the plan administrator. Thus, Petitioner's claims, if affirmed by this Court, would mandate a restructuring of the Employer's health benefits plan in this case as well as other ERISA plans in Florida with similar physician service relationships, thereby undermining the ability of employer plans to provide a uniform interstate benefit package. *See id.* at 658, 660.

Further, the Supreme Court clearly anticipated the implications of Petitioner's vicarious liability claims for the Employer's plan when it held that ERISA preemption under Section 514(a) would be triggered by state law that produces "such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Id*. at 668. Given that Petitioner's claims seek to hold administrators of ERISA plans vicariously liable for every negligent act of any participating provider based solely on the plan's benefit structure, the cost of administering such a managed care plan would increase exponentially with each vicarious liability claim. As a result, employers would be forced to adopt schemes of substantive coverage that do not contain core managed care elements in order to retain their ability to uniformly calculate benefit levels and provide a uniform benefits structure in multiple states. *See id*. at 657-60. ERISA Section 514(a) was designed to prevent such an outcome, and Petitioner's vicarious liability claims should therefore be preempted.[3]

III. There Is No Blanket Exception to ERISA Section 514(a) Preemption for Claims Characterized as "Quality of Care" or "Treatment" Claims

[3] To the extent that Petitioner relies on the same or similar terms of coverage regarding the administration and structure of the Employer's health benefits plan to establish Petitioner's non-delegable duty claim, the same ERISA preemption analysis would apply to such a claim.

The issue in this case is whether a state law vicarious liability claim premised wholly on the core managed care elements of an ERISA plan is preempted under Section 514(a). Any suggestion that merely characterizing a vicarious liability claim as a "treatment" or "quality of care" issue places it outside the scope of Section 514(a) preemption not only ignores the trial record and the nature of Petitioner's claims, but misconstrues a critical legal distinction between ERISA Section 502(a) and 514(a) as they relate to federal preemption. In this case, federal question jurisdiction under Section 502(a) of ERISA is not an issue. Thus, any preemption analysis under ERISA Section 502(a) is irrelevant because the instant case deals with the validity of the Respondent's ERISA Section 514(a) preemption defense as adjudicated by the state courts of Florida.

In *Dukes v. U.S. Healthcare, Inc*., 57 F.3d 350 (3d Cir. 1995), the court considered whether it had federal question jurisdiction under ERISA Section 502(a) over state law claims based on negligence and apparent agency raised against an HMO that provided coverage for an ERISA plan. *See id.* at 352-53, 356-57. In drawing a distinction between quality of care and benefit eligibility claims, the court held that as a jurisdictional matter, quality of care claims are not "completely preempted" by Section 502(a), but the defense of express preemption by Section 514(a) of ERISA could be properly raised and determined in state court. *See id.* at 353-54, 361 (stating that its holding "leaves open for resolution by the state courts the issue of whether plaintiffs' claims are preempted under § 514(a)"). This principal guidepost in ERISA law was reaffirmed by *In re: U.S. Healthcare, Inc*., 193 F.3d 151 (3d Cir. 1999), which held that efforts to classify a state law claim as one involving a "treatment" decision rather than "eligibility" for purposes of federal question jurisdiction under Section 502(a) did not place it in a category of claims that exists outside of the scope of ERISA's preemption. *See id.* at 162, 165.

It also has been suggested that the Supreme Court's recent decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), reinterprets the parameters of ERISA preemption in regard to "treatment" claims. However, *Pegram* actually addressed the very different question of whether the use of physician incentives in an HMO plan context violated ERISA's fiduciary requirements when applied to "mixed eligibility and treatment" decisions made by physician employees. *Id.* at 229-30.

According to *Pegram*, an eligibility decision turns on the plan's coverage of a particular condition or medical procedure for its treatment, while treatment decisions are choices about diagnosing and treating a patient's condition. *See id.* at 228. The Supreme Court found that in the case of *Pegram*, physician judgments about reasonable medical treatment could not be untangled from their benefit eligibility implications. *See id.* at 228-29. A finding that ERISA fiduciary principles applied to these decisions would have had the effect of "federalizing" state malpractice claims against the treating physicians with no real benefit to be achieved by adopting such a standard. *See id.* at 236-36. As a result, the Supreme Court concluded that ERISA fiduciary standards were not applicable to the "mixed" eligibility and treatment decisions at issue in *Pegram*. *See id.* at 231.

Pegram is, however, particularly noteworthy here for its recognition of the preservation of certain core managed care plan elements. The Supreme Court strongly rejected the application of ERISA fiduciary standards to "mixed" eligibility and treatment decisions made by physician employees on the basis that it would eliminate certain HMOs and would be inconsistent with Congress's long-standing policy to promote HMO practices. *See id.* at 232-34. The Supreme Court indicated that if Congress wished to restrict its approval of HMO practices to certain preferred forms, it may choose to do so. *See id.* at 233-34. It warned that "the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm." *Id.*

Thus *Pegram* does not shift the foundations for analyzing ERISA preemption under either Section 502(a) or Section 514(a). Instead, it cautions against judicial action that would eliminate structural alternatives in managed care settings. As a result, the legal precedent from *Dukes* to *Pegram* to the present demonstrates that the "treatment" or "quality" versus "eligibility" distinction as applied to state claims does not create a categorical bar to ERISA preemption principles. This is particularly the case here where the vicarious liability claims at issue are dependent upon the core managed care elements of the ERISA plan itself. Finally, the application of ERISA preemption in this case would have no effect on Petitioner's state malpractice claims against any of the treating providers.

Conclusion

In view of Petitioner's reliance on plan design features that define the boundaries of coverage as the basis for Petitioner's claims of vicarious liability, Respondent properly raised Section 514(a) of ERISA as a defense in the lower court proceedings. Although Petitioner characterizes his vicarious liability claims as claims regarding treatment, they are premised on an ERISA plan's core managed care elements that are prerequisites for benefits coverage. The Petitioner's attempt to rely on the primary care physician's agreement does not alter this conclusion.

If the mere existence of an ERISA plan's core managed care features becomes the basis for establishing strict liability for the outcome of every clinical judgment of a physician, plaintiffs can then launch wholesale attacks against any administrator of an ERISA plan that includes these core managed care elements. As a result, the range of benefit options available to sponsors of ERISA plans would be severely limited in Florida at a time when the need to manage the cost of health care services is particularly acute.

Both courts below reached the appropriate legal conclusion that Section 514(a) of ERISA preempts Petitioner's claims in this case because they wholly relate to the core terms of the ERISA plan administered by Respondent and would not exist in the absence of that plan. Attempts to characterize Petitioner's claims as "treatment" or "quality of care" claims that lie outside the scope of ERISA preemption under Section 514(a) should be rejected. Such characterizations are tied to federal question jurisdiction issues that are not relevant to this case. Unmasked, Petitioner's claims can best be seen as an attack premised solely on an ERISA plan's lawful structure and "untethered to claims of concrete harm," the kind of attack that the *Pegram* court cautioned the judiciary against legitimizing. *Id.* at 234. Therefore, the lower courts' decisions should be affirmed.

Certificate of Type Size and Font

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Certificate of Service

I CERTIFY that this brief and the accompanying motion were served by U.S. Mail on James C. Blecke, Esquire, Deutsch & Blumberg, P.A., New World Tower, Suite 2302, 100 North Biscayne Boulevard, Miami, FL 33132; Steven M. Ziegler, Esquire, Law Offices of Steven M. Ziegler, P.A., 4000 Hollywood Boulevard, Suite 375 South, Hollywood, FL 33021; and David J. Sales, Esquire, Searcy, Denney, Scarola, Barnhart & Shipley, 2139 Palm Beach Lakes Boulevard, West Palm Beach, FL 33402, on this fourth (4th) day of February, 2002.

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