IN THE SUPREME COURT OF FLORIDA

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

ROLANDO VILLAZON, *et al.*,

Petitioner,

vs.

PRUDENTIAL HEALTH CARE
PLAN, INC.,

Respondent.
________________________________/

AMENDED BRIEF OF THE ACADEMY OF FLORIDA TRIAL LAWYERS AS AMICUS CURIAE

Dated: January 2, 2002

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Statement of Interest of the Academy of Florida Trial Lawyers

The Academy of Florida Trial Lawyers is a voluntary statewide association of more than 4,000 trial lawyers concentrating on litigation in all areas of law. The Academy is pledged to the preservation of the American legal system, the protection of individual rights and liberties, the evolution of the common law, and the right of access to courts. The Academy has appeared as amicus curiae in hundreds of cases in the Florida appellate courts and this Court, particularly where tort law issues are concerned.

This case presents an important issue about the scope of federal regulation over Florida's tort system, more particularly the extent to which the federal Employee Retirement Income Security Act ("ERISA") preempts Florida common law claims for medical negligence. The case also asks this Court to consider, for the first time, the application of the common law doctrine of nondelegable duties to claims for medical negligence. Over the last several years, health care delivery has changed significantly. Health maintenance organizations ("HMOs") are now a significant part of the health care delivery system. Unfortunately, the pace of court decisions articulating the nature of HMO liability for medical negligence has not kept pace with the growth of HMOs. Given the prevalence of HMOs, however, the necessity for clear and precise rules in this field is obvious.

This case also raises important issues concerning the method by which personal injury plaintiffs and all other civil litigants may prove the existence of an agency relationship, and impose vicarious liability for the negligent acts of others. Florida's agency law is well-developed and succinctly summarized in the Florida Standard Jury

Instructions. The Academy believes that the opinion of the Third District Court of Appeal constitutes a departure from Florida agency law that is inconsistent with those standard instructions. If not corrected by this Court, the Third District's decision may lead to an inconsistent application of this important part of our common law.

A major focus of the practices of many of the Academy's members is the representation of plaintiffs in personal injury and medical negligence cases. Clients of the Academy's members have encountered, and will continue to encounter, the issues raised by this case. The Academy believes that its input may be of assistance to the Court in resolving the issues in this case and the outcome will have a significant impact on its members and their clients.

Summary of Argument

The most recent and authoritative decision on the question on ERISA preemption of medical malpractice claims is the United States Supreme Court's opinion in *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143 (2000) ("*Pegram*"). *Pegram* holds that state law claims for medical malpractice are preempted by ERISA only when a party challenges a decision concerning his or her "eligibility" for employer-supplied medical benefits. Claims arising out of "treatment" decisions, as well as mixed "eligibility" and "treatment" decisions, are not preempted as a matter of law.

In this medical malpractice wrongful death case, the only claim against the Respondent HMO, Prudential Health Care Plan, Inc., was that it is vicariously liable for the negligence of its member physician. Claims of vicarious liability against an HMO are not preempted as "eligibility" decisions as a matter of law. Any party arguing for ERISA preemption of a state civil action necessarily contends that there is no state court subject matter jurisdiction over that action. There is no indication

that, in passing ERISA, Congress intended to terminate state court jurisdiction for common law malpractice claims, and in particular claims for vicarious liability.

The Third District's decision appears to derive from the notion that ERISA preemption is a function of the method by which a plaintiff seeks to prove the existence of an agency relationship. Villazon sought to prove agency by resort to the agreement between the HMO and its member physician. As a result, the Third District assumed that Villazon's suit was over the administration of what it termed an ERISA "plan," which is a term of art under ERISA. This reasoning is faulty because the contractual arrangements between the HMO and its providers do not constitute an ERISA "plan" as matter of law. When a suit does not "relate to" an ERISA, "plan," the statute's preemption provisions are simply not in play.

The existence of an agency relationship (and the vicarious liability which inheres in such a relationship) depends on the right of one party (in this case, the HMO) of control over another (the provider). Under well-established precedents and Florida's Standard Jury Instructions, proof of agency does not require that a purported principal exercise actual control over another in any particular instance. Evidence of the right of control may be proven through the terms of the parties' contracts or other arrangements. A party may not avoid vicarious liability by merely labeling someone an

independent contractor. In this case, the Third District appeared to ignore these important rules by (1) failing to consider proof of a right of control contained in the agreement between the HMO and the provider, (2) demanding proof of actual control by the HMO over patient care and (3) crediting the legally insufficient labels employed by the HMO in its contracts.

The Legislature has declared that the policy of this state is to ensure that HMOs "deliver high quality health care." Florida Statutes §641.18(4)(c). To that end, the Legislature has also demanded that HMOs "*ensure* that health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with prevailing standards of medical practice in the community." Florida Statutes §641.51(1) (emphasis added). While HMOs must necessarily deliver medical care through physicians, the Legislature has required that they "ensure" that such care meets or exceeds the common law standard for non-negligent care. As a matter of law, such a duty is nondelegable. When a party charged with such an obligation fulfills it by engaging the services of a purported independent contractor, that party cannot escape liability for the negligence of the purported independent contractor.

Argument and Citations of Authority

I. ERISA Does Not Preempt State Law

Regulation of Health Care.

ERISA is a comprehensive federal statute regulating the establishment and administration of employee benefit plans. It imposes participating, funding and vesting requirements on pension plans. It sets uniform reporting and disclosure obligations for pension and employee welfare plans. It imposes fiduciary obligations on plan administrators. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91, 103 S.Ct. 2890, 2896 (1983) ("*Shaw*").

Section 514(a) of ERISA states that the statute supersedes "any and all State laws" which "relate to any employee benefit plan." 29 U.S.C. §1144(a). Certain state laws are exempt from the preemption provision, including those regulating insurance, banking or securities. *Shaw*, 463 U.S. at 92, 103 S.Ct. at 2897 (citing 29 U.S.C. §1144(b)(2)(a), (d)). The "question whether a certain action is pre-empted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45, 107 S.Ct. 1549, 1552 (1987) ("*Pilot Life*") (citations and internal quotations omitted). "[D]espite the variety of . . . opportunities for federal preeminence," the Supreme Court has "never assumed lightly that Congress had derogated state regulation, but instead [has] addressed claims of pre-emption with the starting presumption that Congress does not intend to

supplant state law." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654, 115 S.Ct. 1671, 1676 (1995) ("*Travelers*") (citations omitted). In areas of traditional state regulation, such as health care, the Supreme Court has demanded a clear expression of congressional intent before finding preemption of state law. *Id.*, 514 U.S. at 662, 115 S.Ct. 1680 ("[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.")

Thus, in *Travelers*, the Supreme Court held ERISA did not preempt a New York law requiring hospitals to collect surcharges from HMOs and certain insurers. Insurers challenging the law argued that it was preempted by ERISA because it "related to" employee benefit plans that provided health insurance. Any impact of such a law on an ERISA-covered "plan" was too "tenuous, remote or peripheral." *Id.*, 514 U.S. at 661, 115 S.Ct. At 1680. Congress "could not possibly have intended" to eliminate such a law, the Court held. *Id.*, 514 U.S. at 668, 115 S.Ct. at 1683.

Decisions of the United States Supreme Court, of course, are authoritative as to issues of federal law and they necessarily bind this Court. *See e.g., Miami Home Milk Producers Ass'n v. Milk Control Board*, 169 So. 541, 544 (Fla. 1936) ("[W]e

are of course bound by decisions of that eminent tribunal [*i.e.,* the United States Supreme Court] construing the meaning and effect of acts of Congress."); *Donald & Co. Securities, Inc. v. Mid-Florida Community Services, Inc.*, 620 So.2d 192, 193 (Fla. 2d D.C.A. 1993) ("Florida courts are bound only by the United States Supreme Court in interpreting acts of Congress."). The scope of ERISA preemption of state law and the proper interpretation of ERISA's provisions are obviously issues of federal law and the United States Supreme Court's decisions on this issue necessarily bind this Court.

II. Villazon's Claim Is Not Preempted.

A. Villazon Does Not Seek Relief for Any "Eligibility" Decision.

In *Pegram*, the Court considered for the first time the relationship between ERISA and claims for medical malpractice. Following the framework of the United States Court of Appeals in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995) ("*Dukes*"), the court held ERISA is not implicated in the realm of medical "treatment decisions," as distinct from "eligibility decisions." *Pegram*, 120 S.Ct. at 2154-2158. ERISA implicates only the fiduciary actions of an ERISA plan's administration. *Id.* When a patient challenges a decision that is "mixed"--partly a treatment decision and partly an eligibility decision--the fiduciary regulations imposed by ERISA are not in play. *Id.*

The facts of *Pegram* help place the decision in context. In *Pegram*, the patient's employer contracted with an HMO to provide medical services to its employees, one of whom was Herdrich. One of the HMO's physicians detected an inflamed mass in Herdrich's abdomen. Herdrich needed an ultrasound, but the HMO physician decided that she had to wait eight days for the test, to be performed at

another HMO facility 50 miles away. While Herdrich waited for the test, her appendix ruptured and peritonitis set in. 120 S.Ct. at 2147.

In the typical case of this sort, the parties argue over whether state law claims for malpractice, based on state principles of common law, are preempted by ERISA. Many of the federal decisions arise in the context of removed actions in which a malpractice defendant asserts that federal law, ERISA, governs a particular malpractice claim. The arguments of preemption typically relate to the defense that state common law claims are preempted. That is the case here, where the basis of the Third District's decision is that there is no subject matter jurisdiction in the trial court for Villazon's wrongful death suit against the Respondent HMO. Rather, Villazon's exclusive remedy would be under ERISA (*i.e.,* in federal court and under the "fiduciary" standards imposed by ERISA).

In *Pegram*, however, the situation was somewhat different. Herdrich sued not only on theories of common law negligence, but also on the theory that the HMO had violated its fiduciary obligations under ERISA. The Supreme Court rejected the notion that ERISA's effect is to federalize state law claims for medical malpractice. The Court's explanation for this result sheds new light on the limitations of ERISA preemption in the area of medical malpractice.

In making a distinction between "eligibility" and "treatment" decisions described above, the Supreme Court cited *Dukes* with approval. Notably, *Dukes* reversed a trial court decision finding that ERISA preempted claims of vicarious liability.[1] *Dukes* started with the proposition that an HMO is distinct and separate from an employee welfare "plan" governed by ERISA, a position with which the Supreme Court agreed. *Compare Dukes*, 57 F.3d at 357 *with Pegram*, 120 S.Ct. at 2153. The Supreme Court noted that it is frequently difficult to distinguish between the two types of decisions and that many decisions made by providers will be inextricably mixed ones. This is due to the role that providers play in making the decisions as to the level of care to be received, and because many such decisions are not ones of coverage, but "when-and-how" an HMO member will receive a covered service. 120 S.Ct. at 2154. As the Supreme Court explained,

> these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment, and in the case before us, [*i.e.*, the timing of a diagnostic test], Dr. Pegram's decision was one of that sort. She decided (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the consequence for that medical determination was that [the HMO] would not cover immediate

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[1]The Fourth District Court of Appeal cited *Dukes* with approval in *In re Estate of Frappier*, 678 So.2d 884, 887 (Fla. 4th D.C.A. 1996) ("*Frappier*") ("We agree with the factual dichotomy expressed in *Dukes* that is critical for this analysis."), to conclude that vicarious liability claims against HMOs are not preempted by ERISA.

> care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat.

Id.

Congress, the Supreme Court concluded, did not intend to extend ERISA to reach "medical necessity determinations," or "mixed eligibility decisions acting through its physicians." Because ERISA covers only "fiduciary" decisions, such decisions are beyond its reach. This result was necessary, the Court explained, because the position urged by Herdrich would have the effect of not only "replicat[ing] . . . state malpractice actions," *id.*. at 2157, it would also subject physicians to a new standard of liability (that of ERISA fiduciaries) in federal court. The Court expressed serious doubt that Congress had written such a "prescription for preemption of state malpractice law." *Id.* at 2158. As the Court noted, its earlier decision in *Travelers*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 1676 (1995), "throws some cold water on the preemption theory" because there, the Court held that "in the field of health care, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 2158. Because there is no indication that Congress ever sought to federalize medical negligence law, such claims are not preempted. *See id.* ("we know that Congress had no such haphazard boons in prospect").

In *Pegram*, the United States Supreme Court gave examples of the types of "mixed" decisions that do not implicate ERISA's preemption clause:

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO]; about proper standards of care, . . . the reasonableness of a certain treatment, and the emergency character of a medical condition.

Id. at 2155-56. The allegations of malpractice in this case were precisely of this type. Villazon contended that various medical providers failed to diagnose and treat his late wife's tongue cancer. Villazon also contended that these providers had failed to make proper referrals, obtain diagnostic tests and monitor his wife's medical condition. The cancer spread and caused her death, leaving Villazon and his three sons as statutory survivors under the Wrongful Death Act.

Villazon asserted that the Respondent HMO was vicariously liable for the negligence of these providers. Notably, Villazon did not contend that the Respondent HMO had failed to authorize or approve any service or test. 794 So.2d at 626 (Villazon does not allege that HMO "denied" proper testing or referrals). This is not a case in which Villazon attacks any "eligibility" decision of the HMO.

B. Vicarious Liability Claims Are Not Preempted.

1. Neither HMOs Nor Their Contracts With

Physicians Constitute an ERISA "Plan."

The only *claim* against the HMO Respondent is that it is vicariously liable for the negligent acts of its member providers. As the Fourth District Court of Appeal recognized in 1996, vicarious liability claims for medical malpractice against an HMO do not deprive a Florida court of subject matter jurisdiction. *Frappier*, 678 So.2d at 888 ("in no event may the vicarious liability count be dismissed as the same does not 'relate to' an employee benefit plan"). In reaching this conclusion, *Frappier* quoted the following passage from *Dukes*, 57 F.3d at 361: "there is no allegation here that the HMOs denied anyone benefits that were due under the plan. Instead the plaintiffs here are attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment." 678 So.2d at 887.

In *Frappier*, the Fourth District also recognized the importance of making a determination that ERISA was in play, *before* a court can even consider whether there is preemption of a malpractice claim. "Before a state court can conclude that the applicable ERISA federal preemption statute divests it of subject matter jurisdiction, it must be proven that the HMO was an ERISA plan." 678 So.2d at 885. *See also id.*

at 887-88 (remanding with instructions for trial court to determine in the first instance whether the subject HMO is an ERISA plan, "subject to federal preemption").[2]

This aspect of the Fourth District's approach has proven wise. In addition to adopting the reasoning of the United States Court of Appeals for the Third Circuit in *Dukes*, in *Pegram,* the United States Supreme Court held that HMOs themselves are not ERISA plans subject to federal preemption. Important language from the Supreme Court's opinion in *Pegram* includes the following:

> Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement

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[2] Another claim in *Frappier* was for "corporate liability" based upon a "common law and statutory duty to assure the competence of [the HMO's] physicians." *Id.* at 886. Despite the clear indications from *Dukes* (upon which the Fourth District relied heavily) that such a claim was not preempted, the Fourth District held to the contrary. This aspect of the Fourth District's holding is somewhat confusing. The court correctly concluded that claims over the "fail[ure] to provide, arrange for, or supervise qualified doctors to provide the actual medical treatment" were not preempted, *id.* at 887, but nonetheless *held* that claims over the obligation to "assure the competence" of HMO physicians were preempted as "related to the administration of the plan." *Id.* at 885, 887. The Academy believes the Fourth District's holding on this issue was incorrect. Several decisions following *Dukes* or anticipating the result in *Pegram* have authorized claims against HMOs for negligent selection or supervision of physicians. *See, e.g., In re U.S. Healthcare, Inc.*, 193 F.3d 151, 157, 163 (3d Cir. 1999); *Lupo v. Human Affairs International, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994); *Herrera v. Lovelace Health Systems, Inc.*, 35 F. Supp. 1327, 1328, 1332 (D.N.M. 1999). While *Pegram* validates the results in these latter cases, the Court need not consider the correctness of this aspect of *Frappier* because Villazon does not assert such a claim.

> to services *are the sorts of provisions that constitute a plan.* Thus, when employers contract with an HMO to provide benefits to employees subject to ERISA, *the provisions of documents that set up the HMO are not, as such, an ERISA plan*, but the agreement between an HMO and an employer who pays the premiums may . . . provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.

530 U.S. at 223, 120 S.Ct. at 2151 (emphasis added). Villazon did not allege that the Respondent HMO had been negligent in the processing of claims, and there was no disagreement over benefits or any "entitlement" which Villazon's late wife may have had to benefits. Importantly, the reference to the HMO's arrangements does not run afoul of ERISA's preemption provision because the HMO is not a "plan" under ERISA.

As the United States Court of Appeals for the Third Circuit has explained, accepting arguments of the Secretary of Labor (the "Secretary"),

> when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through contracts with hospitals, doctors or nurses. . . . In performing these activities, the *HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care.*

U.S. Healthcare, Inc., 193 F.3d at 162 (emphasis added). The Secretary made the same arguments as *amicus curiae* in *Pegram*:

> Because the HMO and its parent entities are not themselves ERISA plans, not all the acts that constitute management of the HMO are acts

> that constitute administration of an ERISA plan, to which ERISA duties may attach.
>
> * * *
>
> Insofar as an HMO is a provider of medical services, it is not more subject to ERISA fiduciary duty standards than is any other provider of services to an ERISA plan. . . . [A]n HMO, in its role as provider of medical treatment to patients who are beneficiaries of ERISA plans, is not an ERISA fiduciary.

Brief for the United States as *Amicus Curiae*, *Pegram v. Herdrich*, 1999 Westlaw 1067499 (November 19, 1999) at 10-12. It is obvious that the Government's position was adopted by the United States Supreme Court.[3]

As two authors recently explained in the University of Florida Law Review,

> [T]he *Pegram* Court . . . *removed the ERISA preemption bar to state law claims for medical malpractice* and breach of state fiduciary duty

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[3]The Secretary of Labor has primary authority for the enforcement and interpretation of the relevant portions of ERISA. *See* 29 U.S.C. §§1002(13), 1132-35. Accordingly, the views of the Secretary of Labor are entitled to deference in the interpretation of ERISA, a statutory scheme the Secretary is charged to enforce. *See, e.g., Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 2781 (1984) ("We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations."). The fact that the Secretary's position is stated in a legal brief, where the Secretary is appearing as an amicus, does not diminish the amount of deference to be paid to it. *Auer v. Robbins*, 519 U.S. 452, 117 S.Ct. 905, 912 (1997). *See also U.S. Healthcare*, 193 F.3d at 162 (adopting the position of the Secretary of Labor as amicus curiae, quoted above).

> law. Paradoxically then, although the defendant HMO in *Pegram* won, the managed care industry *lost*.
>
> * * *
>
> There are two keys to understanding Justice Souter's opinion. The most important is the Court's narrow view of what constitutes an employee health plan under ERISA. This *excludes the HMO from ERISA preemption* because the provision of medical care is not the ERISA plan.

T. R. McLean, M.D. and E. P. Richards, "Managed Care Liability for Breach of Fiduciary Duty After *Pegram v. Herdrich*: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making, 53 Fla. L. Rev. 1, 3, 19 (2001) (emphasis added).

Another law review article similarly described the post-*Pegram* landscape:

> Causes of action will be preempted only if they relate to the contract between the employer and the HMO and not the HMO's structure and workings. The [Pegram] Court's definition of plan is in line with the cases holding that claims based on vicarious liability, medical malpractice and the like do not relate to an employee benefit plan. Those types of claims would be based on the HMO structure and not the contract between the HMO and the employer providing the insurance.

McAuliffe, The Changing World of HMO Liability Under ERISA, 22 J. Legal Med. 77, 104 (2001). *See also* Note, What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws after *Pegram*, 101 Colum. L. Rev. 1107, 1122 (2001) ("Thus, though an ERISA plan after *Pegram* does include the service

agreement between the MCO [managed care organization] and the employer, it does not include activities such as the MCO's contracting with providers to arrange for health care services.”).

2. Proof of Agency Does Not Convert the Character of Respondent’s Claim to One Sounding in “Eligibility.”

In this case, the Third District Court of Appeal concluded that Villazon’s vicarious liability claim was preempted because Villazon sought to prove an agency relationship by reference to indicia of control appearing in arrangements between the Respondent HMO and its provider. Villazon’s approach was consistent with Florida decisions acknowledging that agreements between an alleged principal and agent may establish a right of control. *See, e.g., Parker v. Domino’s Pizza, Inc.*, 629 So.2d 1026 (Fla. 4th D.C.A. 1993) (“*Domino’s*”) (reversing summary judgment that pizza franchise was independent contractor for national pizza chain on the basis of franchise agreement); *Nazworth v. Swire Florida, Inc.*, 486 So.2d 637 (Fla. 1st D.C.A. 1986) (“*Nazworth*”) (reversing summary judgment that management firm was independent contractor for shopping center owner on the basis of management agreement); *DeBolt v. Department of Health & Rehabilitative Services*, 427 So.2d 221 (Fla. 1st D.C.A. 1983) (reversing summary judgment that HRS “contract home” was independent

contractor charged with caring for delinquent minor; contract with HRS imposed "conditions and limitations" which created factual dispute as to home's status).

Contractual labels that a party is an independent contractor do not control. *Domino's*; 629 So.2d at 1027; *Nazworth*, 486 So.2d at 638. When the right of control exists, it is not necessary to prove actual control by a purported principal to establish the existence of an agency relationship. *Nazworth*¸ 486 So.2d at 638. If the right of control extends to methods, the relationship is one of agency and not that of an independent contractor. *Domino's*, 629 So.2d at 1027. In this case, Villazon raised a factual dispute over the extent of the Respondent HMO's right of control over the primary care physician, Dr. Sarnow, including the following: he was subject to "rules" established by its medical director, he was obliged to adhere to standards in its manual; he was obliged to obtain pre-authorization for diagnostic or therapeutic procedures; he could refer only to physicians who acted as providers for the HMO; and he could not refer without approval from the HMO's medical director.

The Third District's opinion appears to have assumed that these issues were in fact materially disputed. *See* 794 So.2d at 626-27. They should have been sufficient

to defeat summary judgment on the question of agency.[4] The court concluded, however, that ERISA prohibited consideration of these facts to establish an agency relationship because they "directly relate[d] to the health plan." *Id.* Respectfully, this is simply wrong. As the foregoing authorities demonstrate, neither the Respondent HMO, nor its contracts and other arrangements with physicians, can constitute a "plan" under ERISA. Resort to a review of the HMO's contracts with member physicians to prove agency could not, therefore, run afoul of ERISA. *Pegram* makes it clear that preemption turns on the types of medical decision ("eligibility" versus "treatment" or "mixed") involved in a particular claim. The method by which an agency relationship is proven does not alter the character of that decision.[5]

3. Post-*Pegram* Decisions Recognize The Vitality of Vicarious Liability Claims.

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[4]4A right of control over such things as decisions whether and how to order testing, and whether and how to refer a patient constitutes an obvious usurpation of a physician's traditional obligation to use independent judgment.

[5] 5 The Third District also relied on the decision of the United States Court of Appeals for the Seventh Circuit in *Jass v. Prudential Healthcare Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) ("*Jass*"). A pre-*Pegram* decision, *Jass* does hold that certain types of vicarious liability claims are preempted. At least one state court in the Seventh Circuit has rejected the reasoning in *Jass*. *See Hinterlong v. Baldwin*, 308 Ill. App.3d 441, 452-53, 720 N.E.2d 315, 323 (1999) ("*Jass* suffers several infirmities"; *Jass* "completely ignores" the United States Supreme Court's decision in *Travelers*).

In the intervening year since the United States Supreme Court decided *Pegram*, three courts have addressed the issue whether ERISA preempts vicarious liability claims against HMOs: the United States Courts of Appeals for the Fifth and Third Circuit and Florida's Third District Court of Appeal. *See Corporate Health Ins. Co. v. Texas Department of Insurance*, 220 F.3d 641, 643 (5th Cir. 2000) ("*Corporate Health II*"), denying rehearing in *Corporate Health Ins., Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000) ("*Corporate Health I*"); *Lazorko v. Pennsylvania Hosp.,* 237 F.3d 242, 246 (3rd Cir. 2000) ("*Lazorko*"); and the Third District Court of Appeal in this case. The Third District stands alone among these courts in finding that ERISA may preempt vicarious liability claims for medical negligence.

In *Corporate Health I*, an HMO challenged a Texas statute that imposes "vicarious liability on managed care entities" for the negligence of the HMO's participating physicians. The court explained that vicarious liability claims are not preempted: "[t]he vicarious liability does not 'relate to' the managed care provider's role as an ERISA plan administrator or affect the structure of the plans themselves so as to require preemption." 237 F.3d at 534. As the court indicated, at least three other United States Courts of Appeals have concluded that

> medical negligence claims against HMOs for vicarious and direct liability are not within the scope of §502(a) [of ERISA] and, therefore, are not completely preempted because they involve conduct by the HMO in its capacity as a provider and arranger of health services and not as plan administrator.

Id., 215 F.3d at 534 n. 25. Moreover, vicarious liability claims are not preempted as "referring to" ERISA because they apply "neutrally" to ERISA plans and all other types of plans. *Id.,* 215 F.3d at 534. As the Fifth Circuit noted, *Dukes* holds there is no preemption of vicarious liability claims. *Id.* 215 F.3d at 534 n. 25.

In *Lazorko*, the Third Circuit held that claims of direct and vicarious liability against an HMO for imposing disincentives on physicians to discourage prescribing additional treatment, are not preempted by ERISA because the physician's treatment decisions were contested and not the HMO plan's administration system. 237 F.3d at 246. Again, the court explained that in a claim regarding refusal of treatment, the court must "determine whether it is the quality of care provided or the denial of a plan benefit that is implicated when treatment is refused." *Id.* at 250. Claims regarding quality of treatment provided by HMO health care providers are not preempted by ERISA. *Id.*

This is not a "coverage" or "eligibility" case. No one contends that Mrs. Villazon was *ineligible* for the care that she was allegedly denied as a result of

negligence. Under these circumstances, as the Supreme Court recognized in *Pegram*, however, an "HMO is not the ERISA plan" within the meaning of ERISA. 120 S.Ct. at 2153. Claims for vicarious liability do not implicate the administration of any "plan" thus understood, and are not preempted.[6]

4. Other Defects in the Third District Opinion.

The failure of the Third District to cite *Pegram* makes its decision below questionable, if not infirm. The court ignored the critical distinction adopted by the Supreme Court ("eligibility" versus "treatment" or "mixed" decisions) to resolve the preemption question in the context of medical malpractice. Just as infirm is the failure of the Third District to explain its (incorrect) assumption that the subject HMO was an ERISA *plan*. As noted, after *Pegram*, this position can no longer be properly maintained. Finally, *Villazon* inexplicably appears to cite *Frappier* for the proposition that ERISA preempts vicarious liability claims. 794 So.2d at 627. *Frappier* could not more clearly state just the opposite. *See* 678 So.2d at 888 ("in no event may the

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[6]The use of the word "plan" in describing the terms of the contractual arrangement between the HMO and its member physicians should not be confused with the statutory definition, which is a term of art. An HMO may be a health care 'plan,' in the colloquial sense of the word. As *Pegram* holds, under ERISA, an HMO (together with its contractual arrangements with physicians) is not an ERISA plan.

vicarious liability count be dismissed as the same does not 'relate to' an employee benefit plan").

III. The Third District's Opinion Contains An Incorrect Statement of Agency Law.

As an alternative ground for affirming the trial court's summary judgment on the question of agency, the Third District said,

> Here, all the contractual provisions clearly designated the physicians as independent contractors. There is no evidence on this record that Prudential Health exercised any control over the medical judgments and decisions made in the care and treatment of patients, including Villazon's wife.

794 So.2d at 627. For the reasons expressed in §II(B)(2), *supra*, this reasoning is, respectfully, inconsistent with established principles of Florida agency law. First, it exalts the labels used by Respondent HMO in describing its providers over the substance of the parties' arrangements. Second, it appears to require proof of actual control, rather than a right of control. This is inconsistent with Florida Standard Jury Instruction 3.3(b)(1), which provides,

> An independent contractor is a person who is engaged by another to perform specific work according to his own methods *and* whose methods of performing the work are not controlled by the person engaging him *and* are not *subject to that person's right of control*" (emphasis added).

If the Third District's application of agency law stands, it may lead to confusion over the proper burden assigned to a party seeking to prove the existence of an agency relationship.

IV. The Legislature Has Required HMOs to "Ensure" The Quality of Health Care, Which Gives Rise to A Nondelegable Duty.

Florida Statutes Chapter 641 includes the Health Maintenance Organization Act. Florida Statutes §641.17. The Act contains an expression of legislative intent, findings and purposes, Florida Statutes §641.18, including the following:

- The Legislature has determined that there is a need to explore alternative methods for health care delivery, considering the cost of health care and "the state's interest in high quality care." §641.18(1)

- The policy of the state is to "[e]nsure that comprehensive prepaid health care plans deliver high-quality health care." §641.18(4)(c).

As part of the Act, an HMO is defined as a *provider* of health care, either "directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians." Florida Statutes §641.19(13)(d). While HMOs are authorized to provide services through such arrangements, they are not relieved from the responsibility of delivering "high-quality" care. Pursuant to another part of Chapter 641 (the purpose of which is also to

"ensure" that HMOs deliver "high quality health care," Florida Statutes §641.48), HMOs are obliged to formulate extensive quality assurance programs. Florida Statutes §641.51. The statute clearly states the overriding purpose and extent of an HMO's obligation: "The organization[7] shall ensure that health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community." Florida Statutes §641.51(1). When physicians providing services through HMOs pursue a "course of treatment . . . inconsistent with the prevailing standards of medical practice in the community," HMOs have the right to step in and override the "professional judgment" of the physician. Florida Statutes §641.51(3).

The Legislature has imposed a duty on HMOs to deliver a particular level of medical care, care that meets prevailing reasonable standards. If an HMO's member physicians are truly independent contractors, rather than agents or employees, the

[7] "Organization" in this part is defined as "any health maintenance organization." Florida Statutes §641.47(5).

HMO still cannot delegate the *quality* of medical care to those providers.[8] As the Restatement of Torts §424 (1965) (the "Restatement") provides,

> One who by statute or by administrative regulation is under a duty to provide specified safeguards or precautions for the safety of others is subject to liability to others for whose protection the duty is imposed for harm caused by the failure of a contractor employed by him to provide such safeguards or precautions.

See also Restatement of Agency (Second) §214 (1958) ("A master or other principal who is under a duty to provide protection for or to have care used to protect others . . . and who confides the performance of such duty to a servant or other person is subject to liability to such others for harm caused to them by the failure of such agent to perform the duty.").

Florida decisions have recognized this principle. In *Sammons v. Broward Bank*, 599 So.2d 1018 (Fla. 4th D.C.A. 1992), for example, a lender hired independent contractors to repossess an automobile after the borrower defaulted. The contractors

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[8] There are other indications that Chapter 641 was not intended to allow HMOs to avoid responsibility for the negligence of member physicians. Under the Act's implementing regulations promulgated by the Department of Insurance, HMOs are obliged to maintain specific levels of liability insurance for malpractice claims (or establish a self-insurance plan for this purpose). Fla. Admin. Code §4-191.069(1). The level of "acceptable insurance" maintained by HMOs (ranging between $1,000,000 and $10,000,000) is a function of the number of HMO members or subscribers. *Id.* §4-191.069(3).

used rather extreme methods, slashing the automobile's tires and pursuing the borrowers in a game of automobile "tag." *Id.* at 1018. The borrowers sued the lender for tortious repossession of the automobile. The trial court concluded that the bank could not be liable for the acts of its independent contractor, even if wrongful. The Fourth District Court of Appeal reversed, citing the Florida Statutes §679.503, which provides that a secured party has a right to repossession without judicial process in the event of a default. Under the statute, this may occur only "without breach of the peace" by the secured party. Longstanding principles give rise to civil liability in the event that the secured party commits an "unlawful trespass or other breach of the peace." 599 So.2d at 1019 (citation omitted). The Fourth District concluded that a secured party (*i.e.*, the lender) could not avoid liability under the statute by hiring an independent contractor to perform the repossession. *Id.* While independent contractors may be employed, the duty to repossess peaceably cannot be delegated. *Id.* at 1020.[9]

In *Newsome v. Department of Corrections*, 435 So.2d 887 (Fla. 1st D.C.A. 1983), the Department of Corrections (the "DOC") assigned an inmate to a work detail

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[9] The vitality of this decision was recently confirmed in *Reliance Ins. Co. v. Wiggins*¸ 763 So.2d 450 (Fla. 4th D.C.A. 2000).

with the Department of Transportation (the "DOT"). The inmate left the site of the work detail without permission and raped the plaintiff during his absence. The plaintiff sued the DOC. The DOC maintained it was not responsible to the plaintiff because, on the date in question, DOT personnel had been responsible for the inmate's supervision. The First District Court of Appeal explained that the DOT is authorized by statute, Florida Statutes §945.11, to enter into agreements with other state agencies to use the services of inmates. The DOC may do so, however, only when it determines "that such services will not be detrimental to the welfare of such inmates or the interests of the state." The First District concluded that this is a "clear legislative mandate" that the DOC "is responsible for the supervisions of inmates assigned to . . . work details." 435 So.2d at 888. Thus, if the DOC elects to rely on other agencies to perform the "statutory responsibility of providing adequate supervision of inmates while on . . . work details, it does so at its peril." *Id.*

Mastrandrea v. J. Mann, Inc., 128 So.2d 146 (Fla. 3d D.C.A. 1961) concerned certain Miami Beach ordinances relating to the storage of construction materials at a construction site. Materials were stored in violation of the ordinances, resulting in a personal injury. The Third District Court of Appeal reversed a directed verdict in favor of the general contractor, holding that the subject ordinances gave rise to a

nondelegable duty. The evidence was undisputed that an independent contractor was responsible for the improper storage of the materials. As the court explained, however, a duty imposed by statute or ordinance cannot be delegated to an independent contractor. *Id.* at 148.

In this case, the Third District's brief discussion of the issue of nondelegable duties in this case is confusing. The court states that all the medical providers were independent contractors. 794 So.2d at 627. If a duty is nondelegable, however, it does not matter if the contractor employs his own methods or is not otherwise controlled by the party sought to be charged with vicarious liability. The active tortfeasor (*e.g.*, the repossessors of the automobile in *Sammons*) may be a true independent contractor and still subject another to vicarious liability. That is the point of the rule. *See* Restatement §424 comment a ("The rule stated in this Section applies whenever a statute or an administrative regulation imposes a duty upon one doing particular work to provide safeguards or precautions for the safety of others. In such a case the employer cannot delegate his duty to provide such safeguards or precautions to an independent contractor."). As the Third District has said on another occasion, "[h]olding a particular undertaking to be nondelegable means that responsibility, *i.e.,* ultimate liability, for the proper performance of that undertaking

may not be delegated. The term nondelegable does not preclude delegation of the actual performance of the task. 'Nondelegable' applies to the liabilities arising from the delegated duties if breached." *Atlantic Coast Development Corp. v. Napoleon Steel Contractors, Inc.*, 385 So.2d 676, 679 (Fla. 3d D.C.A. 1980) (citations omitted).

Florida Statutes Chapter 641 strikes a balance between the need for economic and efficient alternatives to traditional health care arrangements and the promotion of high standards of medical care. The Legislature obviously did not want the quality of care to suffer as a result of the economic efficiencies obtained through this new form of insurance. To that end, the Legislature required that HMOs "shall ensure" that care is delivered within "reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community." This is the same as the standard for non-negligent medical care. *See* Florida Standard Jury Instruction 4.2 (defining negligence of a "physician, hospital or other health provider").

It is obviously within the prerogative of the Legislature to impose standards of care as a condition for licensing or authorization of various public and private business activities within the State. In this instance, the policy of Chapter 641 is clear. The plain meaning of the word "ensure" is to "secure or guarantee," "to make sure or certain," "to make secure or safe," or to "insure." Random House College Dictionary

440 (1979). HMOs are charged with the duty of 'ensuring' the delivery of care that is non-negligent. If they elect to employ independent contractors, they are not relieved of that duty as a matter of law. The Third District should have ruled in favor of Villazon on this issue.[10]

Conclusion

Before *Pegram* was decided, the courts had already begun to question prior law on the issue of ERISA preemption in this field. *See McDonald v. Damian*, 56 F. Supp. 2d 574, 576 (E.D. Pa. 1999). Following *Dukes* and foreshadowing *Pegram*, courts had already begun to "examine whether a plaintiff states a claim that attacks an administrative decision to deny benefits . . . or a medical decision to deny treatment to a patient." *Id.* As we now know, it is only the former type of claim that a court can properly conclude is preempted. This case did not present such a claim and the Court should reverse on this issue.

The Court should also reverse on the merits of Villazon's claim of vicarious liability. "The existence of an agency relationship is ordinarily a question to be determined by a jury in accordance with the evidence adduced at trial." *Orlando Executive Park, Inc. v. Robbins*, 433 So.2d 491, 494 (Fla.1993), *limited on other grounds*, *Mobil Oil Corp. v. Bransford*, 648 So.2d 119 (Fla. 1995). Villazon presented sufficient evidence over the right of control for a jury to conclude that the Respondent HMO has a right of control over its member physicians. The Third District's application of agency principles is erroneous and may lead to an inconsistent application of the law, if not corrected.

On the issue of nondelegable duties, the Third District's analysis did not even

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[10] In the Third District, the Respondent HMO argued that the Health Maintenance Organization Act did not give rise to a private right of action for medical negligence. This argument misses the point. The right of action for medical negligence exists separate and apart from the Act. The question is who bears the responsibility for that negligence.

consider the impact of the Health Maintenance Organization Act. This is a matter of first impression for this Court. The Legislature has declared, however, that HMOs must deliver high quality, non-negligent care. This is a nondelegable duty and to the extent that HMOs employ the services of independent contractors, they are vicariously liable when their contractors deliver negligent care.

Certificate of Service

I CERTIFY that this amended brief was served by U.S. Mail on Steven K. Deutsch, Esquire and James C. Blecke, Esquire, Deutsch & Blumberg, P.A., 100 North Biscayne Boulevard, Miami, FL 33132; Steven M. Ziegler, Esquire, Law Offices of Steven M. Ziegler, P.A., 4000 Hollywood Boulevard, Hollywood, FL 33021; and Diane Tutt, Esquire, 8211 West Broward Boulevard, Suite 420, Plantation, FL 33324, on this 2d day of January, 2002.

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