SUPREME COURT OF FLORIDA

Case No: SC01-1397

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

Petitioner,

vs.

PRUDENTIAL HEALTH CARE
PLAN, INC.

Respondent.

AMICUS CURIAE BRIEF OF FLORIDA ASSOCIATION OF HEALTH PLANS

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STATEMENT OF THE CASE AND FACTS

This brief is submitted by the FLORIDA ASSOCIATION OF HEALTH PLANS (hereafter the Association) as amicus, pursuant to the motion to appear as amicus curiae in support of the position of Respondent, PRUDENTIAL HEALTH CARE PLAN, INC. The Association adopts the statement of the case and facts set forth by the Respondent, with the following supplementation.

The health maintenance organization is a creature of the last two decades, created as an alternative to the traditional form of indemnity insurance for fee-for-service medical care in which the delivery of health care services was becoming unaffordable or unattainable to many of the citizens of this state. It is legislatively recognized as a business of "health maintenance organization type insurance" that has been specifically exempted from the operation of Florida's general insurance laws which would otherwise apply. Sections 641.2017, 641.18(4)(b), Fla. Stat.

Under the statutory framework which the Legislature has devised, a health maintenance organization may be one of three types. The first is the staff model, in which licensed direct health care providers, e.g., physicians, nurses and other "hands-on" treaters, are employed directly by the HMO. 4 Fla. Admin. Code 4-191.024(21). The second pattern is the individual practice association model (IPA), in which the HMO contracts with individual licensed physicians and other practitioners who render

the health care services to subscribers. 4 Fla. Admin. Code 4-191.024 (12). The third pattern is the combination model, with features of the staff and of the IPA models. 4 Fla. Admin. Code 4-191.024(4). In accordance with these models, an HMO may thus be an organization, inter alia, which provides health care services "either directly or through arrangements with other persons." Section 641.19 (7)(c), Fla. Stat.

For purposes of the rendering of the medical services, the "provider" is the person, entity, or institution that actually furnishes the health care services and is licensed to practice in the state. Section 641.19(9), Fla. Stat.

ISSUES PRESENTED TO THE COURT

As Amicus in support of Respondent's position, only two issues are addressed in this brief, both arising under state law:

> WHETHER STATUTORY LIMITATIONS ON THE PRIVATE RIGHTS OF ACTION FOR ENFORCEMENT OF THE STATUTORY DUTIES CREATED BY CHAPTER 641, AND PRINCIPLES OF STATUTORY CONSTRUCTION, PRECLUDE CONSTRUCTION OF THE STATUTE SO AS TO IMPOSE A NON-DELEGABLE DUTY TO RENDER NON-NEGLIGENT MEDICAL TREATMENT TO HMO SUBSCRIBERS?
>
> WHETHER HMO NETWORK PROVIDERS ARE AGENTS OF THE HMOS WITH WHOM THEY CONTRACT AS A MATTER OF LAW?

SUMMARY OF ARGUMENT

As a preliminary matter, Petitioner confounds the meanings of ordinary words, confusing "provide" with "render" or "perform." Chapter 641 does not require an HMO to render direct health care, although an HMO may choose to do so. Chapter 641 merely authorizes the provision of health care services through a three-way insurance system in which an HMO may arrange for health care services by means of independently contracting with licensed providers and with subscribers who agree to the terms and conditions of access to those providers. Consequently, the proposed "duty" which is presented as a nondelegable one, is nonexistent.

Secondly, even if there were a duty to render medical care, Chapter 641 is a comprehensive regulatory statute which also creates a limited number of private rights of enforcement. Applying common law rules of statutory construction, the statute does not create a private right of action against an HMO on account of a physician's negligence regardless of the relationship of the physician to the HMO. To the contrary, the private rights of enforcement of the chapter are enumerated, are few, and are limited in nature. Consequently, a so-called "nondelegable duty" cannot be read into the statute to provide a predicate for a right of action that is clearly not provided by the express terms of the statute.

Further, the terms of the statute do not create an agency in fact for all

physicians and other treaters who contract with HMO's to serve as members of the HMO network. To the contrary, Chapter 641 does not change the common law of agency, and proof of an agency relationship between a particular treater and a particular HMO continues to rest upon the elements required by that common law.

ARGUMENT

Because the substantive issues presented are pure questions of law regarding the proper application of statutory and contractual provisions, this Court reviews the issues de novo. Volusia County v. Aberdeen at Ormond Beach, L.P., 760 So.2d 126 (Fla. 2000);Execu-Tech Business Systems, Inc. v. New Oji Paper Company Ltd., 752 So.2d 582 (Fla. 2000); Racetrac Petroleum, Inc. v. Delco Oil, Inc., 721 So.2d 376 (Fla. 5th DCA 1998). For the reasons stated in Respondent's Brief and below, amicus submits that the decision of the district court should be affirmed in all respects.

I. STATUTORY LIMITATIONS ON THE PRIVATE RIGHTS OF ACTION FOR ENFORCEMENT OF THE STATUTORY DUTIES CREATED BY CHAPTER 641, AND PRINCIPLES OF STATUTORY CONSTRUCTION, PRECLUDE CONSTRUCTION OF THE STATUTE SO AS TO IMPOSE A NONDELEGABLE DUTY TO RENDER NON-NEGLIGENT MEDICAL TREATMENT TO HMO SUBSCRIBERS

A. The nature of the statute at issue:

Chapter 641, Fla. Stat., is a comprehensive licensing and regulatory statute created to authorize and govern health maintenance organizations and prepaid medical clinics. It creates new duties, rights, and remedies. It requires certification of every

HMO and makes each HMO subject to the administrative oversight of the Department of Insurance and the Department of Health and Rehabilitative Services. Sections 641.21, 641.23, Fla. Stat. It authorizes the agency to take action against the licensee in the event of enumerated conditions. Section 641.23, Fla. Stat. Section 641.28, Fla. Stat., gives the prevailing party a right to recover attorneys' fees in any civil action to enforce the terms and conditions of an HMO contract. The contents of the contract are specified in Section 641.31, Fla. Stat., and all contracts must be approved by the Department of Insurance. Required provisions of the contract include, for example, "coverage" for HIV, a description of grievance procedures, the rate of payment, a statement that emergency services shall be provided without prior notice, a statement of the grace period for payment, and disclosure of the extent of coverage for preexisting conditions. Sections 641.31(3)(a)(7); 641.31(5), (6), (12), (16), Fla. Stat.

Contrary to the assertions of Petitioner, the legislative specification of contract terms clearly reveals that the HMO contract is one of "coverage" for health services. For example, Section 641.31(17) states that contracts "that provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that ...." Section 641.31(18) states that contracts "which provide coverage, benefits, or services for maternity care shall provide, as an option to the subscribe, the services of nurse-midwives...." Section 641.31(19) states that contracts which

"provide coverage, benefits, or services as described in s. 463.002(5), shall offer to the subscriber the services of an optometrist...." Sections 641.31(20) and (21) similarly refer to the provision of "coverage" by the HMO contract. As with other types of health insurers, HMO's are permitted to coordinate benefits with other health policies as an insurer under Section 627.4235, Fla. Stat. 641.31(7), Fla. Stat.

There is thus no requirement that the HMO contract include a promise to render care directly, but only that it offer coverage, benefits, or services.

Section 641.3101, Fla. Stat., then provides that additional terms may be included in the contract:

> A contract may contain additional provisions not inconsistent with this part **which are necessary on account of the manner in which the organization is constituted or operated, in order to state the rights and obligations of the parties to the contract....**

Perhaps anticipating challenges of the sort seen in this case, the Legislature then emphasizes that "every contract **shall be construed according to the entirety of its terms and conditions** as set forth in the contract." Section 641.3106, Fla. Stat.

Part III of Chapter 641 addresses Health Care Services and imposes certain obligations on HMOs in order to ensure the delivery of high quality health care services to HMO subscribers. Section 641.48, Fla. Stat. Part III then spells out what those obligations are. HMOs must, inter alia, demonstrate adequate geographic

access for its subscribers to providers who are licensed and/or credentialed practitioners, must maintain accessible medical records systems, and must have a grievance procedure. Section 641.495, Fla. Stat. Each organization must also have a quality assurance program that includes peer review and written procedures for appropriate remedial action. Section 641.51, Fla. Stat. Quality of care issues are to be addressed by the grievance procedures and then by the Department of Insurance; quality of care issues that remain unresolved may be presented to the Statewide Subscriber Assistance Program Panel. Section 641.511, Fla. Stat. This part imposing quality assurance review procedures does not require that an HMO directly render non-negligent care to HMO subscribers but only that an HMO have in place procedures to assure that policyholders have adequate access to properly licensed and/or credentialed practitioners and to assure that policyholders have grievance procedures available to obtain administrative review of quality of care issues as they may arise.[1]

Contrary to Petitioner's assertion that an HMO is a "health care provider" under Section 766.102, Fla. Stat., and therefore must be a "provider" for all purposes under Chapter 641, that section simply adopts from a repealed collateral source statute the definition of "health care provider". Section 766.102 does not otherwise mention

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[1]This part also imposes certain reporting requirements for administrative oversight.

HMO's. The HMO's under Chapter 641 obtain certificates of authority for the purpose of quality assurance procedures contained in Part III of Chapter 641, Fla. Stat., but are not licensed as practitioners and are not practitioners.[2] Further, Chapter 641 itself defines a "provider" not as the HMO, but as the person or entity that actually "furnishes" health care services and is licensed or authorized to practice in Florida. Therefore, it is apparent that the terms and the definitions of "provider" under Section 641.19(19) and "health care provider" under Section 768.50(2)(b) are different.

B. <u>The nature of Petitioner's challenge to the statute:</u>

Petitioner's position is first one of semantics. Because Chapter 641 creates and regulates a new form of health care delivery system through the use of insurer-managed access to services, Petitioner seizes upon certain terms to suggest a state of affairs that is by no means the intent of the statute as revealed by its plain language and confirmed by reading the statute as a whole. That is, Petitioner reasons that because HMO's are authorized to "provide" medical services through a managed access and utilization system, HMO's are required to render those services directly.

Merriam-Webster's Collegiate Dictionary (10th Ed.) defines "provide" as "to take precautionary measures;" "to make a proviso or stipulation;" to "make

[2]Chapter 641 does authorize an HMO to employ a practitioner.

preparation to meet a need;" "to prepare or get ready in advance;" to "supply or make available;" to "have as a condition." None of these definitions includes direct rendering. Funk & Wagnall's includes several definitions of "provide," including: to afford, yield; to prepare, make ready, or procure beforehand; to take measures in advance; to furnish means for subsistence; to make a stipulation. Funk & Wagnalls Standard College Dictionary.

"Render," however, includes as a definition "to perform; to do." Id. This is the meaning that Petitioner would have this Court ascribe to the word "provide." Without candidly stating so, Petitioner presumes that the definition of "provision" of medical services in Chapter 641 is "performance, doing" of medical services, not making preparation to meet a need; affording (by means of exchanging the premium dollar for the promise of access to described levels of service), procuring beforehand (by means of creating a network of contracted physicians), or taking measures in advance (by means of per capita arrangements with physicians for described levels and types of treatments for specified numbers of subscribers).

The Association submits as a preliminary matter that correction of the definitions ascribed sub silentio by Petitioner to Chapter 641 resolves the entire issue, for a duty to "afford," "procure beforehand" or to "take measures in advance" could never support the theory of nondelegable duty to treat that underlies Petitioner's case.

Moreover, the remainder of the terms of Chapter 641 are inconsistent with such a narrow meaning as Petitioner gives the word, for the statute clearly authorizes the provision of services through arrangements with others and clearly identifies the contents of an HMO contract as offering "coverage, benefits, or services."

C. The Pertinent Principles of Statutory Application and Construction:

It is axiomatic that the extent to which a statute changes the common law is only the extent to which the statute clearly and explicitly says so:

> The presumption is that **no change in the common law is intended unless the statute is explicit and clear in that regard.** Unless a statute unequivocally states that it changes the common law, or is so repugnant to the common law that the two cannot coexist, the statute will not be held to have changed the law.

State v. Ashley, 701 So.2d 338, 341 (Fla. 1997), quoting, Thornber v. City of Walton Beach, 568 So.2d 914, 918 (Fla. 1990). In the instant case, the issue is whether Chapter 641 has changed the common law regarding a duty to render medical care by one who is neither a licensed practitioner nor the employer of a licensed practitioner, under the guise of governing a three-way system of delivering health care services.

It is also axiomatic that mention of specific matters in a statute excludes those matters not mentioned, pursuant to expressio unius est exclusio alterius. Dobbs v. Sea Isle Hotel, 56 So.2d 341 (Fla. 1952). This familiar axiom applies to statutes which

create a right and then supply a remedy for violation of that right. Where a remedy is conferred by statute, it ordinarily excludes any other remedy. Transamerica Mortgage Advisors, Inc. (TAMA) v. Lewis, 444 U.S. 11, 19 - 20, 100 S.Ct. 242, 247, 62 L.Ed.2d 146 (1979); Dorman v. Jacksonville, 13 Fla. 538 (1870); State v. Barquet, 358 So.2d 230 (Fla. 3rd DCA 1978). The right conferred is subject to any limitations expressed in the statute. Smitz v. Wright, 64 Fla. 485, 60 So. 225 (1912). A remedy conferred by statute can be invoked only to the extent and in the manner prescribed. Gunn v. Robles, 100 Fla. 816, 130 So. 463 (1930). Accord, City of Miami v. Cosgrove, 516 So.2d 1125 (Fla. 3rd DCA 1987). The issue here is whether Chapter 641 creates a private right of action in the face of the enumerated and limited mechanisms of enforcement.

Further, statutes that relate to the same subject are regarded in pari materia. Willis v. Morgan, 176 So.2d 73 (Fla. 1965); Okaloosa County Water & Sewer Dist. V. Hilburn, 160 So.2d 43 (Fla. 1964). The issue here is whether Petitioner's theories of nondelegable duty fly in the face of the clear terms of the many parts of the Chapter clarifying that the contract between an HMO and a policyholder is one for coverage, benefits or service and not one for direct performance of medical treatment.

It is unnecessary to resort to the legislative history of a statute to determine the legislative intent when the wording of the statute is clear. See, e.g., Aetna Cas. & Sur.

Co. v. Huntington Nat'l. Bank, 609 So. 2d 1315, 1317 (Fla. 1992); Suwannee River Water Management Dist. v. Pearson, 697 So. 2d 1224, 1226 (Fla. 1st DCA 1997). Cf., Acosta v. Richter, 671 So. 2d 149 (Fla. 1996)(the polestar of statutory construction is the plain meaning of the statute itself). Where the words selected by the Legislature are clear and unambiguous, judicial interpretation is not appropriate to displace the expressed intent. Foley v. State ex rel. Gordon, 50 So. 2d 179, 184 (Fla. 1951); Platt v. Lanier, 127 So.2d 912, 913 (Fla. 2d DCA 1961). The issue here is whether legislative history, though unnecessary, nevertheless confirms that the rights of enforcement by civil action are limited.

In older case law, judicial inference of a right of action was accomplished by construing a violation as negligence per se or as evidence of negligence, based upon an examination of classes of people that the statutes were designed to protect and the particular risks the statutes protected against. See, deJesus v. Seaboard Coast Line R. Co. , 281 So.2d 198 (Fla. 1973); Murthy v. Sinha, 644 So.2d 983, 985 (Fla. 1994). However, the United States Supreme Court revised the test for implication of a private right of action in 1979, adopting a strict examination of the intent of the legislature as revealed in the terms of the statute, rather than an examination of classes of persons and types of dangers the statute was designed to protect and protect against. TAMA, supra, 444 U.S. 11, 15 - 16, 100 S.Ct. 242, 245 - 46, 62 L.Ed. 146, (1979)("[W]hat

must ultimately be determined is whether Congress intended to create the private remedy asserted"); Cort v. Ash, 422 U.S. 66 (1975)(precluding implied private cause of action from statute not expressly providing one). The test articulated in TAMA was adopted by the Florida Supreme Court in Murthy, supra. In Murthy, the Court decided that the licensing and regulatory statutes governing construction contracting, which provided administrative remedies but did not expressly provide for a private civil cause of action, did not provide an implied private right of action, explaining:

> Today, however, most courts generally look to the legislative intent of a statute to determine whether a private cause of action should be judicially inferred. Transamerica Mortgage Advisors, Inc. (TAMA) v. Lewis, 444 U.S. 11, 15 - 16, 100 S.Ct. 242, 245 - 46, 62 L.Ed. 146, (1979)("[W]hat must ultimately be determined is whether Congress intended to create the private remedy asserted.")... [remaining cites omitted]

Id., at 985.

Under this test, courts in this state have since held that there is no private cause of action under Section 415.504, Fla. Stat., for violation of the duty to make child abuse reports, or under Section 415.1034, Fla. Stat. for violation of the duty to report elder abuse.[3] Freehauf v. School Board of Seminole County, 623 So.2d 761 (Fla. 5th DCA 1993); Fischer v. Metcalf, 543 So.2d 785 (Fla. 3rd DCA 1989); Mora v. South Broward Hospital District, 710 So.2d 633 (Fla. 4th DCA 1998). In Mora, an elderly

[3]Section 415.1111, Fla.Stat., now provides certain rights of private action.

lady told her psychologist that her live-in care giver was stealing from her and abusing her. The matter was not reported. The elderly lady continued to suffer emotional and physical abuse until her death eight weeks later.

Similarly, there is no private right of action under Section 465.003(5), Fla. Stat., the drug interaction counseling statute governing pharmacists Johnson v. Walgreen Co., 675 So.2d 1036 (Fla. 1st DCA 1996). In Johnson, a patient died as a result of drug interactions; the pharmacist violated that act's requirement of assessing potential adverse interactions and counseling the customer on proper drug usage. Similarly, there is no private right of action for violation of Florida's Food, Drug, Cosmetic and Household Products Act. T.W.M. v. American Medical Systems, Inc., 886 F.Supp. 842 (N.D.FL 1995). See also, Wilson v. Danek Medical, Inc., 1999 WL 1062129 (M.D.FL 1999)(no private cause of action under Murthy for violation of the Medical Device Amendments to the Food, Drug and Cosmetic Act, 21 U.S.C. 360).

D. Applying These Principles to Chapter 641:

It is unnecessary to address the legislative history to determine that the plain words of Chapter 641, Fla. Stat., create rights, obligations, and remedies that did not exist at common law, but which are limited by their terms. Chapter 641 creates rights for HMO's to create a contractual three-way structure in which payment of a premium to the HMO translates into an assurance that access to medical care will be available,

but in a "managed" access system that is designed to contain the costs associated with the traditional fee-for-service, indemnity health insurance system. In the indemnity system of health care insurance, medical malpractice threats caused practitioners to adopt a defensive rather than diagnostic approach to medical care with a corresponding overusage of medical benefits available by the purchase of a health care policy. The HMO system developed as a response to spiraling medical malpractice premiums that translated to spiraling costs of health care services that translated to spiraling costs of health insurance and that translated ultimately to spiraling numbers of uninsured citizens without access to health care services as a pure matter of economics.

As a corollary to the HMO's new right to "manage" access to medical services, the HMO must participate in certain activities which are designed to assure that the services which are made available are high-quality services. Thus HMO's must obtain Health Care Provider Certificates. Section 641.48(1), Fla. Stat. As part of that process, employees who are physicians must be organized as a medical staff; quality assurance programs must be implemented, and internal risk management program requirements must be met. Sections 641.49(l), (o), (p), Fla. Stat. See, also, Section 641.51, Fla. Stat. (requiring quality assurance program including review of physicians). As stated earlier, Chapter 641 thus creates both prospective and

retrospective mechanisms that work with agency oversight to assure that policyholders have adequate access to properly licensed and/or credentialed practitioners.

Actions to enforce the chapter's requirements are also specified. Subscribers are given the right to initiate and participate in grievances. Section 641.22, Fla. Stat. These grievance rights which are mandated by the statute must be set forth in each HMO policy, with an explanation of the procedures for participation. Section 641.31(5), Fla. Stat. Unresolved grievances relating to quality of care issues may be presented to the Statewide Subscriber Assistance Program panel. Section 641.511, Fla. Stat. Section 641.28, Fla. Stat., gives prevailing parties a right to recover attorneys' fees in any civil action to enforce the terms of an HMO contract. Section 641.3903, Fla. Stat. delineates unfair methods and practices which will result in departmental investigation, including failing to provide contracted services. Penalties are set forth in Sections 641.3905, .3909, Fla. Stat. Pursuant to Section 408.7056, Fla. Stat., fines may be imposed.

Under the axiom expressio unius est exclusio alterius, and absent the expression of a legislative intent to create a private right of action under TAMA, supra, and Murthy, supra, the grievance and administrative remedies contained within Chapter 641 thus exclude a right to file a civil lawsuit to enforce the statutory duties. Greene

v. Well Care HMO, Inc., 778 So.2d 1037 (Fla. 4th DCA 2001)[4]. "Construing" Chapter 641 to create a private right of action to enforce a statutory duty when there is no explicit intent to do so invades the province of the legislature and ignores the longstanding limitation that "courts cannot legislate." State v. Wershow, 343 So.2d 605, 607 (Fla. 1977).

E. Legislative History: Proof Of Limited Remedies and Rights of Action:

Having said that the legislative history is not necessary or appropriate in order to apply the statute, reference to the legislative history nevertheless confirms that Chapter 641 limits the remedies and enforcement mechanisms available to subscribers and thus precludes judicial expansion of those rights of action. In 1996, the Legislature passed a bill that would have expanded a subscriber's rights of action under Section 641.3917, Fla. Stat., the section entitled "Civil Liability." The new right of action would have been the bringing of a civil action by any person to whom a duty was owed when a violation of the unfair methods section occurred. Obviously, if the mere passage of the unfair methods section sufficed to create a duty enforceable by a subscriber by means of a civil action for damages, the amendment to provide such a right of action would have been totally unnecessary. This would clearly

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[4]This decision wrongly suggests that the contract may give rise to tort liabilities aside from any possible contract claims.

offend the principle that the legislature is presumed **not** to have enacted useless legislation. Williams v. State, 492 So.2d 1051 (Fla. 1986).

The amendment of the chapter to provide a civil cause of action, though, was vetoed by Governor Chiles. His reasons are equally applicable here, where this Court is being asked to create a new private right of action by judicial construction:

> It is likely that over time more physicians would authorize treatment whenever there was any doubt about the need or efficacy of that treatment. This would encourage a return to the era of "defensive medicine" that helped to spur sharp increases in health care costs during the 1980's.
>
> * * *
>
> Throwing these cases into our already overly crowded and overly litigious tort system is also troubling. The tendency in most cases would be to require the HMO to pay for the service, regardless of cost. This in turn would result in an erosion of the ability of HMO's to perform utilization management which is an important tool for controlling costs.
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> * * *
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> The lawsuits generated by this bill would threaten to eviscerate the concept of utilization review and cost control that are the heart of managed care. We have progressed too far toward our goal of assuring affordable health care insurance for all Floridians to turn our backs on it now.

Appendix A, attached hereto for the Court's convenience.

Considering the limitation of enforcement rights and the grievance and unfair methods provisions in pari materia with other provisions confirms that the purpose of the statute is **not** to make the HMO accountable for the professional judgment of the

licensed practitioner/treaters who are not direct employees.

II. THE STATUTE DOES NOT CREATE AGENCY BETWEEN HMO's AND LICENSED PROVIDERS

Although Petitioner argues that the issue of agency is one of fact, Petitioner rests his case initially upon the same definition of "provide," essentially arguing as a matter of law that because the HMO contract was one to "provide" medical services, the contract necessarily undertook the duty to render those services directly. Fallacious reasoning applied to the statute is equally fallacious when applied to the contract which is mandated by the statute.

Petitioner's secondary argument is also one of law, that the "right to control" which is an element of the HMO alternative delivery system's cost-containment feature is, as a matter of law, the right to control the professional judgment of the licensed practitioners who actually render the health care services.

However, the statute clearly refutes this proposition, for Section 641.51(3), Fla. Stat., states that the professional judgment of a licensed physician "**shall not be subject to modification**" unless the "course of treatment prescribed" is inconsistent with prevailing standards of practice. In other words, the only extent of "control" of the professional judgment is a potential "veto" power as to a course of treatment in its

entirety.[5] How the licensed practitioner implements or completes a course of treatment is by no means under the control of the HMO.

Petitioner is thus simply wrong on the points of law underlying the theory of agency Petitioner proposes. The statute clearly permits the contracts between the HMO and the licensed providers and between the HMO and its subscribers to contain such terms and conditions as are necessary to describe accurately the relationships among the three, and requires that the contracts be construed in accordance with all of their terms. Section 641.3101, 641.3106, Fla. Stat. Clearly, a contract that spells out that licensed providers in the network are independent contractors has met with the approval of the Department of Insurance. Its terms and conditions are permitted under Section 641.3101 in order to describe the true nature of the independent contract relationship. As opposed to excising or dismissing the contract terms, the court is required to construe the contract in accordance with those terms. Section 641.3106, Fla. Stat.

In so the extent that an agreement to "provide" services must be redefined as an agreement to "render" services, and to the extent that a clear term in the HMO contract with the subscriber specifying that licensed providers are independent

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[5]This is the "stuff" of which grievances may be made, further contradicting any legislative intent to impose civil liability on HMO's for a practitioner whose course of treatment was not vetoed but was carried out negligently by the practitioner.

contractors must be ignored, Petitioner's argument fails as a matter of law.

The Association does not address the situations in which neither the HMO/provider contract nor the HMO/subscriber contract creates an independent contractor relationship between the HMO and the licensed provider, for such situations would, at this juncture, require the development of additional information about the remaining terms of the pertinent contracts. In such situations, an agency relationship would only be created if there has been acknowledgment by the principal that the agent will act for it, acceptance of the undertaking by the agent, and retention of control over the agent's actions or manner of performance by the principal. State v. American Tobacco Co., 707 So.2d 851, 854 (Fla. 4th DCA 1998). In a situation somewhat similar to "provision" of medical services through network physicians, the "provision" of the medical services of a private duty nurse by an employment agency did not result in a finding of agency. Robinson v. Faine, 525 So.2d 903 (Fla. 3d DCA 1987). The Third District Court of Appeal applied the ten-step test set forth in the Restatement of Law and determined that the nurse was an independent contractor. RESTATEMENT (SECOND) OF AGENCY Section 220 (1999). Thus, the common law governing the creation of an agency relationship must be resorted to in order to impose liability upon an HMO for the negligence of a practitioner, and it remains the plaintiff's burden to plead and prove such a relationship in fact. The Association

leaves further argument on the specifics of this case to Respondent.

III. PETITIONER'S CASES DO NOT SUPPORT PETITIONER'S THEORIES

Without belaboring the matter, Amicus respectfully submits that the case law relied upon, and the statutes referenced, do not support Petitioner's position on the issue of a nondelegable duty or of agency in fact. None of the cases involve HMO's. Only a few involve involve medical malpractice and the relationships between practitioners and institutions. Those cases address apparent agency and vicarious liability in the context of medical centers and hospitals, respectively, for injuries of patients treated by on-call or emergency room doctors. There is no mention of nondelegable duty as cited by Petitioner or agency in fact as a matter of law due to a right of cost-containment blended with regulated quality assurance grievance procedures and administrative oversight. Orlando Regional Medical Center, Inc. v. Chmielewski, 573 So.2d 876 (Fla. 5th DCA 1990); rev. denied 583 So.2d 1034, 1036 (Fla. 1991), abrogated by Boulis v. Fla. Dept. of Transportation, 733 So.2d 959 (Fla. 1999), Irving v. Doctors Hospital of Lake Worth, Inc., 415 So.2d 55 (Fla. 4th DCA 1982), rev. den. 422 So.2d 842 (Fla. 1982); Webb v. Priest, 413 So.2d 43 (Fla. 3d DCA 1982).

Jaar v. University of Miami, 474 So.2d 239 (Fla. 3d DCA 1985), rev. den. 484 So.2d 10 (Fla. 1986) is another of the medical malpractice cases, in which vicarious

liability was based upon numerous contractual provisions requiring a University employee both to serve as a physician providing medical services to Jackson Memorial Hospital patients and to supervise residents in training at the hospital. The physician was actually employed by the University. Petitioner seizes upon one of several terms of the contract, i.e., that the University would "provide" medical services to the hospital's patients, to support its argument here. However, the word "provide" alone was not the basis of the decision, nor would it have been had the contracts at issue clearly spelled out that the "provision" of medical services could be done directly or through arrangement with others who were independent contractors. To the contrary, Petitioner acknowledges that the contract at issue specified that the University "[s]hall **through members of its faculty** provide professional medical care." 474 So.2d at 242, n.4. The case simply cannot stand as authority for the proposition that "provide" can only meaning "to do," "to perform," or "to furnish directly," much less that "provide" has such a meaning where the entirety of the

statutory and contractual frameworks at issue contradict that definition and confirm the more common and preferred definitions discussed supra.

The remaining cases are not related to health care services or health care insurance and merely apply the common laws of contractual duty or agency to particular circumstances and specific agreements. E.g., Gordon v. Sanders, 692 So.2d

939 (Fla. 3d DCA 1997)(duty arising from oral contract to remove trees); Metrolimo Inc. v. Lamm, 666 So.2d 552 (Fla. 3d DCA 1995)(contractual agreement for special transportation services); U.S. Security Services Corp. v. Ramada Inn, Inc., 665 So.2d 268 (Fla. 3d DCA 1995)(premises owner's duty to business invitee); Atchley v. First Union Bank of Florida, 576 So.2d 340 (Fla 5th DCA 1991)(contract duty to perform roof repairs); City of Coral Gables v. Prats, 502 So.2d 969 (Fla. 3d DCA 1987)(contract to maintain street in "trip-free" condition).

IV. IMPORTANT ISSUES REGARDING THE PUBLIC'S ACCESS TO HEALTH SERVICES ARE IMPLICATED BY A THEORY WHICH WOULD RECREATE THE HEALTH CARE CRISIS WHICH LED TO LEGISLATIVE ADOPTION OF THE HMO FORM OF INSURANCE

As Governor Chiles' veto message acknowledged, the components of the total health care delivery system are economically interrelated and interdependent. In the past, civil claims against medical practitioners gave rise to increasing malpractice premiums which were passed on as increasing costs of obtaining health services. The increasing costs of health services in turn gave rise to increasing costs of indemnity insurance and a decreasing number of carriers issuing insurance for the fee-for-service delivery system. The ultimate result was a rising number of citizens who were unable to pay for, or obtain insurance to cover, health services.

It was this state of affairs that led the Legislature to adopt the newer health delivery system which is not a direct indemnity arrangement between a policyholder

and his insurer for treatment that the policyholder obtains on a fee-for-service basis. As, perhaps, with all human affairs, the social structure resembles a living organism in which change in one area may affect the whole of the organism. Though Petitioner argues that the area of vicarious liability should be changed, the danger of spiraling costs to the whole organism of health care delivery remains. See, FPIC's Health Business Contributes to Decline in First-Quarter Net, BEST'S INSURANCE NEWS (May 10, 2001), 2001 WL 4366568 (losses associated with accident and health insurance business; that business soon to be eliminated); Florida Doctors Hit Hard by Rising Malpractice Premiums, TAMPA TRIBUNE BUSINESS NEWS (December 19, 2001), 2001 WL 31599529 (rising medical malpractice premiums threatening viability of medical practices and causing either overuse of diagnostic tests or underuse of tests like mammograms which have a technologically built-in failure rate).

The theories that Petitioner proposes would create liability for all HMO's for all negligence of all practitioners as a matter of law. HMO's would, of necessity, be required to purchase the same medical malpractice insurance that originally helped drive the costs of the health delivery system to the crisis point. Contrary to Petitioner's assertion that HMO's must carry medical malpractice insurance, under the current system, all HMO's are **not** required to purchase coverage for medical

malpractice. 4 Fla. Admin. Code 4-191.069 requires IPA model HMO's to carry general liability and professional liability, but not medical malpractice insurance.[6] IPA model HMO's instead must require the independently contracted practitioners to carry medical malpractice insurance of a certain level.

In sum, the intent of the Legislature is clear, but so, too, is the danger that the legislative system attempts to contain. A judicial declaration that so greatly changes the components of the HMO health delivery system would greatly risk the viability of that delivery system. The Court should maintain the system put in place by the Legislature: contain the spiraling-cost danger to health delivery systems by permitting the system to function without the imposition of legislatively-unintended liability exposure.

CONCLUSION

The decision of the district court should be affirmed. To create a nondelegable duty by judicial fiat would eviscerate the very purpose of making an alternative health care delivery system available by permitting cost-containment features to be built into a three-way HMO/provider/subscriber system. Such a ruling would provoke a return to the malpractice insurance crisis which precipitated the very implementation of this new health care delivery system.

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[6]Professional liability policies typically **exclude** coverage for medical malpractice.

CERTIFICATES OF SERVICE AND COMPLIANCE

I HEREBY CERTIFY that a true copy of the foregoing amicus brief was served by mail this 7 February 2002, on: James C. Blecke, Esq., DEUTSCH & BLUMBERG, P.A., New World Tower, Suite 2802, 100 North Biscayne Blvd., Miami, Florida, 33132; Steven M. Ziegler, Esq., LAW OFFICES OF STEVEN M. ZIEGLER, P.A., Presidential Circle, 4000 Hollywood Blvd., Suite 375 South, Hollywood, Florida , 33021; and Diane H. Tutt, Esq., DIANE H. TUTT, P.A., 8211 West Broward Blvd., Suite 420, Plantation, Florida.

I HEREBY CERTIFY that the foregoing brief was prepared in Times New Roman font, 14 point.

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