IN THE SUPREME COURT OF FLORIDA

CASE NUMBER SC01-1397

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

RESPONDENT'S ANSWER BRIEF

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INTRODUCTION

This Answer Brief is filed on behalf of Respondent, PRUDENTIAL HEALTH CARE PLAN, INC., in support of the decision by the Third District Court of Appeal dated March 14, 2001, which affirmed the Summary Final Judgment entered on May 25, 2000 in Respondent's favor.[1]

STATEMENT OF THE CASE

Plaintiff instituted this lawsuit against several dental and health care providers alleging that they provided negligent medical care in the treatment of SUSAN VILLAZON's tongue cancer. Plaintiff also asserted claims against PRUDENTIAL, a federally qualified and state licensed independent practice association health maintenance organization ("IPA HMO"), that administered the health benefits offered to SUSAN VILLAZON by her employer, Valdes-Fauli, Cobb, and Petrey, P.A. ("Valdes-Fauli"). These benefits were codified in a Certificate of Coverage distributed to all beneficiaries, including SUSAN VILLAZON. ("Plan").[2]

As an IPA HMO, PRUDENTIAL contracts with thousands of independent medical providers including physicians, hospitals, pharmacies, nursing homes, outpatient diagnostic centers, rehabilitation facilities, laboratories, home health agencies, and a myriad of other medical providers who render medical benefits to PRUDENTIAL members for an agreed upon fee.[1] These medical providers, including

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[1] By contrast to an IPA HMO, a "Staff Model HMO" employs its providers and generally furnishes services at specific locations. See Fl. Admin. Code 4-191.024

the former co-Defendants herein, are not agents of PRUDENTIAL, but rather maintain their own practices or facilities, use their own independent medical judgment, provide services to numerous third-party payors other than PRUDENTIAL, and are independent contractors. Indeed, the Certificate of Coverage defining the Plan benefits (as distributed to SUSAN VILLAZON and all other Plan beneficiaries) explicitly and unambiguously stated that medical providers under the Plan (1) were "independent contractors," not PRUDENTIAL's "agents," (2) would maintain provider-patient relationships directly with Plan subscribers, and (3) would be "solely responsible" for medical care furnished under the Plan.

Plaintiff's claims against PRUDENTIAL are based on theories of agency and breach of non-delegable duty, both directly related to the structure and design of the benefits under the Plan and the manner in which PRUDENTIAL administered the benefits according to those parameters. (R. Vol. I, 22-28). Plaintiff does not allege that PRUDENTIAL did anything wrong and seeks only to hold PRUDENTIAL liable for the negligence of the former co-Defendant medical providers, who were all independent contractors.

Plaintiff exclusively sought to establish PRUDENTIAL's liability by directly

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(definitions of IPA HMO and Staff Model HMO).

targeting the mechanisms created by the Plan to establish the boundaries of covered benefits. Plaintiff specifically alleged that, by virtue of the Plan's inclusion of certain specified managed care features - requiring members to use services of primary care physicians, requiring members to obtain medical care from a select list of providers, controlling the referral process and requiring that pre-authorization be obtained for diagnostic and therapeutic procedures, PRUDENTIAL is liable for the actions of its independent contractors. (R. Vol. I, 22-28, R. Vol. II, 208-210). Plaintiff claims that PRUDENTIAL's mere existence as an IPA HMO makes it liable for the medical care provided by any medical provider who treats a PRUDENTIAL member.

The Trial Court entered Summary Final Judgment in favor of PRUDENTIAL holding that all of Plaintiff's claims were preempted by Section 514 of ERISA, as they directly challenged the administration of benefits pursuant to the terms of the Plan. (R. Vol. V, 43). The Trial Court also entered Summary Final Judgment for Defendant on state law grounds finding that as an IPA HMO, PRUDENTIAL did not have a non-delegable duty through which it could be held liable for the actions of health care providers that were independent contractors and that Plaintiff could not prevail on state law grounds because the uncontroverted evidence established that DR.

SARNOW was acting at all times as an independent contractor. (R. Vol. V, 43).[2]

Plaintiff appealed the ruling by the Trial Court both on ERISA preemption and state law grounds. On March 14, 2001, the Appellate Court affirmed the Trial Court's decision on both grounds. See Villazon v. Prudential Health Care Plan, Inc., 794 So.2d 625 (Fla. 3d DCA 2001). The Appellate Court held that plaintiff's claims were preempted by ERISA because plaintiff's agency and non-delegable duty claims impermissibly "attacked the administration of the Plan and because recognizing such a claim would undermine the uniform administration of ERISA plans." The court also held both that Summary Judgment was appropriate on the agency issue, since "all the contractual provisions" designated the provider as an independent contractor and there was "no evidence" of any contrary actual practice, and that PRUDENTIAL never owed a non-delegable duty.[3]

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[2] At the time that the Motion for Final Summary Judgment was heard, Plaintiff had settled with DRS. GARCIA-SELECK and SATZ, which disposed of all the claims against those medical providers and PRUDENTIAL for the actions of those medical providers. All the claims were dismissed with prejudice. Prior to the filing of the Notice of Appeal, Plaintiff settled with DR. SARNOW. However, the settlement did not dispose of the claim against PRUDENTIAL for the alleged negligent actions of DR. SARNOW. Therefore, the only issue remaining is whether PRUDENTIAL can be held liable for the actions of DR. SARNOW. See Petitioner's Main Brief at Page 5.

[3] Plaintiff requested review of the Appellate Court's preemption ruling as allegedly conflicting with the decision in In re Frappier, 678 So.2d 884 (Fla. 4th DCA 1996). Plaintiff did not seek conflict review of any other ruling, including Summary Final

STATEMENT OF FACTS

Valdes-Fauli established and maintained the ERISA Plan at issue for the benefit of its employees and made contributions toward the payment of premiums. (R. Vol. II, 215-217, R. Vol. IV, 656-659). It was a ". . . Health Plan of the Contract Holder providing health care expense coverage." (R. Vol. IV, 656-659, R. Vol. VI, 706-744). The individuals entitled to health care expense coverage through the Plan were employees and qualified dependents. (R. Vol. IV, 656-659, R. Vol. VI, 706-744). At all material times, SUSAN VILLAZON was a beneficiary of the Plan, which was being administered by PRUDENTIAL. (R. Vol. II, 215-217, R. Vol. IV, 656-659). The structure of the Plan and the parameters of eligible benefits were codified in the Certificate of Coverage that was provided to all beneficiaries. (R. Vol. IV, 656-659, R. Vol. VI, 706-744).

The Plan provided coverage that included payment for many of the services required for the care and treatment of the employees' and their dependents' sicknesses and injuries or to maintain their good health, as determined by a Primary Care

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Judgment on state law grounds, as there was no conflict with any other appellate ruling. Plaintiff also did not seek conflict review of the Appellate Court's ruling that the non-delegable duty claim was preempted by ERISA, as that ruling was consistent with the ruling in Frappier, supra. Defendant respectfully contends that this Court is limited to only addressing the alleged conflict presented in the request for review.

Physician such as DR. SARNOW. Each covered person selected a Primary Care Physician to provide primary medical care and maintain continuity of care, and those physicians had agreed, directly or indirectly, to arrange for or provide medical services and supplies to covered persons. The Certificate of Coverage given to plan members, including SUSAN VILLAZON, explicitly stated (1) that each provider of medical services or supplies was an "independent contractor," not an agent of the HMO; and (2) that that each provider would maintained the provider-patient relationship with covered persons and was "solely responsible" for care provided. (R. Vol. IV, 672-682, R. Vol. VI, 706-744).

Based on the structure of the Health Plan, PRUDENTIAL, as an IPA HMO, entered into contracts with medical providers who had their own independent practices and who agreed to provide covered services for a contracted rate. DR. SARNOW was one such doctor. In fact, SUSAN VILLAZON selected DR. SARNOW as her treating physician before she became a member of the PRUDENTIAL HMO. (R. Vol. IV, 684, R. Vol. VI, 820-825). PRUDENTIAL's agreement with DR. SARNOW specifically provided that his relationship would be as an independent contractor, not an agent.[3] The agreement allowed him to continue his independent practice and also provided that he was not precluded from rendering care to patients who were not

insured with PRUDENTIAL. (R. Vol. IV, 677, R. Vol. VI, 798-819). DR. SARNOW funded, supplied and maintained his own independent, private office and rendered care and treatment to patients insured through numerous companies. Every time he treated a patient, including SUSAN VILLAZON, he did so at his private office. No member of his office staff was associated with PRUDENTIAL. His office staff managed the scheduling of patients, including SUSAN VILLAZON, and all medical records generated when he treated his patients, including SUSAN VILLAZON, were maintained at his private office. (R. Vol. IV, 677-682, R. Vol. VI, 820-825).

As noted above, the Plan specified that DR. SARNOW was solely responsible for his medical decisions. The unrebutted evidence established that he rendered care to all his patients, including SUSAN VILLAZON, regardless of their insurance status, in the same manner and in accordance with the same standard of care. (R. Vol. IV, 677-682, R. Vol. VI, 820-825, R. Vol. II, 235). He maintained his own malpractice insurance and rendered care according to his own medical judgment and guidelines. (R. Vol. IV, 677-682, R. Vol. VI, 820-825).

SUMMARY OF ARGUMENT

The courts below properly entered judgment for PRUDENTIAL because Plaintiff's claims are preempted by ERISA as they exclusively seek to hold PRUDENTIAL liable by directly attacking the mechanisms created by the Plan to establish the bounderies of covered services, which would result in mandating a change in employee benefit structures or their administration. New York State Conf. of Blue Cross & Blue Shield v. Travelers, Inc. Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). Additionally, the courts properly entered judgment for PRUDENTIAL because Plaintiff's claims are meritless as a matter of state law.

In Travelers, the United States Supreme Court reaffirmed its opinion that the purpose of ERISA is to avoid a multiplicity of regulation in order to permit a nationally uniform administration of employee benefits plans, and further opined that ERISA preempts state laws that mandate employee benefit structures. The Supreme Court further held that ERISA preempts state laws even if they may only have an indirect economic effect so as to force an ERISA plan to adopt a certain scheme of coverage or effectively restrict its choice of insurers. See Travelers at 1683.

That is precisely what Plaintiff's extraordinarily broad claims here would do. Plaintiff attacks the structure of SUSAN VILLAZON's employers' Plan by alleging

that PRUDENTIAL is liable for the negligence of the independently contracted health care providers because of its implementation of the structure of the Plan by defining the boundaries of covered benefits. Plaintiff's claims assert that the inclusion of certain specified core managed care benefit features – such as use of primary care physicians and lists of participating physicians, referral requirements, and pre-authorization rules make PRUDENTIAL liable for those provider's alleged malpractice. A ruling that ERISA does not preempt claims of this nature would mandate a change in the core managed care benefits structure of this Plan, and other similarly situated plans that offer benefits through the IPA HMO structure, as PRUDENTIAL and other managed care organizations would not be able to exist in this fashion if they were liable for the negligence of thousands of medical providers, whether contracted or not, on a daily basis. Such a ruling would require this Plan, and other similarly situated plans, to exclude the specific benefits that Plaintiff contends creates the liability. This Plan, and other similarly situated plans, would have to eliminate structuring their benefits through IPA HMOs such as PRUDENTIAL, and eliminate benefit structures that have Primary Care Physicians, a list of specialty providers credentialed by the IPA HMO, and eliminate pre-authorization requirements for diagnostic testing, all of which would destroy the structure of this Plan and others.[4] Furthermore, an application of the law that would allow claims under this set of circumstances would result in limiting

consumer choice by eliminating this structure of health plan, which would have an immediate and tremendous adverse affect on health care costs. Additionally, such a holding would result in a conflict with Congress' intent that a plan not be subject to a myriad of state laws applying to employee benefit plans, as it would require interstate employers to administer their plans differently in each state in which they have employees. For these reasons, Plaintiff's claims are clearly preempted under Section 514 of ERISA.

Moreover, there is no genuine issue of material fact that at all times, DR. SARNOW rendered care and treatment as an independent contractor. All the record evidence shows that DR. SARNOW's and PRUDENTIAL's intent was only to create an independent contractor relationship. PRUDENTIAL never treated DR. SARNOW as an agent or employee. DR. SARNOW never acted as an agent of PRUDENTIAL and PRUDENTIAL never controlled or had the right to control DR. SARNOW's medical decisions. At all times, DR. SARNOW had his own independent, private office where he rendered care and treatment to his patients, including SUSAN VILLAZON. At all times, DR. SARNOW exercised his own independent medical judgment on how to render care and treatment to all his patients, including SUSAN VILLAZON. PRUDENTIAL at no time interfered with, controlled, or had the right to control his medical judgments. The physician-patient relationship was at all times

exclusively between DR. SARNOW and SUSAN VILLAZON. The record is also completely devoid of any evidence whatsoever that would render PRUDENTIAL liable for the actions of its independently contracted physician, DR. SARNOW, through a theory of apparent agency.

Furthermore, Plaintiff cannot avoid the independent contractor relationship through claims for breach of a non-delegable duty allegedly created by statute and/or contract. The Florida Legislature created a system whereby IPA HMOs could develop and charge a reasonable premium for health care coverage by contracting with private medical providers who would render and be responsible for their own medical care. There is no doubt that the Florida Legislature envisioned an alternate system of access to health care involving three primary components: the HMO, subscriber, and provider. As a result, it drafted statutory provisions that govern the relationship between those parties and which provide for administrative mechanisms to ensure access to quality care. There is absolutely no statutory basis for interpreting the legislative intent to mean that IPA HMOs, which may contract with hundreds or thousands of medical providers, are to be liable for the medical negligence that might occur at every office visit, out-patient testing, laboratory visit, hospitalization, home health visit, nursing home visit, and every other type of medical care provided to its members.

Additionally, the record evidence unequivocally demonstrates that there was no contractual non-delegable duty through which PRUDENTIAL as an IPA HMO could be held liable. The Certificate of Coverage specifically notified SUSAN VILLAZON that her medical care would be supplied by independent contractors who are solely responsible for the care rendered. In addition, the independent contractor relationship existed in actual practice, as previously discussed.

Based on the foregoing, the Appellate Court correctly affirmed Summary Final Judgment in favor of PRUDENTIAL on ERISA preemption and state law grounds.

ARGUMENT

POINT I

PLAINTIFF'S CLAIMS ARE PREEMPTED BY SECTION 514 BECAUSE THEY RELATE TO THE BENEFIT STRUCTURE UNDER THE PLAN

As we now show, Plaintiff's state law claims in this case are preempted by Section 514 of ERISA because those claims if recognized would mandate drastic changes to the core benefit features of the ERISA plan under which SUSAN VILLAZON was covered, as well as to all other ERISA health benefit plans that utilize IPA HMOs. Such a result, moreover, would restrict plan sponsor and consumer

choices as to types of plans available, result in a multiplicity of regulation of ERISA plans, and undermine policy decisions of the United States Congress to encourage the use of IPA HMOs. Plaintiff's claims are therefore preempted by Section 514 of ERISA as a matter of law. [4]

A. The Scope of Preemption Under ERISA Section 514

ERISA was enacted to serve as the body of federal substantive law to regulate the administration of employee benefit programs and to govern issues regarding rights and obligations under private welfare and pension plans. In order to advance the legislative-Rand Co.29 U.S.C. § 1144(a) Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987)-Rand Co.-Rand Co.Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 111 S. Ct. 478, 484, 112 L. Ed. 2d 474 (1990)-Rand Co.-Rand Co.29 U.S.C. § 1144(a)Shaw v. Delta Airlines, Inc., 463 U.S. 85, 103 S.

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[4] Plaintiff has not contested at any stage in these proceedings, and does not contest now, that the employer-sponsored Plan established and maintained by Valdes-Fauli was an ERISA welfare benefit plan. (R. Vol. II, 207-212, R. Vol. V, 1-48). Accordingly, the portion of the Amicus Brief asserting that this case does not involve an ERISA plan violates established law as to what issues can be presented in an Amicus Brief and should be ignored. See Higbee v. Housing Authority of Jacksonville, 197 So. 479 (Fla. 1940); Turner v. Tokai Financial Servs. Inc., 767 So.2d 494 (Fla. 2d DCA 2000); Acton II v. Ft. Lauderdale Hosp., 418 So.2d 1099 (Fla. 1st DCA 1982).

Ct. 2890, 77 L. Ed. 2d 490 (1983)Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S 724, 105 S. Ct. 2380, 85 L. Ed.2d 728 (1985)

Moreover, in New York State Conf. Of Blue Cross & Blue Shield v. Travelers Inc. Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), the Supreme Court reaffirmed its opinion that ERISA's purpose is to avoid multiplicity of regulation and further held that laws that mandate employee benefit structures are preempted under Section 514 of ERISA. In Travelers, the Supreme Court addressed whether ERISA preempted a New York statute, which required collection of surcharges from patients not covered by Blue Cross and Blue Shield.

As part of its ruling, the United States Supreme Court in Travelers specifically distinguished the case with cases based on claims that directly deal with the administration of benefits or structure of an ERISA plan. The Supreme Court recognized that Congress' intent in enacting ERISA was to avoid a multiplicity of regulation in order to permit a nationally uniform administration of employee benefit plans. Id. at 1678. The Court specifically approved its previous decisions, such as in Shaw, supra; wherein it ruled that ERISA preempted claims that mandated employee benefit structures or administration. Id. Additionally, the Supreme Court held that claims requiring alternative enforcement mechanisms also relate to ERISA plans and also opined that a state law that might produce an indirect economic impact, so as to

force an ERISA plan to adopt a certain scheme of coverage where it effectively restricted the choice of insurers, is preempted by Section 514. Travelers at 1683.

B. Plaintiff's Claims Against PRUDENTIAL are Preempted

The preemption of Plaintiff's claims is consistent with the test articulated by the United States Supreme Court in Travelers because it would mandate drastic changes in the core managed care benefit structure of this Plan. The Appellate Court understood that based on Plaintiff's allegations and the record evidence, that PRUDENTIAL could only be held liable by a trier of fact through an examination and interpretation of the Plan benefit design, as all of Plaintiff's claims attacked the structure and administration of the Plan.

A determination that ERISA does not preempt state law in this context would force a complete restructuring of this Plan and other similarly situated plans, as they would be liable for the acts of thousands of medical providers, whether contracted or not, on a daily basis. That would transform PRUDENTIAL's role from an administrator of coverage benefits (i.e., payment) into a guarantor of the medical care being provided by all sorts of independent health care professionals delivering services far from PRUDENTIAL's supervision. The enormous potential liability imposed by such a ruling would have the economic effect of forcing these plans to adopt a

different scheme of coverage and effectively restrict the plan beneficiaries' choice of insurers, as this liability would necessarily force PRUDENTIAL, and other insurers, to stop offering this benefit structure to employer sponsored plans. Furthermore, to allow a cause of action like this in Florida would create a multiplicity of regulation whereby different states would be interpreting their state laws on vicarious liability in different ways, thereby destroying the uniformity across state lines envisioned by ERISA.

The first step in the analysis that leads to the inescapable conclusion that Plaintiff's claims are preempted by Section 514 of ERISA is to understand the true nature of the claims against PRUDENTIAL. As the Appellate Court properly concluded, and Plaintiff clearly acknowledges, this is not a case in which Plaintiff is alleging that Defendant did anything wrong in connection with the health care provided. Instead, Plaintiff sets forth a medical malpractice claim against the independent health care providers, who allegedly rendered the negligent care, failed to treat, and failed to obtain diagnostic tests. Plaintiff then attempts to hold PRUDENTIAL liable on theories of agency by alleging that the structure of the employer's plan makes PRUDENTIAL liable for the acts of the former co-Defendant independent contracted providers. In the alternative, Plaintiff claims that if there is no vicarious liability, PRUDENTIAL is still liable pursuant to breach of a non-delegable duty allegedly created by the Plan.

Throughout this lawsuit, Plaintiff has pointed out the differences between an insurer and an IPA HMO under Florida law. Plaintiff argues that if health coverage is provided through an indemnity insurer, there are no administrative regulations such as the ones alleged to exist in this Plan, and an insurer would not be vicariously liable because the insured would be free to seek health care anywhere, anytime, and without reference to any structure. Plaintiff's attempt to demonstrate "control" in an IPA HMO setting, which is the structure of benefits chosen by the Plan, conclusively shows that it is the Plaintiff's own contention that it is the structure of the Plan that serves as the basis for liability. This being the case, Plaintiff's claims are preempted under ERISA. Travelers, Inc. Co., supra; Pilot Life, supra; Metropolitan Life Ins., supra; Foott v. Stempel, D.O., et al., No. 99-7087 (S.D. Fla. Nov. 22, 1999) (R. Vol. IV, 662, R. Vol. VI, 787-797); Jass v. Prudential Healthcare Plan, Inc., 88 F.3d 1482 (7th Cir. 1996).

In Foott, the court specifically held that agency claims against an HMO are preempted when they directly implicate the administration of benefits. The plaintiffs in Foott specifically alleged that the HMO limited the plaintiffs' use of the plan by requiring them to utilize those physicians and hospitals listed in the provider directory, by controlling the health care providers through practice guidelines, and by

discouraging the use of specialists.

Like in Foott, Plaintiff directly attacks PRUDENTIAL's administration of benefits pursuant to the structure of the Plan. Here, Plaintiff argues that PRUDENTIAL's implementation of the benefit structure for eligibility of benefits under the Plan exposed it to liability because PRUDENTIAL allegedly: 1) controlled the referral process and required that pre-authorization be obtained prior to the performance of diagnostic tests and procedures; 2) required physicians to provide and arrange health care services through contracted providers; and 3) limited access to specified physicians. (R. Vol. I, 22-28, R. Vol. II, 208-210, R. Vol. V, 7-9, 11, 13-16, 17-20, 30, 32-33).

These are the exact elements of the benefit eligibility structure created by the Certificate of Coverage provided to each beneficiary of the Plan established and maintained by Valdes-Fauli, including SUSAN VILLAZON. (R. Vol. VI, 706-744). The Plan Certificate of Coverage specifically states that all covered benefits must be furnished by a primary care physician or by another participating or non-participating provider authorized by the primary care physician. (R. Vol. VI, 706-744). In addition, the Plan specifically states that certain services and supplies must be authorized by a medical director in order to be covered. (R. Vol. VI, 706-744). Therefore, just as the court in Foott, the Appellate Court correctly concluded that Plaintiff's agency claims

against PRUDENTIAL were preempted.

Similarly, in Jass, supra, the plaintiff brought an action against the HMO alleging that it was liable for the acts of co-defendant medical providers. The court held that both claims were preempted by ERISA and stated that:

> In this case, both of Jass' vicarious liability claims against PruCare for Dr. Anderson's alleged negligence (Counts I and II) directly "relate to" the Plan. The Plan listed Dr. Anderson as a physician and provided a higher level of benefits if participants sought treatment from him. If an agency relationship existed between PruCare and Dr. Anderson, as Jass alleged, it was solely as a result of the Prucare's health care plan of which Jass was a participant. Without a benefit plan, PruCare would have no need for a relationship with Dr. Anderson and Jass would probably not have sought treatment from him. Additionally, to determine whether an actual or apparent agency relationship existed between Dr. Anderson and PruCare would require an examination of the health care benefit plan to determine the relationship between Dr. Anderson, PruCare and Jass. Id. at 1493.

As stated above, the Plan in this case specifically mandated that in order for services to be covered, they needed to be provided by a primary care physician or a physician authorized by a primary care physician. (R. Vol. VI, 706-744). Additionally, the Plan specifically mandated that covered services be provided by independent contractors and that each provider, including DR. SARNOW, maintain the provider-patient relationship and be solely responsible to the beneficiaries for the services furnished. (R. Vol. VI, 706-744). Just as in Jass, Plaintiff's agency claims must be

preempted because the Plan must be examined to determine the relationship between DR. SARNOW and PRUDENTIAL, pursuant to its benefit structure. Additionally, the Plan provided for coverage if participating or authorized providers rendered the services. Therefore, just as in Jass, it is solely due to the benefit structure created by the Plan that there is a relationship between DR. SARNOW and PRUDENTIAL.

The recent decision in Krasny v. Aetna Life Ins. Co. & Aetna U.S. Healthcare, Inc. et. al., 2001 WL 710048 (M.D. Fla. 2001) further supports the conclusion that Plaintiff's claims based on the administrative structure of the Plan and administrative decisions by PRUDENTIAL are preempted by ERISA. In Krasny, the plaintiff filed an action against the managed care organization seeking to hold it liable for the health care providers on a theory of agency. The plaintiff alleged that the organization was liable because it required the decedent to be examined by "gatekeeping" health care providers before authorizing necessary medical treatment.

In ruling that the agency claims were preempted, the court's analysis focused on determining whether the complaint was entirely an attack on the quality of the care provided or whether, at least in part, the complaint targeted the benefits structure under the terms of the plan. Even though the court recognized that some of the allegations attacked the quality of the care, there were other allegations that could not be

described as an attack on the quality of care, but instead targeted the benefit eligibility structure under the plan.

Even though Plaintiff continues to categorize this case as a medical malpractice case against PRUDENTIAL and makes mention of the quality of care provided by DR. SARNOW, an independent contractor, the fact is that the agency claims set forth against Defendant attacked exclusively the benefit structure developed by the Plan that utilizes primary physicians, participating providers, and the determination of covered benefits through authorization procedures.

Pursuant to the preemption analysis developed above, the inescapable conclusion is also that Section 514 of ERISA preempts Plaintiff's alternative claims that PRUDENTIAL is liable because it breached its alleged non-delegable duty to provide comprehensive health care, as required by the terms of the Plan.[5] As with the agency claims, these claims require the trier of fact to refer to the Plan's provisions, and therefore are preempted by ERISA. (R. Vol. I, 1-29, R. Vol. II, 207-212, R. Vol. IV, 702). In order for a trier of fact to determine if the Plan created a non-delegable duty, the trier of fact must specifically scrutinize the Plan benefit structure and interpret

[5] A non-delegable duty claim is an alternative to vicarious liability claims in that regardless of the independent contractor relationship with the health care providers, which eliminates any vicarious liability claim, it seeks to hold PRUDENTIAL directly and strictly liable for the negligent care and treatment.

its terms as creating such a duty. This would inevitably lead to multiple administrative standards and the mandating of a benefit scheme under the Plan. These are the exact types of claims Travelers contemplated would be preempted by ERISA.

In fact, claims based on breach of a non-delegable duty theory have been specifically found to be preempted by ERISA, as they inherently relate to the ERISA plan. See Frappier v. Wishnov, D.O., 678 So. 2d 884 (Fla. 4th DCA 1996). In Frappier, the plaintiff sued two doctors and the health maintenance organization. Count V of the Complaint against the HMO was premised on a theory of corporate liability (non-delegable duty) based on allegations that the HMO had a common law duty to provide appropriate medical care. The court held that the allegations related to the administration of the plan and were preempted by ERISA. Id. at 887.

The claim in Frappier was based on allegations that the terms of the ERISA plan created the non-delegable duty and that the HMO assigned the medical providers to the patients and thereby limited the access to care. Similarly, in the instant case, Plaintiff's claims of breach of a non-delegable duty are based on allegations that the Plan's terms create the non-delegable duty and that PRUDENTIAL assigned medical providers and required referrals to contracted providers, thereby limiting access to care. (R. Vol. II, 208-210). Plaintiff specifically argued before the Trial Court that PRUDENTIAL was liable, because as part of managing the health care benefits under

the Plan, PRUDENTIAL decides who provides the benefits, when the benefits are provided, where the benefits are provided, and why benefits need to be provided. (R. Vol. V, 32-33).

C. Plaintiff's Contrary Argument is Meritless

The arguments raised against preemption under Section 514, as presented in Petitioner's Main Brief and the Amicus Brief, are flawed in that they fail to understand the fundamental differences between the test for complete preemption under Section 502 and the test for ordinary or conflict preemption under Section 514, and the failure to understand the purpose behind the two Sections.

The difference in the application of these sections was best explained in Krasny, supra, wherein that court stated that, "[a]lthough they share similar titles, the doctrine of complete preemption and the doctrine of ordinary preemption present distinctly different issues – a difference not merely **in scope** but of quality." Id. at 3. The court also stated that "[t]he former is used to establish a federal court's jurisdiction over a case, while the latter merely provides a party with an affirmative defense to a state law claim in either federal or state court." Id. After which, the court went on to state that a claim that seeks to remedy a loss or denial of a benefit is completely preempted under Section 502 and removal is proper. However, if the claim only "relates to" an

ERISA plan, such a claim is not completely preempted, and the federal court would lack jurisdiction over the dispute and remand is required, "although defensive preemption would allow the defendants to prevail over such claims in state court." Id. at 4; See also Lazarko v. Pennsylvania Hospital, 237 F.3d 242, 248 (3d Cir. 2000).[6]

The principles of complete preemption are triggered under ERISA when claims seek to recover benefits, enforce rights under the terms of the plan, or clarify rights to future benefits. Krasny at 5. However, as discussed above, a broader test was developed by the United States Supreme Court for ordinary preemption pursuant to Section 514's "relate to" language, which holds that even though the claim does not fall within the purview of Section 502, if the claim directly related to the administrative or benefit structure under the ERISA plan, then the claim is preempted by Section 514. See Travelers, supra.

The failure to comprehend the difference in the scope and purpose between the tests has resulted in the misplaced reliance by Plaintiff and the Amicus Curiae on cases applying the complete preemption analysis applicable to claims under Section 502 of ERISA to the instant case, which was decided on Section 514 grounds. In fact, many

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[6] The failure to understand the difference between complete preemption and ordinary preemption is exemplified by the argument raised by the Amicus Curiae that the basis of the Third District's decision is that there is no subject matter jurisdiction in the trial court for Plaintiff's claim. See Amicus Brief at Page 9.

of the cases relied upon by these parties specifically acknowledge that even though there is no federal jurisdiction, the claims could still be found by the state court to be preempted under Section 514. See In re: U.S. Healthcare, Inc., 193 F.3d 151, 164-165 (3d Cir. 1999) (holding that the claims were not completely preempted under Section 502 as they did not seek to recover benefits and stating that it will be the state court that will decide whether express preemption applies.); Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 361 (3d Cir. 1995) (holding that it did not have removal jurisdiction because the claims did not deal with the denial of any benefits, or some other plan-created right and bore no resemblance to claims under Section 502. However, still open for the state court's resolution is whether the claims were preempted by Section 514); and Lazarko, 237 F.3d at 249, 250 (holding that the claims were not preempted by Section 502 because plaintiff did not seek a remedy of a denial of a benefit and on remand, the state court would decide whether the claims were preempted under Section 514).

The main argument in opposition by Plaintiff and the Amicus Curiae is that the claims by Plaintiff do not seek "to recover plan benefits due, or to enforce rights, or to clarify rights" under the Plan, or as the Amicus Curiae refers to it, "eligibility decisions". The crux of what these parties are arguing is that the "relates to" test under Section 514 is the same as the test for complete preemption under Section 502

and preemption under Section 514 is limited to claims that deal with the recovery of benefits. However, this conclusion is not supported by the cases cited by Plaintiff and the Amicus Curiae, and more importantly, is contrary to the test developed by the United States Supreme Court. At no time did the Supreme Court in Travelers hold that the "relates to" test is limited to claims that fall exclusively within the provisions of Section 502. Instead, the Supreme Court was specific in only limiting the test to claims that deal with the administration of benefits or mandate a benefit structure, in order to promote Congress' intent of a uniform law governing the administration of ERISA plans.[7]

The misunderstanding by Plaintiff and the Amicus Curiae between complete preemption under Section 502 and ordinary preemption under Section 514 may be rooted in their reliance on the decision by the court in Frappier, supra. However, a close analysis of that decision reveals that the Frappier court used the wrong test in holding that the vicarious liability claims were not preempted by Section 514. As

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[7] Had Congress intended that Section 514 be limited to claims governed by Section 502, it would have used the same language or specifically referred to Section 502 within Section 514. Instead, Congress specifically created a broader test and used the "relates to" language. It is obvious that if a claim is to recover benefits, then it relates to the ERISA plan and falls within the purview of Section 514. However, as the authority cited clearly establishes, just because a claim does not fall within Section 502 does not mean that it is not preempted by Section 514. See Krasny, supra, In re: U.S. Healthcare, Inc., supra, Dukes, supra, and Lazarko, supra.

Plaintiff correctly points out, the court held that the claims were not preempted because the plaintiff did not seek to recover plan benefits due, enforce rights, or clarify rights to benefits under the terms of the plan. Frappier, 678 So.2d at 887. As stated above, this is the test to determine whether a claim is completely preempted under Section 502 and whether there is removal jurisdiction. Instead, the Frappier court should have used the test under Section 514 as developed by the United States Supreme Court and determined not whether the claims requested plan benefits, but instead, as the Appellate Court in this case did, whether the claims challenged the administration of benefits, which relate to the structure of the benefit Plan.[8]

Plaintiff's and the Amicus Curiae's reliance on the holding in Pegram, supra, to oppose the ruling by the Appellate Court is also misplaced. The United States Supreme Court in Pegram was only addressing whether there was a claim for breach of fiduciary duty and at no time addressed the preemption of claims under ERISA.[9]

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[8] The fact that the Frappier court used the wrong test in concluding that the vicarious liability claims were not preempted is exemplified by the fact that, as the Amicus Curiae states, it relied so heavily on the decision in Dukes, supra, a case that specifically recognizes that even though the claims were not governed by Section 502, the claims may be preempted by the broader provision under Section 514. Dukes, 57 F.3d at 361.

[9] A mere cursory reading of the decision in Pegram reveals that the Supreme Court was not addressing the issue of preemption under Section 514. However, the Amicus Curiae makes this misrepresentation throughout the Amicus Brief, even though the law review articles it so heavily relies upon specifically state the opposite. See Goodrich,

In fact, numerous courts have specifically held that Pegram provides no authority to the preemption analysis under ERISA. See Rosenkrans v. Wetzel, 131 F.Supp.2d 609 (M.D. Pa. 2001) (wherein the court stated that "Pegram is confined to its own particular factual background and it provides us with no authority"); Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266 (3d Cir. 2001) (wherein the court stated that Pegram was exclusively concerned with fiduciary acts and not ERISA preemption and held that the ultimate distinction to make as to ERISA preemption is whether claims challenge the administration or eligibility of benefits); and Schusteric v. United Healthcare Ins. Co. of Illinois, 2000 WL 1263581 (N.D. Ill. 2000) (wherein the court stated that "Pegram's discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA Section 1109 says nothing about whether a negligence claim of the type alleged in this case is completely preempted by Section 502(a)").[10]

The Amicus Curiae contends that this case does not involve an ERISA plan

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What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws after Pegram, 101 Colum. L. Rev. 1107 (2001) (wherein the author begins by stating that "though Pegram dealt with a fiduciary liability question, and not preemption specifically ÿ").

[10] The Amicus Curiae argues that the Appellate Court incorrectly relied on the decision in Jass, supra. However, the Schusteric court specifically confirmed the validity of the Jass holding in light of the fact that the Pegram decision had nothing whatsoever to do with preemption under ERISA.

arguing that Plaintiff is challenging the relationship between the independent health care provider and PRUDENTIAL and not the Health Plan. The argument relies on the analysis by the United States Supreme Court in Pegram, in the context of determining what actions by an HMO are fiduciary in nature, wherein it stated that "ÿ the agreement between the employer and the HMO provides the elements of the ERISA plan." Pegram, 530 U.S. at 223, 120 S.Ct. at 2151.

At no time has PRUDENTIAL ever taken the position that it is the ERISA plan. Instead, the position taken, which is completely consistent with ERISA and Pegram, is that Defendant is the Plan Administrator of the Plan sponsored by Valdes-Fauli, through which SUSAN VILLAZON had coverage.

The argument presented by the Amicus Curiae is not well founded in that it conveniently ignores the fact that Plaintiff is not simply attacking the relationship between PRUDENTIAL and the independent contractor, DR. SARNOW. Plaintiff is challenging the structure specifically required by the Plan for health care benefits to be covered. As developed above, the Plan Certificate of Coverage specifically states that all covered benefits must be furnished by a primary care physician or by another participating or non-participating provider authorized by the primary care physician. (R. Vol. VI, 706-744). In addition, the Plan specifically states that certain services and supplies must be authorized by a medical director in order to be covered. (R. Vol. VI,

706-744). The undeniable facts are that if it were not for the structure of the Plan, the relationship with the providers would not exist and SUSAN VILLAZON could have gone to any provider of her choice, and the lawsuit would never have been brought. Therefore, Plaintiff's contention that PRUDENTIAL is liable because through its administration of the Plan it 1) controlled the referral process and required that pre-authorization be obtained prior to the performance of diagnostic tests and procedures; 2) required physicians to provide and arrange health care services through contracted providers; and 3) limited access as to the physicians subscribers could see, (R. Vol. I, 22-28, R. Vol. II, 208-210, R. Vol. V, 7-9, 11, 13-16, 17-20, 30, 32-33), challenges the very benefit structure created by the Plan. Moreover, the Plan specifically created a benefit structure wherein any provider of medical services or supplies, including DR. SARNOW, was an independent contractor, with each provider maintaining the provider-patient relationship and being solely responsible to the beneficiaries for the supplies and services furnished. (R. Vol. IV, 672-682, R. Vol. VI, 706-744). In order for Plaintiff to prevail on his claims, the trier of fact would have to alter the specific benefit structure of the Plan and find that an agency relationship exists between the health care providers and the Plan, despite the clear wording of the Certificate of Coverage that all providers are independent contractors. Therefore, there is no question that Plaintiff's claims relate to and attack the benefit structure precisely

provided for and referenced in the Plan and are therefore preempted.[11]

POINT II

THE CONCLUSION THAT DR. SARNOW WAS RENDERING CARE AS AN INDEPENDENT CONTRACTOR RAISES NO GENUINE ISSUE OF MATERIAL FACT.

Because plaintiff's claims are preempted by ERISA, there is no need to address the lower courts' alternative state law grounds for summary judgment. As we now show, however, those rulings too were clearly correct. First, the courts below rightly held that there is no material fact in dispute as to Plaintiff's agency law claim and that PRUDENTIAL is entitled to judgment against that claim as a matter of law. In particular, the record evidence can only lead to only one conclusion -- that DR. SARNOW was acting as an independent contractor, not as PRUDENTIAL's agent, and thus Summary Final Judgment in favor of PRUDENTIAL was mandated. Food Fair Stores of Fla, Inc. v. Patty, 109 So.2d 5 (Fla. 1959); Johnson v. Gulf Life Ins.

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[11] A conclusion that is also supported by the articles so heavily relied upon in the Amicus Brief. See Goodrich, What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws after Pegram, 101 Colum. L. Rev. 1127-28 (2201) (wherein in addressing general any provider laws, the author conceded that "if stipulation regarding provider selection are moved into the agreement between the MCO and the employer (in this case the Certificate of Coverage), then laws like AWP laws that address provider selection would relate to an employee benefit plan, even under Pegram").

Co., 429 So.2d 744 (Fla. 3d DCA 1983).

This Court has specified the analysis used to decide whether an independent contractor or agency relationship exists. See Cantor v. Cochran, 184 So.2d 173 174 (Fla. 1966); Keith v. News & Sun Sentinel Co., 667 So.2d 167 (Fla. 1995). Under that analysis, courts first look to the agreement entered into between the parties and should "honor that agreement" unless the parties' actual practice is contrary to the terms of their agreement. Keith, supra. In other words, the focus should be on the parties' agreement and a fact-specific analysis of the parties' actual conduct should be conducted only if their intent cannot be ascertained from the written agreement or their actions demonstrate a different status. Id. at 168, 171. In performing such a fact-specific review of the parties' conduct, the court is to employ the test set forth in Restatement of Agency (2d Edition) Section 220. See Cantor, 184 So.2d at 174; Keith, 667 So.2d at 167.[12]

[12] The test looks to ten different factors which include: 1) the extent of control which, by the agreement, the master may exercise over the details of the work; 2) whether or not the one employed is engaged in a distinct occupation or business; 3) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision; 4) the skill required in the particular occupation; 5) whether the employer or the workmen supplies the instrumentalities, tools, and the place of work for the person doing the work; 6) the length of time for which the person is employed; 7) the method of payment, whether by the time or by the job; 8) whether or not the work is a part of the regular business of the employer; 9) whether the parties believe they are creating the relation of master

In this case, all the relevant contracts explicitly state that the relationship between PRUDENTIAL and DR. SARNOW was that of an independent contractor. First, as set forth above, the Agreement between PRUDENTIAL and DR. SARNOW expressly and repeatedly states that the parties were creating an independent contractor relationship, not an agency relationship. Article III of the "Primary Care Physician Capitation Agreement" specifically states:

> The relationship among The PRUDENTIAL Medical Director, Participating Physicians, and Participating Health Care Providers are those of **independent contractors**. None of the provisions of this Agreement are intended to create or to be construed as creating any agency, partnership, joint venture or employee/employer relationship. (R. Vol. IV, 675, emphasis added).

Article V (c) of the Agreement also states that:

> Primary Care Physician at all times relevant hereto, shall act and perform services as an **independent contractor**. Primary Care Physician will not be treated as an employee by The PRUDENTIAL for any reasonÿ(R. Vol. IV, 675, emphasis added).

Furthermore, the Plan Certificate of Coverage provided to SUSAN VILLAZON also specifically states in pertinent part that:

> The relationship between PruCare and any Participating Physician, other Participating Health Care Provider, or Consulting Physician is that of

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and servant; and 10) whether the principal is or is not in business.

> **independent contractor**. No Participating Physician, Participating Health Care Provider, or Consulting Physician is an agent or employee of PruCareÿ (R. Vol. IV, 674, emphasis added).

The Certificate of Coverage also expressly states that

> "[e]ach Participating Physician . . . will maintain the provider-patient relationship with Covered Persons under the Group Contract and is **solely responsible** to Covered Persons for supplies and services furnished to Covered Persons." (Id., emphasis added).

In the face of those explicit and unambiguous terms in both PRUDENTIAL's agreement with DR. SARNOW and the ERISA materials provided to SUSAN VILLAZON, only compelling evidence of a contrary actual practice could create a genuine factual issue as to whether DR. SARNOW was PRUDENTIAL's agent. As both lower courts held, however, all of the record evidence clearly establishes that this independent contractor relationship was in fact implemented at all times.[13] In particular, (1) DR. SARNOW funded, supplied, and maintained his own independent, private office; (2) all of DR. SARNOW's patients, including SUSAN VILLAZON, were treated at his private office; (3) no member of his office staff was associated with

[13] The Amicus Curiae mistakenly asserts that the Appellate Court only relied on the terms of the contracts to reach its decision. A review of the decision clearly shows that the Appellate Court first looked at "the contractual provisions" and then separately found that "[t]here is no evidence on this record" of any actual practice contrary to those contract terms.

PRUDENTIAL; (4) his office staff managed the scheduling of patients, including SUSAN VILLAZON; (5) all medical records generated when he treated his patients, including SUSAN VILLAZON, were maintained at his private office (R. Vol. IV, 677-682, R. Vol. VI, 820-825); (6) DR. SARNOW rendered care and treatment to all his patients, including SUSAN VILLAZON, regardless of their insurance status, in the same manner and in accordance with the same standard of care (R. Vol. IV, 677-682, R. Vol. VI, 820-825, R. Vol. II, 235); (7) DR. SARNOW maintained his own malpractice insurance and rendered care according to his own medical judgment and guidelines (R. Vol. IV, 677-682, R. Vol. VI, 820-825); and (9) DR. SARNOW rendered care and treatment to patients insured through numerous and varied third party payors, not just PRUDENTIAL (R. Vol. IV, 677-682, R. Vol. VI, 820-825); (10) DR. SARNOW was paid based on the number of members to whom he provided services, not on a time basis, and with no withholdings or fringe benefits; and (11) DR. SARNOW was engaged in a highly skilled profession. Likewise, plaintiff concedes that PRUDENTIAL did not instruct DR. SARNOW on how to render care to SUSAN VILLAZON in particular.

Indeed, plaintiff does not rely on **any** contrary evidence of the parties' actual practice, but instead on the basic managed care features of the ERISA Plan. As

shown above, however, that Plan explicitly states that providers will be independent contractors with sole responsibility for medical services, and its inclusion of core managed care features does not even begin to create a genuine issue of material fact as to DR. SARNOW's status as an independent contractor. [14]

Florida courts have repeatedly upheld summary judgment rulings on agency claims involving even less conclusive evidence. In Wiseman v. Miami Rug Co., 524 So.2d 726 (Fla. 4th DCA 1988), the court affirmed summary judgment where the independent contractor owned the vehicle to deliver the carpets, the independent contractor was paid after submission of a bill, the alleged principal did not deduct social security or withhold taxes from the amount paid, the principal did not furnish any equipment, the principal did not supervise the work done, the principal did not set the working hours,

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[14] The Amicus Curiae argues that the Appellate Court's ruling addresses actual control instead of the right of control. As the record evidence clearly demonstrates, PRUDENTIAL did not have the right of control over the medical decisions and the manner in which covered services were to be provided to any patient. Indeed, the ruling was based on the lack of right of control. The Appellate Court stated that "there is no evidence that PRUDENTIAL exercised any control over the medical care and decisions made in the care and treatment of patients, including Villazon's wife". The court's reference to all patients demonstrates that it was addressing the right of control because it obviously did not have information as to the care of any patient other than SUSAN VILLAZON and therefore could not have been addressing actual control as to those patients.

the independent contractor was required to maintain its own liability coverage, the principal did not provide any fringe benefits, and principal also used other independent contractors. Id. at 728-29. In Kane Furniture Corp. v. Miranda, 506 So.2d 1061 (Fla. 2d DCA 1987), the court affirmed summary judgment finding that the independent contractors had discretion in the physical performance of their tasks, the independent contractor performed the job without supervision, carpet installation was viewed as a distinct occupation and the independent contractor had his own business, carpet installers were considered skilled workers, the carpet installers were required to complete specialized training, the independent contractor provided his own supplies and equipment, the independent contractor was not required to work exclusively for the alleged principal, the independent contractor was paid per job not by time, and the parties' intent was to only create an independent contractor relationship. Id. at 1065. Lastly, in Ware v. Money-Plan Int'l Inc., 467 So.2d 1072 (Fla. 2d DCA 1985), the court ruled that the insurance agents were independent contractors focusing on the type of services being performed and regarded the selling and interpreting of insurance contracts as a service not usually performed under the strict supervision of an employer because of the high degree of skill required.

Plaintiff's alternative assertion that PRUDENTIAL could be held liable under

a theory of apparent agency is equally foreclosed as a matter of law.[15] Not only is the record completely devoid of any evidence of representations made by PRUDENTIAL indicating that DR. SARNOW was its agent, but the Plan materials furnished to SUSAN VILLAZON, as quoted above, explicitly and unambiguously informed her that each plan provider was an "independent contractor," not an "agent," and further informed her that each provider would be "solely responsible" for all health care services. See (R. Vol. IV, 674). That notification alone precludes any claim of implied agency. Moreover, the record further establishes that neither DR. SARNOW nor his staff advised SUSAN VILLAZON that he or his staff were agents or employees of PRUDENTIAL; that PRUDENTIAL's name did not appear on DR. SARNOW's door; and that neither DR. SARNOW nor his employees wore any badges or clothing with insignias or emblems bearing PRUDENTIAL's name. Indeed, these facts were also verified by Plaintiff's testimony. (R. Vol. IV, 682-687, Vol. VI, 820-825). Indeed, the record evidence confirms that SUSAN VILLAZON knew that DR. SARNOW was not PRUDENTIAL's agent because her relationship with DR.

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[15] In order to hold a principal liable under the doctrine of apparent agency, three elements must be established; 1) a representation by the principal; 2) reliance on that representation by a third person and; 3) a change in position by the third person in reliance on the representation. Abuznaid v. Sirhal, 638 So.2d 188, 189 Fla. 4th DCA 1994).

SARNOW began approximately a year **before** she became a member of the PRUDENTIAL HMO. (R. Vol. IV, 483-685, Vol. VI, 820-825). Finally, the record evidence also conclusively refutes any prospect that Plaintiff could establish the other elements required to establish apparent agency. In particular, the fact that SUSAN VILLAZON selected DR. SARNOW as her doctor a year before she became a Plan member demonstrates that she did not rely on any representations made by PRUDENTIAL when she chose DR. SARNOW, as does Plaintiff's testimony that her decision to initially visit DR. SARNOW was based upon the recommendation of her sister. (R. Vol. IV, 684). For all of these reasons, the courts below properly granted summary judgment against plaintiff's state law agency claims.

POINT III

THERE IS NO BASIS FOR LIABILITY BASED ON BREACH OF A NON-DELEGABLE DUTY.

Plaintiff also argues that even if the parties' agreements and practices made DR. SARNOW an independent contractor rather than agent, PRUDENTIAL still should be held liable for DR. SARNOW's allegedly negligent care through a theory of non-delegable duty. Plaintiff's contention is that, either by operation of Florida law or by

virtue of the terms of its contracts, PRUDENTIAL became responsible for providing comprehensive medical care to plan members and therefore could not avoid liability by delegating that responsibility to an independently contracted physician. As we now show, this claim has no basis under Florida law. [16]

The Alleged Statutory Non-Delegable Duty

The Florida Health Maintenance Organization Act ("HMO Act"), Section 641, et. seq., Florida Statutes, specifically Parts 1 and 3, describes the obligations of HMOs, such as PRUDENTIAL. The legislative intent in enacting the HMO Act was to create a regulatory mechanism by which the state could create an alternative system that would make access to health care affordable without exposing the citizens of the state to injury, loss, or damage. § 641.18, Fla. Stat. (1999). As a result, the HMO Act provides for administrative mechanisms for HMOs, enforceable by the Department of

[16] Contrary to the position expressed in the Amicus Brief, Plaintiff has never claimed or taken the position that PRUDENTIAL is liable for the failure to "ensure" the quality of health care. For example, Plaintiff has never claimed PRUDENTIAL failed to take the necessary steps to credential the independent medical providers and that PRUDENTIAL improperly delegated that responsibility to an independent third party. Rather, Plaintiff contends that even if PRUDENTIAL had taken every imaginable reasonable precaution to "ensure" that adequate care be provided, it nevertheless can be held strictly liable for the negligent medical decisions because it had the non-delegable duty to actually provide the care and treatment.

Insurance, which assist in assuring that there is access to quality healthcare. However, there is absolutely no Section within the HMO Act that creates a duty through which tort liability flows to an HMO. In fact, the only civil remedy provision found within the HMO Act, § 641.28, Fla. Stat. (1999), offers the prevailing party in an action to enforce an HMO contract, the right to reasonable fees, and does not provide remedies for violations of any statutory Sections.[17] There are no cases in the State of Florida where a court has ruled that there is a statutory non-delegable duty through which an IPA HMO, taking every imaginable precaution to ensure access to quality care, could be held strictly liable for the negligent medical decisions of independent contractors.[18]

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[17] In 1996, the Legislature considered expanding the HMO Act, through CS/HB 1853, to include tort remedies in connection with the HMO's alleged involvement in the medical care. However, Governor Chiles vetoed the bill fearing its impact on the vitality of HMOs and stated that "we have progressed too far toward our goal of assuring affordable health care insurance for all Floridians to turn our back on it now." See Veto filed with the Department of State, Tallahassee, Florida on May 28, 1996.

[18] Plaintiff and Amicus Curiae place great importance in Florida Code Section, 4-191.069, contending that IPA HMOs are considered health care providers because of the alleged requirement that they maintain medical malpractice insurance. However, a close reading of that section demonstrates that it makes a clear distinction in the type of insurance that must be maintained because IPA HMOs are not considered health care providers. The Administrative Code section does not require that an IPA HMO maintain medical malpractice insurance, rather it is required to maintain **professional liability insurance**, compared to staff HMOs, which are required to maintain medical malpractice insurance. Additionally, the fact that the Legislature requires medical providers to maintain medical malpractice insurance in addition to the IPA HMO's professional liability insurance demonstrates that it did not envision that IPA HMOs

In Pegram, supra, the United States Supreme Court discussed at length the background of fact and law regarding HMOs and distinguished between traditional fee for service medical care and new models that were developed in the 1960's, including HMOs. The Court noted that an HMO, unlike a fee-for-service physician, assumes the financial risk of providing the benefits promised and accordingly, takes steps to control costs. In concluding that the plaintiff did not have a breach of fiduciary cause of action, the Court also examined the impact the plaintiff's remedy would have on HMOs:

> . . . [H]er remedy in effect would be nothing less than elimination of the for-profit HMO. Her remedy might entail even more than that, although we are in no position to tell whether and to what extent non-profit HMO schemes ultimately survive the recognition of Herdrich's theory. It is enough to recognize that the Judiciary has no warrant to precipitate the upheaval that would follow a refusal to dismiss Herdrich's ERISA claim. The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices. . . . If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so. But the Federal Judiciary will 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 . . . See Pegram v. Herdrich, 530

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would be strictly liable for the actions of independently contracted providers, otherwise, it would have required that IPA HMOs maintain medical malpractice insurance for the medical providers just as is mandated for staff HMOs.

U.S. 211, 233, 120 S.Ct. 2143, 2156, 147 L.Ed.2d 164 (2000).

Like the plaintiff in Pegram, Plaintiff in this case is attempting to create a cause of action against an HMO, which finds no support in the legislative intent underlying the creation of HMOs in Florida. Additionally, like the breach of fiduciary duty theory in Pegram, Plaintiff's non-delegable duty theory, if adopted, would eliminate IPA HMOs such as PRUDENTIAL. If this Court were to hold that IPA HMOs had a non-delegable duty and were liable for every act of medical care provided to every one of its members, this would essentially turn the HMOs into medical malpractice liability insurers on a scale never dreamed of by anyone.[19] Rather than charge the public several hundred dollars a month for health care coverage, HMOs would have to charge premiums that no individual or entity could afford, thereby causing a collapse of the very system Congress and the Florida Legislature intended to create to make health care more affordable. Instead, the Florida Legislature has provided for access to affordable quality health care by creating state regulations to ensure quality of care

[19] Under Plaintiff's theory of liability, there would be no bounds to the potential liability of the IPA HMO. The IPA HMO provides for coverage of emergency services by non-participating providers or may authorize coverage for services by other non-participating providers. If Plaintiff's theory of liability through breach of a non-delegable duty to provide the care were allowed, then an IPA HMO would be strictly liable not just for contracted providers, but for hundreds of providers that it has no possible connection with.

without exposing the HMO organization to insurmountable costs by creating a strict liability cause of action based on a non-delegable duty theory. As the Supreme Court stated in Pegram, the Judiciary has "no warrant to precipitate the upheaval" that would follow if Plaintiff's theory of non-delegable duty were recognized in a case such as this one.

Another fundamental problem in Plaintiff's claim is that the HMO Act recognizes that the HMO is not the health care provider. The HMO Act recognizes that the health care services will be arranged for and paid by the HMO and delivered by a contracted medical provider. Section 641.19(13), Fla. Stat. (1999), defines a "health maintenance organization" as follows: "Health maintenance organization" means any organization authorized under this part which: a) provides emergency care, in-patient hospital services, physician care including care provided by physicians licensed under Chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, provider of health care services; b) provides, either directly or through arrangements with other persons . . .; and c) provides, either directly or through arrangements with other persons . . . ."

The HMO Act makes it clear that the HMO can contract with private physicians and other health care providers who will render the care. In fact, the HMO Act has a statutory provision, §641.315, Fla. Stat. (1999), exclusively dedicated to governing the

contractual relationship between the HMO and the physicians that will provide the medical services. This statutory section clearly demonstrates that under an HMO system, the physicians will provide the care and treatment and maintain the physician-patient relationship, while the HMO is responsible for paying the covered services.

Recognizing the foregoing, the Florida Legislature included provisions to protect the subscribers to ensure that claims for services rendered by providers would be paid. See § 641.255, Fla. Stat. (1999) (HMO required to have sufficient capital to pay medical providers for services rendered to subscribers); § 641.225, Fla. Stat. (1999) (subscribers protected for expense of services and supplies rendered by medical providers for services covered under health plan); § 641.3155, Fla. Stat. (1999) (ensuring prompt payment for services rendered to subscribers or prompt explanation by HMO to medical providers justifying non-payment). In addition, the Legislature recognized the need for protections to ensure that medical providers not drop HMO members with no notice thereby leaving them without a medical provider to continue the care and treatment. § 641.51, Fla. Stat. (1999).

Clearly, the Florida Legislature created a system whereby IPA HMOs could develop and charge a reasonable premium for health care coverage by contracting with private medical providers who would render and be responsible for their own medical care. There is no doubt that the Florida Legislature envisioned an alternate system of

access to health care involving three primary players: the HMO, subscriber, and provider. As a result, it drafted statutory provisions that govern the relationship between those parties and which provide for administrative mechanisms to ensure access to quality care. There is absolutely no statutory basis for interpreting the legislative intent to mean that IPA HMOs, who may contract with hundreds or thousands of medical providers, are to be liable for the medical negligence that might occur at every office visit, out-patient testing, hospitalization, home health visit, nursing home visit, and every other type of medical care provided to its members.

In an attempt to misconstrue Plaintiff's non-delegable duty claim, the Amicus Curiae's argument focuses on a duty to "ensure" access to quality care. However, as previously pointed out, there is absolutely no allegation that PRUDENTIAL did anything wrong. Rather, Plaintiff seeks to hold PRUDENTIAL strictly liable as if it had actually rendered the alleged negligent care. PRUDENTIAL recognizes that the HMO Act imposes requirements, such as quality assurance programs, to ensure that access be provided to the best possible care. § 641.51. However, Plaintiff's claims are not based on the duty to "ensure", but instead, on the alleged non-delegable duty to provide the medical care. Under Plaintiff's theory, regardless of the steps PRUDENTIAL could take to "ensure" access to quality medical providers, PRUDENTIAL would still be liable because it could not delegate the actual rendering

of medical care.[20] However, neither the Plaintiff nor the Amicus Curiae cite one statutory provision that creates a non-delegable duty through which PRUDENTIAL can be held directly liable for the negligent actions of independently contracted providers, whom the Legislature has already mandated must carry their own medical malpractice insurance.

A reading of the HMO Act, consistent with Congress' intent of providing affordable access to care, is that HMOs operate as a sound business by complying with statutory requirements for the establishment of a healthcare network in which medical providers render care. The penalty for failing to comply with the statutory requirements leaves the state with the power to suspend the authority of an organization to enroll new subscribers, revoke the right to do business in the state, and levy fines. §641.52, Fla. Stat. (1999).

B. The Alleged Contractual Non-Delegable Duty

The record evidence likewise squarely refutes any claim that the terms of the applicable contracts imposed a non-delegable duty on PRUDENTIAL to directly

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[20] Even if Plaintiff's claim had been based on PRUDENTIAL's alleged failure to take the proper steps to "ensure" access to quality care, for example that it was negligent in failing to implement an adequate quality assurance program, PRUDENTIAL would argue that there is no statutory remedy. As previously developed, the remedies provision under the HMO Act is very limited and efforts to expand that provision were unsuccessful.

provide medical care to SUSAN VILLAZON. In particular, as quoted above, the Certificate of Coverage expressly provided that health care would be provided by independent contractors. The Certificate also explicitly stated that each plan doctor "will maintain the provider-patient relationship with Covered Persons under the Group Contract and is **solely responsible** to Covered Persons for supplies and services furnished to Covered Persons." (R. Vol. IV, 690, emphasis added). Finally, the Certificate also defined the Plan as "the Plan of the Contract Holder providing health care expense coverage" (R. Vol. IV, 690) and expressly stated that "all eligible services and supplies must be furnished to a person: (a) by a Primary Care Physician; or . . . ". (R. Vol. IV, 690).

In short, there is no basis on which a trier of fact could find that PRUDENTIAL contractually undertook a non-delegable duty to provide medical care to SUSAN VILLAZON. To the contrary, the Plan materials expressly stated that such care would be provided by, and would be the sole responsibility of, independent contractors.

Plaintiff and the Amicus Curiae fail to cite to any cases in Florida or any other jurisdiction that have held that an IPA HMO, such as PRUDENTIAL, has a contractual non-delegable duty rendering it liable for the negligence of independent contracted providers. The cases they do rely on can be easily distinguished because,

in those cases, the negligent actions by the independent contractor were in the context of performing the specific function that the alleged principal had specifically contracted to perform. See Gordon v. Sanders, 692 So.2d 939 (Fla. 3d DCA 1997) (wherein the court ruled that there was no independent contractor defense because the alleged principal contracted to specifically perform the task of removing the trees); Metrolimo, Inc. v. Lamm, 666 So.2d 552 (Fla. 3d DCA 1995) (wherein the court ruled that the alleged principals were liable because under the contract they were specifically responsible for carrying out the transportation services); City of Coral Gables v. Prats, 502 So.2d 969 (Fla. 3d DCA 1987) (wherein the court specifically pointed to the contract between the City and DOT which expressly imposed on the City the duty to protect the public from harm from any trip and fall hazard, which was distinguishable from the case of Coudry v. City of Titusville, 438 So.2d 197 (Fla. 5th DCA 1983), wherein the City of Titusville had not expressly agreed by contract to assume the duty of maintaining the streets safe for pedestrians); and U.S. Security Servs. Corp v. Ramada Inn Inc., 665 So.2d 268 (Fla. 3d DCA 1995) (wherein the court held that the law as created by this Court specifically imposes on hotels, apartments, and innkeepers, the duty to keep premises reasonably safe and that the "duty of maintaining the safe premises cannot be delegated away"). Unlike the specific duties imposed on the alleged principals in those cases, the contracts here unambiguously

demonstrate that PRUDENTIAL was not going to be rendering the medical care (and, instead, that independent contractors were going to do so), and unlike those cases, a non-delegable duty was never created.

Plaintiff also erroneously relies on cases involving hospitals to establish that PRUDENTIAL had a non-delegable duty. The overriding theme in these hospital cases, in which courts have found that the hospital had a non-delegable duty, focuses on the specific nature and operation of a hospital, which differs from that of an IPA HMO, such as PRUDENTIAL. In Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So.2d 55 (Fla. 4th DCA 1982), for example, the court in that case found that a hospital could be liable for the negligence of an emergency room physician when it undertook to treat the decedent for a charge and furnished the doctors and staff to render that treatment, noting that patients entering through the emergency room "could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital". Id. at 61. Plaintiff likewise is wrong in asserting that the court in Jaar v. University of Miami, 474 So.2d 239 (Fla. 3d DCA 1985), held that the duty to provide medical care is non-delegable. Instead, the court looked to the specific contractual and employment relationship between the parties in order to find that the University of Miami, having contracted with the Dade County Public Health Trust to provide medical care to hospital patients, remained liable for negligent acts performed by its

employee in executing its contractual obligations. Id. at 244. It should be noted that the plaintiff's claims were predicated on the alleged negligence of a physician employed by the University of Miami who allegedly was not present when three medical residents administered an excess amount of anesthetic to the decedent who died as a result. Like the plaintiff's claims in Irving, supra, the alleged negligence in the Jaar case occurred within the confines of the hospital.

A case that is more relevant to an IPA HMO setting is Reed v. Good Samaritan Hosp. Assoc., Inc., 453 So.2d 229 (Fla. 4th DCA 1984). In Reed, the court pointed to the Irving case cited by Plaintiff here to establish that the law is clear that if the doctor is an independent contractor, that shields the hospital from liability. The court stressed that the Irving case on its facts made it abundantly clear that it was concerned with the negligence of the emergency room physician who was paid a salary by the hospital and possessed no private patients. In holding that the defendant hospital was not liable for a private practice physician who had been granted staff privileges, the court concluded that there was no evidence from which it could ascertain that the physician with staff privileges was either an agent or an employee of the hospital. See also Arango v. Reyka, 507 So.2d 1211 (Fla. 4th DCA 1987); Snead v. LeJeune Road Hosp., Inc., 196 So.2d 179 (Fla. 3d DCA 1967).

The distinction appreciated by the court in Reed between the emergency room

physician and a physician with staff privileges is also present in the context of participating providers of an IPA HMO such as PRUDENTIAL. Unlike the hospital emergency room physician or radiologist, and more similar to a physician who has simply been granted staff privileges by a hospital, participating providers of the PRUDENTIAL plan are independent physicians who maintain their own private practices. Similar to the physician who has been granted staff privileges in the Reed case, DR. SARNOW maintained his own private practice and saw patients from other HMOs and private paying patients. Contrary to the emergency room physician and radiologist, DR. SARNOW saw patients in his private medical office. When these points are combined with the fundamental point that the Plan materials explicitly told SUSAN VILLAZON that her health care would be provided through independent contractors who would be solely responsible for her care, there simply is no basis on which a trier of fact could find that PRUDENTIAL contractually assumed a non-delegable duty to furnish medical care directly to SUSAN VILLAZON.

CONCLUSION

Based on the foregoing arguments and authorities, the decision by the Third District Court of Appeal should be affirmed in all respects.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing Answer Brief of Appellees was served by hand-delivery this 4th day of February, 2002 on: JAMES C. BLECKE, ESQUIRE, Deutsch & Blumberg, P.A., 100 North Biscayne Boulevard, New World Tower, Suite 2802, Miami, Florida 33132.

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CERTIFICATION OF COMPLIANCE WITH FONT STANDARDS

I CERTIFY that Respondent's Answer Brief complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2), which became effective on January 1, 2001. This Answer Brief has been prepared using Times Roman, 14-point font.

By: _____
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[1]. Respondent will be referred to throughout the Answer Brief as "PRUDENTIAL" or "Defendant." The Petitioner, ROLANDO VILLAZON, as Personal Representative of the Estate of SUSAN VILLAZON, will be referred to as "Plaintiff." The Third District Court of Appeal will be referred to as "Appellate Court" and the Honorable David Tobin, Circuit Court Judge, Eleventh Judicial Circuit will be referred to as the "Trial Court." In addition, references to the documents included in the appellate record will be designated "R."

[2]. (R. Vol I, 1-29, 52, R. Vol. II, 215-217, R. Vol. IV, 656-659, R. Vol. VI, 706-744).

[3]. The Agreement stated that "the relationships among The PRUDENTIAL Medical Director, Participating Physicians, and Participating Health Care Providers are those of independent contractors. None of the provisions of This Agreement are intended to create or to be construed as creating any agency, partnership, joint venture, or employee/employer relationship." The Agreement also specifically stated that the "primary care physician at all times relevant hereto, shall act and perform services as an independent contractor. Primary Care Physician will not be treated as an employee by The PRUDENTIAL for any reasonÿ." (R. Vol. IV, 675, R. Vol. VI, 798-819).

[4]. The United States Supreme Court has specifically recognized that Congress has promoted the formation of HMOs and that the judiciary has no warrant to precipitate their upheaval. See Pegram v. Herdrich, 530 U.S. 211, 233, 120 S.Ct. 2143, 2156, 147 L.Ed.2d 164 (2000).