IN THE SUPREME COURT OF FLORIDA

CASE NOS. SC05-870, SC05-871 AND SC05-872

HEALTH OPTIONS CONNECT, INC.
F/K/A PRINCIPAL HEALTH CARE OF FLORIDA, INC., *ET AL.*

Petitioners,

v.

WESTSIDE EKG ASSOCIATES,

Respondent.

ON DISCRETIONARY REVIEW OF A DECISION OF THE DISTRICT COURT OF APPEAL OF FLORIDA, FOURTH DISTRICT

BRIEF FOR AMERICA'S HEALTH INSURANCE PLANS, AS *AMICUS CURIAE* SUPPORTING PETITIONERS

(Filed with Consent and with Motion for Leave of Court)

Law Offices of
STEVEN M. ZIEGLER, P.A.
DOROTHY F. EASLEY
Fla. Bar No. 0015891
STEVEN M. ZIEGLER
Fla. Bar No. 344443
Counsel for America's Health Insurance Plans
Presidential Circle – Suite 375 South
4000 Hollywood Blvd.
Hollywood, Florida 33021
Tel.: (954) 966-2696
Fax: (954) 966-2446

TABLE OF CONTENTS

AUTHORITIES ii

OTHER AUTHORITIES iv

STATEMENT OF IDENTITY AND INTEREST OF AMICUS 1

SUMMARY OF THE ARGUMENTS 2

ARGUMENTS

I. *WESTSIDE EKG* WILL HAVE AN ADVERSE IMPACT ON HEALTH CARE COSTS ACROSS THE COUNTRY AND IN FLORIDA 4

II. ADMINISTRATIVE SCHEMES DESIGNED IN FLORIDA AND AT THE FEDERAL LEVEL DO NOT ALLOW PRIVATE LAWSUITS. 6

III. THIS COURT AND COURTS AROUND THE COUNTRY HAVE RECOGNIZED THAT THEIR RESPECTIVE HMO ACTS DO NOT CREATE PRIVATE CAUSES OF ACTION OR THIRD-PARTY BENEFICIARY RELATIONSHIPS. 12

IV. MAXIMUS-CHDR IS RECOGNIZED AROUND THE COUNTRY AS AN EFFECTIVE HEALTH DISPUTE RESOLUTION ADMINISTRATIVE ALTERNATIVE. 17

CONCLUSION 19

CERTIFICATE OF SERVICE 20

CERTIFICATE OF COMPLIANCE 20

TABLE OF AUTHORITIES

Aetna Cas. & Sur. Co. v. Oregon Health Sciences Univ.,
793 P.2d 320 (Or. 1990) 17

Burden v. Johnson & Johnson Med., Inc.,
332 F. Supp. 2d 1023 (S.D. Tex. 2004) 6

Cobb v. Allstate Ins. Co.,
663 A.2d 38 (Me. 1995) 6

Cohen v. Health Net of Cal.,
2005 WL 980629 (Cal. Ct. App.),
as modified on denial of reh'g (2005) 13

Cole, M.D. v. Metropolitan Life Ins. Co.,
708 N.Y.S.2d 789 (N.Y.A.D. 2000) 16

English v. Blue Cross Blue Shield of Mich.,
688 N.W.2d 523 (Mich. App. 2004) 18

Franks v. Prudential Health Care Plan, Inc.,
164 F. Supp.2d 865 (W.D. Tex. 2001) 12

Gomer v. Philip Morris Incorporated,
106 F. Supp. 2d 1262 (M.D. Ala. 2000) 17

Grant Thornton v. Windsor House, Inc.,
566 N.E.2d 1220 (Ohio)
reh'g den., 571 N.E.2d 135, *cert. den.*, 502 U.S. 822 (1991) 17

Hall v. Unum Life Ins. Co. of Am.,
300 F.3d 1197 (10th Cir. 2002) 9

Health Care Plan, Inc. v. Aetna,
776 F. Supp. 118 (W.D.N.Y. 1991) *aff'd,* 966 F.2d 738 (1992) 12

Healthcare Servs., Inc. v. Nat'l Prescription Adm'rs, Inc.,
867 F. Supp. 1223 (E.D. Pa. 1994) 17

Hollywood Lakes Country Club, Inc. v. Community Ass'n Servs., Inc.,
770 So. 2d 716 (Fla. 4th DCA 2000) 16

IVTX v. United Healthcare,
112 F. Supp. 2d 445 (D. Md. 2000) 12

McIntire v. Fortis Ins. Co.,
2004 WL 2272166 (S.D. Ind. 2004)... 18

NN Investors Life Ins. Co., Inc. v. Crossley,
580 N.E.2d 307 (Ind. 1991), *transfer den.* (1992).. 16

Parrish Chiropractic Ctrs., P.C. v. Progressive Cas. Ins. Co.,
874 P.2d 1049 (Colo. 1994) 17

Pilot Life v. Dedeaux,
481 U.S. 41, *on remand to* 821 F.2d 277 (1987).. 8

Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002) 6

Solomon v. U.S. Healthcare Sys. of Pa., Inc.,
797 A.2d 346 (Pa. Super.), *appeal den.*, 808 A.2d 573 (2002) 13

State Farm Mut. Auto. Ins. Co. v. Fitts,
99 P.3d 1160 (Nev. 2004) 6

State Farm Mut. Auto Ins. Co. v. Powers,
732 A.2d 730 (Vt. 1999) 6

United Autoworkers v. Ring Screw Works,
741 F. Supp. 660 (E.D. Mich.1990) 12

Varity Corp. v. Howe,
516 U.S. 489 (1996) 9

Villazon v. Prudential Health Care Plan, Inc.,
843 So. 2d 842 (Fla. 2003) .... *passim*

Wegoland Ltd. v. NYNEX,
27 F.3d 17 (2d Cir. 1994) 6

Westside EKG Assoc. v. Foundation Health,
--- So. 2d ---, 2005 WL 1026183 (Fla. 4th DCA 2005) .... *passim*

Zoblotsky v. Tenet Choices, Inc.,
2005 WL 1038136 (E.D. La. 2005) 13

<u>OTHER AUTHORITIES</u>

Section 408.7057, Florida Statutes (2005)... 17,18

Section 641.185, Florida Statutes (2005) 8

Section 641.18, Florida Statutes (2005) 6

Section 641.19, Florida Statutes (2005) 6,15

Section 641.60, Florida Statutes (2005) 15

Section 641.234, Florida Statutes (2005) 15

Section 641.495, Florida Statutes (2005) 15

Section 641.51, Florida Statutes (2005) 15

Section 766.101, Florida Statutes (2005) 15

Florida 1996 House Bill 1853 13

Florida 2000 Senate Bill 1900 13

Florida 2000 Committee Substitute Bill 13

Florida Rules of Appellate Procedure 9.030 18

Florida Rules of Appellate Procedure 9.110 18

29 United States Code Section 1001 3

42 United States Code Section 300 .... *passim*

House of Representatives Report Number 518, 94th Congress, (2d Session 15), *reprinted in* 1976 United States Code Congressional & Administrative News 8

Senate Conference Report Number 129, 93rd Congress, (1st Session), *reprinted in* 1973 United States Code Congressional & Administrative News 6

American Association of Health Plans, *Independent Medical Review of Health Plan Coverage Decisions: A Framework for Excellence* (Apr. 2001) 19

American Association of Health Plans, *Savings Due to Managed Care*, Managed Care Facts (Oct. 1999) 11

Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *Exhibit 1.1, National Health Expenditures and Their Share of Gross Domestic Product, 1960-2002*, (2002 National Health Care Expenditures Data Files for Downloading) 4

Chiles, Hon. Lawton *Introduction to The Review Of Legislation Health Care Reform In Florida: Promoting Improved Access, Cost, And Quality*, Fla. State L. Rev. (1996) 14

Disease Management, *Cost-savings for a Preferred-Provider Organization Population with Multi-Condition Disease Management: Evaluating Program Impact Using a Predictive Modeling with a Control Group,* (2003) 11

Frech, Dr. H.E., III, *et al.*, *MANAGED HEALTH CARE EFFECTS: MEDICAL CARE COSTS AND ACCESS TO HEALTH INSURANCE* (LECG Nov. 2000) 11

Gold, William, *How Broadening DM's Focus Helped Shrink One Plan's Costs,* Managed Care Magazine (Nov. 2003) 11

Gruber, J. & M. Lettau,
How Elastic Is the Firm's Demand for Health Insurance?
National Bureau of Economic Research Working Paper
No. 8021 (July 2000) 5

Ignagni, Karen, President and CEO of American Association
of Health Plans, testimony before the U.S. House Committee
on Education and the Workforce, Subcommittee on
Employer-Employee Relations, *Examining Pay-for-Performance
Measures and Other Trends in Employer-Sponsored Health
Care* (May 17, 2005) 11

Ignagni, Karen, President and CEO of American Association
of Health Plans, *Health Plan Initiatives to Improve Quality
and to Provide Information to Consumers*, Statement before
FTC/DOJ Hearings on Health Care and Competition Law
and Policy (May 27, 2005) 11

Joffe, Mark S. *Legal Issues in Provider Contracting, in*
ESSENTIALS OF MANAGED HEALTH CARE, at ch. 32, 705-06
(Peter R. Kongstvedt ed., 4th ed. 2001).. 11

Kaiser Commission on Medicaid and the Uninsured,
Exhibit 1.12: Total Medicaid Spending, 1992-2002 (2003)......................... 4

Kaiser Family Foundation,
*Exhibit 1.11: Concentration of Health Spending in the U.S.
Population, 2002,* 2002 Full Year Population.. 5

Kaiser Family Foundation,
State Health Facts: Population Distribution by Insurance Status................. 5

Kaiser Family Foundation & Health Research and Educational Trust,
Employer Health Benefits 2003 Annual Survey,
71 Ex. 5.1 (2003).. 10

McGlynn, Elizabeth A., *et al.*,
*The Quality of Health Care Delivered to Adults in the
United States,* 348 New Eng. J. Med. 2635 (2003) 10

Paramore, L. Clark & Anne Elixhauser,
Assessments of Quality of Care for Managed Care and Fee-for-Service Patients Based on Analysis of Avoidable Hospitalizations, 2 Value in Health 258 (1999) 11

Snyder, J., *et al.*,
Quality Improvement and Cost Reduction Realized by a Purchaser through Diabetes Disease Management, Disease Management (2003) 11

The Washington Post,
The Deeper Problem, June 29, 2003 10

Villagra, Victor & Tamim Ahmed,
Effectiveness of a Disease Management Program for Patients with Diabetes, Health Affairs (2004) 11

STATEMENT OF IDENTITY AND INTEREST OF AMICUS[1]

America's Health Insurance Plans ("AHIP") respectfully submits this brief as amicus curiae supporting Petitioners.[2] AHIP is the national association representing the private health plan and insurer community. AHIP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to its members. AHIP represents nearly 1,300 member companies that administer or insure benefits, including health, pharmaceutical, long-term care, disability, and supplemental coverage, to more than 200 million Americans. The District Court of Appeal's decision in *Westside EKG* undermines the current system for the delivery of health care in Florida, and its precedential implications will adversely affect the health care delivery system throughout the country. The result will be increased health

---

[1] The Parties to the Petition will be referred to as they were below and in the appeal to the Fourth District Court of Appeal. The Petitioners: Health Options and Health Options Connect, Inc., will collectively be referred to as "Health Options" or "HOI". Foundation Health Plan, a Florida Health Plan, Inc. and Vista Health Plan (formerly known as HIP Health Plan of Florida, Inc.) will be referred to collectively as "Vista". Humana Medical Plan, Inc., will be referred to as "Humana". The Respondent: Westside EKG Associates will be referred to as "Westside".

The *Amici* who appeared in the Fourth District Court of Appeal proceeding: the Florida Association of Health Plans in support of the Petitioners will be referred to as "FAHP" and the AARP in support of the Respondent will be referred to as "AARP".

The record shall be referred to as it was in the proceedings below: "R__-__".

[2] This brief was prepared in its entirety by amicus and its counsel. No monetary contribution toward the preparation or submission of this brief was made

care costs, reduced health care quality and less choice for all Americans.

<u>SUMMARY OF THE ARGUMENTS</u>

The decision in *Westside EKG Assoc. v. Foundation Health*, --- So. 2d ---, 2005 WL 1026183 (Fla. 4th DCA 2005), functionally creating a private cause of action under the Florida HMO Act, chapter 641, for both medical providers and health plan subscribers, eviscerates the administrative processes of the health care delivery system in Florida, which was designed by the Legislature to ensure accessible as well as affordable health care for Florida citizens. This decision will result in a significant increase in health care related litigation, inspiring all types of new claims never contemplated by the Florida Legislature and courts. The costs of that litigation will be passed on to consumers and health care premiums will inevitably rise, precluding many more Floridians and others nationwide from obtaining affordable health care coverage and incentivizing employers (especially small employers) to drop ever-more expensive coverage.

Westside EKG also has national implications, as this decision works contrary to the clear wording of both the Florida HMO Act and Federal benefits law (Employee Retirement Income Security Act of 1974 ("ERISA")),[3] and the import of both federal and state systems designed to assure quick and efficient resolution of disputes. The practical effect of *Westside EKG* will be to render the current

---

by any person other than amicus, its members, and their counsel.

scheme of overseeing health care delivery in Florida meaningless, as subscribers and providers will now be able to use the provisions of the Florida HMO Act to file lawsuits. The decision impacts individuals covered through federally regulated employer sponsored health benefit plans as well, just as the plaintiffs here have skirted the preemptive provisions of ERISA by advising a federal court that they were not suing as "subscribers", and then advising the state court that functionally they were "subscribers" and, on that basis, entitled to enforce the HMO Act through the subscribers' contracts.

The Supreme Court of Florida and other state courts have recognized that their respective HMO Acts do not create private causes of action. *Westside EKG's* construct of the Florida HMO Act also has been rejected previously by the Florida Executive Branch and other reasoned decision makers that have considered these issues. Moreover, there exists a better alternative: Florida's Maximus-Center for Health Care Dispute Resolution ("Maximus-CHDR") program, recognized by 24 other states, the federal government and state courts as an effective alternative for resolving disputes between health care providers and health insurance plans. This program reduces litigation costs and thus, promotes affordable health care coverage for consumers.

---

[3] 29 U.S.C. § 1001, *et seq*.

ARGUMENTS

I. *WESTSIDE EKG* WILL HAVE AN ADVERSE IMPACT ON HEALTH CARE COSTS ACROSS THE COUNTRY AND IN FLORIDA.

We are well past any debate over whether U.S. and Florida health care costs are spiraling upward and directly impacting consumers. Since 1992, U.S. health care expenditures have nearly doubled (up 88 percent) and, at nearly $1.6 trillion in 2002, those costs are more than 6 times the $246 billion spent in 1980.[4] The roughly $1.6 trillion in national health expenditures in 2002 represents almost 15 percent of the Gross Domestic Product,[5] about 3 times more than it was in 1960.[6] Federal and state Medicaid spending grew at an average annual rate of 8 percent from 1992 and 2002, up from $119.5 billion to $257.3 billion, respectively.[7]

These health care costs are felt by the individual consumer; in 2002, 85 percent of the civilian, non-institutionalized U.S. population had health care

---

[4] Source: *Exhibit 1.1, National Health Expenditures and Their Share of Gross Domestic Product, 1960-2002*, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.gov/statistics/nhe/default.asp (2002 National Health Care Expenditures Data Files for Downloading, file nhegdp02.zip) ("*Exhibit 1.1, National Health Expenditures*, Kaiser"); Kaiser Foundation Website: http:// www.kff.org/insurance/7031/print-sec1.cfm.

[5] *Exhibit 1.1, National Health Expenditures*, Kaiser.

[6] *Exhibit 1.1, National Health Expenditures*, Kaiser.

[7] Source: *Exhibit 1.12: Total Medicaid Spending, 1992-2002*. Kaiser Commission on Medicaid and the Uninsured estimates prepared by the Urban Institute using data from the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, Financial Management Reports (tabulations from Form HCFA-64/CMS-64), 2003; Kaiser Foundation Website: http://www.kff.

expenses.[8] The reality of escalating health care costs is no less real in Florida, widely known for its large retirement population.

As health care costs continue to spiral, employers and individuals are unable to afford health insurance coverage. Empirical studies have found that a 3.0 percent rise in health insurance costs results in a 1.0 percent fall in the number of employees covered by employer-sponsored plans.[9]

By allowing private causes of action under the HMO Act and creating additional, unnecessary litigation, the opinion of the bwer court in *Westside EKG* exacerbates the cost and access challenges of the health care system. The costs of unnecessary litigation will cause premiums to rise at a faster rate, making health care coverage even more unaffordable to many Florida consumers.[10] Courts around the country have recognized that "[c]osts reduced in defending and insuring

---

org/insurance/7031/print-sec1.cfm.

[8] *Source: Exhibit 1.11: Concentration of Health Spending in the U.S. Population, 2002.* Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2002 Full Year Population, available at http://www.meps.ahrq.gov/Puf/PufDetail.asp?ID=135; Kaiser Foundation Website: http://www.kff.org/insurance/7031/print-sec1.cfm.

[9] J. Gruber & M. Lettau, *How Elastic Is the Firm's Demand for Health Insurance?* National Bureau of Economic Research Working Paper No. 8021 (July 2000).

[10] In 2003, approximately 2,957,290 Floridians were uninsured. *State Health Facts: Population Distribution by Insurance Status*, Kaiser Family Foundation, Website: http://www.statehealthfacts.org.

against lawsuits benefit the consumers as a whole."[11] Moreover, it is also understood that "[t]he reduced need for litigation will not only result in lessened costs to consumers, but will reduce the strain on overburdened judicial resources."[12]

II. ADMINISTRATIVE SCHEMES DESIGNED IN FLORIDA AND AT THE FEDERAL LEVEL DO NOT ALLOW PRIVATE LAWSUITS.

The administrative schemes in Florida and at the federal level are designed to ensure access to quality care that is affordable.[13] The Federal HMO Act's legislative history shows that it had two central purposes. First, the Act was designed "to provide assistance and encouragement for the establishment and expansion of health maintenance organizations. . . ."[14] Thus, the federal government authorized grants, loans, guarantees and other financial inducements in

---

[11] *Burden v. Johnson & Johnson Med., Inc.*, 332 F. Supp. 2d 1023 (S.D. Tex. 2004).

[12] *State Farm Mut. Auto Ins. Co. v. Powers*, 732 A.2d 730, 738 (Vt. 1999) (quoting *Cobb v. Allstate Ins. Co.*, 663 A.2d 38, 40-41 (Me. 1995)); *State Farm Mut. Auto. Ins. Co. v. Fitts*, 99 P.3d 1160 (Nev. 2004) (unnecessarily encouraging litigation will inevitably result in higher costs to the insurance consumer and unnecessary consumption of precious judicial resources.); *Wegoland Ltd. v. NYNEX*, 27 F.3d 17 (2d Cir. 1994) (use of the class action to attack the rate-making process tends to frustrate these legitimate interests and might end up costing the consumers even more in litigation expenses).

[13] *See* §§ 641.18 & 641.19, Fla. Stat.; The Health Maintenance Act of 1973, 42 U.S.C. § 300e ("Federal HMO Act"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

[14] S. Rep. No. 129, 93rd Cong. (1st Sess.) *reprinted in* 1973 U.S. Code Cong. & Admin. News 3033.

an effort to assist persons wishing to construct and operate HMOs.[15]

Second, the Act was designed to make available to middle and working class Americans the option of HMO membership. "[T]he goal of this legislation is to increase the [health care] options from the point of view of the consumer. . . ."[16] In passing the Act, Congress clearly hoped that HMOs would assume a larger and more important role in providing health care to the nation, noting "HMO enrollees receive high quality care at a lower cost--as much as one-fourth to one-third lower than traditional care in some parts of this country."[17]

Congress also understood that administration of the Federal HMO Act would be a task too burdensome for Congress alone and delegated administration of the Act to the Secretary of Health and Human Services. Under the Act, the Secretary was delegated the power to: (i) qualify those HMOs that wish to be included in an employer's health benefit plan, § 300e-9(c); (ii) assess civil fines against employers who fail to comply with the Act under certain circumstances, § 300e-9; (iii) regulate the quality of health care benefits provided by qualified HMOs, § 300e(b); (iv) decide which HMOs will receive federal grants, loans, or

---

[15] *Id*. at 3036; *see, e.g.,* 42 U.S.C. § 300e-4 ("Loans and loan guarantees for initial operation costs").

[16] 1973 U.S. Code Cong. & Admin. News at 3039. The Committee on Labor and Public Welfare noted President Nixon, in his 1971 and 1972 health messages to the nation, endorsed the concept of an HMO health plan option for most Americans. 1973 U.S. Code Cong. Admin. News at 3034.

[17] 1973 U.S. Code Cong. & Admin. News at 3034.

loan guarantees, § 300e-4 through § 300e-7; and (v) otherwise police obligations under the Act.[18]

Florida has modeled their regulatory scheme after the federal system, delegating duties to administer Florida's HMO Act to the Department of Financial Services, Financial Services Commission and the Agency for Health Care Administration ("AHCA"), all known for their expertise in these subjects.[19] The legislative history of Florida chapter 641 which sets forth the purposes of the Florida HMO Act also is similar to the Federal HMO Act's legislative history.

By opening new venues for private rights of action, *Westside EKG* obstructs the key administrative objective set forth in both federal and state statutes and legislative history--namely, promoting HMOs as an affordable health care coverage option for consumers.

Westside EKG's opening of chapter 641 litigation also interferes with the significant policy interests of ERISA, which supports minimizing the costs of claim disputes and ensuring prompt claims-resolution procedures.[20] Courts should take into account Congress' "desire not to create a system that is so complex that

---

18 *See* H.R. Rep. No. 518, 94th Cong. (2d Sess. 15) *reprinted in* 1976 U.S. Code Cong. & Admin. News 4312, 4325-26; 42 U.S.C. §§ 300e *et seq*.

19 *See generally* § 641.185, Fla. Stat. (2005) (enforcement of the Act to the Department of Financial Services, the Financial Services Commission, the Office of Insurance Regulation, and AHCA).

20 *See Pilot Life v. Dedeaux,* 481 U.S. 41, 54 (1987), *on remand to* 821 F.2d 277 (1987).

administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans."[21] *Westside EKG* fails to recognize these larger interests.

Critically, if the *Westside EKG* decision is allowed to stand, then plaintiffs can argue in federal court that ERISA does not apply to them because they are not suing as health plan subscribers, and seek a remand of their case to state court.[22] Then, upon remand, plaintiffs can argue in state court, as they did here, that they are, in fact, third-party beneficiaries under the subscribers agreement to enforce the agreements in a breach of contract action, extracting all of the contractual rights of subscribers, while avoiding all of the ERISA enforcement provisions that subscribers are subject to. Providers will thus obtain, through a judicially (though not statutorily) approved third-party beneficiary theory, more rights than subscribers have under ERISA; providers will be able to avoid all of ERISA's enforcement provisions while, at the same time, advocating their status as ERISA-

---

[21] *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Hall v. Unum Life Ins. Co. of Am.*, 300 F.3d 1197, 1202 (10th Cir. 2002).

[22] After the HMOs removed the case to federal court and moved to dismiss based on ERISA preemption and no private right of action under chapter 641, Westside EKG argued in federal court that it was not subject to ERISA preemption because it was not relying on any assignments of benefits from the HMOs' subscribers. (R1-10-12, 22-40, 60-64, 65-73). On that basis, the federal court remanded the case to state court. *Id*. In state court, Westside opposed the HMO's motion to dismiss with the opposite argument: that its claims were not based on statutory violations directly under chapter 641, but instead on their rights as a third-party beneficiary of the subscriber agreements on a breach of the HMO

like beneficiaries to sue on a contract theory to avoid chapter 641's regulatory scheme that otherwise directs these claims into administrative remedies.

Further, *Westside EKG* fails to recognize that the success of the voluntary employment-based health benefits system is due not only to a uniform regulatory regime over health insurance plans and their ability to credential the providers rendering health care,[23] but also due to the way that health plans and insurers have been able to modify and adapt the traditional fee-for-service (FFS) model of health insurance to address the special challenges posed by modern American health care economics.[24] Health insurance plans currently offer innovative products that allow

---

subscribers' contracts. (R9-1529-61, 1552-53, 1554-57; R12-1929-30, 1931-34).

[23] Voluntary plans have almost universally adopted managed care techniques. In 1988, 16 percent of covered workers were enrolled in HMOs, whereas 73 percent were still enrolled in traditional indemnity insurance plans. Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, 71 Ex. 5.1 (2003) ("Kaiser Foundation 2003 Survey"), *available at* http://www.kff.org/insurance/employer.cfm. By 1996, 27 percent of employees were enrolled in traditional indemnity plans, while 73 percent were enrolled in some form of managed care organization (MCO) plan. This year, 95 percent of covered employees are enrolled in some type of MCO plan. *Id.*

[24] A comprehensive national study of health care quality by researchers from the RAND Foundation found a substantial gap, for a wide range of illnesses, between what practicing physicians recommend to their patients and what medical scientists would describe as appropriate treatment. Elizabeth A. McGlynn, *et al.*, *The Quality of Health Care Delivered to Adults in the United States,* 348 New Eng. J. Med. 2635 (2003). The lead author concluded, "[w]e need to fundamentally re-engineer the way that health care is delivered" by relying on information technology systems, rather than individual practitioners, as the key to higher quality care. Editorial, *The Deeper Problem,* Wash. Post, June 29, 2003, at B6 (quoting Dr. McGlynn).

intelligent management of limited resources[25] as well as promote high-quality, truly effective patient care.[26] They additionally have sought to empower consumers with useful health care information by measuring and publicly reporting results on key measures of quality for nearly a decade.[27] By allowing private causes of action under the HMO Act, the appellate court decision hinders the flexibility of health insurance plans to continue to make progress in addressing cost and quality challenges, ultimately jeopardizing the success of the voluntary system.

---

[25] *See* Managed Care Facts, *Savings Due to Managed Care*, American Association of Health Plans (Oct. 1999); Dr. H.E. Frech III, *et al.*, MANAGED HEALTH CARE EFFECTS: MEDICAL CARE COSTS AND ACCESS TO HEALTH INSURANCE (Nov. 2000).

[26] *See e.g.*, *Cost-savings for a Preferred-Provider Organization Population with Multi-Condition Disease Management: Evaluating Program Impact Using a Predictive Modeling with a Control Group*, Disease Management (2003); William Gold, *How Broadening DM's Focus Helped Shrink One Plan's Costs*, Managed Care Magazine (Nov. 2003); J. Snyder, *et al.*, *Quality Improvement and Cost Reduction Realized by a Purchaser through Diabetes Disease Management*, Disease Management (2003); Victor Villagra & Tamim Ahmed, *Effectiveness of a Disease Management Program for Patients with Diabetes*, Health Affairs (2004); *Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care*, Testimony of Karen Ignagni, President and CEO of AHIP before the U.S. House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations (May 17, 2005).

[27] L. Clark Paramore & Anne Elixhauser, *Assessments of Quality of Care for Managed Care and Fee-for-Service Patients Based on Analysis of Avoidable Hospitalizations,* 2 Value in Health 258 (1999). *See Health Plan Initiatives to Improve Quality and to Provide Information to Consumers*, FTC/DOJ Hearings on Health Care and Competition Law and Policy, Statement of Karen Ignagni, President and CEO of American Association of Health Plans (May 27, 2005).

III. THIS COURT AND COURTS AROUND THE COUNTRY HAVE RECOGNIZED THAT THEIR RESPECTIVE HMO ACTS DO NOT CREATE PRIVATE CAUSES OF ACTION OR THIRD-PARTY BENEFICIARY RELATIONSHIPS.

Florida and many other states have recognized that subscribers who are direct beneficiaries of their contracts with HMOs do not have a private cause of action under a state statute. In *Villazon v. Prudential*, the Court has found that the Florida Legislature did not provide a private cause of action to enforce the terms of the Florida HMO Act.[28] Similarly, New York, under the federal HMO Act, has concluded that: (1) there was no basis for finding that Congress intended to create an express or implied private right of action to enforce its provisions; (2) the section contemplated administrative rather than judicial enforcement of the section's requirements; and (3) a private administrative remedy would be consistent with the underlying purposes of the legislative scheme.[29] Michigan[30] and Texas[31] have held similarly.[32]

---

[28] *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 852 (Fla. 2003).

[29] *Health Care Plan, Inc. v. Aetna*, 776 F. Supp. 118 (W.D.N.Y. 1991) *aff'd,* 966 F.2d 738 (1992) (construing § 300e-9 and its legislative history of the federal HMO Act).

[30] *United Autoworkers v. Ring Screw Works,* 741 F. Supp. 660, 663 (E.D. Mich.1990).

[31] *Franks v. Prudential Health Care Plan, Inc.*, 164 F. Supp. 2d 865 (W.D. Tex. 2001).

[32] **Maryland** has also held that the Maryland HMO Act contains no implied private right of action under its state HMO statute; the Maryland General Assembly included in the statute of an express provision charging the Commissioner to enforce the statute's terms. *IVTX v. United Healthcare*, 112 F.

The *Westside EKG* decision supplants Florida legislative intent and creates an inherent conflict with that intent and with *Villazon* and the decisions driving it, as well as numerous other jurisdictions recognizing that controlling litigation costs by reinforcing administrative remedies advances the purposes of the HMO Act.

Allowing *Westside EKG* to stand will trigger a monumental increase in litigation from providers who can now bring chapter 641 claims not intended to exist--not by legislative mandate, not by Governor Chiles' and the Florida Legislature's vetoes,[33] and not by this Court's precedent. This decision effectively

---

Supp. 2d 445 (D. Md. 2000). **Louisiana** has held similarly that enforcement of the standards under the Louisiana Health Maintenance Organization Act lies exclusively with the Commissioner of Insurance. *Zoblotsky v. Tenet Choices, Inc.*, 2005 WL 1038136 (E.D. La. 2005). **Pennsylvania** has further determined that there is no private cause of action under its HMO Act prompt payment of claims section, basing its determination on the lack of legislative history, like Florida, in support of a private cause of action. *Solomon v. U.S. Healthcare Sys. of Pa., Inc.*, 797 A.2d 346, 353 (Pa.), *appeal den.*, 808 A.2d 573 (2002). And **California** has held that a plaintiff cannot recover for violations of its HMO Act because those claims fall within the Act's distinct statutory enforcement scheme regulating HMO's and enforcement lies with the California Department of Managed Health Care. *Cohen v. Health Net of Cal.*, 2005 WL 980629 (Cal. Ct. App.), *as modified on denial of reh'g* (2005).

[33] In 1996 Governor Lawton Chiles vetoed House Bill 1853 ("1996 House Bill 1853") at 3, which sought to create a civil action against a health maintenance organization (HMO) when a person suffered damages as a result of an HMO's failure to provide a covered service. Governor Chiles pointed out that enacting 1996 House Bill 1853 would thwart the efforts of managed care providers to offer affordable healthcare services to the citizens of Florida, and warned that "[t]he lawsuits generated by this bill would threaten to eviscerate the concept of utilization review and cost control that are at the heart of managed care." 1996 House Bill 1853 at 5. Senate Bill 1900 ("2000 Senate Bill 1900") was the second, and also rejected, attempt to create a private statutory cause of action under chapter

gives providers and subscribers rights to sue that were never contemplated by chapter 641. Arguably any provision of the Florida HMO Act mandated by the Florida Legislature to be enforced by the state regulatory body can now be wielded as the basis for a chapter 641 lawsuit. As a result, the regulatory bodies that are charged by law with enforcing and regulating health care will be rendered ineffective, with no influence over the health care systems under their responsibility.

The decision will have quality and cost ramifications across the country. *Westside EKG*, as a practical matter, removes any incentive for providers to contract with health plans. Under *Westside EKG*, they can seek compensation for all of their billed charges, reasonable or not, by simply suing in court under the HMO subscribers' contracts. Indeed, post-*Westside EKG*, why would *any* provider

---

641. Section 4 of the 2000 Committee Substitute Bill, at 4, was the third, equally unsuccessful attempt at creating a private cause of action against HMOs. The Senate Staff Analysis, in fact, noted that "[t]here has been no Florida appellate court decision that had held an HMO liable in a civil negligence or malpractice action. . . ." 2000 Committee Substitute Bill at § II, 8. As a result of Governor Chiles' and the Legislature's steps to preserve ch. 641's administrative remedies, in lieu of opening ch. 641 to litigation,

> Today, a record number of consumers are embracing managed care as a high-quality, more affordable health care option. More than 60,000 Floridians--fifty-four percent who were previously uninsured--now have health care coverage through the state's new Community Health Purchasing Alliances. In 1994, Florida employers saw. . .health care costs decrease for the first time in six years by 10.6 percent.

Hon. Lawton Chiles, *Introduction to The Review Of Legislation Health Care Reform In Florida: Promoting Improved Access, Cost, And Quality*, Fla. State L.

agree to a discounted contract rate when they can sue in court for any rate they choose to put in their bill?

This point is not merely significant to health insurance plans, but also to any health care system and health plan subscribers. If providers are not contracted, any legislatively mandated scheme--designed to ensure that HMOs and providers are jointly regulated to advance the delivery of quality care in a cost-efficient manner[34]--will be abolished. Further, chapter 641's requisite credentialing of contracted providers, quality assurance, and utilization review will cease.[35] Important and needed protections for both parties would be eradicated[36] and the system will return to the health care system that managed care was intended to replace.

Additionally, although the subscriber agreement at issue here clearly had a non-assignment provision and did not suggest an intent to benefit non-contracted ("non-par") providers, *Westside EKG* concludes that non-par providers are implicitly intended beneficiaries of subscriber health plan agreements by virtue of

---

Rev. (1996).

[34] § 641.19, Fla. Stat. (2005).

[35] *See, e.g.,* §§ 641.60, 641.234(2), 641.495, 641.51, 766.101, Fla. Stat. (2005). If no providers apply to be contracted, there is no ability to guarantee a certain provider pool size to render medical care to HMO subscribers and no ability to credential providers to assure that quality standards are met, as chapter 641 requires.

[36] *See* Mark S. Joffe, *Legal Issues in Provider Contracting, in* ESSENTIALS OF MANAGED HEALTH CARE, at ch. 32, 705-06 (Peter R. Kongstvedt ed., 4th ed.

chapter 641, not by virtue of the contract. That is inconsistent with Florida law and decisions around the country.[37]

The New York courts, for example, have held that a Pennsylvania physician, who had sued a medical insurer to enforce an insurance contract between the insurer and New York State (that provided medical insurance benefits to state employees): (1) lacked standing; (2) was not an intended beneficiary of the contract between the insurer and the state; and (3) that the patients' assignments of rights to the physician were void.[38] Alabama, likewise, held that recipients of Medicaid benefits were not third-party beneficiaries to a settlement between tobacco companies and Alabama arising from a lawsuit in which Alabama sought to recover money spent in providing payments to healthcare providers for the treatment of tobacco-related illnesses of Medicaid recipients.[39]

Colorado held that a chiropractic clinic, which provided services to insureds, and had sued the insurer, seeking payment of benefits under insureds' automobile

---

2001).

[37] *See, e.g., Hollywood Lakes Country Club, Inc. v. Community Ass'n Servs., Inc.*, 770 So. 2d 716 (Fla. 4th DCA 2000). In **Indiana**, the court concluded that a health care provider was not a third-party beneficiary of an insurance contract, reasoning that the provider did not receive an intended direct benefit from policy by virtue of assignment, as the contract provided that all benefits were payable to the insured individual. *NN Investors Life Ins. Co., Inc. v. Crossley*, 580 N.E.2d 307 (Ind. 1991), *transfer den.* (1992).

[38] *Cole, M.D. v. Metro. Life Ins. Co.*, 708 N.Y.S.2d 789 (N.Y.A.D. 2000) (Assignments to physician by patients of their rights under medical insurance contract void because contract contained language prohibiting same).

policies that provided personal injury protection benefits, was only an incidental beneficiary of the policy, rather than an intended third-party beneficiary, and, thus, the clinic was not entitled to recovery in a direct action to enforce the policy's terms.[40]

These states have not permitted the counterproductive and costly interpretation of their respective HMO Acts that the Fourth District has accorded the Florida HMO Act in *Westside EKG.*

IV. MAXIMUS-CHDR IS RECOGNIZED AROUND THE COUNTRY AS AN EFFECTIVE HEALTH DISPUTE RESOLUTION ADMINISTRATIVE ALTERNATIVE.

Section 408.7057, Fla. Stat., sets forth one of the key ways in which Florida intended to resolve disputes between health providers and health care plans. In an effort to keep litigation costs down, that statute creates and mandates that Florida's

---

[39] *Gomer v. Philip Morris Inc.*, 106 F. Supp. 2d 1262 (M.D. Ala. 2000).

[40] *Parrish Chiropractic Ctrs., P.C. v. Progressive Cas. Ins. Co.*, 874 P.2d 1049 (Colo. 1994); *see also Grant Thornton v. Windsor House, Inc.*, 566 N.E.2d 1220 (Ohio) *reh'g den.*, 571 N.E.2d 135, *cert. den.*, 502 U.S. 822 (1991) (Held: Medicaid care provider subject to audit of reimbursable costs under Medicaid program not intended third-party beneficiary of audit contract between Ohio Department of Public Welfare (ODPW) and auditor.); *Aetna Cas. & Sur. Co. v. Oregon Health Sciences Univ.*, 793 P.2d 320 (Or. 1990) (Held: absent intention to confer contract right on third party who has paid no value, contract will not be interpreted to promise performance to third-party stranger to contract, even though stranger may incidentally benefit from contract.); *Healthcare Servs., Inc. v. Nat'l Prescription Adm'rs, Inc.*, 867 F. Supp. 1223 (E.D. Pa. 1994) (Pennsylvania held under New Jersey law that a prescription medicine provider, who sued a prescription program administrator for unpaid claims that allegedly resulted from the administrator's improper rejection of claims for reimbursement, was not an intended third-party beneficiary of the agreement between administrator and

AHCA maintain an alternative dispute resolution program for health plans and providers. To fulfill this requirement, AHCA has contracted with Maximus-CHDR,[41] a program that allows providers and HMOs to resolve their billing disputes before experts, in 60 days, without extensive motions practice, without the need to even have any attorney present and without the costs of attorneys' fees. At the same time, Maximus-CHDR is a venue through which complainants can be awarded and can enforce money damages and costs, and the process is open to full appellate review upon the entry of a final administrative order.[42]

Aside from Florida, 24 states and the federal government recognize that Maximus-CHDR reduces health care litigation costs.[43] State courts also recognize Maximus-CHDR as a viable administrative alternative to resolve health care disputes.[44]

---

company to fill prescriptions.).

[41] Section 408.7057, Fla. Stat. (2005), reflects throughout that this is not a process depending on the parties' mutual agreement, but a process turning on either a health plan or provider submitting claims that fall within § 408.7057's jurisdiction. *See also* §§ 408.7057(2)(b) & (c).

[42] *See* § 408.7057; *see also* Fla. R. App. P. 9.030(b)(1) & 9.110.

[43] *See* MAXIMUS/CHDR website address: http//www.healthappeal.com/ index.asp. MAXIMUS/CHDR operates the nation's largest system for the resolution of health insurance appeals through independent external review, has resolved over 100,000 cases drawn from over 600 managed care plans across the U.S. Maximus/CHDR has a full-time, on-site interdisciplinary team that includes healthcare attorneys, medical professionals, public health experts and medical technicians, supported by a large panel of physicians and practitioner consultants in every medical specialty area. *Id*.

[44] *See generally English v. Blue Cross Blue Shield of Mich.*, 688 N.W.2d 523

Maximus-CHDR, like other administrative processes, is a quick, fair and effective method for resolving disputes between parties. These processes ultimately benefit consumers by promoting accountability, encouraging quality improvement and controlling skyrocketing health care costs.[45]

CONCLUSION

For the reasons and legal authorities set forth herein, Amicus Curiae, America's Health Insurance Plans, respectfully requests that this Court quash the decision of the Fourth District Court of Appeal. Health management programs promote prudent management of limited *joint* resources, to ensure consumers receive the *right* care at the right time, and value for their investment and that of their employers. However, what good can a global legislative makeover of the health care system accomplish if courts judicially rewrite sections that undo provider cost-controlling and quality monitoring, and further make way for litigation costs anew? Preventing health care providers from circumventing legislative intent and *Villazon* through artful pleading preserves precedent and advances sound health care policy, both in Florida and nationally.

(Mich. 2004); *McIntire v. Fortis Ins. Co.*, 2004 WL 2272166 (S.D. Ind. 2004).

[45] *Independent Medical Review of Health Plan Coverage Decisions: A Framework for Excellence*, American Association of Health Plans, April 2001.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true copy of the foregoing was mailed this 23rd day of June, 2005, to all counsel named on the attached Service List.

Respectfully submitted,

Law Offices of
STEVEN M. ZIEGLER, P.A.
Counsel for AHIP
Presidential Circle – Suite 375 South
4000 Hollywood Blvd.
Hollywood, Florida 33021
Tel.: (954) 966-2696
Fax: (954) 966-2446

By________________________________
DOROTHY F. EASLEY
Fla. Bar No. 0015891

By________________________________
STEVEN M. ZIEGLER
Fla. Bar No. 344443

CERTIFICATE OF COMPLIANCE

I HEREBY CERTIFY that the foregoing complies with the typeface and font size, Times New Roman 14 point proportionately spaced, as set forth in Rule 9.210, Fla. R. App. P.

By________________________________
DOROTHY F. EASLEY

<u>SERVICE LIST</u>
HEALTH OPTIONS, ET AL V. WESTSIDE EKG ASSOCIATES

Philip M. Burlington, Esquire
Philip M. Burlington, P.A.
Appellate Counsel for Westside
2001 Palm Beach Lakes Boulevard
Suite 205
West Palm Beach, FL 33409
Tel: 561-253-0400
Fax: 561-253-0402

Richard Barnett, Esquire
Counsel for Westside
P.O. Box 223248
Hollywood, FL 33022-3248
Tel: 954-980-8217
Fax:

Louis M. Silber, Esquire
Silber & Valente
Counsel for Westside
1800 Old Okeechobee Road
Suite 200
West Palm Beach, FL 33409
Tel: 561-615-6200
Fax: 561-615-6206

Jene P. Williams, Esquire
Jeffrey M. Liggio, Esquire
Liggio, Benrubi & Williams, P.A.
Counsel for Westside
1615 Forum Place, Suite 3-B
West Palm Beach, FL 33401
Tel: 561-616-3333
Fax: 561-616-3266

Edward H. Zebersky, Esq.
Zebersky & Payne, LLP
Counsel for Westside
4000 Hollywood Blvd.
Suite 400N
Hollywood, FL 33021
Tel: 954-989-6333
Fax: 954-989-7781

Rochelle Bobroff, Esq.
Appellate Counsel for AARP
AARP Foundation Litigation
601 E Street, N.W.
Washington, D.C. 20049
Tel: 202-434-3060
Fax:

Bradley Winston, Esq.
Winston & Clark, P.A.
Counsel for AARP
8211 West Broward Blvd.
Plantation, FL 33324
Tel: 954-475-9666
Fax: 954-475-2279

Brian D. Boyle, Esq.
Brian P. Brooks, Esq.
O'Melveny & Myers
Counsel for Humana
1625 Eye Street
Washington, DC 20006
Tel: 202-383-5300
Fax: 202-383-5414

Andrew S. Berman, Esq.
Young, Berman, Karpf & Gonzalez
Counsel for Humana
17071 W. Dixie Highway
N. Miami Beach, FL 33160
Tel: 305-945-1851
Fax: 305-940-4616

Gerald M. Cohen, Esq.
Vista Health Plan, Inc.
Counsel for Vista
300 South Park Road
Hollywood, FL 33021
Tel: 954-962-3008
Fax: 954-985-4379

Heidi E. Garwood, Esq.
Humana, Inc.
Counsel for Humana
500 W. Main Street, 27th Fl.
Louisville, KY 40201
Tel: 502-580-3734
Fax: 502-580-3699

Glenn J. Waldman, Esq.
Craig Trigoboff, Esq.
Waldman, Feluren & Trigoboff
Counsel for Foundation and Vista
2200 N. Commerce Pkwy.
Suite 202
Weston, FL 33326
Tel: 954-467-8600
Fax: 954-467-6222

Nancy W. Gregoire, Esq.
W. Edward McIntyre, Esq.
Daniel Alter, Esq.
Bunnell, Woulfe, Kirschbaum, Keller, McIntyre
& Gregoire
Counsel for Health Options
One Financial Plaza, 9th Fl
100 S.E. Third Avenue
Ft. Lauderdale, FL 33394
Tel: 954.761.8600
Fax: 954.525.2134

George N. Meros, Jr., Esq.
Carlos G. Muniz, Esq.
Gray Robinson, PA
Counsel For Amicus Curiae FAHP
301 S. Bronough Street
Suite 600
P.O. Box 11189
Tallahassee, FL 32302
Tel: 850- 577-9090
Fax: 850- 577-3311