IN THE SUPREME COURT
STATE OF FLORIDA

CASE NO. SC05-871

FOUNDATION HEALTH, A FLORIDA HEALTH PLAN, INC.; HEATH OPTIONS, INC.; VISTA HEALTH PLAN f/k/a HIP HEALTH PLAN OF FLORIDA, INC.; HUMANA MEDICAL PLAN, INC. f/k/a PCA FAMILY HEALTH PLAN, INC.; HUMANA MEDICAL PLAN, INC. f/k/a PCA HEALTH PLANS OF FLORIDA, INC.; and HEALTH OPTIONS CONNECT, INC. f/k/a PRINCIPAL HEALTH CARE OF FLORIDA, INC., INC., Petitioners,

v.

WESTSIDE EKG ASSOCIATES, Respondent.

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

BRIEF OF AMICUS CURIAE FLORIDA ASSOCIATION OF HEALTH PLANS, IN SUPPORT OF PETITIONERS
(Filed with Consent and with Motion for Leave of Court)

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STATEMENT OF IDENTITY AND INTEREST OF *AMICUS*

The Florida Association of Health Plans ("FAHP") comprises 14 state-licensed health maintenance organizations ("HMOs"). Florida HMOs provide health care services to more than 4.8 million Florida residents in 64 counties. FAHP's mission is to improve the health of Florida's citizens by promoting the growth of health plans dedicated to providing the highest quality, best value, and affordable health care.

FAHP has a substantial interest in ensuring the public's access to high-quality, affordable health care. The decision under reviews poses a clear and present danger to that interest. If left in place, the decision will cause inefficiency and increased litigation, harming all health care consumers in our State.

SUMMARY OF ARGUMENT

The appellate court's conclusion that the prompt pay provisions of the HMO Act are enforceable by private causes of action is wrong. Despite the Legislature's direction that no civil action be brought to enforce the terms of the HMO Act, the lower court decided that a plaintiff could sidestep this mandate by bringing a "common law contract" claim to do the very same thing—enforce the terms of the HMO Act. This conclusion is illogical, contrary to the Legislature's intent, and harmful to Florida's health care system.

The decision under review will decrease efficiency in Florida's health care system and substantially increase the amount of healthcare litigation—further burdening an already beleaguered court system. This result could have a devastating impact on the health care of Floridians, and it is precisely the result the Florida Legislature sought to avoid. The Legislature determined that the HMO Act should be enforced through the administrative process, not through private actions. This is evident from the text of the Act itself, from the Legislature's repeated rejection of proposals to allow private suits, from the creation of a dispute resolution mechanism for health care claim disputes, and from decisions of this Court.

Even if the HMO Act could be enforced through breach of contract actions (which it cannot), Westside lacks standing to sue under the contracts at issue here. Undisputedly a non-party to the contracts, Westside cannot meet the stringent standard for establishing third-party beneficiary status. Most importantly, because Westside has no right to direct payment under the contracts, it is clear that the parties did not intend to benefit Westside. This is fatal to Westside's ability to establish standing to enforce the contracts.

ARGUMENT

I. WESTSIDE MAY NOT PURSUE BARRED HMO ACT CLAIMS UNDER THE GUISE OF A BREACH OF CONTRACT ACTION.

This Court recently recognized that there is no private right of action to enforce the terms of Florida's Health Maintenance Organization Act, Chapter 641, Florida Statutes (the "HMO Act"). *See Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 852 (Fla. 2003); *see also Florida Physicians Union, Inc. v. United Healthcare of Florida, Inc.*, 837 So. 2d 1133 (Fla. 5th DCA 2003); *Greene v. Well Care HMO, Inc.*, 778 So. 2d 1037 (Fla. 4th DCA 2001). Despite this legislative mandate, the district court concluded that private parties *can* enforce the terms of the HMO Act—by the simple expedient of labeling their private enforcement action as a breach of contract. Because form must never be elevated over the substance of legislative intent, the decision under review must be reversed.

A. The Decision Under Review is Squarely at Odds with the Legislative Policy Choices Embodied in the HMO Act.

The Legislature does not operate in a vacuum, and neither should this Court. The HMO Act, and specifically the establishment of an administrative means of resolving provider disputes with HMOs, reflect Florida citizens' concerns with the high cost of health care, as well as the equally-high cost and inefficiency in

Florida's court system. A faithful interpretation of the Act demands a full understanding of these dual crises.

1. Florida suffers a recognized health care crisis.

Section 408.70, Florida Statutes (2004), states the following:

> The Legislature finds that the current health care system in the state does not provide access to affordable health care for all persons in this state. Almost one in five persons is without health insurance. For many, entry into the health care system is through a hospital emergency room rather than a primary care setting. . . . Health care costs have been increasing at several times the rate of general inflation, eroding employer profits and investments, increasing government revenue requirements, reducing consumer coverages and purchasing power, and limiting public investments in other vital government services.

Significantly, the reports of the Governor's Task Force on Access to Affordable Health Insurance and the House Select Committee on Affordable Health Care for Floridians both cited litigation as a substantial cause of rising health care costs. *See* Governor's Task Force on Access to Affordable Health Insurance, *Final Report* 31 (Feb. 15, 2004); Fla. H.R. Select Comm. on Affordable Health Care for Floridians, *Final Report* 90 (Feb. 18, 2004) (available at http://www.myfloridahouse.com/custFiles/39/2220.pdf) (last visited June 9, 2005).

2. Florida's court system is overburdened.

The problems facing the state court system are similarly well-documented. Historically "under-resourced," our state courts are burdened by workloads "well beyond capacity." *In Re: Certification Of Need For Additional Judges*, 863 So. 2d

1191 (Fla. 2003). This Court recently concluded that, if left unaddressed, the courts' workload demand will "jeopardize the Rule of Law." *Id.* at 1195. Based on an objective assessment of the state of the court system, this Court certified the need for a total of 88 additional judges. *Id.* at 1200, 1203. On June 8, 2005, Governor Bush approved Senate Bill 2048, which provides a number of new judgeships and related funding.

The workload problem spans all levels of the court system. Florida's circuit judges handle 31% more filings than the national average. *Id.* at 1197. Florida's appellate courts have sought efficiencies in many ways, yet, "in spite of these efforts, judicial workload in the districts is becoming too great." *Id.* at 1201. Its review of the district courts left this Court "concerned that timely, high-quality appellate review is at a risk of being compromised due to a lack of judges to handle the high workload." *Id.* at 1202.

There are many causes for the burgeoning workload of Florida's courts. Major factors include our state's rapid population growth and its aging population, which has led to an increase in guardianship and related probate cases. *Id.* at 1195. But among the most significant causes of the courts' workload problem is a substantial increase in more labor-intensive cases, *id.* at 1196, such as the one at issue in this appeal and the scores of similar cases that will follow if the district court's decision is allowed to stand.

3. The Legislative intent clearly favors administrative enforcement of the HMO Act.

The decision below would yield results directly contrary to manifest legislative intent. Rather than promote efficiency and minimize state court litigation—goals furthered by the Legislature's preference for administrative enforcement of the HMO Act—this decision will burden the courts with innumerable, fact-intensive disputes over the myriad provisions of the HMO Act. The resulting inefficiency would impose greater financial costs on Florida's health care consumers.

The Legislature's intent is evident from the text of the Act itself. *See* § 641.185, Fla. Stat. (2004) (committing enforcement of the Act to the Department of Financial Services, the Financial Services Commission, the Office of Insurance Regulation, and the Agency for Health Care Administration ("AHCA")). The Legislature's preference for administrative enforcement is further evidenced by its creation of a dispute resolution program for health care claim disputes. In Chapter 2000-252—now codified at Section 408.7057, Florida Statutes—the Legislature directed AHCA to establish a program "to provide assistance to contracted and noncontracted providers and health plans for resolution of claim disputes that are not resolved by the provider and the health plan." Under the program, AHCA contracts with a "resolution organization" to conduct an expedited dispute resolution process that results in a recommended disposition and a final agency

order within 120 days. *See* Fla. Stat. § 408.7057(2)(a), (3), and (4) (2004). This program is up and running and has already resolved numerous claims.

Legislative action since passage of the HMO Act further demonstrates that the Legislature did not intend to provide a private right of action to enforce the Act. As discussed more thoroughly in Petitioners' initial brief, the Legislature has rejected attempts to amend the HMO Act to provide a private cause of action. (Br. of Pet. at 18.) In 1996, the Legislature passed a bill to allow private suits, but the Governor vetoed it, explaining that the legislation would "destroy the very positive benefits of managed care." *See id.* Subsequent bills to allow private actions have also been rejected. *See id* at 18-19.

4. The Decision Below Threatens the Separation of Powers.

Because the Legislature's intent is clear, judicial frustration of that intent threatens the constitutional separation of powers. As the United States Supreme Court noted in the federal context, judicial tests for determining the existence of a private right of action "reflect[] a concern, grounded in separation of powers, that Congress rather than the courts controls the availability of remedies for violations of statutes." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508 n.9 (1990). Our State Constitution requires that this Court show similar respect for the prerogatives of the Florida Legislature. *See* Art. II, § 3, Fla. Const. (separation of powers provision).

Here, the Legislature intended to preclude private actions to enforce the HMO Act. But the district court allowed such a suit relying on *common-law* principles. The problem is that what a statute precludes, no common-law principle can allow. A statute preserves the common law *only* to the extent it is not inconsistent with the acts of the Legislature. *Ripley v. Ewell*, 61 So. 2d 420, 421 (Fla. 1952), *overruled in part on other grounds by Gates v. Foley*, 247 So. 2d 40 (Fla. 1971). Private enforcement of the HMO Act is flatly inconsistent with the intent of the Legislature. Where the Legislature has not established a private right of action, neither should the courts.

B. The District Court Employed Flawed Reasoning in Concluding that the HMO Act Could Be Privately Enforced.

The decision below rests on faulty reasoning. The district court relied on authority that did not support its conclusion, and it unsuccessfully attempted to distinguish authority that quite clearly compelled the opposite result.

1. The district court fails to distinguish Villazon and other authority.

Recognizing *Villazon*'s clear holding that private suits to enforce the terms of the HMO Act are not permitted, the district court attempted to distinguish this case by using this logic: (1) the individual HMO subscribers and the providers were parties to HMO contracts; (2) the HMO contracts implicitly incorporated the terms of the entire HMO Act; (3) a violation of the terms of the HMO Act

therefore equaled a breach of the terms of the contract; and (4) a plaintiff could sue *based on the contract* for violations of the HMO Act, even though he could not sue directly for a violation of the HMO Act.[1] This strained theory, of course, renders *Villazon* meaningless.

Setting aside inventive labels, Westside undeniably seeks to enforce the terms of the HMO Act. Under the common law, a contract claim is based on a breach of covenants voluntarily negotiated by competent parties. *See Abbott Laboratories, Inc. v. General Elec. Capital*, 765 So. 2d 737, 740 (Fla. 5th DCA 2000). But here, the purported covenants of the contract are the express terms of the HMO Act. And while the district court strains to contend that the claim does not enforce the terms of the HMO Act, it ignores the fact that *without the HMO Act, the contract claim would not exist*.

In addition to *Villazon*, the district court below attempted to distinguish other cases that concluded there is no private right of action to enforce the HMO Act. For example, the court considered its own decision in *Greene v. Well Care HMO Inc.*, 778 So. 2d 1037 (Fla. 4th DCA 2001). In *Greene*, an insured sued her HMO for violating the HMO Act, claiming that the HMO wrongfully refused to pay for treatment. *Id*. at 1039. The insured claimed that Well Care violated Sections 641.3901-.3905 of the HMO Act, which generally prohibit an HMO's

[1] The theory also included another premise—that Westside was a third-party beneficiary to the contracts at issue. This too is wrong. *See* Section II, *infra*.

unfair practices. The district court rejected the plaintiff's claims, concluding that the alleged violations of the HMO Act did not provide a basis for a private cause of action. *Id.* at 1040.

Had the court in *Greene* applied the new theory it employed in this case, the result could have been different. The plaintiff simply could have styled her complaint a breach of contract action, alleged that the entire HMO Act—including the provisions she sued upon—were incorporated into her contract with the HMO, and claimed damages from the HMO's alleged violation of the Act (and by extension, breach of the contract). This result, of course, would have nullified *Greene*'s correct conclusion that there was no private right of action.

A similar analysis applies to *Florida Physicians Union, Inc. v. United Healthcare of Florida, Inc.*, 837 So. 2d 1133 (Fla. 5th DCA 2003), another case the district court purported to distinguish. In *Florida Physicians*, an organization representing doctors and their associations sued an HMO under the HMO Act claiming billing violations. *Id.* at 1134. In *Florida Physicians*, as here, providers complained that they were not receiving timely and proper payments from HMOs, in violation of the Act. The court, relying on the *Greene* decision, likewise concluded that there is no private cause of action based on the HMO Act. *Id.* at

1136.[2] And just as in *Greene*, the decision in *Florida Physicians* loses any meaning once plaintiffs are permitted to bring actions to enforce the HMO Act under the guise of contract actions.

Although the district court's opinion deals only with the "prompt pay" provisions of the HMO Act, its flawed logic extends to all of the Act's many requirements. For example, Section 641.26 requires all HMOs to submit annual financial reports. Under the district court's theory, this requirement, by virtue of being included in the HMO Act, is a term of the contracts at issue. A provider could therefore sue to enforce that statutory requirement by claiming breach of contract. This makes no sense.

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[2] The court went further and explained some of the problems with reading into the statute a private cause of action:

> Indeed, if in the context of a declaratory judgment, a circuit court found that statutory violations were ongoing or in existence, its judgment would either be advisory and still require the Department to take action, or it would usurp the jurisdiction of the Department to investigate, find violations of and enforce the provisions of the statute. Conceivably the Department might disagree with a circuit court about the existence of a violation or the method to remedy it. And, there would be no ready appellate mechanism to resolve the dispute.

Id. at 1137. The *Florida Physicians* opinion included this language to refute arguments that Sections 641.28 and 641.3917 implied a private cause of action—the very same arguments that the district court relied on in the case at bar.

2. *The district court's reliance on* Foundation Health *was misplaced.*

The district court's opinion relied in part on the Third District Court of Appeal's decision in *Foundation Health v. Garcia-Rivera, M.D.*, 814 So. 2d 537 (Fla. 3d DCA 2002). That decision, though, did not consider the issue of private enforcement of the HMO Act. Instead, the one-page opinion did no more than reject the defendants' argument that class certification was improper because of the parties' arbitration agreement. *Id.* at 538. The decision does indicate that the underlying cause of action was based on "alleged violation of the 'prompt pay' provisions of section 641.3155," but it does not consider, discuss, or decide whether private enforcement of the HMO Act was permissible. *Id.* at 537. And neither did the parties brief the issue of private rights of action. The briefs that the parties submitted to the Third District Court of Appeal are attached to this brief as an Appendix.

The opinion below quoted *Foundation Health's* pronouncement that it is "meaningfully indistinguishable [from] *Colonial Penn Insurance Co. v. Magnetic Imaging Systems, I, Ltd.*, 694 So. 2d 852 (Fla. 3d DCA 1997)." But the similarity between *Colonial Penn* and *Foundation Health* has nothing to do with the HMO Act—indeed *Colonial Penn* was a case dealing with automobile insurance, not an

HMO.[3] Instead of having anything to do with the HMO Act or private actions under the HMO Act, those cases deal with the procedural commonality requirement of class actions—specifically whether different class members' entitlement to different amounts is fatal to a class action. *Colonial Penn*, 694 So. 2d at 854; *Foundation Health*, 814 So. 2d at 538.[4] This procedural issue is not before this Court, and it was not before the district court. The district court's reliance on *Foundation Health* is misplaced.[5]

3. The district court's reliance on irrelevant and inapplicable out-of-state authorities was improper.

Equally misplaced was the court's reliance on out-of-state authorities interpreting other states' healthcare or insurance statutes. The court first cited

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[3] Perhaps some of the confusion can be blamed on the ambiguous opening sentence in *Foundation Health*: "As in the meaningfully indistinguishable case of *Colonial Penn* . . . the trial court properly certified a class of contract providers to the appellant HMOs in an action for the alleged violation of the 'prompt pay' provisions of section 641.3155." *Foundation Health* at 537. Because the appellant in *Colonial Penn* was not an HMO and Section 641.3155 was not at issue in that case, it is clear that the phrase "[a]s in . . . *Colonial Penn*" modifies only the first part of the sentence.

[4] The short opinion in *Foundation Health* does not even expressly address this commonality issue. Instead it concludes that the defendants waived the defense. It does note, though, that the argument that class certification was improper was "without substantive merit." *Foundation Health* at 538. Based on the arguments of the parties, *see* Appendix, and the court's reference to *Colonial Penn*, it is evident that *Foundation Health* rejected the defendants' commanality argument.

[5] At any rate, this Court's decision in *Villazon* is more recent than the *Foundation Health* opinion. So if the *Foundation Health* opinion did support a finding that parties could privately enforce the HMO Act, which it did not, it would have been implicitly overruled by *Villazon*.

Wallace v. State Farm Fire and Casualty Co., 539 S.E.2d 509 (Ga. App. 2000). *Wallace* does not support the proposition for which it was cited. The case affirms summary judgment in favor of an automobile insurer on an injured plaintiff's disability claims. *Id.* at 510. Perhaps the court in this case was persuaded by footnote 4 of the *Wallace* opinion, which cited Georgia Code Section 33-4-6. That section provides that an insured who does not receive timely payment because of the insurer's bad faith is entitled to a statutory penalty and attorney's fees. The statute makes provisions "for the prosecution of the action against the insurer." Ga. Code Ann. § 33-4-6(a). No such statute is at issue in this case.

The New York decision in *St. Clare's Hospital v. Allstate Insurance Company* is likewise unhelpful. 215 A.D.2d 641 (Sup. Ct. N.Y. 1995). That case evaluates the plaintiff's right to attorney's fees under New York's complex automobile no-fault insurance scheme, which includes this provision: "If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim. . . ." N.Y. C.L.S. Ins. § 5106. If there is any parallel between New York's no-fault statute and Florida's HMO Act, it is difficult to see how it applies to this case.

The district court next cited *J.C. Penney Life Insurance Company v. Heinrich*, 32 S.W.3d 280 (Tex. App. 2000). That case involved another insurance

prompt-pay statute, *but that statute expressly included a right of action for aggrieved parties*. *See* Tex. Ins. Code art. 21.55 ("In all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefore is not in compliance with the requirements of this article, such insurer shall be liable to pay the holder of the policy, or the beneficiary making a claim under the policy, in addition to the amount of the claim, [interest and attorney's fees] . . . If suit is filed, such attorney fees shall be taxed as part of the costs in the case.") (repealed effective April 1, 2005).

II. WESTSIDE LACKS STANDING AS A THIRD-PARTY BENEFICIARY.

Even if the law permitted a Plaintiff to bring an action under the HMO Act masquerading as a contract action—which it does not—the action in this case still must fail because Westside has no standing. Acknowledging that it is not a party to the contracts at issue in this case, Westside contends it may sue as a third-party beneficiary. But that is not the case.

The rules relating to third-party beneficiaries are well established. A non-party may not sue for breach of contract if it has received only an incidental or consequential benefit from the contract. *Metropolitan Life Ins. Co. v. McCarson*, 467 So. 2d 277 (Fla. 1985). There is an exception to this general rule only where the parties clearly express, or the contract itself expresses, the parties' "intent to *primarily and directly* benefit the third party." *Hirshenson v. Spaccio*, 800 So. 2d

670, 673 (Fla. 5th DCA 2001) (emphasis added). There is no indication here, and indeed the Fourth DCA did not determine, that the contracts at issue were intended to "primarily" and "directly" benefit a health care provider. It is axiomatic that the purpose of a contract between a health care subscriber and an HMO is to benefit the subscriber (and the HMO). The benefit to health care providers because of these contracts is undeniable—much of their revenue derives from HMOs—but this is simply the natural and logical consequence of the contracts. A health care subscriber does not set out to benefit doctors; he sets out to protect his own health and well being.

Westside's purported third-party beneficiary status is particularly untenable based on the contracts at issue. In the case of non-participating providers such as Westside, the contracts call for payment directly to the subscriber—not to the provider. Under the Health Options contract, non-participating providers have no right to direct payment from the insurer. The contract states that, "[f]or services rendered by Non-Participating Providers, Benefits are payable to the Covered Employee or other person as required by law." (R9-1554-57). Similarly, the Vista contract provides: "The Member cannot assign any benefits or payments due under this contract to any person, corporation, or organization." (R-9-1552-53).

By contrast, in the few cases that concluded providers *were* third-party beneficiaries, the agreements provided for payments directly to the providers. *See*,

e.g., *Vencor Hosp. v. Blue Cross Blue Shield of Rhode Island*, 169 F.3d 677, 680 (11th Cir. 1999) ("By providing for payment *directly* to the hospital, the contracting parties showed a clear intent to provide a direct benefit to Vencor (or any other service-providing hospital, and thus Vencor has standing to bring this suit.") (emphasis added); *United States v. Auto. Club Ins. Co.*, 522 F.2d 1, 2-3 (5th Cir. 1975) (finding third-party beneficiary status depended on contract language authorizing payment to the "person or organization rendering the services" and distinguishing cases where there was no such authorization); *Orion Ins. Co. v. Magnetic Imaging Sys. I.*, 696 So. 2d 475, 478 (Fla. 3d DCA 1997) (noting that insurance agreement specifically anticipated payment directly to providers).

FAHP has found no authority for the proposition that, under the circumstances of this case, a health care provider has standing to sue as a third-party beneficiary of a contract between an insurer and its enrollee. Instead, courts throughout the country have rejected this notion. *See, e.g., United States v. Dairyland Ins. Co.*, 674 F.2d 750, 752-53 (8th Cir. 1982) (no third-party beneficiary status because no intent in health insurance policy to benefit health care provider); *Methodist Hospitals of Dallas v. Wal-Mart Stores, Inc.*, 2003 WL 21266775, *7-*8 (N.D. Tex. May 30, 2003) (same); *American Medical Ass'n v. United Healthcare Corp.*, 2001 WL 863561, *13 (S.D.N.Y. July 31, 2001) (same); *Parrish Chiropractic Centers, P.C. v. Progressive Casualty Ins. Co.*, 874 P.2d

1049, 1056 (Colo. 1994) (same); *Kelly Health Care, Inc. v. Prudential Ins. Co. of America, Inc.*, 309 S.E.2d 305, 307 (Va. 1983) (no third-party beneficiary status because provider merely "a potential and incidental, and never the intended, beneficiary of the contract"); *Ochs v. Pacificare of California*, 9 Cal. Rptr. 3d 734, 743 (Cal. Ct. App. 2004) ("[u]nder ordinary circumstances, noncontracting health care providers . . . would only be incidental beneficiaries of a contractual agreement to pay for an enrollee's medical care"); *NN Investors Life Ins. Co, Inc. v. Crossley*, 580 N.E. 2d 307, 309 (Ind. Ct. App. 1991) (same).

Despite this weight of authority, the district court concluded that Westside was a third-party beneficiary by applying an automobile personal injury protection ("PIP") case, *Allstate Insurance Co. v. Kaklamanos*, 843 So. 2d 885 (Fla. 2003). The court explored in detail the *Allstate* decision, which addressed whether a PIP claimant had to wait until his provider sued him before he had standing to sue *his own insurer* based on *his own insurance contract*. *Id.* at 891. While relying on *Kaklamanos*, the court here acknowledged "that *Kaklamanos* does not determine whether the PIP statute allows a private right of action." Indeed, as *Kaklamanos* said, "it is clear that actions for PIP benefits are based on the insurance contract and thus are governed by contract principles." *Kaklamanos*, 843 So. 2d at 892.

Kaklamanos plainly is not a third-party beneficiary case, and it does nothing to support an argument that Westside has standing to sue the Petitioners in this case.

The court's reliance on *Jim Macon Building Contractors v. Lake County*, 763 So. 2d 1223 (Fla. 5th DCA 2000) is even more misplaced. The court equates Westside's third-party beneficiary status to that of a beneficiary under a letter of credit agreement. There is no comparison. Letters of credit are specific financial instruments governed by the Uniform Commercial Code (the "UCC"). They are designed to benefit identifiable persons named in the letter of credit agreement. "'Beneficiary' means a person who *under the terms of a letter of credit* is entitled to have its complying presentation honored." § 675.103(1)(c), Fla. Stat. (2004) (emphasis added). And the UCC specifically grants the beneficiary, as defined by the statute, a cause of action to collect what it is owed. If the letter of credit issuer wrongfully refuses to honor the letter, "the beneficiary, successor, or nominated person . . . may recover from the issuer the amount that is the subject of the dishonor or repudiation." § 675.111(1), Fla. Stat.

In this case, Westside has not alleged that it was named to receive payment in the relevant contracts, nor has it alleged that a statute expressly permits its suing the HMOs. This case is not governed by the UCC, and it is obvious that a letter of credit agreement and a health care agreement are completely different instruments.

The overwhelming weight of authority compels the conclusion that Westside may not assert rights as a third-party beneficiary of the Health Options and Vista contract. Therefore, even if this Court concludes that a health care provider may bring a contract action to enforce the prompt pay provisions of the HMO Act, which it should not, Westside's suit must fail because Westside lacks standing.

CONCLUSION

For the foregoing reasons, this Court should quash the decision of the District Court of Appeal.

Respectfully submitted,

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George N. Meros, Jr.

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing was furnished by U.S. Mail on this _____ day of June, 2005 to the following:

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CERTIFICATE OF COMPLIANCE WITH FONT REQUIREMENT

I certify that the font used in this brief is Times New Roman 14 point and in compliance with Rule 9.210, Florida Rules of Appellate Procedure.

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APPENDIX