IN THE SUPREME COURT OF THE STATE OF FLORIDA

TALLAHASSEE, FL

CASE NO. SC05-870, SC05-871, SC05-872

FOUNDATION HEALTH, A FLORIDA HEALTH PLAN, INC.; HEALTH OPTIONS, INC., etc., et al.

Petitioners,

-vs-

WESTSIDE EKG ASSOCIATES,

Respondent.

___________________________________/

BRIEF OF RESPONDENT ON THE MERITS

On Appeal from the Fourth District Court of Appeal of the State of Florida

LIGGIO, BENRUBI & WILLIAMS, P.A.
1615 Forum Place, Ste. 3B
West Palm Beach, FL 33401
and
Edward H. Zebersky, Esq.
ZEBERSKY & PAYNE, LLP
4000 Hollywood Boulevard, Suite 400
Hollywood, FL 33021-6700
and
BURLINGTON & ROCKENBACH, P.A.
2001 Professional Building/Suite 410
2001 Palm Beach Lakes Blvd.
West Palm Beach, FL 33409
(561) 721-0400
Attorneys for Respondent

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES	ii
PREFACE	ix
STATEMENT OF THE CASE AND FACTS	1
SUMMARY OF ARGUMENT	11-12
ARGUMENT	13-48
QUESTION PRESENTED	13-48
ARE THE PROMPT PAY PROVISIONS OF THE HEALTH MAINTENANCE ORGANIZATION ACT ENFORCEABLE BY COURTS IN AN ACTION FOUNDED ON PRINCIPLES OF BREACH OF CONTRACT BROUGHT AGAINST A HMO BY A SERVICE PROVIDER?	
Standard of Review	13
CONCLUSION	48
CERTIFICATE OF SERVICE	49
CERTIFICATE OF TYPE SIZE & STYLE	50

TABLE OF AUTHORITIES

PAGE

Allison v. Imperial Cas. & Indem. Co.
222 So.2d 254 (Fla. 4th DCA 1969) 20

Allstate Ins. Co. v. Kaklamanos
843 So.2d 885 (Fla. 2003) 10, 14, 19, 21, 22, 36, 37

Augustin v. Health Options of South Florida, Inc.
580 So.2d 314 (Fla. 3d DCA 1991) 28

B.Y. v. Dept. of Children and Families
887 So.2d 1253, 1255 (Fla. 2004) 13

Berger v. AXA Network, LLC
2003 WL 21530370 (N.D.Ill. 2003) 26

Caufield v. Cantele
837 So.2d 371, 377, n.5 (Fla. 2002) 48

Citizens Ins. Co. v. Barnes
124 So. 722 (Fla. 1929) 17, 20, 23, 49

Coira v. Florida Medical Assn., Inc.
429 So.2d 23 (Fla. 3d DCA 1983) 25

Colonial Penn Ins. Co. v. Magnetic Imaging Systems I, Ltd.
694 So.2d 852 (Fla. 3d DCA 1997) 35

Council Oaks Learning Campus, Inc. v. Farmington Cas. Co.
2000 WL 376623 (10th Cir. 2000) 25

Cycle Dealers Ins., Inc. v. Bankers Ins. Co.
394 So.2d 1123 (Fla. 5th DCA 1981) 25, 31

Davis v. United Air Lines
575 F.Supp. 677 (E.D.N.Y. 1983) 26

Florida Physicians Union v. United Healthcare of Florida
837 So.2d 1133 (Fla. 5th DCA 2003) 30-31, 37, 45

Foundation Health v. Garcia-Rivera, M.D.
814 So.2d 537 (Fla. 3d DCA 2002) 35

Grant v. State Farm Fire & Casualty Co.
638 So.2d 936 (Fla. 1994) 20

Greene v. Well Care HMO, Inc.
778 So.2d 1037 (Fla. 4th DCA 2001) 29, 30, 31

Guin & Hunt, Inc. v. Hughes Supply, Inc.
335 So.2d 842 (Fla. 4th DCA 1976) 21

Hawaiian Inn of Daytona Beach, Inc. v. Dunn
342 So.2d 132 (Fla. 1st DCA 1977) 21

Health Options, Inc. v. Agency for Healthcare Administration
889 So.2d 849 (Fla. 1st DCA 2004) 43

Houdaille Industries, Inc. v. United Bonding Ins. Co.
453 F.2d 1048 (5th Cir. 1972) 21

Humana Health Ins. Co. of Florida, Inc. v. Chipps
802 So.2d 492 (Fla. 4th DCA 2001) 28

Humana Medical Plan, Inc. v. CAC-Ramsay Health Plans, Inc.
714 So.2d 1025 (Fla. 3d DCA 1997) 23

In Re Humana, Inc. Managed Care Litigation
2000 WL 1925080 (J.P.M.L. 2000) 46

Keehn v. Carolina Cas. Ins. Co.
758 F.2d 1522 (11th Cir. 1985) 25

Key Haven Associated Enter., Inc. v. Board of Trustees of Internal

Improvement Trust Fund
427 So.2d 153 (Fla. 1982) 44

Medical Center Health Plan v. Brick
572 So.2d 548 (Fla. 1st DCA 1990) 28

Morrison v. Allstate Indemnity Co.
228 F.3d 1255, 1267, n.8 (11th Cir. 2000) 21

Murthy v. N. Sinha Corp.
644 So.2d 983 (Fla. 1994) 14

Orion Ins. Co. v. Magnetic Imaging Systems I
696 So.2d 475, 478 (Fla. 3d DCA 1997) 32

Parkway General Hospital, Inc. v. Allstate Ins. Co.
393 So.2d 1171 (Fla. 3d DCA 1981) 34

Pasteur Health Plan, Inc. v. Salazar
658 So.2d 543 (Fla. 3d DCA 1995) 32

Plantation General Hospital Ltd. Partnership v. Horowitz
895 So.2d 484 (Fla. 4th DCA 2005) 14

Riera v. Finlay Medical Centers HMO Corp.
543 So.2d 372 (Fla. 3d DCA 1989) 28

Schappell v. Motorists Mut. Ins. Co.
868 A.2d 1 (Pa.App. 2004) 26

Shelby Mutual Ins. Co. v. Smith
556 So.2d 393 (Fla. 1990) 38

Standard Accident Ins. Co. v. Gavin
184 So.2d 229 (Fla. 1st DCA 1966)
cert. dism., 196 So.2d 440 (Fla. 1967) 20

Standard Marine Ins. Co. v. Allyn
333 So.2d 497 (Fla. 1st DCA 1976) 21

State Farm Mut. Auto. Ins. Co. v. Swearingen
590 So.2d 506 (Fla. 4th DCA 1991)
rev. den., 599 So.2d 1280 (Fla. 1992) 21

State Farm Mut. Ins. Co. v. Lee
678 So.2d 818, 820 (Fla. 1996) 35

State Farm v. Palma
629 So.2d 830, 832 (Fla. 1993) 21, 49

Stern v. Miller
348 So.2d 303 (Fla. 1977) 23

United States Fire Ins. Co. v. Van Iderstyne
347 So.2d 672 (Fla. 4th DCA 1977) 21

United States v. Automobile Club Ins. Co.
522 F.2d 1 (5th Cir. 1975) 32

Vencor Hospitals v. Blue Cross Blue Shield of Rhode Island
169 F.3d 677 (11th Cir. 1999) 32

Villazon v. Prudential Healthcare Plan, Inc.
843 So.2d 842 (Fla. 2003) 3-5, 8, 22, 28, 29

Weldon v. All American Life Ins. Co.
605 So.2d 911 9Fla. 2d DCA 1992) 21

Ch. 2002-389 ' 12 19
Ch. 82-243 ' 59 25

Ch. 98-79 ' 5, Laws of Florida 40

Fla.R.App.P. 9.030(a)(2)(A)(v) 14

' 408.7056, Fla. Stat. 42

' 408.7056(2)(f), Fla. Stat. 38, 43

' 408.7056(2)(j), Fla. Stat. 43

' 408.7057, Fla. Stat. 42, 43

' 408.7057(2)(b)(6), Fla. Stat. 37, 43

' 408.7057(2)(b)1, Fla. Stat. 43

' 624.155, Fla. Stat. (1997) 30, 31

' 624.155(1)(a)1, Fla. Stat. 25

' 626.951, Fla. Stat. 25

' 626.9541, Fla. Stat. 25

' 627.418, Fla. Stat. 17, 25, 27

' 627.418(1), Fla. Stat. (2001) 36

' 627.428, Fla. Stat. 21

' 627.613, Fla. Stat. 1, 2, 18

' 627.736(4), Fla. Stat. 18, 35

' 641.18(4)(b), Fla. Stat. 15
' 641.21, Fla. Stat. 16

' 641.228, Fla. Stat. 16

' 641.28, Fla. Stat. 28, 31, 37, 48

' 641.282, Fla. Stat. 16

' 641.31, Fla. Stat. 16, 25

' 641.31(11), Fla. Stat. 16

' 641.3101, Fla. Stat. 16, 25

' 641.3103, Fla. Stat. 16

' 641.3104, Fla. Stat. 16

' 641.3105, Fla. Stat. 8, 11, 16, 22, 25, 27

' 641.3105(1), Fla. Stat. 17, 36

' 641.3106, Fla. Stat. 16

' 641.3108, Fla. Stat. 16

' 641.3154(1), Fla. Stat. 33, 47

' 641.3154(4), Fla. Stat. 10

' 641.3154(4)(b), Fla. Stat. 19, 37

' 641.3154(4)(d), Fla. Stat. 42

' 641.3155, Fla. Stat. 1, 2, 18, 19, 37, 40, 41, 44

' 641.3155(2)-(4), Fla. Stat. 4, 10, 18, 22, 35, 47
' 641.3155(3)-(4), Fla. Stat. (2002) 19

' 641.3155(4), Fla. Stat. 18

' 641.3155(6), Fla. Stat. (2002) 19

' 641.3155(8), Fla. Stat. (2002) 19

' 641.3155(9), Fla. Stat. (2002) 19, 34

' 641.3901, Fla. Stat. (1997) 30

' 641.3901-95, Fla. Stat. 31

' 641.3905, Fla. Stat. (1997) 30

' 641.3917, Fla. Stat. 11, 16, 17, 28, 31, 37, 42

' 641.395, Fla. Stat. (2000) 15

' 641.418, Fla. Stat. 11

' 95.11(2)(b), Fla. Stat. 35

' 95.11(3)(f), Fla. Stat. 35

PREFACE

This proceeding is before the Court on a certified question from the Fourth District Court of Appeal. The parties will be referred to by their proper names or as they appeared in the trial court. The following designations will be used:

(HA) - Petitioner Humana=s Appendix

(IB) - Initial Brief of Petitioners

(R) - Record-on-Appeal

(RA) - Respondent=s Appendix

(T) - Hearing Transcript of May 21, 2003

STATEMENT OF THE CASE AND FACTS

Plaintiff, Westside EKG Associates (hereafter AWestside@), filed a Complaint on September 20, 2001, naming as Defendants seven health maintenance organizations (hereafter AHMOs@) (RI-1-9). Count I stated a claim for medical services rendered, and alleged that Westside had provided emergency and non-emergency medical services to Defendants=members (RI-1-9). Plaintiff alleged that it charged usual and customary rates and, despite repeated demands, the Defendants failed to pay or contest the charges within 45 days, and that the full balance was due and owing (RI-1-9). Count II alleged a claim for breach of the HMO contract, of which Westside was a third party beneficiary, and Count III sought a declaratory judgment that the Defendants have a general business practice of failing to pay outstanding claims within 45 days in violation of ' 627.613, Fla. Stat., and ' 641.3155, Fla. Stat. (RI-1-9). The Complaint also included allegations seeking class certification on behalf of all medical providers with outstanding claims that Defendants had not timely paid or contested (RI-1-9).

The Defendants initially removed the action to the United States District Court for the Southern District of Florida; however, that court remanded the action to state court (RI-1-10-19, 65-73). Thereafter, the trial court granted Defendants=Motion to Dismiss, however, it provided Plaintiff leave to amend the Complaint (RI-155-56).

Westside filed an Amended Complaint naming the same Defendants (RII-232-43). Paragraph ten of the Amended Complaint alleged (RII-234):

> Each Defendant is responsible for receipt, review, processing, payment of medical claims pursuant to contracts Defendant issued and/or administered by Defendants and each of them. Plaintiff is not currently in possession of such contracts, which have been requested in discovery promulgated to Defendants prior to the filing of this Amended Complaint. Notwithstanding that, each such contract must, as a matter of law, incorporate Florida Statutes pertinent to claims processing and payment.

Count I alleged a claim for medical services rendered, and claimed that the Defendants failed to properly pay or contest claims within 45 days, and failed to pay interest on such claims, in violation of ' 627.613, Fla. Stat. and/or ' 641.3155, Fla. Stat. (RII-236-37). Count II alleged breach of the HMO contracts, and that Plaintiff was a third party beneficiary to those contracts. Count III sought a declaratory judgment, determining that the Defendants had violated ' 627.613 Fla. Stat. and/or ' 641.3155, Fla. Stat. (RII-237-40).

The Defendants filed a Joint Motion to Dismiss, arguing, inter alia, that the HMO Act did not provide a private cause of action, and that Westside had not properly alleged its third party beneficiary status (RII-244-48). The trial court entered an order denying the Defendants=Joint Motion to Dismiss (RIII-365-66). Thereafter, the Defendants filed Answers to the Amended Complaint, however, they did not attach any of their contracts as exhibits thereto (RIII-406-53, 503-20).

On April 5, 2003, the Defendants filed a Joint Motion for Judgment on the Pleadings, arguing that as to Counts I and III there was no private cause of action for

violations of the HMO Act; and that as to Count II that the Plaintiff was not a third party beneficiary entitled to pursue that claim (RVII-1144-50). A hearing was held on Defendants= Joint Motion for Judgment on the Pleadings on May 21, 2003 (T1-49). At that hearing, Defendants reiterated the arguments contained in their motion and memorandum, and relied primarily on Villazon v. Prudential Healthcare Plan, Inc., 843 So.2d 842 (Fla. 2003), for the proposition that there was no private right of action under the HMO Act (T5-16). As to Count II, the Defendants claimed that the Plaintiff was not a third party beneficiary, and characterized that Count as an attempt to Aend run@ the Villazon decision (T13).

In his argument, Plaintiff=s counsel noted that the Defendants= contracts had been sought in discovery, but the Plaintiff was not yet in possession of all of them. However, Plaintiff had filed, as exhibits to its memorandum in opposition to the Defendants= Joint Motion, copies of two of the Defendants= contracts (RIX-1552-53, 1554-57). One contained a provision stating that the provision of covered services would be in accordance with Athe applicable requirements of Florida insurance law, including regulations promulgated thereunder and any amendments thereto;@ while the other specifically tracked the provisions of ' 641.3155(2)-(4), Fla. Stat. (RIX-1552-53, 1554-55).

Plaintiff=s counsel argued that Villazon had not overruled approximately 75 years of jurisprudence in Florida that statutory provisions are incorporated into contracts regulated

by legislation, and that Plaintiff=s action was brought as common law contract claims and, thus, were not violative of <u>Villazon</u> (T17-22). As to the third party beneficiary issue, Plaintiff cited numerous cases holding that medical care providers are third party beneficiaries of health insurance/HMO contracts (T27-29).

The trial court expressed concern regarding the third party beneficiary issue, and asked defense counsel (T38):

> THE COURT: I am concerned about the third-party beneficiary aspects of this because you are basically saying that Villazon stands for the proposition that no matter how long these insurance companies hold this money, that the Department of Insurance would only have an action and that the patient or the insurer - - I=m sorry, the provider would never have a - -
>
> MR. SMEREK: No, your Honor, that=s not what I=m saying. I=m saying they wouldn=t have an action to enforce the statutory terms. They would have an action if they had a separate written contract.
>
> THE COURT: I know a lot of these contracts just - -
>
> MR. SMEREK: They would also have perhaps an action to enforce the express terms of a contract....

Subsequently, the court asked regarding the remedy of the policyholder, as follows (T40):

> THE COURT: What are you saying is the remedy of the policyholder against the carrier for not paying the claims pursuant, just the one contract said, we=re going to pay it within X days, what are you saying is the policyholder=s right of action if he has one? Are you saying his right is to notify the Department of Insurance?

> MR. SMEREK: I would say in the first instance his right is to notify the Department of Insurance, that=s absolutely correct and in the second instance if we are talking about a provider, the policyholder isn=t going to be involved in these reimbursement issues.

At the conclusion of the hearing, the trial court granted the Judgment on the Pleadings as to Count I and III, concluding that they were prohibited under Villazon. The trial judge stated that while he was Atroubled@ by the third party beneficiary claim, he believed the Amended Complaint stated nothing more than a statutory cause of action, and that the Plaintiff might be able to state a common law cause of action (T45-46). For that reason, the trial court stated it would grant five days for the parties Ato submit law in terms of what they want me to do@ (T46).

Thereafter, Plaintiff filed a Motion for Leave to Amend the Complaint, with a memorandum of law in support thereof, realleging third party beneficiary/breach of contract claim (RXIV-2222-39, RXV-2572-76). The proposed Second Amended Complaint alleged, in pertinent part (RXIV-2231-32):

> 11. The subject contracts adopt and incorporate Florida Statutes and Administrative Code Sections governing health insurers/health maintenance organizations in this state.
>
> 12. Therefore, the requirements of Florida Statutes 627.613, 627.662(7) and/or 641.3155 are to be read not only as requirements governing the health insurance/HMO industry in general, but also as actual contractual provisions contained within the contracts issued and/or administered by the Defendants= within the State of Florida.

13. All health insurance policies and/or HMO Subscriber contracts must incorporate the Florida Statutes 627.613, 627.662(7) and/or 641.3155 by virtue of long established common law as well as Florida Statutes 627.418(1) and 641.3105(1), which states:

> 627.418. Validity of noncomplying contracts
>
> (1) Any insurance policy, rider, or endorsement otherwise valid which contains any condition or provision not in compliance with the requirements of this code shall not be thereby rendered invalid, except as provided in s. 627.415, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this code. In the event an insurer issues or delivers any policy for an amount which exceeds any limitations otherwise provided in this code, such insurer shall be liable to the insured or his or her beneficiary for the full amount stated in the policy in addition to any other penalties that may be imposed under this code.
>
> 641.3105. Validity of noncomplying contracts
>
> (1) Any health maintenance contract, rider, endorsement, attachment, or addendum otherwise valid which contains any condition or provision not in compliance with the requirements of this part shall not be thereby rendered invalid, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such contract, rider, endorsement, attachment, or addendum been in full compliance with this part. In the event an organization issues or delivers any contract for an amount which exceeds any limitations otherwise provided in this part, such organization shall be liable to the subscriber or her or his beneficiary for the full amount stated in the contract in addition to any other penalties that may be imposed under this part.

> 14. Accordingly, even if Defendants= contracts do not specifically enumerate the provisions of Florida Statutes 627.613, 627.662(7) or 641.3155, Plaintiff=s cause of action herein still arises from the health insurance/HMO Contracts, which pursuant to long established Common Law as well as Florida Statutes 627.418 and/or 641.3105, incorporate such statutory provisions.

Plaintiff=s memorandum cited extensive case law for the proposition that when a contract is entered into in a subject area regulated by statutory provisions, those statues become part of the contract and are enforceable in a breach of contract action (RXIV-2222-28). Nonetheless, the trial court entered a Final Judgment on the Pleadings, and an Order denying Plaintiff=s Motion to Amend the Complaint (RXVI-2618-19, 2620).[1] Plaintiff filed a timely Notice of Appeal (RXVI-2621-26).

The Fourth District reversed, holding that medical providers were entitled to bring a breach of contract claim, in their capacity as third-party beneficiaries, to enforce the Aprompt pay@ provisions of the HMO Act. The court relied on the principle of common law, which it noted was also incorporated in the HMO Act, <u>see</u> ' 641.3105, <u>Fla</u>. <u>Stat</u>., that contracts covering subjects regulated by statute are presumed to incorporate the

---

[1] /Health Options argued below that Westside abandoned any third-party beneficiary theory, relying on the concluding remarks of Plaintiffs= counsel and the court that the August 21, 2003 hearing. At that hearing, Plaintiffs= counsel simply asked the court that if it believed that dismissal of the Complaint was mandated by <u>Villazon v. Prudential Healthcare Plan, Inc.</u>, 843 So.2d 842 (Fla. 2003) the court should enter a dismissal for the entire case (R17-8/21/03 pp.14-15). The court responded that he thought any attempt to amend would be futile, and that (R17-8/21/03 p.15): AI should

provisions of those statutes. The Fourth District did not conclude that there was a private right of action to directly enforce the provisions of the HMO Act. The court noted that the regulatory scheme for the HMO Act is patterned after the provisions of the Florida Insurance Code, and cited Florida case law applying the common law principle to such contracts.

The Fourth District rejected the HMOs=argument that the Act contemplated solely administrative remedies to enforce the Aprompt pay@ provisions, noting that the Act recognized the existence of parallel legal remedies; and that to accept the HMOs= argument would restrict unpaid medical providers to relief by administrative proceedings, while the HMOs would be free to file civil actions to determine their liability for payment.[2] As discussed infra, the Fourth District reconciled its decision with existing

---

have, back in May or June dismissed the entire case with prejudice. I do so today,....@

[2]/Health Options is incorrect in claiming that the Fourth District did not distinguish between contract and non-contract medical providers. The Fourth District recognized the distinction, but noted that the legislation treated all providers equally with regard to their right to enforce payment (RA9):

> HMOs acknowledge that the Act contemplates non-contract, as well as contract, providers rendering services to subscribers, and that the legislature intended that non-contract providers stand on an equal footing with contract providers in enforcing their right to payment. See ' 641.3154(4), Fla. Stat.

It should also be noted that the Aprompt pay@ provisions of the HMO Act do not

Florida case law addressing the HMO Act, and relied, in part, on this Court=s decision in *Allstate Ins. Co. v. Kaklamanos*, 843 So.2d 885 (Fla. 2003), which specifically authorized a PIP insured to enforce the Aprompt pay@ provisions of that statute through a breach of contract action.

Based on its determination that Westside could pursue a breach of contract claim, the Fourth District reversed and remanded Afor further proceedings on the common law contract and declaratory judgment claims.@ However, the Fourth District certified the following question to this Court as one of great public importance:

> ARE THE PROMPT PAY PROVISIONS OF THE HEALTH MAINTENANCE ORGANIZATION ACT ENFORCEABLE BY COURTS IN AN ACTION FOUNDED ON PRINCIPLES OF BREACH OF CONTRACT BROUGHT AGAINST A HMO BY A SERVICE PROVIDER?

---

distinguish between contract and non-contract providers for purposes of deadlines and interest rates, *see* ' 641.3155(2)-(4), *Fla*. *Stat*.

SUMMARY OF ARGUMENT

The Fourth District properly determined that a medical provider is authorized to bring a breach of contract action to enforce the Aprompt pay@ provisions of the HMO Act. The Fourth District did not recognize a private cause of action to enforce the Act; it only applied the unambiguous provisions of that statutory scheme which specifically preserved common law remedies and acknowledged the viability of contract claims against HMOs. None of the Defendants seriously challenge Westside=s standing as a third-party beneficiary, nor do they challenge the incorporation principle, which provides that the provisions of statutes which regulate contracts are incorporated into those agreements. That principle is a part of the common law and is also explicitly adopted in the HMO Act, utilizing the same language that the legislature used in incorporating that concept in Florida=s Insurance Code, compare ' 641.3105, Fla. Stat., with ' 641.418, Fla. Stat.

The Defendants= contention that administrative remedies are the exclusive means of resolving such claims is directly contrary to unambiguous provisions of the Act. The Act specifically preserves rights under the general, civil and common law, and states that no action of the Department of Financial Services or AHCA shall abrogate such rights to damage Aor other relief in any court,@ ' 641.3917, Fla. Stat. Moreover, the administrative remedies relied upon by the Defendants specifically preclude their application if the dispute is the subject of an action in state or federal court. Moreover, the HMO Act recognizes in numerous places the viability of civil actions to enforce contractual

provisions, including those regarding the payment of claims. There is no language in the HMO Act that provides that the Aprompt pay@ provisions cannot be enforceable in that manner, nor is there any language that states that administrative remedies are exclusive. Therefore, for these reasons, the Fourth District=s decision should be approved, and the Certified Question answered in the affirmative.

ARGUMENT

QUESTION PRESENTED

ARE THE PROMPT PAY PROVISIONS OF THE HEALTH MAINTENANCE ORGANIZATION ACT ENFORCEABLE BY COURTS IN AN ACTION FOUNDED ON PRINCIPLES OF BREACH OF CONTRACT BROUGHT AGAINST A HMO BY A SERVICE PROVIDER?

Standard of Review

The issue before this Court is a question of law and, therefore, the standard of review is de novo, B.Y. v. Dept. of Children and Families, 887 So.2d 1253, 1255 (Fla. 2004).

Introduction

Contrary to the Petitioners= contentions, the Fourth District=s decision does not establish a private right of action under the HMO Act. The Fourth District only determined that a medical provider can bring a contract claim as a third-party beneficiary to enforce statutory provisions that are incorporated into the HMO contract. The District Court relied on unambiguous provisions of the HMO Act which authorized civil actions, including claims for breach of an HMO contract. The court also based its decision on a well-settled common law principle holding that the statutory provisions are incorporated into contracts they regulate; a principle that is also explicitly adopted in the HMO Act.

In their briefs, Defendants concede that the HMO Act authorizes breach of contract actions, and they do not seriously challenge the common law principle regarding the incorporation of statutory provisions, its explicit inclusion in the HMO Act, and the conclusion that medical providers are third-party beneficiaries of HMO contracts.

Instead, the Defendants mischaracterize the Fourth District=s decision as establishing a private right of action, so they can rely on the case law holding that the HMO Act creates no private right of action. However, those cases are inapposite here, e.g., Murthy v. N. Sinha Corp., 644 So.2d 983 (Fla. 1994); Plantation General Hospital Ltd. Partnership v. Horowitz, 895 So.2d 484 (Fla. 4th DCA 2005), since the Fourth District only determined the viability of a breach of contract claim.

This Court=s jurisdiction over this appeal is, of course, discretionary, Fla.R.App.P. 9.030(a)(2)(A)(v). In view of the fact that this Court has recently held that the Aprompt pay@ provisions of the PIP statute are enforceable by the insured through a breach of contract action, Allstate Ins. Co. v. Kaklamanos, 843 So.2d 885 (Fla. 2003), it is respectfully submitted that it is unnecessary to plow this very similar ground again. The Fourth District=s decision is eminently correct and, respectfully, this Court should decline jurisdiction and expend its limited resources on other matters. Alternatively, this Court should answer the certified question in the affirmative.

Health Maintenance Organization Act

The Health Maintenance Organization Act (hereafter AHMO Act@) is contained in Part I of Chapter 641, '641.17-641.395, Fla. Stat. (2000).[3] The legislative intent was to explore alternative methods for the delivery of healthcare services, and to ensure that comprehensive prepaid healthcare plans deliver high quality healthcare, '641.18, Fla. Stat. While the legislature provided that HMO plans would be exempt from the operation of state insurance laws Aexcept in the manner and to the extent set forth in this part,@ '641.18(4)(b), Fla. Stat., the regulatory scheme for HMOs is patterned after the Florida Insurance Code and, more particularly, the provisions of the Code which address health insurance.

For example, HMOs are required to obtain a certificate of authority from the Department of Financial Services (previously the Department of Insurance), and there are surplus requirements and other prerequisites to marketing HMO plans explicitly outlined in the Act, '641.21-641.228, Fla. Stat. Consistent with the Insurance Code, the legislature intended the HMO Act to regulate virtually all aspects of HMO contracts. There are provisions in the Act which regulate the execution of HMO contracts, see '641.3104, Fla. Stat., the content of HMO contracts, '641.31, Fla. Stat., '641.3101,

[3]/The references to the HMO Act in this brief are to the 2000 version, except where otherwise noted.

Fla. Stat., '641.3103, Fla. Stat., '641.3105, Fla. Stat.; the construction of HMO contracts, '641.3106, Fla. Stat., the delivery of HMO contracts, '641.3107, Fla. Stat.; as well as the cancellation of such contracts, '641.3108, Fla. Stat. The legislature also included a prevailing party attorney=s fee provision for actions under HMO contracts, '641.3917, Fla. Stat., and a provision requiring that judgments against HMOs be paid within sixty days, '641.282, Fla. Stat.

The HMO Act includes a statute itemizing certain provisions which must be contained in an HMO contract, '641.31, Fla. Stat.; which includes the following provision, '641.31(11), Fla. Stat.:

> No contract shall contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to health maintenance organizations.

While the HMO Act provides that contracts may contain additional provisions, other than those provided for in the Act, they cannot be Ainconsistent with this part,@'641.3101, Fla. Stat.

The HMO Act also contains a provision controlling the interpretation of contracts that deviate from the terms of the Act, '641.3105(1), Fla. Stat. which provides, in pertinent part:

> Any health maintenance contract, rider, endorsement, attachment, or addendum otherwise valid which contains any condition or provision not in compliance with the requirements of this part shall not be thereby rendered invalid,

> but shall be construed and applied in accordance with such conditions and provisions as would have applied had such contract, rider, endorsement, attachment, or addendum been in full compliance with this part.

That provision is virtually identical to language contained in Florida=s Insurance Code, ' 627.418, Fla. Stat., and is essentially a codification of the common law principle that contracts regulated by a statutory scheme are deemed to incorporate those statutory provisions into the agreement. That incorporation principle has existed in Florida for at least 75 years, see Citizens Ins. Co. v. Barnes, 124 So. 722 (Fla. 1929), and discussion infra pp. 20-21.

The HMO Act includes a statute addressing ACivil Liability@ which states, ' 641.3917, Fla. Stat.:

> The provisions of this part are cumulative to rights under the general civil and common law, and no action of the department shall abrogate such rights to damage or other relief in any court.

Section 641.28, Fla. Stat., entitled ACivil Remedy,@ provides Athe prevailing party@ Ain any civil action brought to enforce the terms and conditions of a health maintenance organization contract,@ with an entitlement to attorney=s fees and costs.

The provisions of the HMO Act that are at issue in this lawsuit are contained in ' 641.3155, Fla. Stat., entitled APayment of Claims.@ That statute includes provisions very similar to those contained in the personal injury protection (PIP) statute, see ' 627.736(4), Fla. Stat., see also ' 627.613, Fla. Stat. (which applies to health insurance

contracts). Section 641.3155(2)-(4), Fla. Stat., imposes deadlines for the HMO to contest or deny providers=claims requires a specific communication process for disputes and creates an obligation on the HMO to pay interest on overdue payments. Additionally, ' 641.3155(4), Fla. Stat., provides that if the HMO does not pay or deny a claim within 120 days after receiving it, it has an Auncontestable obligation to pay the claim.@

The Defendants contend that the subscriber has absolutely no exposure to suit by a provider, based on the provisions of ' 641.3154(4), Fla. Stat. However, that provision does not insulate subscribers from claims unless the provider knows, or should know, that the HMO is liable. That provision also specifically contemplates that one of the ways in which a provider is deemed to know that the HMO is liable is if Aa court of competent jurisdiction determines that the organization is liable,@ ' 641.3154(4)(b), Fla. Stat. Moreover, if the HMO contests or denies the provider=s claim, the subscriber is only insulated from suit or other collection attempts by the provider, as long as the claim is pending or an internal dispute resolution process is in place, ' 641.3155(8), Fla. Stat. (2002).[4] Therefore, especially in situations in which the HMO contests or denies a

[4]/In 2002, ' 641.3155, Fla. Stat., was also amended to provide, inter alia, different deadlines for the HMOs= responses, depending on whether the claim was filed Aelectronically@ or not, ' 641.3155(3)-(4), Fla. Stat. (2002), and to raise the interest rate on overdue payments to 12%, ' 641.3155(6), Fla. Stat. (2002), see Ch. 2002-389 ' 12. The 2002 amendments also added the following provision, ' 641.3155(9), Fla. Stat. (2002):

provider=s claim, the subscriber has a direct interest in resolution of each provider=s claim. Humana=s contention that subscribers have Aabsolutely no legal concern@ regarding the processing of providers= claims by an HMO is simply wrong. Moreover, as this Court noted in Kaklamanos, supra, when an insurer fails to pay a healthcare provider of an insured in a proper or timely manner, it necessarily undermines the relationship between the healthcare provider and the insured, and that damage can be irreparable. For these reasons, the subscriber has an immediate and critical interest in the manner in which providers= claims are processed by an HMO.

The Statutory Incorporation Principle

This statutory incorporation principle was first recognized in Florida in Barnes, supra, where this Court held that certain ordinances were incorporated into a fire insurance contract and governed the manner in which the scope of the insured=s loss should be determined. This Court stated (124 So. at 723):

> This is in line with the general doctrine that, where parties contract upon a subject which is surrounded by statutory limitations and requirements, they are presumed to have

---

> The provisions of this section may not be waived, voided, or nullified by contract.

> entered into their engagements with reference to such statute, and the same enters into and becomes a part of the contract. There would seem to be no logical reason why this general rule should not apply to a case of this kind. The parties are presumed to know of the ordinances. They directly and materially affect their rights in case of a loss under the policy, and should govern and control in the adjustment and settlement of such loss. [Emphasis supplied.]

That principle has been applied consistently by Florida courts since Barnes, see Grant v. State Farm Fire & Casualty Co., 638 So.2d 936 (Fla. 1994);Allison v. Imperial Cas. & Indem. Co., 222 So.2d 254 (Fla. 4th DCA 1969); Standard Accident Ins. Co. v. Gavin, 184 So.2d 229 (Fla. 1st DCA 1966), cert. dism., 196 So.2d 440 (Fla. 1967); Standard Marine Ins. Co. v. Allyn, 333 So.2d 497 (Fla. 1st DCA 1976); Guin & Hunt, Inc. v. Hughes Supply, Inc., 335 So.2d 842 (Fla. 4th DCA 1976); Hawaiian Inn of Daytona Beach, Inc. v. Dunn, 342 So.2d 132 (Fla. 1st DCA 1977); United States Fire Ins. Co. v. Van Iderstyne, 347 So.2d 672 (Fla. 4th DCA 1977); State Farm Mut. Auto. Ins. Co. v. Swearingen, 590 So.2d 506 (Fla. 4th DCA 1991), rev. den., 599 So.2d 1280 (Fla. 1992); Weldon v. All American Life Ins. Co., 605 So.2d 911 9Fla. 2d DCA 1992); Houdaille Industries, Inc. v. United Bonding Ins. Co., 453 F.2d 1048 (5th Cir. 1972) (Fla. law).

For example, this Court applied this principle in State Farm v. Palma, 629 So.2d 830, 832 (Fla. 1993), where it held that the prevailing party attorney fees provision in the Insurance Code, ' 627.428, Fla. Stat., is Aan implicit part of every insurance policy issued@ in Florida. Thus, as noted by the Eleventh Circuit in Morrison v. Allstate Indemnity Co.,

228 F.3d 1255, 1267, n.8 (11th Cir. 2000), the insured=s right to attorney=s fees under '627.428, Fla. Stat., Aessentially is derived from [the insured=s] individual insurance policy.@

This Court recently applied the statutory incorporation principle in holding that the Aprompt pay@ provisions of the PIP statute are enforceable by an insured through a contract claim, Allstate Ins. Co. v. Kaklamanos, 843 So.2d 885 (Fla. 2003). As discussed, infra, Kaklamanos is directly analogous to the case sub judice, and provides strong support for the Fourth District=s decision here.

Health Options concedes that '641.3105, Fla. Stat., establishes that the relevant statutes are incorporated into HMO contracts, but claims that does not mean that those rights are enforceable (Health Options IB p.22).[5] This would mean that there are two classes of contract rights, those which are enforceable and those which are not. This distinction has never been recognized, nor even suggested, in the 75 years of jurisprudence applying the statutory incorporation principle. The only case cited by Health Options for this contention is Villazon v. Prudential Healthcare Plan, Inc., 843

---

[5]/As noted in the Statement of the Case and Facts, supra, two of the Defendants= contract forms were finally produced in discovery, and one specifically tracked the language of '641.3155(2)-(4), Fla. Stat., and the other incorporated the requirements of AFlorida Insurance Law; including regulations promulgated thereunder@ (RIX-1552-53, 1554-55).

So.2d 842 (Fla. 2003), which does not mention the statutory incorporation principle, and addressed tort claims, not contract claims.

The legislature is presumed to know the existing law surrounding the subject upon which it legislates, Stern v. Miller, 348 So.2d 303 (Fla. 1977). The statutory incorporation doctrine was in existence long before the enactment of the HMO Act, both in the common law, see Barnes, supra, and in the Insurance Code, see ' 627.418, Fla. Stat. In drafting the HMO Act, the legislature chose to utilize virtually the same language in ' 641.3105, Fla. Stat., that has been part of the Insurance Code for over 40 years in ' 627.418, Fla. Stat. Neither the common law, nor the Insurance Code provision, have ever been construed as establishing second class contract rights. Thus, there is no reason to believe that the legislature has decided to create that concept for purposes of the HMO Act.

In fact, the incorporation principle was applied to an HMO contract in Humana Medical Plan, Inc. v. CAC-Ramsay Health Plans, Inc., 714 So.2d 1025 (Fla. 3d DCA 1997). That case involved a dispute regarding which of two HMOs were responsible for payment of a patient=s medical bills. One of the HMOs argued, inter alia, that its policy did not provide coverage because its plan excluded pre-existing conditions of the subscriber. The Third District rejected that argument, stating (714 So.2d at 1027):

> To exclude pre-existing medical conditions, the CAC policy would have to contain the explicit disclaimer required by section 641.31(16), Florida Statutes (1989). The CAC policy

> contains no such disclaimer. Thus, CAC was obligated to provide coverage to Dallard, Jr. for his injuries from January 1, 1990, onward.

Thus, the court construed the CAC contract as if it was in compliance with the terms of the HMO Act, even though that was directly contrary to the terms of that contract. Significantly, the Third District enforced the terms of the HMO Act without engaging in an analysis whether the Act created a private right of action, obviously because the applicable statutory provision was enforceable as a contract right.

Humana relies on cases from other jurisdictions holding that certain statutory provisions were not deemed incorporated into the parties= contract. An examination of those authorities demonstrate that they bear no relevance to the case sub judice, because they did not involve statutes that regulated the particular type of contract at issue.

For example, in Keehn v. Carolina Cas. Ins. Co., 758 F.2d 1522 (11th Cir. 1985), the court rejected an argument that certain provisions of the Florida Unfair Insurance Trade Practices Act (UITPA), ' 626.951, Fla. Stat., et seq., were incorporated into a liability insurance contract. The Eleventh Circuit relied on existing Florida case law, holding that there was no private right of action under UITPA, see Cycle Dealers Ins., Inc. v. Bankers Ins. Co., 394 So.2d 1123 (Fla. 5th DCA 1981); Coira v. Florida Medical Assn., Inc., 429 So.2d 23 (Fla. 3d DCA 1983). However, those cases are distinguishable, because UITPA is not a statutory scheme designed to regulate contracts, but rather is designed to define unfair methods of competition and deceptive acts in, inter alia, advertising, marketing, and claim settlement practices, see ' 626.9541, Fla. Stat.[6] The HMO Act, on the other hand, is specifically designed to regulate HMO contracts. Furthermore, there is no legislative intent to incorporate UITPA into any contracts, since that act does not contain any provision similar to inter alia, ' 641.31, Fla. Stat., ' 641.3101, Fla. Stat., ' 641.3105, Fla. Stat.

The other cases relied upon by Humana for this line of argument are similarly inapposite. Council Oaks Learning Campus, Inc. v. Farmington Cas. Co., 2000 WL 376623 (10th Cir. 2000), is an unpublished opinion construing the Oklahoma Unfair

---

[6]/It should be noted that certain provisions of UITPA are now enforceable in a private right of action pursuant to ' 624.155(1)(a)1, Fla. Stat., which was originally enacted in 1982, see Ch. 82-243 ' 59, Laws of Florida.

Claims Settlement Practices Act, a statutory scheme that bears no similarities to Florida=s HMO Act.[7] As with Florida=s UITPA, the Oklahoma Unfair Claims Settlement Practices Act does not attempt to regulate contracts, nor does it contain any indication of legislative intent to incorporate its terms into any contracts.

The two federal trial court decisions relied upon by Humana, Berger v. AXA Network, LLC, 2003 WL 21530370 (N.D.Ill. 2003), and Davis v. United Air Lines, 575 F.Supp. 677 (E.D.N.Y. 1983), also bear no relevance here. In Berger, a plaintiff sued his employer contending that the Federal Insurance Contributions Act (FICA) was incorporated into his employment contract; and in Davis, the plaintiff sought to enforce the Federal Rehabilitation Act through his employment contract. Neither of those statutory schemes bear any similarity to Florida=s HMO Act.

---

[7]/The Defendants also rely on Schappell v. Motorists Mut. Ins. Co., 868 A.2d 1 (Pa.App. 2004), which found no private right of action under Pennsylvania=s Motor Vehicle Financial Responsibility Law for a chiropractor to sue for interest on overdue bills covered by the insurer. That act is not similar to Florida=s HMO Act, and the opinion is noteworthy only for the following comment (868 A.2d at 2):

> Analysis of the relevant statutory sections reinforces the notion that the MVFRL is one of the most confusing statutes ever drafted. We are unaware of any comprehensive statutory scheme that manages to pack so many uncertainties in so few sections.

The uncertainty in the issue before the Court was sufficient to generate a strong dissent, see 868 A.2d at 6-8 (McEwen, J. dissenting).

What Humana is attempting to do is to mischaracterize Plaintiff=s argument as being that every statutory provision which is potentially relevant to a contract is enforceable by a private party through a breach of contract action. That has never been Westside=s position. Westside has relied on a long-standing principle of Florida law that applies to contracts that are directly regulated by legislation. Its application here is further supported by the statutory provision in the HMO Act that is virtually indistinguishable from provisions in the Florida Insurance Code, which has been consistently construed in the identical manner argued by the Plaintiff herein, compare ' 641.3105, Fla. Stat., with ' 627.418, Fla. Stat. Humana=s attempt to distort Plaintiff=s argument should be rejected.

The Fourth District=s Decision is Consistent with Other Case Law Construing the HMO Act

As previously noted, the Fourth District=s decision did not create a private cause of action under the HMO Act, but only determined that a breach of contract action could be pursued against an HMO to enforce the statutory provisions governing the payment of claims. It is well-established in Florida that HMOs can be sued for breach of contract, Humana Health Ins. Co. of Florida, Inc. v. Chipps, 802 So.2d 492 (Fla. 4th DCA 2001); Augustin v. Health Options of South Florida, Inc., 580 So.2d 314 (Fla. 3d DCA 1991);

Medical Center Health Plan v. Brick, 572 So.2d 548 (Fla. 1st DCA 1990); Riera v. Finlay Medical Centers HMO Corp., 543 So.2d 372 (Fla. 3d DCA 1989).

Health Options contends that such contract actions are limited to coverage issues raised by subscribers, but it cites no statutory provision, case law, nor contract principle that supports that limitation. The legislature clearly did not intend to limit common law remedies, since it expressly provided that they were not abrogated by the Act, ' 641.3917, Fla. Stat. The provision for an award of attorney=s fees in an action to enforce an HMO contract is not limited to coverage issues, nor is it limited to subscribers, ' 641.28, Fla. Stat. Thus, the terms of the Act itself belie Health Options= position.

Contrary to Defendants= contention, the Fourth District=s decision is not inconsistent with this Court=s holding in Villazon v. Prudential Heathcare Plan, Inc., 843 So.2d 842 (Fla. 2003). Villazon was a wrongful death action brought by an estate against the decedent=s HMO and her primary care physician. The plaintiff alleged that the decedent had died as a result of the negligence of the primary care physician. The plaintiff claimed that the HMO was directly liable for breach of a non-delegable duty of care imposed by the HMO Act, and was also vicariously liable for the doctor=s negligence. The trial and district courts rejected the plaintiff=s argument that the HMO Act imposed a non-delegable duty on the HMO to render medical care to the decedent, and this Court agreed (Id). This Court stated that the HMO Act did not provide an explicit right of

action for such damages, and did not provide an expression of intent sufficient to imply such a right of action (843 So.2d at 852). This Court noted, however, (Id):

> This does not, however, preclude the right to bring a common law negligence claim based upon the same allegations.

This Court then determined that there were genuine issues of material fact regarding the plaintiff=s vicarious liability claim against the HMO, and remanded for further proceedings on that claim.

Villazon did not involve any claim for breach of contract, nor did it recede from, or even address, the well-established principle that contracts regulated by statute are construed according to those provisions, which are deemed incorporated into the agreement. Furthermore, that decision cannot be construed as overruling sub silentio 75 years of jurisprudence on that issue.

The Fourth District=s holding is also consistent with its decision in Greene v. Well Care HMO, Inc., 778 So.2d 1037 (Fla. 4th DCA 2001), and the Fifth District=s decision in Florida Physicians Union v. United Healthcare of Florida, 837 So.2d 1133 (Fla. 5th DCA 2003). The Fourth District stated (RA4):

> Both Greene and Florida Physicians Union are distinguished by the nature of the facts and claims in those cases, and by virtue of each acknowledging the availability of a civil remedy for breach of contract.

An analysis of those cases supports that distinction.

In Greene v. Well Care HMO, Inc., supra, the plaintiff/subscriber filed a four count complaint against an HMO arising out of its denial of coverage. Count I sought an injunction requiring the HMO to pay for the patient=s treatment, and Count II sought the same relief by way of a specific performance claim. Count III of the Complaint alleged a claim for bad faith handling of the claim and for unfair trade practices in violation of ' 641.3901, ' 641.3905, and ' 624.155, Fla. Stat. (1997). Count IV alleged a claim for loss of consortium by the insured=s spouse. The trial court granted summary judgment in the plaintiff=s favor as to Counts I and II, but dismissed Counts III and IV with prejudice. The Fourth District upheld the dismissal of Counts III and IV, specifically noting that they Adid not seek to enforce the terms and conditions of the contract@ (778 So.2d at 1040). In the case sub judice, however, Plaintiff is seeking to enforce the terms and conditions of the contract, which is deemed, as a matter of law, to incorporate the statutory provision of the Act. The Greene decision only rejected the plaintiff=s attempt to bring a bad faith claim and to seek loss of consortium damages. Therefore, Greene is entirely consistent with the Fourth District=s decision herein.

In Florida Physicians Union v. United Healthcare of Florida, supra, the Fifth District followed the Greene decision in holding that there was no statutory cause of action against an HMO for bad faith handling of a claim in violation of ' 641.3901-95, Fla. Stat. and ' 624.155, Fla. Stat. (1997). However, the Fifth District specifically stated that (837 So.2d at 1136):

> We agree with the court in Greene that civil suits to enforce a contract with an HMO are unaffected by the statute and clearly can be brought in a proper case. This statute ['641.28, Fla. Stat.] merely authorizes prevailing party attorney fees for those lawsuits. Suit on a contract with an HMO is not involved in this appeal. [Emphasis supplied.]

The Fifth District also noted the language in '641.3917, Fla. Stat., to the effect that the provisions of the HMO Act were cumulative to rights under the general and civil and common law...,@ and stated (837 So.2d at 1137):

> In our view, this statute merely clarifies that other causes of action which may exist, are not superceded or cancelled by any provision in chapter 641. See Cycle Dealers Ins., Inc. v. Bankers Ins. Co., 394 So.2d 1123 (Fla. 5th DCA 1981).

Thus, the Florida Physicians case is consistent with the Fourth District=s decision in the case sub judice.

Westside Is a Third Party Beneficiary of the HMO Contract

None of the Defendants directly challenge the Fourth District=s determination that medical providers, such as Westside, who provide services or goods to HMO subscribers, are third-party beneficiaries of the HMO contracts. The Defendants do not even mention the case upon which the trial court relied for that proposition, Orion Ins. Co. v. Magnetic Imaging Systems I, 696 So.2d 475, 478 (Fla. 3d DCA 1997) (Amedical service providers like Magnetic have been recognized as third party beneficiaries of insurance contracts@

[citations omitted]). See also, Pasteur Health Plan, Inc. v. Salazar, 658 So.2d 543 (Fla. 3d DCA 1995); United States v. Automobile Club Ins. Co., 522 F.2d 1 (5th Cir. 1975).

In Vencor Hospitals v. Blue Cross Blue Shield of Rhode Island, 169 F.3d 677 (11th Cir. 1999), the Eleventh Circuit determined that a hospital could bring a breach of contract suit for payment against a patient=s health insurer, based on its status as a third party beneficiary. The insurer=s argument that the hospital had no standing to sue in that capacity was rejected based on the following analysis (169 F.3d at 680):

> We hold that Vencor is a third-party beneficiary of the contracts between BCBS and Butler and Esposito [the insureds], and therefore has the right to sue for breach of the insurance contract. A party has a cause of action as a third-party beneficiary to a contract if the contracting parties express an intent primarily and directly to benefit that third party (or a class of persons to which that third party belongs). It would be hard to imagine a more direct benefit under a contract than the receipt of large sums of money. That is exactly the benefit intended for Vencor- - as the hospital providing services to the insured - - under the contracts between BCBS and Butler and Esposito. The Medigap policy held by Butler and Esposito states, ABenefit payments may be paid to the doctor, hospital or to you directly at our discretion.@ 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. [Footnotes and citations omitted.]

Health Options claims that a nonparticipating provider such as Westside is not a third-party beneficiary, relying on a provision in its contract that states (R9-1556), AFor services rendered by nonparticipating providers, benefits are payable to the covered

employee or other person as required by law.@ Ignoring for the moment that Health Options= contract was not part of the pleadings,[8] that provision does not eliminate Westside=s standing, because the law, i.e., the HMO Act, clearly requires payment directly to the provider. The legislature addressed this issue in ' 641.3154(1), Fla. Stat.:

> If a health maintenance organization is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.

Additionally, ' 641.3155(9), Fla. Stat. (2002), states that, Athe provisions of this section may not be waived, voided, or nullified by contract.@

Therefore, the Fourth District=s determination that Westside was a third-party beneficiary of the HMO contract is clearly correct and consistent with long-standing Florida law.[9]

---

[8]/The case was resolved in the trial court based on Defendants= Motion for Judgment on the Pleadings, and none of the HMO contracts were attached to the Amended Complaint, nor the Answers of the Defendants.

[9]/In the Fourth District, an Amicus for the Defendants cited Parkway General Hospital, Inc. v. Allstate Ins. Co., 393 So.2d 1171 (Fla. 3d DCA 1981), as rejecting third-party beneficiary status for a healthcare provider. However, that case simply held that where the provider alleged one count against the insurer based on assignment of contract rights from the insured, it could not allege a separate and independent claim based on its third-party beneficiary status.

Prompt Pay Provisions of the HMO Act Should Be Construed Similarly to Those in the Pip Statute

The prompt pay provisions in the HMO Act bear many similarities to those in the PIP statute, compare ' 641.3155(2)-(4), Fla. Stat., with ' 627.736(4), Fla. Stat. In fact, in Foundation Health v. Garcia-Rivera, M.D., 814 So.2d 537 (Fla. 3d DCA 2002), the Third District approved a class action by medical providers against an HMO for alleged violations of the HMO Act prompt pay provisions, and relied on Colonial Penn Ins. Co. v. Magnetic Imaging Systems I, Ltd., 694 So.2d 852 (Fla. 3d DCA 1997), which involved the PIP Aprompt pay@ provision, as being Ameaningfully indistinguishable.@

Consistent with the incorporation principle discussed, supra, the provisions of the PIP statute are incorporated into the insurance contract, and an action to enforce them is treated as a breach of contract claim, see State Farm Mut. Ins. Co. v. Lee, 678 So.2d 818, 820 (Fla. 1996) (insured=s cause of action against PIP insurer Ais a first party claim in contract for failure to pay the contractual obligation for personal injuries sustained@). In Lee, this Court determined that a claim for PIP benefits was governed by the statute of limitations applicable to contracts, ' 95.11(2)(b), Fla. Stat.; even though there is a separate statute of limitations for actions Afounded on a statutory liability,@ ' 95.11(3)(f), Fla. Stat.

In Allstate Ins. Co. v. Kaklamanos, supra, this Court addressed the issue of whether an insured could bring an action against her PIP insurer for failing to pay her medical providers in accordance with the Aprompt pay@ provisions contained in ' 627.736(4), Fla. Stat. This Court noted that Aactions for PIP benefits are based on the insurance contract and, thus, are governed by contract principles@ (843 So.2d at 892). However, this Court refused to enforce a provision in the insurance contract which purported to limit the insured=s right to sue for medical payments solely to claims for indemnity, and only in the event the medical provider sued the insured for payment. This Court rejected the lower court=s enforcement of that provision, stating (843 So.2d at 896):

> Moreover, even if the county and circuit courts= interpretation was supported by the plain language of the policy provision, such a provision would be inconsistent with the purposes of the PIP statute and would have to be construed and applied to be in full compliance with the code. See ' 627.418(1), Fla. Stat. (2001).

That statutory provision relied upon by this Court in making that determination is virtually identical to the provision in the HMO Act, ' 641.3105(1), Fla. Stat.

Even though the insured in Kaklamanos was not being sued by her healthcare provider, this Court held she had standing to sue her insurer for breach of contract for failing to comply with the Aprompt pay@ provision in the PIP statute. This Court reasoned that, otherwise, the insurer would be able to drive a wedge between the medical care provider and the patient, and threaten irreparable injury to the doctor-patient relationship

(843 So.2d at 893). This Court also noted that without the risk of legal action by the insured, Athere would be no incentive for the insurer to promptly pay claims@ (843 So.2d at 897). That is precisely the result that the Defendants seek here. They want this Court to hold that ' 641.3155, Fla. Stat., is not enforceable by any court action, whether brought by the providers or the subscribers. Until the Fourth District=s decision, they had prevailed in this position, despite the havoc it wreaked on the system, see Florida Physicians quoted infra p.45. There is no valid reason to believe that the legislature intended that result, and this Court should reach the same conclusion as it did in Kaklamanos.

Humana contends that the PIP Act is distinguishable, because there are two references to lawsuits in that statute. However, the HMO Act contains numerous references to lawsuits to enforce its terms, see ' 641.28, Fla. Stat. (expressly recognizing civil remedy); ' 641.282, Fla. Stat. (payment of judgment by HMO); ' 641.3154(4)(b), Fla. Stat. (acknowledging that court of competent jurisdiction can determine that organization is liable for payments to provider); ' 641.3917, Fla. Stat. (recognizing rights under general, civil and common law, and that no action of the department Ashall abrogate such rights to damage or other relief in any court@). Additionally, the statutes relied upon by Defendants as providing the Aexclusive@ administrative remedy specifically state they do not apply if the claim Ais the basis for an action pending in state or federal court,@ see

'408.7056(2)(f), Fla. Stat.; and '408.7057(2)(b)(6), Fla. Stat. Therefore, Humana=s attempt to distinguish the PIP Act is unpersuasive.

For these reasons, consistent with the case law construing the PIP statute, the prompt pay provisions of the HMO Act should be incorporated into the HMO contract, and be enforceable as a breach of contract action, not a statutory right of action.

Legislative History

The Petitioners claim that the legislative history relating to the HMO Act supports their position that the prompt pay provisions are not enforceable in any civil action. However, legislative history is only resorted to when there is an ambiguity in a statute, see Shelby Mutual Ins. Co. v. Smith, 556 So.2d 393 (Fla. 1990). The issue here is resolved by the unambiguous provisions of the HMO Act, and well-established principles of contract law. Moreover, consideration of the legislative history relied upon by the Defendants demonstrates that it does not, in fact, support their position.

Defendants rely on Governor Chiles= veto of the 1996 proposed amendments to the HMO Act, which was based, in part, on the fact that a private right of action in tort was included in that bill (A2). It is clear that the Governor=s concern was the creation of a tort remedy against the HMOs in the context of their decisions regarding appropriate medical treatment and services, not any concern regarding enforceability of the prompt pay provisions (A2). The Governor=s veto letter states, in pertinent part (A2-1, 2):

> This legislation would significantly expand the rights of HMO subscribers to sue their HMO in cases where the HMO denies a medical treatment or service to the subscriber. Under this bill, HMO subscribers would be allowed to sue for compensatory and punitive damages as well as attorneys fees when any physician within the HMO=s panel ordered a treatment or service and the HMO declined to authorize payment for that treatment. Florida would be the first state in the nation to enact a statute authorizing such suits.
>
> * * *
>
> Clearly, subscribers must have an improved mechanism to insure that they are not unfairly denied treatment by their HMO. The question raised by this legislation is not whether an expanded remedy is needed, but rather whether opening up the issue to resolution through the tort system through suits for compensatory and punitive damages is in the best interest of the consumer and is best for Florida=s health care system as a whole. For the reasons which I will address below, I believe that it is not.

Obviously, that veto did not arise from any concern regarding the enforcement of the prompt pay provisions through a contract claim. Moreover, the prompt pay provisions were not even enacted until 1998, see Ch. 98-79 ' 5, Laws of Florida. Therefore, Governor Chiles= concerns clearly did not arise from their enforceability.

Humana relies upon a Senate Staff Analysis and Economic Impact Statement relating to Senate Bill 1584, from which ' 641.3155, Fla. Stat., was derived (HA 15-19). That document notes administrative penalties for failure to comply with that statute=s provisions, but never states that the administrative remedies are exclusive. Also, that bill in any way recede from the existing language in the HMO Act that authorize civil actions,

including breach of contract actions. It is also significant that the senate staff analysis states (HA19), AThis senate staff analysis does not reflect the intent or official position of the bill=s sponsor or the Florida Senate.@ For these reasons, that document does not provide support for Defendants= position.

Defendants= note that in 2001, an amendment to the HMO Act was proposed which included a section listing twenty different categories of rights and responsibilities of HMOs, and providing for a right of action for their violation (A3-7-12). A provision in that section authorized a cause of action for actual and punitive damages (A3-12-13). Clearly, the decision not to enact those provisions did not have any effect on the preexisting right to sue for breach of contract, which the Petitioners concede exists under the HMO Act.

The proposed amendments in 2002, 2004, and 2005 also do not reflect any intent to eliminate the contractual remedy specifically authorized by the HMO Act. In fact, the existence of that remedy was specifically acknowledged in the 2005 bill, which stated, in pertinent part (A6-13):

> Without regard to any other remedy or relief to which a person is entitled or obligated under contract, anyone aggrieved by a violation of this section...may bring an action for damages or to obtain a declaratory judgment that an act or practice violates this section.... [Emphasis supplied.]

Thus, in that proposal, the continued viability of contract actions was explicitly recognized.

Moreover, Defendants do not provide any empirical basis on which to determine the reason the proposed amendments to the HMO Act in 2002, 2004, and 2005 were not enacted. It is reasonable to conclude that one reason was that the legislature determined that the existing civil remedies, including breach of contract claims, were sufficient. Moreover, the fact that those proposed amendments did not become law does not affect the civil remedies explicitly authorized by the existing HMO Act. Therefore, even if this Court considers the legislative history relied upon by the Defendants, it does not support their position that a provider cannot bring a contract action to enforce the prompt pay provisions of ' 641.3155, Fla. Stat.

Administrative Remedy - Maximus

Health Options contends that the legislature has provided an effective alternative remedy to litigation through AMaximus,@ a private entity that has contracted with AHCA to provide alternative dispute resolution services for HMO disputes contemplated by ' 641.3154(4)(d), Fla. Stat.[10] However, the statutory provisions governing those programs, see ' 408.7056 and ' 408.7057, Fla. Stat., do not support the Petitioners=

[10]/Health Options chastises the Fourth District for not being aware of AHCA=s contract with Maximus to implement an alternative dispute resolution program. However, none of the Defendants provided that information to the Fourth District, so that criticism is unwarranted.

contention that administration proceedings are the exclusive remedy for violations of the Aprompt pay@ provisions. More importantly, '641.3917, Fla. Stat., specifically provides that the rights created under the HMO Act are cumulative to existing rights and that Ano action of the department [of Financial Services] or office shall abrogate such rights to damages or other relief in any court.@

Contrary to Health Options claim, '408.7056, Fla. Stat., does apply to providers, as well as subscribers. In fact, it is titled AStatewide Provider and Subscriber Assistance Program@ [emphasis supplied]. That statute contemplates the establishment of a panel to hear grievances, but does not authorize it to hear grievances if the claim Ais the basis for an action pending in state or federal court,@ '408.7056(2)(f), Fla. Stat. Additionally, it specifically precludes consideration of a grievance that involves Aaccrued interest on unpaid balances,@ '408.7056(2)(j), Fla. Stat. Thus, obviously that program was not designed to address the Aprompt pay@ provisions at issue herein, nor to supplant litigation as a remedy.

Health Options claims that the dispute resolution program established by '408.7057, Fla. Stat., is the exclusive remedy for alleged violations of the prompt pay provisions. However, that statute specifically provides that the resolution organization, in this case Maximus, Inc., is authorized to review claim disputes, unless the claim Ais the basis for an action pending in state or federal court,@ '408.7057(2)(b)6, Fla. Stat. That statute also excludes from consideration any claim that Ais related to interest payment,@

' 408.7057(2)(b)1, Fla. Stat. Therefore, obviously, that statute was not intended to be an exclusive remedy, nor was it designed to resolve Aprompt pay@ violations.

Moreover, as Health Options acknowledges, the court in Health Options, Inc. v. Agency for Healthcare Administration, 889 So.2d 849 (Fla. 1st DCA 2004), characterized the procedure as voluntary. Therefore, since these alternative dispute resolution provisions explicitly contemplate litigation as an alternative, and do not apply to Aprompt pay@ violations, the doctrine of primary administrative jurisdiction cannot apply, see Key Haven Associated Enter., Inc. v. Board of Trustees of Internal Improvement Trust Fund, 427 So.2d 153 (Fla. 1982).

Miscellaneous Arguments

Apparently finding logic an insufficient ally, the Petitioners have included other contentions in their briefs. Health Options claims that the Fourth District=s opinion Aeffectively dismantles the concept of managed healthcare in this state,@ and that it Abrings the system to its knees@ (IB 7, 10). It also claims that the effect of the Fourth District=s decision is Ainconceivable havoc@ (IB 11). However, no empirical evidence is proffered for the proposition that the sky is falling.

It bears repeating that all the Fourth District has held is that medical providers are entitled to bring a breach of contract action when the HMO fails to comply with ' 641.3155, Fla. Stat., regarding the timely processing and payment of claims. This does

not expose the industry to anything more than contractual damages, which are limited to payment of the claims and the statutorily established interest, '641.3155, Fla. Stat. Under the Fourth District=s holding, the HMOs are not exposed to any tort damages, statutory penalties, or punitive damages. Both Defendants=briefs concede that providers are already entitled to bring actions under theories of quantum meruit, unjust enrichment, goods sold (Health Options p.31, Humana p.35), so it is difficult to see how the limited claims authorized by the Fourth District could cause Ainconceivable havoc.@

Health Options does not provide any empirical basis to conclude that the Fourth District=s decision would harm the HMO system. In fact, the empirical evidence indicates that the HMO=s pattern of delaying claims is the biggest threat to the healthcare system. In Florida Physicians Union, Inc. v. United Healthcare of Florida, Inc., supra, 837 So.2d at 1136 n.1, the court noted:

> The problem complained about in this case, deliberate delaying of and refusal to pay valid claims, and other interference in the payment process of valid claims, is an increasing problem in the managed care industry. See AManaging Managed Care: Providers Fight Back Against HMOS,@ Ralph W. Barbier and Matthew B. Roberts, South Carolina Lawyer, September/October 2001 (13 Oct SCLAW 22). Hospitals and physicians complain that they are forced to submit the same valid claim numerous times, and that valid claims are denied for no reason or some arbitrary reason. Id. When claims are paid, they are often paid late, even though most provider agreements require payment within 30 to 60 days of the receipt of the claim. Id. At least forty-five states have passed prompt payment statutes which generally impose financial penalties, e.g., interest or fines, if the statute is

> violated. Id. Some state insurance commissioners have levied stiff fines, including Florida. Id. But this apparently has not solved the problem. Nearly one-third of hospitals in this country have terminated contracts with HMOs, citing poor financial results; for large hospitals, that number increases to 60 percent. Id. When providers terminate HMO contracts, consumers of healthcare are negatively impacted.

Thus, the managed care system is not threatened by permitting providers to enforce the unambiguous statutory provisions governing the timely payment of claims, but rather the HMO=s continuing practice of violating them. The Defendants have failed to present empirical evidence, or even a rational reason, why enforcing compliance with the Aprompt pay@ provisions would harm them or the system. Moreover, if there is a systemic problem, their remedy is to seek relief in the legislature, not to request this Court to nullify unambiguous statutory provisions.

Apparently believing this Court harbors a prejudice against class actions, Humana makes the contention that this case Ais about perhaps a few pennies of interest to a large number of providers, but a lot of dollars for the class action lawyers@ (IB 16-17). This naked appeal to bias is unfounded. In the trial court below, the Plaintiffs were required to file Notices of Voluntary Dismissal as to two Defendants as the result of class action proceedings in federal court, see In Re Humana, Inc. Managed Care Litigation, 2000 WL 1925080 (J.P.M.L. 2000). One of those Defendants, Aetna Health, filed a Notice of Preliminary Settlement Approval and Injunction in a Related Proceeding, noting its settlement of that litigation in return for changing its business practices, paying $100

million to the class of medical providers, and otherwise providing the class with A$300 million in estimated value@ (R14-2240-2425). Under any measure, that is not Aa few pennies of interest.@ In fact, it is a clear indication of the magnitude of the problem in the industry.

Humana argues that this Court should Aavoid any temptation to elevate the rights of non-contracting businessmen above contracting subscribers and insureds...@(Humana IB p.18). The Fourth District=s decision did no such thing. As noted previously, the HMO Act does not distinguish between contracting and non-contracting medical providers for purposes of the entitlement to payment from the HMO, see ' 641.3154(1), Fla. Stat.; ' 641.3155(2)-(4), Fla. Stat. Additionally, the Fourth District did not elevate non-contracting providers= rights over those of the subscribers, who also had, as Defendants concede, a right to bring an action for breach of contract. Thus, the rights of non-contracting providers are not being elevated over any other party=s rights by virtue of the Fourth District=s decision.

Humana also denigrates Westside=s claim by describing as a Adouble fiction@ theory. The first supposed fiction is that it has no contract with Humana (Humana IB p.3). Of course, by definition, any party that brings a third-party beneficiary claim does not have a direct contract with the party it is suing. Since third-party beneficiary law is not a Afiction,@ neither is that basis for Westside=s argument. The second Afiction@ in Humana=s characterization is that Westside Aseeks to latch onto an enforced prompt pay

provisions that do not exist in the text of the HMO contracts@ (Humana IB p.3). Of course, the incorporation principle discussed supra specifically contemplates that language in a contract will be supplied by the statutory scheme that regulates it. Seventy-five years of Florida jurisprudence applying that principle is not fiction.

Humana Was Not Entitled to an Award of Attorney=s Fees

This issue was not certified by the Fourth District and, therefore, this Court is under no obligation to address it, see Caufield v. Cantele, 837 So.2d 371, 377, n.5 (Fla. 2002).

Humana, the only HMO who sought attorney=s fees in the trial court, contends that if it prevails it should be entitled to an award of attorney=s fees. However, in the trial court, Humana consistently argued that the Plaintiff was not stating a claim for breach of contract, but rather trying to enforce a private right of action granted under the HMO Act. Therefore, it is inconsistent for it to now contend that it is entitled to fees under the provision of the HMO Act allows them in actions brought to enforce an HMO contract, see ' 641.28, Fla. Stat. In fact, the only manner in which that statute could be applied is if it is deemed part of the contract pursuant to the incorporation principle established in Barnes, supra, see State Farm v. Palma, supra. However, Humana argues that that principle does not apply to the HMO Act.

Additionally, Humana will have a difficult time reconciling its position on this point with its contention that Westside=s theory is a Adouble fiction,@ i.e., that it is a fiction that Westside had a contract with Humana, and that it is now trying to enforce a provision that is not a part of the text of any such contract. That characterization applies equally to Humana=s claim for attorney=s fees, so if it has any validity, Humana=s argument on attorney=s fees should be rejected.

For these reasons, the trial court and the Fourth District were correct in rejecting Humana=s Motion for Attorney=s Fees.

CONCLUSION

For the reasons stated above, this Court should answer the Fourth District=s Certified Question in the affirmative, and should decline to award attorney=s fees to Defendant Humana.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY a true copy of the foregoing was furnished to all counsel on the attached service list, by mail on August 22, 2005.

LIGGIO, BENRUBI & WILLIAMS, P.A.
1615 Forum Place, Ste. 3B
West Palm Beach, FL 33401
and
Edward H. Zebersky, Esq.
ZEBERSKY & PAYNE, LLP
4000 Hollywood Boulevard, Suite 400
Hollywood, FL 33021-6700
and
BURLINGTON & ROCKENBACH, P.A.
2001 Professional Building/Suite 410
2001 Palm Beach Lakes Blvd.
West Palm Beach, FL 33409
(561) 721-0400
(561) 721-0465 (fax)
Attorneys for Respondent

By:_________________________

PHILIP M. BURLINGTON
Florida Bar No. 285862

C:\PMB\WESTSIDE\SCT\P\BRF.wpd\GG

CERTIFICATE OF TYPE SIZE & SIZE

Respondent hereby certifies that the type size and style of the Brief of Respondent on the Merits is Times New Roman 14pt.

____

PHILIP M. BURLINGTON

Florida Bar No. 285862