IN THE SUPREME COURT
STATE OF FLORIDA

CASE NO. SC05-871

FOUNDATION HEALTH, A FLORIDA HEALTH PLAN, INC.; HEALTH 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.,

Petitioners,

v.

WESTSIDE EKG ASSOCIATES,

Respondent.

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

INITIAL BRIEF ON THE MERITS OF PETITIONERS HEALTH OPTIONS, INC. and HEALTH OPTIONS CONNECT, INC.

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PREFACE

This case is before the Court on discretionary review of a question certified by the District Court of the State of Florida, Fourth District, to be one of great public importance.

Petitioners Health Options, Inc. and Health Options Connect, Inc. f/k/a Principal Health Care of Florida, Inc., Appellees below, will be referred to as "HOI."

Respondent Westside EKG Associates, Appellant below, will be referred to as "Westside."

The record will be cited as "R__-__."

HOI's Appendix will be cited as "A__."

STATEMENT OF THE CASE AND OF THE FACTS

A. Introduction

The question certified to this Court by the Fourth District is:

> 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 AN HMO BY A SERVICE PROVIDER?

(A1).

HOI believes that the question is more properly phrased as whether a provider may enforce the provisions of Florida's Health Maintenance Organization Act, sections 641.17, *et seq.*, Florida Statutes ("HMO Act"), against a health maintenance organization ("HMO") through a private cause of action as an assignee of the HMO subscriber's benefits, a third party beneficiary of the subscriber's HMO contract, or by any other means.

The answer to the question must be no. Any other result eviscerates the complex and comprehensive statutory and regulatory plans enacted by the Legislature to administer the HMO Act and thus protect Florida's managed health care system – both subscribers and entities – from runaway litigation that threatens the fragile balance between managed health care benefits and health care costs in this state. The Opinion does what no other Florida case has done before by creating a private cause of action where one is neither expressly nor impliedly provided by the Legislature. It should be quashed.

B. Procedure at the Trial Court Level

Westside, a nonparticipating health care provider,[1] filed its purported class-action Complaint against HOI and other HMOs (R1-1-9), alleging: (a) Westside had provided emergency and non-emergency services to the HMOs? subscribers; (b) Westside had timely billed the HMOs for its services at its customary and reasonable rates; (c) despite demands the HMOs neither paid nor contested the claims within 45 days as required by the HMO Act; and (d) the full balance was due and owing.

Count I alleged a claim for medical services rendered, claiming that the HMOs had violated sections 627.613 and 641.3155, Florida Statutes (Supp. 2000), by failing to timely pay Westside?s claims. Count II asserted a claim for breach of the HMO contracts on a third-party-beneficiary theory. Count III sought a declaratory judgment that the HMOs had a general business practice of violating sections 627.613 and 641.3155 by failing to pay claims within 45 days. The Complaint also sought class certification on behalf of other health care providers that Westside alleged were similarly situated (R1-1-9).

The HMOs removed the case to federal court and moved to dismiss the Complaint, arguing that Westside?s claims were preempted by the Employee Retirement Income Security Act of 1974, **29 U.S.C.** ? **1001, *et seq.* (**? **ERISA**? **), and failed to state a claim under the HMO Act, which provides no private right of action** (R1-10-12, 22-40). Westside denied that it was relying on any assignments of benefits from the

[1] Westside is known as a ?non-par? or nonparticipating provider because it has no contract directly with the HMOs to provide services to their subscribers, in contrast to ?par? or participating providers that have contracted directly with the HMOs to provide services to their subscribers.

HMOs? subscribers and that its claims impacted ERISA and, on that basis, the federal court remanded the case to state court (R1-60-64, 65-73). After remand, the trial court granted the HMOs? motions to dismiss with leave to amend (R1-155-56). Westside?s Amended Complaint (R2-232-43) was virtually unchanged.

The HMOs moved to dismiss (R2-244-71), arguing that the Amended Complaint also failed to state a cause of action under the HMO Act and that Westside had no standing to sue because it disavowed reliance upon any assignments of benefits from the HMOs? subscribers. The court denied the Joint Motion to Dismiss (R3-365-66), and the HMOs answered the Amended Complaint (R4-503-09). HOI raised, among other affirmative defenses, failure to state a cause of action, ERISA preemption and exhaustion, preemption under the Federal Employee Health Benefit Act, 5 U.S.C. ?? 8901-8914 (?FEHBA?), preemption and exhaustion under the Medicare Act, 42 U.S.C. ? 1395, *et seq.*, absence of a private cause of action, and lack of third party beneficiary status (R4-53-09).

In March 2003, this Court issued its Opinion in *Villazon v. Prudential Healthcare Plan, Inc.*, 843 So. 2d 842, 846 (Fla. 2003), holding that ERISA preempts state law claims to recover HMO plan benefits or to enforce rights under an HMO plan and that Florida?s HMO Act does not support a private cause of action. Based on *Villazon*, the HMOs filed a Joint Motion for Judgment on the Pleadings (?Joint Motion?) (R7-1144-50) and a Memorandum of Points and Authorities in Support (R7-1159-69). The Joint Motion argued: (a) there was no private right of action under the HMO Act to support Count I, for medical services rendered, or Count III, for declaratory relief; and (b) Westside was not a third party beneficiary of the HMO contracts and thus lacked standing to maintain a cause of action under Count II.

Before hearing on the Joint Motion, Westside filed a Memorandum attaching a copy of HOI?s ?Blue Care Basic for Small Groups Group Plan? (?Group Plan?) (R9-1529-61). The Group Plan showed an initial 35-day claims response period, a 45-day payment or denial period following receipt of any requested additional information, that payment for services rendered by non-participating providers such as Westside would be made only to the subscriber or ?other person as required by law,? that rights under the Group Plan could not be assigned without HOI?s written consent, and that only payment for services rendered by par providers would be made directly to those providers (R9-1554-57).

The Joint Motion was heard in May 2003 (R13-2206-18). The HMOs reiterated that *Villazon* barred Counts I and III of the Amended Complaint, Westside?s statutory claims for medical services rendered and declaratory judgment of its rights under section 641.3155.[2] As to Count II, the HMOs pointed out that Westside admitted that it had no contract directly with any of the HMOs and disavowed any reliance on assignments of benefits from the HMO subscribers, as it had done in federal court in successfully seeking remand. Instead, turning assignment law on its head, Westside sought to assert the rights of the HMO subscribers as a ?third party beneficiary? of their HMO contracts. The HMOs also argued that even if Westside could establish standing as a third party beneficiary of the HMO plans, its attempt to enforce the HMO contracts would violate *Villazon.*

[2] As the HMOs are not health insurers, they are not subject to section 627.613, the other statute upon which Westside relied, because that statute is part of the Florida Insurance Code and involves only health insurers. *See ??* 641.18(4)(b), 641.201, Fla. Stat. (Supp. 2000).

Westside responded that its claims were not based upon statutory violations directly but were, instead, common law causes of action and a third-party-beneficiary claim for breach of the subscribers? HMO contracts. According to Westside, the contracts incorporate Florida law, including the HMO Act, and Westside could indirectly enforce the HMO Act as a third party beneficiary of the contracts. Westside continued to insist, however, that it was not relying on any assignment of benefits to claim the right to sue. On the contract issue, while it claimed that it did not have a number of the HMO contracts, it admitted that it had that of HOI and had submitted it to the court (R9-1552-53, 1554-57; R12-1929-30, 1931-34).

At the conclusion of the hearing, the court granted the Joint Motion on Counts I and III of the Amended Complaint, holding that they were statutory causes of action barred by *Villazon*. On Count II, the court explained that while it believed the Joint Motion should also be granted because the count was statutorily pleaded, the court was concerned that Westside might be able to state a cause of action for breach of contract on a third-party beneficiary theory. Westside?s counsel responded that the court should ?go ahead and strike it in its entirety on these statutory common law cause of action issues.? The court replied that it was willing to comply with Westside?s request but did not want to put it out of court if it could amend to plead a common law cause of action.

Following the hearing, Westside submitted a Motion for Leave to Amend Complaint (R15-2572-76), a Memorandum of Law in Support of Leave to Amend the Complaint (R14-2222-28), and a proposed Second Amended Complaint (R14-2229-48). The proposed Second Amended Complaint contained one count, for breach of contract, alleging that the HMOs? contracts incorporated Florida statutes and administrative code sections governing HMOs in this state, including sections 627.613, 627.662(7), 641.3155,

627.418, and 641.3105, which therefore became contract provisions and gave Westside the right to enforce them through third party beneficiary standing.

During the hearing on Westside?s Motion for Leave to Amend Complaint (R17-8/21/03-1-16), Westside?s counsel told the court that he did not want to go through ?another round of briefings, and memos, and memoranda? if the court believed that the proposed Second Amended Complaint was barred by *Villazon* and requested that the court simply dismiss the case with prejudice (R17-8/21/03-14-15). At the conclusion of the hearing, the court did as Westside requested, denied its Motion, and entered the Final Judgment (R16-2618-19, 2620; R17-8/21/03-14-15). Westside appealed the Final Judgment to the Fourth District.

C. The Fourth District?s Opinion

On May 4, 2005, the Fourth District issued its Opinion (A1), stating:

> The trial court entered judgment on the pleadings in favor of HMOs, concluding that the supreme court?s opinion in *Villazon v. Prudential Healthcare Plan, Inc.*, 843 So. 2d 842 (Fla. 2003), has foreclosed all private causes of action arising out of HMO violations of, or failure to comply with, the Act. We reverse.
>
> * * *
>
> We conclude that service providers, claiming as third party beneficiaries under a subscriber?s contract, may bring an action founded on the HMOs? failure to comply with the prompt pay provisions of the Act.

The Opinion does not distinguish between ?participating? or ?par? providers, those with contracts directly with the HMOs, and ?nonparticipating? or ?non par? providers, those with no such contracts. Nor does the Opinion restrict the right of subscribers or non par providers to sue HMOs in any way. Rather, under the Opinion all health care providers are third party beneficiaries of all HMO contracts. Thus, they may sue all HMOs directly on a third party beneficiary theory for enforcement of any provision of the

HMO Act and may collect attorney?s fees under section 641.28 of the HMO Act if they prevail. The Opinion effectively dismantles the concept of managed health care in this State.

In recognition of the potentially devastating impact of the Opinion on both the managed health care industry and Florida?s consumers of health care services, the Fourth District certified to this Court the question of great public importance for which HOI now seeks review.

QUESTION PRESENTED

The Fourth District certified the following question:

> 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 AN HMO BY A SERVICE PROVIDER?

HOI believes the question should be rephrased as follows:

> MAY A PROVIDER ENFORCE THE PROVISIONS OF THE HMO ACT AGAINST AN HMO THROUGH A PRIVATE CAUSE OF ACTION AS AN ASSIGNEE OF THE HMO SUBSCRIBER?S BENEFITS, A THIRD PARTY BENEFICIARY OF THE SUBSCRIBER?S HMO CONTRACT, OR BY ANY OTHER MEANS?

SUMMARY OF ARGUMENT

The Fourth District erred in interpreting the HMO Act as supporting a private cause of action to enforce its provisions. There is no express right, as the Fourth District acknowledged, and nothing in the HMO Act supports a conclusion that such a right is implied. In the absence of express or implied intent, a court may not judicially create such a right.

The Fourth District's conclusion that providers should be allowed to do through the back door what they cannot do through the front is inconsistent with all existing authority. None of the statutes on which the court relied creates – or even allows – the "parallel legal remedies" now established by the Opinion through a third party beneficiary theory. To allow such an attack on the managed care industry via subscribers' contracts defeats the very purpose of the HMO Act – containment of health care costs – and ignores the fundamental distinction between par and non-par providers. Furthermore, as to HOI itself, its Group Plan specifically prohibits such third party beneficiary standing in requiring that payment for the services of a non-par provider be made to the subscriber and not the provider directly.

The Legislature's unequivocal intent, as expressed throughout the HMO Act, is to vest the right to enforce its provisions exclusively in AHCA and DFS. That intent is highlighted not only by the language of the HMO Act itself but also by the Legislature's creation of an alternative administrative claims procedure available to providers through Maximus. The Fourth District's failure to recognize the existence, purpose, and exclusiveness of Maximus led to its further errors.

The Opinion ignores the Legislature's carefully crafted managed health care

vehicle, undoes all the protections provided to Florida? s citizens to contain health care costs, and brings the system to its knees. It must be quashed.

ARGUMENT

I. THE HMO ACT DOES NOT PROVIDE A PRIVATE RIGHT OF ACTION.

A. Overview

The specific statute at issue before the Fourth District and under consideration here is section 641.3155, Florida Statutes, the HMO Act?s ?prompt pay? provision. The underlying and more important issue, however, is whether any provision of the HMO Act is enforceable by either a health care provider or a subscriber outside the parameters of the administrative proceedings established by the Legislature. Because the issue is the Fourth District?s interpretation of the HMO Act, the Court?s review is *de novo*. *See B.Y. v. Department of Children and Families*, 887 So. 2d 1253, 1255 (Fla. 2004).

The Fourth District?s conclusion that such enforcement is available is based on a series of misunderstandings and erroneous assumptions about the HMO Act and the established administrative enforcement remedies. To conclude, as did the district court, that the HMO Act supports a private right of action, through the vehicle of a contract action or otherwise, ignores legislative intent and condones an attack through the ?back door? of contract law that is unauthorized by the HMO Act itself.

Because of the inconceivable havoc that the Opinion will generate in this State?s managed health care system, for consumers and health care entities alike, it should be quashed.

B. The HMO Act does not expressly authorize a private cause of action for enforcement of its provisions.

The Legislature designed the HMO Act to control Florida? s ? mounting costs of health care? by eliminating ? legal barriers? to the promotion and expansion of medical services through HMOs. ?? 641.18(1), (4)(a), Fla. Stat. As part of the

elimination of legal barriers, the Legislature exempted HMOs from the operation of the Florida Insurance Code, chapters 624 through 632, 634, 635, 641, 642, 648, and 651, Florida Statutes, except as set forth in the HMO Act itself. ?? 641.18(4)(b), 641.201, 641.30(2), Fla. Stat.

To effect its purpose of containing health care costs while providing quality health care to Florida?s citizens, the HMO Act provides a comprehensive array of enforcement techniques and penalties through the Agency for Healthcare Administration (?AHCA?) and the Department of Financial Services (?DFS?), formerly known as the Department of Insurance. As the Fourth District acknowledged, nowhere in the HMO Act is there an express authorization for a subscriber or health care provider to sue an HMO directly under the HMO Act for an alleged violation of its provisions.

C. Nothing in the HMO Act supports a conclusion that the Legislature intended a private right of action for violation of its provisions.

1. The HMO Act does not imply a private cause of action.

The HMO Act also does not support a conclusion that the Legislature intended a private cause of action for violation of its provisions. In *Murthy v. N. Sinha Corp.*, 644 So. 2d 983, 985 (Fla. 1994), this Court held that ?legislative intent, rather than the duty to benefit a class of individuals, should be the primary factor considered by a court in determining whether a cause of action exists when a statute does not expressly provide for one.? The Court then refused to judicially infer a civil cause of action under chapter 489, which provides administrative remedies against a construction company?s qualifying agent, explaining that the

chapter indicated only an intent to ?secure the safety and welfare of the public by regulating the construction industry,? but not to allow a private action against a qualifying agent. *Id.* at 986.

As the Court concluded with respect to chapter 489, nothing in chapter 641 implies the Legislature?s intention to allow a health care provider to sue an HMO under the prompt pay statute or any other. Quite the contrary, chapter 641 shows only an intent that AHCA and DFS regulate and control Florida HMOs. The single statute in which ?civil action? is even mentioned expressly limits such action to enforcement of the HMO contract.[3] ? 641.28, Fla. Stat. Every other statute speaks only of DFS?s power to control, regulate, and penalize HMOs under chapter 641 and the administrative rules promulgated pursuant to the chapter. Where a statute expressly provides particular enforcement mechanisms, as does the HMO Act in this case, the ?integrity of the overall statutory scheme requires restraint in implying private actions.? *A & E Supply Co., Inc. v. Nationwide Mut. Fire Ins. Co.*, 798 F.2d 669, 675 (4th Cir. 1986).

Nor does the fact that the HMO Act constitutes a consumer protection statute weigh in favor of the existence of a private cause of action. That is exactly the analysis rejected in *Murthy*, 644 So. 2d at 985. Nothing suggests that AHCA and DFS are unable to protect HMO consumers and providers through administrative proceedings. In fact, exactly the opposite must be inferred given DFS?s broad authority to promulgate rules, revoke an HMO?s certificate of

[3] As HOI explains more fully at page 17, section 641.28 does not imply a private right of action to enforce the HMO Act. Rather, this section provides for prevailing party attorney?s fees in actions seeking coverage under HMO contracts.

authority, suspend its acceptance of new members, enjoin it from violations, investigate claims of unfair or deceptive acts or practices, and fine it for noncompliance with chapter 641. *See, e.g.*, ?? 641.23, 641.281, 641.36, 641.3905, Fla. Stat.

In *T.W.M. v. American Medical Systems, Inc.*, 886 F. Supp. 842, 845 (N.D. Fla. 1995), a federal district court applying Florida law reached a similar conclusion with respect to chapter 499, Florida Statutes (1993), Florida? s Drug and Cosmetics Act. Citing *Murthy*, 644 So. 2d at 985, the court commented that the Act merely made provision to secure the safety or welfare of the public and thus should not be construed as establishing civil liability. *See T.W.M.*, 886 F. Supp. at 845. The court then noted that the Act specifically charged the Department of Health and Rehabilitative Services with administration and enforcement of the Drug and Cosmetics Act, including imposition of fines and maintenance of enforcement actions. *See id.* On those grounds, the court held that legislative intent did not support the conclusion that the act implied a private right of action. *See id.*

Like the legislative scheme in chapter 499, chapter 641 shows the Legislature? s intent to impose on the managed care industry a high degree of regulation and to vest AHCA and DFS with responsibility to administer the regulations. The conclusion advocated by HOI is consistent with the HMO Act and controlling cases, and does not do violence to any other body of Florida law.

For example, while the HMO Act contains extensive requirements for what must be in an HMO contract, it also contains numerous provisions establishing that enforcement of those requirements is not for a subscriber or provider. Section 641.185 in particular provides that the protections for subscriber rights codified there ? shall serve as

standards to be followed by the [Financial Services] [C]ommission, the [O]ffice [of Insurance Regulation], the [D]epartment [of Insurance], and the Agency for Health Care Administration in exercising **their** powers and duties, in exercising **administrative discretion**, in administrative interpretations of the law, in **enforcing its provisions**, and in adopting rules? (emphases supplied). The section specifically provides that it ?shall not be construed as creating a civil cause of action by any subscriber or provider against any health maintenance organization.? ? 641.185, Fla. Stat.

Section 641.25 provides the Office of Insurance Regulation (?OIR?) with the power to revoke or suspend an HMO?s license for violation of the HMO Act or, alternatively, to impose a variety of fines on the noncompliant HMO. Section 641.281 gives DFS and the OIR the power to seek injunctive relief against HMOs. Sections 641.3905 and 641.3907 through .3913 vest DFS with the authority to determine whether an HMO is in compliance with the HMO Act and to enforce compliance under chapter 120, Florida Statutes, with orders and fines. **Given the complex and comprehensive scheme, chapter 641 should be construed as was chapter 499 in *T.W.M.*, particularly since opening the door to civil litigation and its runaway costs would be profoundly inconsistent with the Legislature? s expressed intent to contain health care costs in this State through the HMO structure.**

Here, while the Fourth District conceded that there is no express private right of action in the HMO Act, and tacitly conceded that there is no implied right of action, it effectively created such a right of action by construing various statutes in the HMO Act to ? recognize or anticipate the existence of parallel legal remedies? (emphasis supplied) for subscribers and providers. The court then extrapolated the concept of ? parallel legal remedies? to infuse a private cause of action into the

HMO Act via every HMO contract in this State. The Opinion stands as the only Florida case ever to find neither express nor implied legislative intent to allow a private right of action ? yet hold that such right of action exists nonetheless.

Not only is there no common law support for the Opinion, the statutes upon which the Fourth District relied provide no support. Among those statutes are sections 641.3154, 641.28, 641.3917, and 641.3105. As to section 641.3154, the Fourth District relied on a portion of the statute that refers to a decision by a ?court of competent jurisdiction . . . that the [HMO] is liable.? For two reasons, the court?s reliance is misguided. First, as the court acknowledged, the HMO Act does not grant a private cause of action. Second, the section does not imply ?parallel? legal remedies to enforce the HMO Act directly. Rather, as section 641.3154(4) clarifies, the purpose of the statute is to foreclose a provider?s right to pursue a subscriber for payment until all issues regarding coverage are resolved. Issues regarding whether a service or supply is covered by the terms of an HMO plan are always within a court?s jurisdiction.[4]

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[4] The Court may take judicial notice of the numerous cases in which HMOs have been sued for breach of contract. *See, e.g.,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). As the cases show, a subscriber always has the right to bring a common law action for breach of contract against an HMO for such issues as whether a surgical procedure is covered by the plan. Until a ?court of competent jurisdiction? determines the coverage issue, the statute prohibits the provider from suing the subscriber patient for payment, impairing his or her credit, or any other collection effort. That is the purpose of the section, not the creation of an unspecified ?parallel? private right of action to enforce the regulatory provisions of the HMO Act directly or indirectly.

This, not a private cause of action under the HMO Act, is the subject of section 641.3154. And while the court noted an agreement by the HMOs that section 641.3154(4) puts non-par providers such as Westside ? on an equal footing with contract providers in enforcing their right to payment,? the agreement was simply that neither par nor non-par may pursue a subscriber pending determination of coverage under the HMO plan. There was no agreement that either a par provider or a non-par provider had any private cause of action under the HMO Act.

Section 641.28, the civil remedy statute, further clarifies section 641.3154 by providing that the prevailing party in any action against an HMO to enforce the terms of the contract is entitled to an attorney? s fees award. ? Civil liability? certainly refers to a private civil lawsuit, but nothing in chapter 641 suggests that the private civil lawsuit is for anything more than enforcement of the HMO contract, as the section recognizes and as the Fourth District concluded in *Greene v. Well Care HMO, Inc.*, 778 So. 2d 1037-38, 1041 (Fla. 4th DCA 2001), and again in the Opinion. And nothing in the HMO Act suggests that enforcement of the HMO contract automatically includes all provisions of the Act itself. To the contrary, enforcement of the HMO contract relates to such issues as plan coverage for medical procedures.

The third section on which the court relied, section 641.3917, also does not support its reading. The section, entitled **?** Civil Liability,**?** says only that remedies under the Act are cumulative to those <u>otherwise</u> existing under general civil or common law. The section cannot be construed to **<u>create</u> other remedies, only to not abrogate them.** ***See, e.g., Wal-Mart Stores, Inc. v. McDonald*, 676 So. 2d 12, 17 (Fla. 1st DCA**

1996), *decision approved sub nom., Merrill Crossings Associates v. McDonald,* 705 So. 2d 560 (Fla. 1997). And in *Greene,* 778 So. 2d at 1040, the Fourth District again recognized that a private cause of action could not be inferred from the language of section 641.3917 alone.

Finally, the Opinion relies on section 641.3105, which provides that HMO contracts be applied as if their terms are in full compliance with the HMO Act. The fact that HMO contracts must comply with the HMO Act, however, cannot create a cause of action in the HMO Act itself where there is none otherwise. Rather, as the HMO Act itself clarifies, enforcement of its provisions has been vested in AHCA and DFS, not in subscribers and providers.

2. The legislative history of the HMO Act is inconsistent with the conclusion that it implies a private right of action.

Beyond the absence of any language in the HMO Act itself from which to infer a private cause of action, the Legislature's clear intention to prohibit any such inference is established by the history of the HMO Act. Since 1996, there have been at least four unsuccessful attempts to amend the HMO Act to create a private cause of action. As *Greene* notes, the first failed attempt was in 1996, when Governor Chiles vetoed House Bill 1853, 1996 Legislative Session, which would have amended section 641.3917 to create a private cause of action against HMOs (A2). *Id.* at 1040. In the Governor's letter, he explained that the bill allowed "HMO subscribers . . . to sue for compensatory and punitive damages as well as attorneys fees," and that Florida "would be the first state in the nation to enact a statute authorizing such suits" (A2-1). The Governor gave a myriad of reasons for

his veto, including his beliefs that the legislation would ?destroy the very positive benefits of managed care? and went ?too far in creating a tort remedy for these denials? (A2-2-5).

Five years later, another bill, Senate Bill 984, was proposed (A3). Section 4 of the bill again attempted to create a private cause of action by enacting ?section 641.275,? entitled ?Subscriber?s rights and responsibilities under health maintenance contracts; required notice? (A3-3, 7). Included in the bill was a civil remedy for violation of section 641.3155 (A3-12-13). The bill died in committee (A3-1).

In 2002, Senate Bill 362 proposed a similar, although more limited, addition, this time to section 641.3155 (A4-45-46). The proposal would have allowed actions for declaratory or injunctive relief regarding violations of the section and included a prevailing party attorney?s fee provision (A4-46-47). While many of the amendments proposed by Senate Bill 362 were enacted, this provision was not.

Senate Bill 2814, in 2004, was the next attempt (A5). This bill also sought to amend section 641.3155 to include a private cause of action for enforcement of the prompt pay provision (A5-4). Like its 2001 predecessor, this bill died in committee (A5-1).

As recently as the 2005 legislative session, there were two further attempts, in the House and in the Senate, to amend section 641.3155 to encompass a private cause of action (A6-13-15; A7-6-8). Again the attempts died in committee (A6-1; A7-1).

As the Fourth District concluded in *Greene*, 778 So. 2d at 1041, to accept that there is a private cause of action implied in chapter 641 notwithstanding the

numerous failed attempts to create one makes no sense. Worse, it runs roughshod over the will of the citizens of this State as expressed by their duly elected representatives in the Florida Legislature.

II. THE FOURTH DISTRICT ERRED IN CREATING A PRIVATE CAUSE OF ACTION THROUGH THE VEHICLE OF A CONTRACT CLAIM.

Rather than rely on a statutory private cause of action to enforce the provisions of the HMO Act directly, the Fourth District did so indirectly by creating a ?back door? through the subscribers? HMO contracts. The court reasoned: (a) each HMO contract incorporates all provisions of the HMO Act pursuant to section 641.3105; (b) settled contract principles allow parties to enforce their contracts in courts of law; (c) health care providers are third party beneficiaries of the HMO contracts; and, therefore, (d) health care providers have standing to sue on the HMO contracts to enforce the HMO Act, including its prompt pay provisions.

To reach its conclusions, the court misconstrued the cases upon which it relied, made leaps of logic that should be rejected by this Court, and allowed Westside to do indirectly that which it could not do directly. *See, e.g., Clafin v. Ambrose*, 19 So. 628, 631 (Fla. 1896). The errors in the Opinion cannot be allowed to stand.

A. *Villazon* does not allow a private cause of action for enforcement of the HMO Act.

In *Villazon*, 843 So. 2d at 852, the Court held that the HMO Act ?does not specifically provide a private right of action for damages based upon an alleged violation of its requirements.? While acknowledging that holding, the Fourth District in this case interpreted the Court?s statement that Mr. Villazon could ?bring a common law negligence claim based upon the same allegations? to mean that the HMO Act could be enforced through a common law contract action such

as the one brought by Westside here. *Id.*

Contrary to the Fourth District? s interpretation, the Court did not allow Mr. Villazon to sue the HMO for enforcement of the HMO Act through the vehicle of common law negligence. Rather, his claim under the HMO Act was based on an alleged nondelegable statutory duty to provide quality health care. *See id.* at 845. The Court expressly rejected his ability to maintain such a claim. In contrast, his negligence claim was based upon ? allegations that Mrs. Villazon? s treating physicians were agents or apparent agents of PruCare? and, thus, the HMO was vicariously liable for their alleged negligence. *Id.* at 852. The suit for common law negligence would not have implicated the HMO Act.

The *Villazon* Court? s conclusion is consistent with the distinction made in cases construing section 514(a) of the Employee Retirement Income Security Act, 29 U.S.C. ?? 1000 *et seq.* ? If a claim relates to the manner in which the ERISA plan is administered,? for example the withholding of benefits, ? ERISA preempts the claim.? *Id.* at 846, 848. Similarly, a claim seeking to attack an HMO plan? s compliance with regulatory standards established by the HMO Act is prohibited because there is no private cause of action in the HMO Act to do so.[5] Pursuant to the HMO Act itself, such a claim lies within the sole jurisdiction of AHCA or DFS in fulfilling their administrative obligations. *See* ? 641.185, Fla. Stat.

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[5] **In contrast, if a claim attacks the quality of benefits provided by an HMO, it is not preempted by ERISA. *Villazon*, 843 So. 2d at 848.** Analogously, and as *Villazon* and *Greene* explain, a similar lawsuit against an HMO would not be to enforce the HMO Act but on a common law theory for medical malpractice.

The Opinion is also incorrect that application of *Villazon* to prohibit the ?back door? approach now approved by the Fourth District restricts subscribers and providers to administrative proceedings while allowing HMOs to sue under section 641.3154(4)(b). As HOI explained above, the ?court of competent jurisdiction? language in the statute refers to a suit by a subscriber or provider regarding liability outside the HMO Act, not to enforce the HMO Act through the vehicle of an HMO plan. If that were the case, the Legislature would have said so plainly, and it did not. To the contrary, the Legislature?s unquestioned recognition that the HMO Act has generated millions of HMO contracts in this State alone, coupled with its repeated rejection of bills designed to create a private cause of action, requires a conclusion that the Fourth District cannot allow the HMO contracts to do through the back door what the Legislature has repeatedly refused to allow through the front.

B. The remaining cases on which the Fourth District relied do not support the Opinion.

The Fourth District?s contract cases are equally irrelevant in the context of this case, because each states only that contracts, including insurance contracts, incorporate relevant statutes. *See Grant v. State Farm Fire and Cas. Co.*, 638 So. 2d 936, 938 (Fla. 1994); *Northbrook Property & Cas. Ins. Co. v. R & J Crane Service, Inc.*, 765 So. 2d 836, 839 (Fla. 4th DCA 2000). Section 641.3105 establishes the same standard for HMO contracts.

There is no authority until the Opinion, however, that such statutory rights are automatically enforceable by the parties even though the statutes themselves do not allow a private cause of action. As the Opinion recognizes, the contract itself may disclose a

contrary intention and thus defeat enforceability, and the Legislature certainly has the same right to prohibit private enforcement. Contrary to the Fourth District?s understanding, Florida contract law does not support a conclusion that incorporation of statutory provisions into a contract automatically creates a private right of action where none exists in the statutes. Rather, the rights are enforceable only in the manner directed by the statutes. *See, e.g., Villazon*, 843 So. 2d at 852 (discussing the incorporation of nursing home residents? statutory private right of action). The Fourth District is simply incorrect that incorporation of the provisions of the HMO Act into an HMO contract creates rights that do not otherwise exist.

The Opinion is also based on a misreading of other cases on which it relies. *Foundation Health v. Garcia-Rivera*, 814 So. 2d 537, 538 (Fla. 3d DCA 2002), is a one-page opinion that addresses only the issues of class certification, arbitration, and waiver. The Third District did not recognize that ?service providers have a right to sue HMOs? under the statutory prompt pay provisions, because that issue was not before it. The case on which *Foundation Health* relied, *Colonial Penn*, 694 So. 2d at 853, also involved only a class action issue ? and in the context of chapter 627, Florida Statutes, which specifically provides a private right of action for insureds and provider-assignees of personal injury protection benefits. *See* ? 627.736, Fla. Stat.; *see also Allstate Ins. Co. v. Kakalamos*, 843 So. 2d 885, 888 (Fla. 2003) (construing Florida?s PIP statute).

The Fourth District?s distinction of *Greene*, 778 So. 2d at 1040, and *The Florida Physicians Union, Inc. v. United Healthcare Of Florida, Inc.*, 837 So. 2d 1133, 1135 (Fla. 5th DCA 2003), as relating only to a statutory cause of action is equally incorrect. In *Greene*, 778 So. 2d at 1042, the court held that a common law breach of contract action may be available to an HMO subscriber to enforce the subscriber?s contract.

Westside, however, is not a subscriber, disclaims relying on an assignment, has no contract with HOI directly, and thus has no interest to enforce through a breach of contract action. And although the *Florida Physicians* court noted that suit on a contract was not before it, nothing in the opinion authorizes suit on a contract that is a thinly veiled attempt to sue on the HMO Act itself.

While both *Greene* and *Florida Physicians* agree that civil suits to enforce a contract with an HMO may be brought in a proper case, both also recognize that chapter 641 does not create a private cause of action. As HOI explained above, the "proper" civil suits discussed in both *Greene* and *Florida Physicians* are those for common law breach of contract and tort, not the statutory cause of action created by incorporation here.

To conclude, as the Fourth District does in the Opinion, that the Legislature intended section 641.28 to incorporate into every HMO contract every provision of the HMO Act ignores rules of statutory construction. If the Legislature had meant that fundamentally different construction, with its fundamentally different result, it could have and would have said so, and it did not. *See Ady v. American Honda Finance Corp.*, 675 So. 2d 577, 582-83 (Fla. 1996) (explaining that a court is not free to second-guess the Legislature's choice).

The cited cases from other states are equally inapplicable. In each, the courts simply recognized that the statutes themselves established private causes of action that were incorporated into the respective contracts. *See Wallace v. State Farm Fire & Cas. Co.*, 539 S.E.2d 509, 510 (Ga. App. 2000) (addressing an insured's suit on an automobile insurance policy); *St. Clare's Hosp. v. Allstate Ins. Co.*, 215 A.D.2d 641, 641-42 (N.Y.A.D. 1995) (adjudicating no-fault benefits under an automobile insurance policy); *J.C. Penney Life Ins. Co. v. Heinrich*, 32 S.W.3d 280, 283 (Tex. App. 2000)

(determining rights under a life insurance policy). Not one of the cases construes an HMO Act such as Florida?s ? or even another statutory scheme that does not specifically grant a private cause of action.

C. Better reasoned cases reject the position of the Fourth District.

While there are numerous ?prompt pay? provisions throughout the statutes of every state, not all give rise to private causes of action, even when they are incorporated into contracts. For instance, in *Schappell*, 868 A.2d at 1 *4, citing *Solomon v. U.S. Healthcare Systems of Pennsylvania, Inc.*, 797 A.2d 346 (Pa. App. 2002), the court rejected a claim such as that made here, noting that although the relevant statute created a ?right? in favor of a health care provider, the statute did not create a private action to enforce that right, ?particularly in light of the stated purpose of reducing automobile insurance costs.? In *Solomon*, 797 A.2d at 351, the court held that Pennsylvania?s version of the HMO Act could not be interpreted to rewrite the parties? contract to allow a private cause of action not allowed by the legislation itself.

Similarly, in *Massachusetts v. Mylan Laboratories*, 357 F. Supp. 2d 314, 327 (D. Mass. 2005), the court rejected the argument that a party could create a private cause of action through the vehicle of a third party beneficiary theory where the underlying statute contained no private cause of action. Quoting *Grochowski v. Phoenix Construction*, 318 F.3d 80, 86 (2d Cir. 2003), the court said:

> **To allow a third-party private contract action aimed at enforcing those wage schedules would be inconsistent with the underlying purpose of the legislative scheme and would interfere with the implementation of that scheme to the same extent as would a cause of action directly under the statute.**

The *Mylan* court explained that a court should be loathe to provide remedies

other than those expressly provided by a statutory scheme and that to do so through a third party beneficiary theory would be sanctioning an ?end-run? around a statute that does not provide a private cause of action. *See id.* (quoting *Davis v. United Air Lines, Inc.*, 575 F. Supp. 677, 680 (E.D.N.Y. 1983)). In *Davis*, as here, a ?key factor? was that Congress had set up a ?comprehensive administrative scheme? to remedy violations of the statutes at issue there. *Mylan* at 327. The above cases should control here.

III. THE FOURTH DISTRICT ERRED IN READING THIRD PARTY BENEFICIARY STATUS INTO HOI? S GROUP PLAN.

Even if the HMO Act could be construed to support a private cause of action, which it should not be, for two reasons the Fourth District incorrectly concluded that Westside is a third party beneficiary of HOI? s subscriber contract, the Group Plan (R9-1554-57)**. ?** A cause of action for breach of a third-party beneficiary contract contains the following elements: (1) a contract between A and B, (2) the ? clear? or ? manifest? intent of A and B that the contract primarily and directly benefit the third-party (or class of persons to which that party belongs), (3) breach of the contract by either A or B, and, (4) damages to the third-party resulting from the breach.? *Jenne v. Church & Tower, Inc.*, 814 So. 2d 522, 524 (Fla. 4th DCA 2002). Quoting *Marianna Lime Products Co. v. McKay*, 147 So. 264, 265 (Fla. 1933), the court said that the test is only whether the ? parties to the contract intended that a third person should be benefitted by the contract.?

First, the contract between HOI and its subscribers, the Group Plan, shows no ? manifest? intent to ? directly benefit? a non-par provider such as Westside (R9-1554-57). To the contrary, the Group Plan explicitly distinguishes between non-par providers such as Westside and those par providers that are part of HOI? s network. The Group Plan specifically states that benefits for medical services rendered by a non-par provider such as Westside will be paid only to the subscriber or other person as required by law (R9-1529-61).[6]

[6] In contrast, HOI? s par providers are paid directly by HOI, thus eliminating the need for the providers to incur the expense of administrative staff to collect from the subscribers.

Rather than a ?direct benefit? to non-par providers such as Westside, the clear purpose of the carefully crafted Group Plan language is to restrict its rights to subscribers and par providers. This, in turn, protects its assets against invasion by strangers to the HMO contractual network. Westside is exactly such a stranger. Thus, according to the clear terms of the Group Plan, Westside is no more than an incidental beneficiary with no right to enforce the subscribers? contracts against HOI. *See, e.g., Metropolitan Life Ins. Co. v. McCarson*, 467 So. 2d 277, 279 (Fla. 1985) (explaining that an incidental beneficiary cannot enforce a contract).

No law requires HOI to pay non-par providers directly or to include such a provision in its Group Plan. And no case or statute allows non-par providers such as Westside to appropriate to themselves the same benefits available to HOI?s par providers and subscribers by claiming standing through a back door of their own creation while vehemently disavowing assignments of the subscribers? Group Plan benefits. To allow them to do so eviscerates the concept of a ?network? of par providers ? the very core of managed health care ? and eliminates the managed care industry?s ability to provide cost effective, affordable health care to Florida?s citizens.

Second, the express purpose of the HMO Act is to codify the type of structure memorialized in HOI?s Group Plan. *See, e.g.,* ? 641.3101, Fla. Stat. (establishing an HMO?s right to contain provisions consistent with the Act, and necessary for the protection of the ?parties to the contract?). As the HMO Act clarifies, the structure is also the cornerstone of the complex HMO structure enacted by the Florida Legislature to ensure quality managed health care for Florida?s residents at affordable costs. Nothing in the HMO Act itself supports a conclusion that a non-par provider such as Westside can acquire any rights under an HMO contract in the absence of an assignment of its benefits.

Until the Opinion, no Florida case ? and certainly not the generic contract cases cited in the Opinion ? allowed a non-par provider in the position of Westside to attack an HMO plan such as HOI?s Group Plan by asserting third party beneficiary rights, ostensibly under a subscriber contract, that are expressly not allowed by the Group Plan itself. Practically speaking, the Opinion has effectively rewritten Florida law and the HMO Act by eliminating any reason for a par provider to contract with an HMO and join its network when a non-par provider may simply proceed as a third party beneficiary of the subscriber-patient?s contract and selectively obtain the same benefits without any of the burdens. The Opinion also allows Westside, which expressly disavowed proceeding as an assignee of the Group Plan benefits so that it could avoid ERISA preemption, to accomplish via a third party beneficiary theory exactly what ERISA preemption was designed to prevent.

The Fourth District?s Opinion, if allowed to stand, effectively eliminates the concept of managed care and the cost-effective delivery of healthcare to Floridians that the HMO Act was designed to promote. It should be quashed.

IV. THE LEGISLATURE HAS PROVIDED AN EFFECTIVE ALTERNATIVE REMEDY THROUGH MAXIMUS.

Overarching all the incorrect reasons given by the Fourth District in judicially creating a private cause of action to enforce the HMO Act through the vehicle of the HMO contract is the court's misunderstanding of the status of the alternative dispute resolution remedy contemplated by section 641.3154(4)(d). As footnote one of the Opinion shows, this incorrect presumption fueled the court's conclusion that a non-par provider such as Westside would be without a remedy in the absence of the availability of a lawsuit to enforce the HMO Act.

Contrary to the Fourth District's understanding, there is no "section 641.3155(c)," and **section 408.7056 does not apply to providers. Rather, that section relates only to subscribers and the legislatively created Subscriber Assistance Program. In contrast, the legislatively created dispute resolution program for providers is that referenced in sections 641.3154(4)(d) and 408.7057. As dictated by section 408.7057(2)(a), the program became effective** on January 1, 2001. Before that time, the HMO Act was purely regulatory, with enforcement authority vested exclusively in state agencies.

The Opinion's assertion that "such a program has not been established" is simply wrong, because as of January 1, 2001, Maximus, Inc., by virtue of its contract with AHCA, began adjudicating provider disputes regarding rights established by the HMO Act (A8; A9). Under the legislatively created plan, a provider has standing to enforce the HMO Act before Maximus, which is required to accept claims within its parameters. "408.7057(2)(b), Fla. Stat. While subscribers and providers may always sue for negligence, as the Court noted in *Villazon*, if they choose to bring a statutory claim under

chapter 641? Maximus is the exclusive remedy for providers.

Although there are few cases thus far addressing the administrative remedy available through Maximus, the court in *Health Options*, 889 So. 2d at 849, described the process. According to *Health Options*, 889 So. 2d at 852, the procedure is initially voluntary for the provider but becomes binding once the parties complete fact finding. Maximus? s obligation is to recommend ? resolution? of claims disputes to AHCA, which is required to accept Maximus? s recommendation after 30 days.

Under well-settled Florida law, administrative remedies such as Maximus may not be avoided in the absence of extraordinary reasons not present here. Rather, ? the principles of primary administrative jurisdiction and exhaustion of administrative remedies? control. *Key Haven Associated Enterprises, Inc. v. Board of Trustees of Internal Imp. Trust Fund*, 427 So. 2d 153, 156 (Fla. 1982). Alternatively, of course, Westside and similarly situated providers are free to pursue their common law remedies in court, such as actions for quantum meruit or unjust enrichment, as they have been doing for years. But they are not free to enforce the HMO Act, either directly or indirectly, through litigation in the courts.[7]

[7] Thus, a provider complaint truly grounded exclusively in common law claims may be pursued in court. But a provider complaint that either directly or indirectly seeks relief based on an alleged violation of the HMO Act ? such as suing to enforce the HMO Act via a common law cause of action ? is prohibited. Such claims may only be privately pursued through Maximus or publicly pursued by AHCA or DFS.

The existence of Maximus, ignored by the Fourth District, coupled with the clearly expressed legislative purpose to contain HMO health care costs by creating the exclusive alternative administrative process to avoid litigation and its concomitant cost, again requires a conclusion that the Fourth District?s Opinion is in error and should be quashed.

CONCLUSION

For the foregoing reasons, the Opinion should be quashed and this case remanded to the District Court of Appeal for the State of Florida, Fourth District, with directions to issue an opinion affirming the trial court?s Final Judgment and clarifying that there is no private cause of action to enforce the HMO Act.

Respectfully submitted,

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CERTIFICATE OF SERVICE

We certify that a true and correct copy of the above and foregoing was furnished by U.S. Mail to the persons on the attached Service List, this ___ day of June, 2005.

CERTIFICATE OF COMPLIANCE

We certify that this brief complies with the font requirements set forth in Florida Rule of Appellate Procedure 9.210(a)(2).

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