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

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

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ARGUMENT[1]

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

A. Overview

Only by ignoring the effect of the Opinion is Westside able to argue that the Opinion does not create a private right of action under Florida's Health Maintenance Organization Act, sections 641.17, *et seq.*, Florida Statutes ("HMO Act") (AB11, 13-15, 27). Through the use of the "incorporation" and "third party beneficiary" theories, the Opinion universally authorizes providers to accomplish through the backdoor what the HMO Act itself does not allow. Every provider[2] becomes a third party beneficiary of

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[1] Petitioners will be referred to as "HOI." Respondent will be referred to as "Westside." The record will be cited as "R___-___." HOI's Initial Brief will be cited as "IB___." HOI's Appendix will be cited as "A___." Westside's Answer Brief will be cited as "AB___." The Providers' Amici Brief will be cited as "P___." HOI will return to the format of its Initial Brief. *See Dania Jai-Alai Palace, Inc. v. Sykes*, 450 So. 2d 1114, 1122 (Fla. 1984). To the extent the *amici* briefs are not directly addressed, it is because they reiterate Westside's arguments.

[2] Westside misunderstands HOI's statement that the Opinion does not distinguish between par and non par providers (AB9-10 n2). The Opinion recognizes the two classes, but relies on section 641.3154 to hold that they are

every subscriber's contract and, thus, gains the right to sue.

While HOI does not contest the existence of the "incorporation" and "third party beneficiary" doctrines, as Westside suggests (AB14), the theories cannot be applied to the "prompt pay" statute, section 641.3155, or other provisions of the HMO Act, without eviscerating this Court's pronouncements in *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 852 (Fla. 2003), ignoring legislative language and intent, and violating the express prohibition in HOI's Group Plan.[3]

As the Court taught in *Villazon*, the HMO Act neither expressly nor impliedly allows a private right of action. It is a legislatively created, comprehensive, and complex

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equal under the HMO Act with respect to enforcing their "right to payment" against HMOs.

[3] The Group Plan is properly before the Court. Westside referenced it in its Complaint and filed it with the trial court in opposition to the Joint Motion for Judgment on the Pleadings (R7-1144-50; R9-1529-6; AB3, 33 n8). *See, e.g.*, *Brooks v. Blue Cross and Blue Shield of Florida, Inc.*, 116 F.3d 1364, 1369 (11th Cir. 1997) (explaining that documents referred to in a complaint that are central to the claim are part of the pleadings).

regulatory system intended to manage health care delivery in Florida. Incorporated into that system is an administrative remedy designed to avoid the court system and contain health care costs. Application of the "incorporation" and "third party beneficiary" theories to the HMO Act undoes the entire regulatory system.

The law in Florida has always been that the HMO Act, including the prompt pay statute, does not directly or indirectly support a private right of action. To allow the Opinion to change that law without review, as Westside suggests (AB14-15) should be rejected. This issue is of paramount concern to the residents of this State and must be addressed.

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

Westside admits that the HMO Act contains no express private right of action (AB13-19). That leaves only two possibilities: (a) the Legislature intended the HMO Act to allow a private right of action but failed to clearly articulate its position; or (b) the Legislature intended to

allow enforcement of the HMO Act through HMO contracts even though it did not intend enforcement of the HMO Act itself. The Opinion accepts the latter alternative. Westside now appears to argue for both alternatives. Neither is correct. Rather, the exclusive remedy is the administrative procedure established by the Legislature.

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.

While Westside has repeatedly denied that it argues for a private right of action under the HMO Act, it now claims that the Legislature intended that result because the HMO Act is "virtually indistinguishable" from the Florida Insurance Code ("Code") (AB15, 27, 35-36).[4]

[4] The Providers mistakenly rely on *Medical Society of New Jersey v. AmeriHealth HMO, Inc.*, 868 A.2d 1162 (N.J. App. 2005) (P9-11, 17). The court there said that New Jersey's act "does not specifically authorize private parties to file enforcement actions" but, "by its terms, is to be enforced by the Commissioner of Banking and Insurance." *Id.* at 1169; *see also Medical Soc. of the State of New York v. Oxford Health Plans, Inc.*, 790 N.Y.S.2d 79, 80 (N.Y. App. Div. 2005).

Extrapolation of the argument shows its defect. Either the HMO Act supports a private right of action, as does the Code, or it does not. If it does, no bootstrapping on a third party beneficiary theory is necessary. If it does not, no bootstrapping on a third party beneficiary theory can create one. No third option exists.

Analysis of the HMO Act statutes in Westside's "comparison" argument further highlights its defect. Most are regulatory provisions that clearly do not give rise to a private cause of action (AB15-16). In fact, their focus on administrative procedures and guidelines supports HOI's argument that the Legislature intended only administrative enforcement.

The remaining statutes (AB16-18, 37) also fail to support Westside's position:

a. Section 641.31 provides that an HMO contract may not be inconsistent with or waive rights provided by the Legislature. But an HMO contract cannot waive or be inconsistent with a right the Legislature has <u>not</u> provided. Here, as Westside admits, the Legislature has provided no private right of action in the HMO Act.

b. Section 641.3105 requires that an HMO contract comply with the HMO Act. If there is no private right of action in the HMO Act, construction of an HMO contract to comply with the HMO Act cannot create one. As the Fourth District said, the section "integrates an administrative procedure for resolving disputes," which strongly suggests that no such right exists outside the administrative arena.

c. Section 641.3917 states that the rights established by the HMO Act are cumulative to general civil and common law rights. Section 2.01 contains the same declaration, but neither it nor section 641.3917 creates new rights. In fact, the Fourth District decided this issue adverse to Westside in *Greene v. Well Care HMO, Inc.*, 778 So. 2d 1037-38, 1040 (Fla. 4th DCA 2001).

d. Section 641.3155 is the statute specifically at issue here. The question is not, as Westside tacitly admits, whether it gives HMO subscribers and providers rights against an HMO; the question is how those rights are enforced. Westside has repeatedly disavowed contending that the HMO Act expressly or impliedly creates a private cause of action – apparently until now.

e. Section 641.28 provides for prevailing party fees in any civil action "brought to enforce the terms and conditions of a health maintenance organization contract." The "terms and conditions" of an HMO contract have always been construed as coverage issues, never a backdoor into the HMO Act.

Westside's analysis also ignores the stark distinctions between the Code and the HMO Act. The Code expressly provides a right of private enforcement in statutes like section 624.155. No analog exists in the HMO Act. The PIP statute, section 627.736, also unequivocally establishes a private right of action. *See* § 627.736(8), (11), Fla. Stat. *State Farm Mutual Automobile Insurance Company v. Lee*, 678 So. 2d 818, 820 (Fla. 1996), and *Allstate Insurance Company v. Kaklamanos*, 843 So. 2d 885 (Fla. 2003) (AB21-22, 35-37), merely recognize and apply that right. No analog exists in the HMO Act. Westside's contention that no "valid reason" exists to distinguish the Code from the HMO Act (AB37) ignores the Legislature's emphatic distinction in sections 641.18(4)(b), 641.201, and

641.30(2), which exempt the HMO Act from the operation of the Code.

Analysis of the HMO Act further highlights the distinctions. The entire Act, like ERISA, is regulatory in nature, as Westside admits (AB25). This Court has held that regulatory statutes do not support private causes of action unless the Legislature expresses or implies such intent. *See Murthy v. N. Sinha Corp.*, 644 So. 2d 983, 986 (Fla. 1994). The HMO Act shows no such intent. HMO plans are expressly exempted from "operation of the insurance laws," including those allowing a private cause of action. The Florida Administrative Code provides that an HMO's failure to promptly pay "shall be cause for examination" by the Department under section 641.27, Florida Statutes, with no mention of a cause of action by a subscriber or provider. Section 641.185 creates a subscriber's bill of rights – yet states that it "shall not be construed as creating a civil cause of action" against an HMO. While the Opinion concludes that this section does not apply to the prompt pay statute, it does so on the basis of "the existence of parallel legal remedies" without

explaining where those remedies exist in the HMO Act exclusive of the "incorporation" theory.

Both Westside (AB18-20) and the Opinion misconstrue the operation of section 641.3154(4), which prohibits a provider from suing a subscriber if the provider "in good faith knows or should know that the organization is liable." The HMO Act contemplates that providers obtain HMO authorization to provide medical services and, thus, know or should know that the HMO is liable. That triggers the prohibition. The Providers acknowledge that the law generally prohibits the "provider from collecting from HMO patients directly" (P7, 13). The caution in *Kaklamanos*, 843 So. 2d at 897, is thus inapplicable in the context of the HMO Act (AB19).

Westside also misunderstands the "court of competent jurisdiction" alternative in section 641.3154(4) (AB19). A subscriber may sue to enforce the terms of an HMO contract, as Governor Chiles' May 28, 1996 letter emphasizes (A2). During pendency of the subscriber's suit, and if it results in a determination that the HMO is liable for coverage, the provider is prohibited from

pursuing the subscriber. The section says nothing about a provider's right to pursue an HMO under the HMO Act. If the Legislature intended such a result, it would have said so, and it did not.

Westside's skewed interpretation of subsection (4) also requires the conclusion that the provider has to be "informed" of its own "legal proceedings" to determine the HMO's liability. The Legislature is not presumed to construct such absurd legislation. Rather, the language clearly contemplates that the "legal proceedings" are those of the subscriber, who would inform the provider of the proceedings to enforce the HMO contract and thus prohibit collection efforts.

Finally, the most compelling distinction between the Code and the HMO Act is highlighted by the Providers themselves (P8). Although sections 627.613 and 627.6131, the Code's "prompt payment" provisions, contain express language requiring their incorporation into every insurance contract, section 641.3155, the HMO Act's prompt payment provision, contains no such language. Had the Legislature intended that the HMO Act be "virtually indistinguishable" from the Code, surely it would have used the same language in these provisions. It did not, and a court may not infer it.

2. The legislative history of the HMO Act is inconsistent with

the conclusion that it implies a private right of action.

In responding that the HMO Act's legislative history supports its position – again apparently arguing for a private right of action despite *Villazon* – Westside fails to understand the significance of the proposed failed bills and gubernatorial veto (AB38-41). The 1996 legislation was intended to authorize "civil actions against health maintenance organizations by certain persons under certain circumstances" (A2). The Governor rejected the legislation, explaining that subscribers "can sue an HMO for breach of contract" or file a grievance and appeal to the Statewide Subscriber Assistance Panel (A2). The Governor explained that the remedies available under existing law were "not insubstantial" and included large fines against noncompliant HMOs.

While Governor Chiles' letter notes the State's already overly crowded and overly litigious "tort" system, its global message is the rejection of any legislation that would authorize any further court suits against HMOs:

> Rather than burden the courts with an abundance of managed care litigation, the Statewide Subscriber Assistance Panel,

> which consists of experts who are familiar with HMO contract and medical procedures, should be strengthened to handle grievances more quickly and to directly mete out penalties to HMOs which do not provide services as ordered by the Panel (A2).

See also Greene, 778 So. 2d at 1040 ("Governor Chiles vetoed the bill and provision for such civil liability was never made."). As the Governor explained, the statutory causes of action proposed by the legislation would have threatened the continued viability and existence of the "managed care principles" he fought to establish, with the only "real winners" the doctors and lawyers who run the system (A2).

In rejecting the legislation, Governor Chiles recognized that no statutory cause of action existed at that time. Nor, as Westside admits (AB39-41), did the subsequent bills, including one specifically intended to create a cause of action under section 641.3155, pass.[5] To avoid the unavoidable implication of those failures, Westside argues

[5] The Providers' argument that an obligation to pay becomes incontestable does not translate into a right to sue (P4, 5-11). It translates into a right to pursue the HMO in a Maximus proceeding.

that they "did not have any effect on the preexisting right to sue for breach of contract" (AB40). This ignores that an action for breach of an HMO contract cannot incorporate a right to enforce the HMO Act that does not exist in the HMO Act itself.

As to any "empirical basis" for the failure of the various proposed bills (AB41), one need go no further than Governor Chiles' letter (A2). Although the legislative history is not dispositive for either Westside or HOI, it is more reasonable than not to conclude that the proponents of the legislation intended to create a private right of action to sue HMOs and the opponents of the legislation opposed the attempt. The opponents obviously prevailed. If any reasonable presumption is to be drawn from that failure, it is in support of HOI's position, not Westside's.

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

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

Westside's dismissal of *Villazon v. Prudential Healthcare Plan, Inc.*, 843 So. 2d 842 (Fla. 2003), as inapplicable (AB22, 28-29), misunderstands HOI's position. In *Villazon*, 843 So. 2d at 852, the Court gave examples of a legislatively created right "and a concomitant private right of action," thus recognizing that no such private right of action exists unless there is such an expression of intent. Rights and rights of enforcement are therefore separate concepts. Here, Westside asks the Court to ignore its statements in *Villazon* and hold that despite the Legislature's intent to the contrary, a court must presume that the existence of a right requires the existence of a right of enforcement. In other words, a court may create a backdoor private right of action not created or intended by the Legislature. *Villazon* requires that the Opinion be quashed.

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

Again apparently changing direction, Westside focuses on *Foundation Health v. Garcia-Rivera*, 814 So. 2d 537 (Fla. 3d DCA 2002), and *Colonial Penn Insurance*

Company v. Magnetic Imaging Systems I, Ltd., 694 So. 2d 852 (Fla. 3d DCA 1997), to argue that Florida courts already allow private causes of action for violation of the HMO Act. As HOI explained (IB24), that issue was not before the court or addressed in either opinion. Furthermore, Westside's argument here is fundamentally inconsistent with its admission that no such right exists.

The other cases cited by Westside (AB28) are classic contract cases in which a subscriber or insured challenged a coverage decision. *See, e.g., State Farm Fire & Cas. Co. v. Palma*, 629 So. 2d 830 (Fla. 1993) (holding that an insured was entitled to prevailing party fees in a coverage dispute). None incorporates the HMO Act into an HMO contract or holds that every statutory violation is actionable as a contract claim. While Westside claims that HOI cited "no statutory provision, case law, nor contract principle" supporting its position that these contract cases are limited to coverage issues (AB28), neither did Westside offer any authority that they are not. The vacuum of cases supporting Westside's position needs no further exposition.

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

Westside's distinction of *Greene*, 778 So. 2d at 1040-41, and *Florida Physicians Union, Inc. v. United Healthcare Of Florida*, 837 So. 2d 1133, 1137 (Fla. 5th DCA 2003), is that they are not contract actions and that the Legislature's presumed knowledge of "75 years of jurisprudence" requires a conclusion that it intended to allow all providers to enforce the HMO Act through HMO contracts (AB20-26, 29-31).

The defect in the argument is that it overlooks the numerous instances of statutes incorporated into contracts that do not create private rights of action, as *Villazon*, 843 So. 2d at 852, inherently recognizes. For example, in *Board of Public Instruction of Dade County v. Town of Bay Harbor Islands*, 81 So. 2d 637, 643 (Fla. 1955), the Court said that the "Constitution and laws of this State are a part of every contract." If Westside's theory were correct, citizens of this State could privately enforce every Constitutional right and statute, including criminal statutes, against every other party to a contract. That is not Florida law, and HOI did not "concede" (AB22) otherwise. HOI

has consistently argued that "incorporation" cannot create rights of action that do not exist in the statutes themselves before their "incorporation." This does not make "two classes of contract rights" (AB22); it simply recognizes that some statutory rights do not support private enforcement. *See, e.g., Coira v. Florida Medical Ass'n, Inc.*, 429 So. 2d 23, 23 (Fla. 3d DCA 1983).

Westside's insurance cases (AB20-23) also fail to support its position. To the contrary, the only HMO case, *Humana Medical Plan, Inc. v. CAC-Ramsay Health Plans, Inc.*, 714 So. 2d 1025 (Fla. 3d DCA 1997), highlights Westside's error, because the HMO statutes addressed there expressly require incorporation into HMO contracts. Using Westside's reasoning, the statutory incorporation language in the *Humana Medical* statutes is redundant, because they would be automatically incorporated into HMO contracts. The Legislature is presumed to know the meaning of the words it uses and not to enact useless legislation. *See Beach v. Great Western Bank*, 692 So. 2d 146, 152 (Fla. 1997). Furthermore, when the Legislature uses a term in one statute but omits it in another closely

related statute, a court may not rewrite the latter statute to include it. *See id.* Here, Westside asks the Court to ignore all those guidelines.

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

Westside overlooks HOI's both "serious" and "direct" challenge to Westside's standing as a third party beneficiary (AB11, 32-34).[6] Even if the Group Plan supported a private cause of action to enforce the HMO Act, which it does not, Westside cannot achieve third-party beneficiary status because the document prohibits such standing (R9-1554-57). The Group Plan states that the services of a non par provider will be paid only to the subscriber or "other person as required by law" (R9-1554-57). Subscriber rights may not be assigned without HOI's written consent (R9-1554-57). Here there was no consent and no assignment[7] (R1-60-64, 65-73). No third party

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[6] HOI did not argue below that Westside abandoned its third party beneficiary theory (AB8 n1). HOI argued that Westside waived its right to amend its pleadings.

[7] Had there been such assignment, or an acknowledgment of one by Westside, the case would have remained in

beneficiary status arises under a document that specifically prohibits it.

Before the Fourth District, and here, Westside contends that the terms of HOI's Group Plan cannot control because the HMO contract incorporates the HMO Act (AB3-4, 11). This is, again, the circular argument that goes nowhere. If the HMO Act itself does not give a provider the right to sue for its enforcement, then incorporation of the HMO Act into an HMO contract does not create that which did not exist before. Contrary to Westside's position (AB34), that conclusion does not involve nullification of any portion of the HMO Act, because it contains no private right of action to be nullified in the first place. Furthermore, HOI's Group Plan comports perfectly with the dictates of the HMO Act, and Westside has never contended otherwise.

None of the cases cited by Westside (AB32-34) involves a subscriber's contract like the Group Plan, which

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federal court under ERISA. The Providers' anti-assignment argument (P19) mistakenly relies on insurance law to claim that anti-assignment clauses are prohibited. No such language appears in the HMO Act.

specifically prohibits "third party beneficiary standing" for a non par provider. *Orion Insurance Company v. Magnetic Imaging Systems I*, 696 So. 2d 475, 478 (Fla. 3d DCA 1997),[8] was a PIP case where both the Code and the contracts recognize such standing. *Pasteur Health Plan, Inc. v. Salazar*, 658 So. 2d 543, 543 (Fla. 3d DCA 1995), has no discussion of third party standing and involves a subscriber's suit for coverage under an HMO contract, not incorporation of the HMO Act. *Vencor Hospitals v. Blue Cross and Blue Shield of Rhode Island*, 169 F.3d 677 (11th Cir. 1999), involves a Medigap policy that allowed payment directly to the hospital. Contrary to the Providers' apparent understanding (P18), contracts between HMOs and par providers are bilaterally enforceable, as are contracts between HMOs and their subscribers to the extent coverage is in dispute. There is no contract between Westside and the HMOs here.

[8] *Orion* was not cited by the trial court (AB32), and while HOI did not address the case by name, HOI addressed the issue involved in cases like *Orion* (IB23-24).

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

Westside's accusation that HOI "chastises" the Fourth District fails to recognize the context in which Maximus arose (AB42 n10). The trial court recognized that only the Department of Insurance had enforcement power under the HMO Act unless the provider had a contract directly with the HMO (AB4-5). The HMOs took the same position in the Fourth District – that the Legislature created an exclusive administrative remedy to enforce the HMO Act.[9] Westside never argued that the remedy did not exist, only that it was not exclusive. There was thus no need for HOI to expand on its position in the Fourth District. In reversing, the Fourth District independently concluded that the legislative

[9] Westside and the Providers misunderstand section 408.7056 (AB42-43; P16 n18). Since July 1, 2004, the section is titled "Subscriber Assistance Program." The former title, "Statewide Provider and Subscriber Assistance Program," was changed to clarify that the section encompasses assistance only to subscribers. *See* H.B. 1629 (2003); 69 F.A.C. 69O-191.078. Contrary to the Providers' position (P4, 13-17), section 408.7057 encompasses prompt pay disputes.

remedy was incomplete because it was not implemented. Only at that point did it become necessary or appropriate to discuss Maximus – in these proceedings. This was not a "chastisement"; it was only a correction of the Fourth District's mistaken impression and a further basis for quashing the Opinion.

Westside also inaccurately construes section 641.3917. As HOI explained above, while the rights created by the HMO Act are "cumulative to rights under the general civil and common law," that does not create rights that did not exist before the HMO Act. *See* § 2.01, Fla. Stat.; *Cycle Dealers Ins., Inc. v. Bankers Ins. Co.*, 394 So. 2d 1123, 1125 (Fla. 5th DCA 1981). Nor does the "action pending in state . . . court" or "accrued interest" language in section 408.7056 (AB43; P16) change the outcome. That section addresses actions by the subscriber, not the provider. Although Maximus claims are voluntary, as Westside and the Providers admit (AB43-44; P17), they are nevertheless exclusive, not "alternative" to a private right of action. The providers' decision to forego the remedy available to them accounts for the "small number of cases" and the

assertion that the remedy is "almost never used" (P17). Maximus may not turn away a claim submitted to it. § 408.7057, Fla. Stat.

Westside and the Providers[10] are also incorrect that there is no "empirical evidence" or "empirical basis" that the Legislature's administrative remedy is effective to prevent abuse and that the Opinion would harm the HMO system (AB37, 45-48; P13-15). Noncompliant HMOs are subject to heavy fines, suspension and loss of their licenses, and criminal penalties. These are the "incentives" to promptly pay claims that Westside argues do not exist without a private right of action (AB37). Westside admits as much by citing to *Florida Physicians*, 837 So. 2d at 1135, 1136 n1, which notes the "financial penalties, interest or fines" imposed by "state insurance commissioners" for violation of prompt pay statutes and which states that the

[10] The Providers misread *In the Matter of: Southwest Florida Physician Hospital Organization*, 28 Fla. Admin. Weekly 1 (Jan. 4, 2002) (P15). The Department said only that the question of the existence of a private right of action was for the courts; it did not say that enforcement was for the courts. This Court has answered the question in *Villazon*.

"general scheme of the statute is to empower the Department of Insurance to enforce the statute's requirements and determine whether the provisions are being complied with or violated."[11] *See also* Senate Staff Analysis, CS/SB 1508, CS/SBs 706, 2234 (2000) (noting the $175,000 in fines the Department of Insurance intended to impose on HMOs failing to comply with the prompt pay statute).[12] In fact, while arguing that its position is supported by "unambiguous statutory provisions," Westside agrees that the remedy is "to seek relief in the [L]egislature"(AB46).

One also need go no further than the Governor's letter to establish the Opinion's harm by creating havoc, clogging the court system, increasing the cost of health care, and effectively dismantling the managed care system (AB44). Governor Chiles' logic is not an "insufficient ally" (AB44).

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[11] This is not to suggest that the system is perfect, but to suggest that improvement of the system is the obligation of the Legislature, not the courts.

[12] www.flsenate.gov/data/session/2000/Senate/bills/analysis/pdf/SB1508.fp.
pdf.

Westside's further contention that such suits would expose the industry to only contractual damages (AB44) is profoundly naive. What Westside and its *amici* avoid discussing in the context of this purported "class action" proceeding is their real goal – large compensatory and punitive damage awards and even larger attorney's fee awards, as Governor Chiles recognized in rejecting exactly the result Westside advocates here (A2). This Court should reject the result as well.

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.

CERTIFICATE OF SERVICE

We certify that a true copy of the above and foregoing was furnished by U.S. Mail to the persons on the attached Service List, this 29th day of September, 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).

Respectfully submitted,

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