

Villazon v. Prudential Health Care Plan, Inc.

Supreme Court of Florida

No. SC01-1397

March 27, 2003

LEWIS, J.

We have for review *Villazon v. Prudential Health Care Plan, Inc.*, 794 So.2d 625 (Fla. 3d DCA 2001), which expressly and directly conflicts with the decision in *In re Estate of Frappier*, 678 So.2d 884 (Fla. 4th DCA 1996). We have jurisdiction. See art. V, § 3(b)(3), Fla. Const.

MATERIAL FACTS AND PROCEEDINGS BELOW

Petitioner Rolando Villazon, personal representative of the estate of his deceased wife, Susan Villazon, seeks review of the decision of the Third District Court of Appeal affirming the trial court's summary judgment in favor of Prudential Health Care Plan, Inc., (PruCare) in Petitioner's action against PruCare for the wrongful death of his wife. Through her employer, Susan Villazon became a member of PruCare, a health maintenance organization. After having a mouth ailment allegedly misdiagnosed or mistreated, Mrs. Villazon died as a result of an untreated cancerous tongue condition. Villazon filed an action for wrongful death based on negligence against Mrs. Villazon's primary care physician, Dr. Melvyn Sarnow, and against her health care provider, respondent PruCare. In Count VI of his amended complaint, Villazon alleged the basis for PruCare's vicarious liability and breach of a nondelegable duty to be that PruCare, a health maintenance organization, had by statute, rule, and contract a non-delegable duty to provide Susan Cohen Villazon with quality health care; that PruCare contracted with Melvyn Sarnow, D.O., Basilio Garcia-Sellek, D.O., and Harvey S. Satz, D.M.D., to provide her with health care services and was responsible for any and all of their negligence in rendering or failing to render that care; and that PruCare, by and through its agents, apparent agents, and employees, breached its duty to provide quality health care, resulting in her death.

As set forth in the Third District's opinion, Villazon argued that Prudential Health controlled the referral process and required that authorization be obtained prior to the performance of diagnostic and therapeutic procedures; that Prudential Health also required that the contracted physicians adhere to rules and seek approval for diagnostic tests; and that physicians had to provide and arrange health care services through Prudential Health and refer subscribers to contracted providers. Villazon, however, did not allege that his wife was denied proper medical testing and referrals to specialists. Villazon, 794 So.2d at 626.

PruCare filed a motion for summary judgment, asserting that the claims filed against it were preempted by section 514(a) of the Employee Retirement Income Security Act (ERISA), and that Villazon could not prevail on those claims as a matter of state law. The trial court entered summary final judgment in favor of PruCare, holding that “ERISA governed the claims filed against [PruCare] because they related to the manner in which [PruCare] administered its health care plans, and further, that there were no issues of fact as to the theory of vicarious liability or any recognizable cause of action for breach of a non-delegable duty against [PruCare] under state law.” Villazon, 794 So.2d at 626-27. On appeal, the district court agreed. *Id.* at 627.

In addressing the state law issues, the Third District rejected Villazon's position and reasoned that the medical providers were independent contractors because as an independent practice associated health maintenance organization (IPA HMO), PruCare entered into contracts with physicians who had their own independent practices and who agreed to provide covered services for a contracted rate. The district court highlighted that Dr. Sarnow was an independent contractor who had his own private practice and agreed to render services to PruCare subscribers pursuant to a Primary Care Physician Agreement, continuing his own independent practice after he entered into this agreement. In rejecting Villazon's argument that PruCare had assumed a nondelegable duty to render medical care to his wife in a nonnegligent manner when she purchased health care coverage from PruCare, the court noted that Villazon had not cited any support for this proposition. The court looked only to the contract between PruCare and the physicians and reasoned that it was the best evidence of the intent of the parties, and its meaning and legal effect were questions of law for determination by the court. It was important to the court below that the contractual provisions designated physicians as independent contractors, and the court found no evidence of control upon which to justify imposing responsibility on PruCare. Villazon, 794 So.2d at 627-28. In focusing solely on the one contract that attempted to designate physicians as independent contractors and also limiting its vision to the issue of actual control, the Third District's decision is also in conflict with *Nazworth v. Swire Florida, Inc.*, 486 So.2d 637 (Fla. 1st DCA 1986), which demonstrates that it is the right to control, not the actual control, that may be determinative.

ERISA PREEMPTION

As did the district courts in Villazon and Frappier, we begin our legal analysis by determining the threshold issue of ERISA preemption. Villazon correctly cites Frappier for the proposition that “[i]f a claim relates to the manner in which the ERISA plan is administered, ERISA preempts the claim.” Villazon, 794 So.2d at 627; see also Frappier, 678 So.2d at 887. However, Villazon directly conflicts

with Frappier in its determination of whether a state law wrongful death claim by a deceased patient member's estate against a health maintenance organization (HMO) based upon vicarious liability for asserted medical malpractice of its member physicians “relates to” administration of the ERISA plan and is therefore preempted. In Villazon, the district court below incorrectly concluded that it did. In Frappier, in contrast, the district court correctly determined that ERISA does not preempt such vicarious liability claims.

In Frappier, the decedent's estate filed an action against Health Options, Inc., an HMO, and the two Health Options physicians who had provided medical care to Frappier, asserting that medical malpractice had occurred. The trial court had dismissed Frappier's complaint with prejudice. Frappier, 678 So.2d at 885. The appellate court remanded the case to the trial court to determine whether an ERISA plan ever existed, agreeing that this threshold question had to be resolved prior to addressing the issue of whether the dismissed counts were preemptable. Nevertheless, the district court addressed the merits and directed that, upon an appropriate finding, the trial court could dismiss the estate's direct negligence, corporate liability, and implied contract claims for a lack of subject matter jurisdiction; however, in no event could the vicarious liability count be dismissed, as the same did not “relate to” an employee benefit plan. Id. at 888.

Because no Florida case had yet addressed whether direct negligence or vicarious liability claims against an entity involved in an ERISA plan are preempted, the Fourth District found guidance from decisions rendered by federal courts. The governing provision of ERISA relevant to this discussion is section 514(a), which provides that the chapter shall supersede any and all state laws insofar as they may relate to any employee benefit plan. 29 U.S.C. § 1144(a). Although *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), suggested an expansive interpretation of the triggering jurisdictional clause, the United States Supreme Court in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), and several more recent lower federal court decisions caution against a literal reading of section 514(a) in determining whether preemption is appropriate. In deciding that ERISA did not preempt Frappier's vicarious liability claim, the district court made a key distinction, drawn from *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), between a lawsuit against an ERISA plan claiming the withholding of benefits and a claim attacking the quality of benefits actually provided by the HMO. The court reasoned that where an ERISA plan is implicated by a complaint for failing to provide, arrange for, or supervise qualified doctors to provide the actual medical treatment for plan participants, federal preemption is inappropriate. Frappier, 678 So.2d at 886-87.

We conclude that this ERISA preemption discussion is a correct interpretation as applied to state law causes of action against HMOs based upon allegations of direct and vicarious liability for negligence in the provision of medical services to member patients. See also *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162–63 (3d Cir. 1999); *Dukes*, 57 F.3d at 356–58; *Rice v. Panchal*, 65 F.3d 637, 645 (7th Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995); *Paterno v. Albuerne*, 855 F.Supp. 1263, 1264 (S.D. Fla. 1994); *Pappas v. Asbel*, 564 Pa. 407, 768 A.2d 1089, 1095–96 (2001) (*Pappas II*), cert. denied, 536 U.S. 938 (2002).

A similar analysis was employed by the Pennsylvania Supreme Court in *Pappas II* upon remand from the United States Supreme Court. In *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (1998) (*Pappas I*), the Pennsylvania Supreme Court had originally held that the plaintiff's claim for vicarious liability against the HMO was not preempted by ERISA. Upon appeal to the United States Supreme Court, the case was remanded for reconsideration in light of *Pegram v. Herdrich*, 530 U.S. 211 (2000). In applying the reasoning in *Pegram*, the *Pappas II* court again determined that the plaintiff's claim was not subject to conflict preemption under ERISA. The court explained that *Travelers* instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment, and that *Pegram* instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. *Pappas II*, 768 A.2d at 1093–96.

The Second Circuit's recent interpretation of *Pegram* also has application here. In *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), the circuit court held that a state law malpractice action, if based on a mixed eligibility and treatment decision, is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a specific patient's symptoms. *Id.* at 102. The court's decision correctly recognizes that HMO plan administration is often inextricably intertwined with treatment decisions, and that ERISA does not preempt viable state law causes of action arising from such decisions. The *Cicio* decision is consistent with and reflective of the current state of the law in Florida.

Here, Villazon bases his vicarious liability claim against PruCare on allegations that agents or apparent agents of PruCare made negligent treatment decisions in caring for Mrs. Villazon. As the *Pappas II* court correctly observed, *Travelers* instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. *Pappas II*, 768 A.2d at 1095. Therefore, applying the analysis employed in *Frappier* and *Pappas II*, we conclude that Villazon's complaint for vicarious liability—which was clearly based upon allegations of negligent failure to provide adequate medical treatment for his

wife's cancer—is not subject to ERISA conflict preemption. Accordingly, we approve the preemption analysis in *Frappier*, and quash the decision in *Villazon* to the extent of inconsistency with our opinion here.

VICARIOUS LIABILITY

Turning now to the state law issue, there are multiple different theories upon which vicarious liability was sought to be imposed: a nondelegable duty under the HMO Act; common law actual agency; and common law apparent agency. We agree with the district court's rejection of *Villazon's* argument that PruCare assumed a non-delegable duty to render medical care to his wife in a non-negligent manner when she purchased health care coverage from Prudential Health. *Villazon*, 794 So.2d at 628. *Villazon* argues that such nondelegable duty arises under the Health Maintenance Organization Act, sections 641.17–641.3923, Florida Statutes (2000) (the Act). The Act does not specifically provide a private right of action for damages based upon an alleged violation of its requirements. There are other regulatory statutes in which the legislature has specifically created a private right of action, such as the nursing home statute. Absent such expression of intent, a private right of action is not implied. Cf. *Murthy v. N. Sinha Corp.*, 644 So.2d 983, 986 (Fla. 1994).

This does not, however, preclude the right to bring a common law negligence claim based upon the same allegations. See *Greene v. Well Care HMO, Inc.*, 778 So.2d 1037, 1042 (Fla. 4th DCA 2001). Further, contrary to the district court's decision below, we conclude that here, at the summary judgment level, it has not been conclusively established that there are no genuine issues of material fact with regard to the motion for summary judgment concerning *Villazon's* common law negligence claim based upon allegations that Mrs. *Villazon's* treating physicians were agents or apparent agents of PruCare. Cf. *Lewis v. Central Okla. Med. Group, Inc.*, 998 P.2d 202, 205–06 (Okla. Ct. App. 1999).

The existence of an agency relationship is normally one for the trier of fact to decide. See *Orlando Executive Park, Inc. v. Robbins*, 433 So.2d 491, 494 (Fla. 1983). In reviewing a judgment entered pursuant to a motion for summary judgment, reasonable inferences should be resolved against the movant. See *Moore v. Morris*, 475 So.2d 666, 668 (Fla. 1985); *Wills v. Sears, Roebuck & Co.*, 351 So.2d 29, 32 (Fla. 1977). “[A] judgment should not be rendered in such proceedings unless the facts are so crystallized that nothing remains but questions of law.” *Shaffran v. Holness*, 93 So.2d 94, 97–98 (Fla. 1957).

Here, in affirming the trial court's summary final judgment in favor of PruCare on the issue of agency, the district court concluded that all medical providers were independent contractors simply because as an IPA HMO, PruCare entered into contracts with physicians who had their own independent practices

and who agreed to provide covered services for a contracted rate. The district court concluded that because the contractual provisions designated the physicians as independent contractors and that there was no evidence that PruCare exercised actual control over the medical judgments and decisions made in the care and treatment of Villazon's wife, summary judgment was appropriate. Villazon, 794 So.2d at 627-28. Although the district court's view was that there was no evidence that PruCare exercised actual control over Dr. Sarnow's medical judgments in this case, that, alone, is not the proper test.

When one considers an action based on actual agency, it is the right to control, rather than actual control, that may be determinative. See *Nazworth v. Swire Fla., Inc.*, 486 So.2d 637, 638 (Fla. 1st DCA 1986) (“The standard for determining whether an agent is an independent contractor is the degree of control exercised by the employer or owner over the agent. More particularly, it is the right of control, and not actual control, which determines the relationship between the parties.”).

As can be seen from decisions such as *Stoll v. Noel*, 694 So.2d 701 (Fla. 1997), independent contractors may indeed become agents depending on the totality of the circumstances. The degree of control retained or exercised may certainly be determined by a single contract or, as in *Stoll*, by reference to multiple writings, policies, or procedures that may be operative in addition to an underlying contract. See *id.* at 703. While an evaluation of a single contract may be a question of law to be determined by the court, when there are multiple relationships along with multiple practices and procedures to be evaluated, and the totality of the evidence is susceptible to multiple inferences and interpretations, the existence and scope of an agency relationship are generally questions of fact.

It is not uncommon for parties to include conclusory statements in documents with regard to the independence of the relationship of the parties. This may occur even when other contractual provisions and the totality of the circumstances reflect otherwise. Such a situation has caused this Court to reason that while the obvious purpose to be accomplished by such a document was to evince an independent contractor status, such status depends not on the statements of the parties but upon all the circumstances of their dealings with each other. *Cantor v. Cochran*, 184 So.2d 173, 174 (Fla. 1966); see also *Parker v. Domino's Pizza, Inc.*, 629 So.2d 1026, 1027 (Fla. 4th DCA 1993); *Nazworth*, 486 So.2d at 638. The physician's contractual independent contractor status does not alone preclude a finding of agency.

Here, the record evidence reflects significant indicia of PruCare's right to control the means by which medical services were rendered by Member Physicians to Member Patients. The facts peculiar to each case must govern the

ultimate disposition. While physicians of the past in the traditional pattern of American life may have constituted distinct independent entities and independent centers of occupation and profession, that model has been dramatically altered through the HMO concept in a significant manner which a legal system cannot simply ignore. The thought of visiting a private and independent office of a totally independent physician may now be one more of history and cultural conditioning than current reality. The economic structures alone may so impact the relationships that the prism through which we consider and evaluate issues of control must be honed for this current reality.

On deposition, the PruCare representative, Dominick Messano, testified regarding PruCare's relationship with the HMO network physicians. Consistent with the Certificate of Coverage, Messano indicated that PruCare determines which providers are part of the HMO network, and that HMO patient members are required to use HMO network physicians. Significantly, the Certificate of Coverage contains provisions which demonstrate PruCare's right to control important aspects of patient care provided by the HMO. The Certificate provides that PruCare will arrange or provide for benefits for the eligible services and supplies, that all such services and supplies must be furnished by or authorized by a Primary Care Physician, and that certain services and supplies must be authorized by the Medical Director to be eligible. The definitions section further provides that covered persons may be referred to consulting physicians only if referred in writing by a participating physician and approved in advance by the Medical Director; that the Medical Director is a physician retained by PruCare to coordinate and supervise the delivery of health care services; and that specialty care physicians provide certain specialty medical care upon referral by a Primary Care Physician, as approved by the Medical Director.

Indeed, while on the one hand the Certificate of Coverage contains a disclaimer which states that participating hospitals and physicians have an independent contractor relationship with PruCare, on the other hand it reflects PruCare's recognition of potential liability for its part in making arrangements for furnishing supplies and services to covered persons. This is evidenced by inclusion of a provision that neither the contract holder nor any covered person will be liable for any acts or omissions of PruCare, its agents or employees, or any hospital, physician, or other health care provider with which PruCare makes such arrangements.

These contractual provisions, along with the contractual provisions between the HMO and the physicians, and the totality of the circumstances operating within the current reality of the interaction within the decision-making process, create genuine issues of material fact sufficient to withstand a motion for summary judgment with respect to the question of whether PruCare can be held

vicariously liable for the alleged medical negligence of its member physicians when providing service pursuant to the PruCare health plan under theories of actual agency. PruCare has not conclusively demonstrated the absence of genuine issues of material fact.

As for the cause of action based on apparent agency, however, it must be remembered that apparent authority exists “only where the principal creates the appearance of an agency relationship.” *Spence, Payne, Masington & Grossman, P.A. v. Philip M. Gerson, P.A.*, 483 So.2d 775, 777 (Fla. 3d DCA 1986). Therefore, as to the claim of apparent agency, because this issue has not been fully addressed, on remand the trial court should have the opportunity to reevaluate whether under an apparent agency theory there are genuine issues of material fact. We express no opinion regarding the ultimate disposition of this case, or whether there will ultimately be sufficient proof of vicarious liability in this matter. Our holding is restricted to a determination that ERISA does not preempt Villazon's vicarious liability claim, and that sufficient record evidence has been adduced to withstand the defendant HMO's motion for summary judgment with respect to the claim of vicarious liability.

Accordingly, we quash the decision in Villazon to the extent of inconsistency with this opinion, and remand to the district court for further proceedings in accordance herewith.

It is so ordered.

ANSTEAD, C.J., PARIENTE and QUINCE, JJ., and SHAW and HARDING, Senior Justices, concur.

WELLS, J., concurring in part and dissenting in part.

I concur with the majority on all issues except I dissent from the quashing of the district court's summary judgment on the issue of agency. I find that the majority decision's finding of a factual basis for agency on a “right to control” theory is not in accord with the record, which demonstrates that the physician was an independent practitioner. I believe this Court should not interfere with and frustrate what this business arrangement was clearly intended to be, which was an independent physician–health care benefit administrator arrangement. I would approve the decision of the district court on this issue.