IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

PETER F. MERKLE, M.D., P.A., etc., et al.,

Plaintiff,

vs.

AETNA HEALTH, INC.,

Defendant.
_____/

CIRCUIT CIVIL DIVISION "AB"

CASE NO. 502005CA004454XXXXMB

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS AND ENTERING FINAL JUDGMENT FOR DEFENDANT

THIS CAUSE came before this Court on Defendant's Motion to Dismiss. This Court has reviewed Defendant's motion and memoranda of law, has reviewed Plaintiff's response thereto, has considered the parties' arguments, and is otherwise fully advised in the premises.

Plaintiff's Complaint, Defendant's Motion, and Plaintiff's Response

Plaintiff's Complaint, in sum, alleges as follows. Plaintiff Merkle is an orthopedic medical practice which provides emergency services in hospitals. Defendant Aetna is a health maintenance organization (HMO). Although Merkle does not participate in Aetna's health plan, Section 641.513(2), Florida Statutes, requires emergency service providers to care for HMO subscribers regardless of whether the provider participates in the HMO's health plan. In exchange, the HMO must compensate the provider according to Section 641.513(5), Florida Statutes, which states, in pertinent part:

> Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:
> (a) The provider's charges;
> (b) The usual and customary provider charges for similar services in the community where the services were provided; or
> (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

Merkle alleges that, since 2003, Aetna has been violating Section 641.513(5) by artificially reducing the "usual and customary provider charges for similar services in the community where the services were provided" to Medicare reimbursement rates plus a small premium. Merkle alleges that, as a result, Aetna has damaged Merkle by causing Merkle to be unable to recoup those "usual and customary provider charges." Merkle therefore filed this class action on behalf of itself and all similarly situated emergency service providers whom Aetna is alleged to have damaged. Merkle's Complaint seeks monetary and injunctive relief against Aetna for violation of Section 641.513(5) (Count I), for unjust enrichment/quantum meruit (Count II), and for account stated (Count III). Merkle's Complaint also seeks a declaratory judgment to determine Merkle's rights under Section 641.513(5) (Count IV).

Aetna's motion to dismiss contends that Merkle's Counts I and IV fail to state a cause of action because Florida law does not authorize a private cause of action for an alleged violation of Section 641.513(5). Rather, Aetna argues that Florida law vests the authority to enforce Section 641.513(5) with the state's Agency for Health Care Administration (AHCA). Aetna's motion also argues that Merkle's Count II for unjust enrichment/quantum meruit fails to state a cause of action because the face of Merkle's complaint does not allege any ultimate facts to show that Merkle conferred a benefit on Aetna or that Aetna knowingly and voluntarily accepted any benefit from Merkle. Aetna's motion further contends that Merkle's Count III for account stated fails to state a cause of action because the face of Merkle's complaint shows that the parties have not agreed on a balance which Aetna has agreed to pay Merkle. In Merkle's response to the motion, Merkle argues, in sum, that an implied private right of action exists under Section 641.513(5), and that the failure to recognize such a private right of action or to allow Merkle to pursue a common law cause of action would deprive Merkle of its right of access to the courts, as guaranteed by Article I, Section 21 of the Florida Constitution. Merkle further argues that it has pled sufficiently the elements of the common law actions of unjust enrichment/quantum meruit and account stated.

Conclusions of Law

This Court concludes that Merkle's Counts I and IV fail to state a cause of action. There is nothing within Section 641.513 or elsewhere in Florida law which expressly authorizes a private cause of action for an alleged violation of Section 641.513(5). Therefore, no such private right of action exists. *See Murthy v. N. Sinha Corp.*, 644 So. 2d 983, 985-986 (Fla. 1994) ("legislative intent, rather than the duty to benefit a class of individuals, should be the primary factor in determining whether a cause of action exists when a statute does not expressly provide for one. ... In general, a statute that does not purport to establish civil liability but merely makes provision to secure the safety or welfare of the public as an entity, will not be construed as establishing a civil liability.") (citation omitted).

This Court's conclusion is consistent with other cases in which the Florida Supreme Court and the Fourth District Court of Appeal have held that a private right of action does not exist under other provisions of Florida's HMO Act because the Legislature has not created such a private right of action. In *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 852 (Fla. 2003), the Florida Supreme Court held that Sections 641.17-641.3923, Florida Statutes (2000), of Florida's HMO Act do not provide a private right of action for damages based upon an alleged violation of their requirements. The Court reasoned, at 852:

> ... There are other regulatory statutes in which the legislature has specifically created a private right of action. In the nursing home statute, for example, the legislature created a nursing home resident's 'right to receive adequate and appropriate health care,' *see* § 400.022(1)(*l*), Fla. Stat. (1997), and a concomitant private right of action for deprivation of a resident's statutory rights. *See* § 400.023(1), Fla. Stat. (1997); *Somberg v. Florida Convalescent Ctrs., Inc.*, 779 So.2d 667, 668 (Fla. 3d DCA 2001), *approved*, 840 So.2d 998 (Fla. 2003). Absent such expression of intent, a private right of action is not implied.

In *Greene v. Well Care HMO, Inc.*, 778 So. 2d 1037 (Fla. 4th DCA 2001), the Fourth District Court of Appeal held that a trial court did not err in dismissing an action that an HMO's failure to honor the plaintiff's claim for benefits constituted bad faith handling of a claim and unfair trade practice in violation of Sections 641.3901-.3905 and 624.155, Florida Statutes (1997). The Fourth District reasoned that the statutes upon which the plaintiff relied did not provide for any private cause of action, and the court could not infer a private cause of action from the statutes. *Id.* at 1040-41.

This Court's conclusion also is consistent with a recent case in which a federal court rejected a plaintiff's claim that Section 641.513(5) implies a private right of action. In *Mariners Hospital, Inc. v. Neighborhood Health Partnership, Inc.*, 2004 WL 3201003 (S.D. Fla. 2004), U.S. District Judge Joan Lenard granted an HMO's motion to dismiss a hospital's action for violation of Section 641.513(5), finding that the hospital's complaint failed to state a claim because Section 641.513(5) does not provide for a private cause of action. Judge Lenard reasoned, at *4 (with footnote and citations omitted):

> Although Plaintiff is right that the statutory provision at issue in the instant case was not directly considered by the Court in *Villazon*, the Court agrees with Defendant that the *Villazon* Court's reasoning applies to Fla. Stat. § 641.513(5), as well. There is nothing in the statutory language of Fla. Stat. § 641.513(5) that indicates a 'clear and specific' legislative intent to create a private cause of action. Moreover, neither passage identified by Plaintiff in its Response can be construed as implying the existence of a private cause of action, much less clearly expressing the legislature's intent to create one.
>
> Furthermore, it appears from a review of the other sections included in Part III of Florida Statutes, Chapter 641, that Fla. Stat. § 641.513 is part of a scheme of comprehensive rules and regulations regarding health care services, which includes, among other things, a requirement that every health maintenance organization have a grievance and appeal procedure, ultimately appealable to the Statewide Provider and Subscriber Assistance Program, to address the grievances of subscribers or providers acting on behalf of subscribers. *See* Fla. Stat. § 641.511. The existence of such administrative remedies implies that the Florida legislature intended to make such remedies exclusive. Thus, the Court finds that Count I of Plaintiff's Complaint fails to state a claim because Fla. Stat. § 641.513(5) does not provide for a private cause of action.

Merkle's reliance on *Westside EKG Associates v. Foundation Health, Inc.*, ___ So. 2d ___, 2005 WL 1026183, 30 Fla. L. Weekly D1123 (Fla. 4th DCA May 4, 2005), is unconvincing. In *Westside*, the Fourth District Court of Appeal held that service providers, claiming as third party beneficiaries under a subscriber's contract, may bring an action for breach of contract and declaratory judgment founded on an HMO's failure to comply with the "prompt pay" provisions of the HMO Act primarily found in Section 641.3155, Florida Statutes. The Fourth District reasoned, at *3 (with footnote omitted):

> ... we recognize [plaintiff's] right to bring these claims, notwithstanding that the Act does not explicitly authorize private enforcement of its provisions. We do not read *Villazon* as receding from the well-established common law principle that contracts covering subjects regulated by statute are presumed to incorporate provisions of statutes regulating the subject of such contracts. Applying *Villazon* to bar breach of contract and declaratory judgment claims would essentially preclude any significant court action against HMOs. Application of *Villazon* in this manner would restrict unpaid service providers to relief by administrative proceedings to resolve violations of the Act, under sections 408.7056 and 408.7057, while leaving HMOs free to sue to determine by litigation if the HMO is liable for payment. *See* § 641.3154(4)(b), Fla. Stat. We note that if such was the legislative intent, it would be more clearly spelled out in the Act.
>
> HMOs acknowledge that the Act contemplates non-contract, as well as contract, providers rendering services to subscribers, and that the legislature intended that

non-contract providers stand on an equal footing with contract providers in enforcing their right to payment. *See* § 641.3154(4), Fla. Stat.

> Failure to allow providers to enforce the Act's prompt payment provisions, integral to the HMO contracts with subscribers, would render HMOs impervious to legal action, granting them exclusive access to the courts but confining service providers to the administrative process. Such a limitation would also deprive service providers of common law rights to civil remedies, including third party claims. Such a result would be to the detriment of subscribers, the protected class under the Act. *See* § 641.185, Fla. Stat.

In reaching its decision, the *Westside* court stated that it had considered its earlier decision in *Greene*, *supra*, which the *Westside* court acknowledged had failed to recognize a private cause of action under the Act. However, the *Westside* court explained that *Greene* was distinguishable by the nature of the facts and claims in that case, which were not the issues in *Westside*. 2005 WL 1026183 at *4. The *Westside* court also commented that, in *Greene*, the court acknowledged the availability of a civil remedy for breach of contract by remanding the case with directions to permit further amendment to plead common law actions against the HMO. 2005 WL 1026183 at *4.

Just as *Westside* was distinguishable from *Greene* by the nature of the facts and claims in those cases, *Westside* is distinguishable from the facts and claims here. Simply put, unlike the plaintiff in *Westside*, Merkle has not brought an action for breach of contract. This Court shall not read *Westside* broadly to apply to other actions besides breach of contract, as Merkle has requested, because the *Westside* court expressly limited its holding to actions for breach of contract. *See* 2005 WL 1026183 at *3 ("We do not deem *Villazon* applicable to an action founded on a theory of breach of contract.").

This Court concludes that Merkle's Count II for unjust enrichment/quantum meruit fails to state a cause of action. The elements of an unjust enrichment/quantum meruit claim are "a benefit conferred upon a defendant by the plaintiff, the defendant's appreciation of the benefit, and the defendant's acceptance and retention of the benefit under circumstances that make it inequitable for him to retain it without paying the value thereof." *Florida Power Corp. v. City of Winter Park*, 887 So. 2d 1237, 1231 n.4 (Fla. 2004). *See also Swafford v. Schweitzer*, 906 So. 2d 1194, 1195 (Fla. 4th DCA 2005) ("To state a cause of action for unjust enrichment, the complaint must allege: (1) plaintiff has conferred a benefit on the defendant, who has knowledge thereof; (2) defendant voluntarily accepts and retains the benefit conferred; and (3) the circumstances are such that it would be inequitable for the defendant to retain the benefit without paying the value thereof to the plaintiff."). Merkle's Count II alleges, in pertinent part (with italics added here):

> 73. Plaintiff and the Class Members have provided medical services to patients insured by Aetna or Aetna's health plans, without entering a written contractual relationship with Aetna.
>
> 74. *Accordingly*, Plaintiff and the class have conferred benefits upon Aetna.
>
> 75. Aetna has knowledge that Plaintiff and the class treated its subscribers and conferred benefits upon Aetna.
>
> 76. Aetna has accepted the benefits conferred.

This Court recognizes that "when presented with a motion to dismiss, a trial court is required to treat the factual allegations of the complaint as true and to consider those allegations in the light most favorable to the plaintiffs." *Siegle v. Progressive Consumers Ins. Co.*, 819 So. 2d 732, 734-35 (Fla. 2002) (citations omitted). However, Merkle has attempted to state a cause of action for unjust enrichment/quantum meruit

using conclusory allegations merely mirroring the required elements, but without stating any ultimate facts showing that Merkle is entitled to relief. Merkle uses the word "Accordingly" in paragraph 74 to suggest that Merkle's provision of medical services to Aetna's insureds *automatically* confers benefits upon Aetna. In other words, under Merkle's theory, Merkle and Aetna, by respectively conferring treatment and insurance coverage on the same patient, necessarily confer benefits on each other. That flawed logic is merely conclusory and lacks any statement of ultimate fact to support it. More importantly, viewing the remainder of Merkle's complaint on its face, it appears self-evident that any benefit from services rendered by Merkle flowed to emergency room patients, not Aetna. Although courts must liberally construe, and accept as true, factual allegations in a complaint and reasonably deductible inferences therefrom, courts "need not accept internally inconsistent factual claims." *W.R. Townsend Contracting, Inc. v. Jensen Civil Construction, Inc.*, 728 So. 2d 297, 300 (Fla. 1st DCA 1999) (citation omitted). As a result, without any benefit conferred on Aetna, Merkle cannot allege that Aetna knew Merkle conferred benefits on Aetna, nor that Aetna accepted any benefits.

Merkle argues that dismissing his unjust enrichment claim would violate his fundamental right of access to the courts. This Court disagrees. Although Florida law vests AHCA with the initial authority to enforce Section 641.513(5), Florida law does not preclude Merkle from later access to the courts. In anticipation of claim disputes between providers and HMOs, Section 408.7057(2)(a), Florida Statutes, requires AHCA to establish a program "to provide assistance to contracted and noncontracted providers and health plans for resolution of claim disputes that are not resolved by the provider and the health plan." Subsection (2)(a) further requires AHCA to "contract with a resolution organization to timely review and consider claim disputes submitted by providers and health plans and recommend to the agency an appropriate resolution of those disputes." Section 408.7057(4) states, "Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order." If AHCA's final order is adverse to a provider, that provider has the right of access to the courts for judicial review and, if appropriate, judicial relief, under Section 120.68, Florida Statutes. Section 120.68(1) states, in pertinent part, "A party who is adversely affected by final agency action is entitled to judicial review." Section 120.68(2)(a) states, in pertinent part, "Judicial review shall be sought in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law." Section 120.68(6)(a) states, in pertinent part:

> The reviewing court's decision may be mandatory, prohibitory, or declaratory in form, and it shall provide whatever relief is appropriate irrespective of the original form of the petition. The court may:
> 1. Order agency action required by law; order agency exercise of discretion when required by law; set aside agency action; remand the case for further agency proceedings; or decide the rights, privileges, obligations, requirements, or procedures at issue between the parties; and
> 2. Order such ancillary relief as the court finds necessary to redress the efforts of official action wrongfully taken or withheld.

The two cases upon which Merkle primarily relies in support of its unjust enrichment action, *Shands Teaching Hospital and Clinics, Inc. v. Beech Street Corp.*, 899 So. 2d 1222 (Fla. 1st DCA 2005), and *Michael Reese Hospital and Medical Center v. Chicago HMO, Ltd.*, 554 N.E.2d 472 (Ill. Ct. App. 1990), are distinguishable. In *Shands*, the First District Court of Appeal held that a hospital stated a cause of action for unjust enrichment against a contracted insurance administrator for the State of Florida for failing to pay the hospital's payment rates in exchange for treating State employees. However, the appellate court's decision noted that the hospital's unjust enrichment action was based upon an underlying agreement between the

hospital and the administrator's subcontractor which provided that the hospital would be paid in accordance with certain agreed-upon terms, and that the administrator knew of, but did not inform the State of, the underlying agreement when the administrator bid for the State contract. Unlike the hospital in *Shands*, Merkle has not alleged the existence of some previously-created contractual arrangement by which Aetna or Aetna's agent agreed to pay Merkle's payment rates, nor has Merkle alleged that Aetna made some kind of misrepresentation about payment rates to obtain business from its insureds which would make it unjust for Aetna to receive the benefit thereof.

In *Reese*, an Illinois appellate court held that a hospital stated a cause of action for unjust enrichment against an HMO when the hospital provided statutorily-obligated emergency care to the HMO's members, but the HMO paid the hospital State-discounted rates instead of the hospital's usual and customary rates. However, the appellate court's decision noted that hospital's unjust enrichment action was based upon an underlying agreement between the State of Illinois and the HMO which provided that the State would provide payments in excess of the State-discounted rates to the HMO if the HMO would provide reimbursement for emergency care, and an understanding that hospitals would bill their usual and customary rates unless there was a contractual agreement to the contrary. The appellate court also mentioned that the hospital attached to its complaint a letter from the State agency administering the State program in which the agency wrote that "at no time has [the agency] contemplated the application of [State-discounted] rates for the reimbursement of hospital services to HMO recipients." Unlike the plaintiff in *Reese*, Merkle has not alleged that Aetna has received from the State of Florida or a similar source any payments which are based on Aetna, in turn, paying providers like Merkle at the providers' usual and customary rate. Also, Merkle has not attached to its complaint any documentation from AHCA indicating that AHCA has not contemplated the payment of discounted rates for the reimbursement of emergency services to Aetna's insureds.

A third case upon which Merkle primarily relies, *In re: Managed Care Litigation*, 298 F.Supp.2d 1259 (S.D. Fla. 2003), comments briefly that providers' rendering of treatment to patients insured by HMOs which fail to pay claims in full will support a claim for unjust enrichment irrespective of the argument that the providers actually conferred a benefit upon the patient, and not the HMOs. To the extent that the court's brief comment in *Managed Care Litigation* may be read to stand for the proposition that providers' treatment of a patient thereby confers a benefit upon the HMOs, this Court respectfully disagrees with that case based on this Court's reasoning stated above. More importantly, in this Court's view, the relationship between the parties in this case was created by statute and, therefore, controlled by statute. As discussed above, Section 641.513, in combination with other statutes, affords providers with an administrative and judicial remedy in the event of a claim dispute between providers and HMOs. For this Court to allow Merkle to pursue an unjust enrichment action based upon an alleged violation of Section 641.513(5) would render the statutory remedy meaningless. As Judge Lenard stated in *Mariners Hospital, supra*, "The existence of such administrative remedies implies that the Florida legislature intended to make such remedies exclusive." 2004 WL 3201003 at *4.

This Court agrees with Aetna that Merkle's Count III for account stated fails to state a cause of action. "For an account stated to exist, there must be agreement between the parties that a certain balance is correct and due and an express or implicit promise to pay this balance." *Carpenter Contractors of America, Inc. v. Fastener Corp. of American, Inc.*, 611 So. 2d 564, 565 (Fla. 4th DCA 1992). Merkle's Count III alleges, in pertinent part:

> 85. Plaintiff and the Class billed Aetna their charges for payment based on the emergency services and care provided to Aetna's HMO subscribers, which are and were at

all relevant times commensurate with the usual and customary charges in the community where those services were provided.

86. Accordingly, Plaintiff and the Class engaged in transactions for services with Aetna.

87. As an HMO operating within the state of Florida, Aetna made a promise to Plaintiff and the Class to pay for the emergency services and care provided to Aetna's subscribers, but paid only a portion of the billed charges to Plaintiff and the Class. A copy of a representative sampling of the EOBs demonstrating Aetna's payment of only a portion of Plaintiff's billed charges for which Aetna agreed to pay is attached hereto as Composite Exhibit "3".

88. Accordingly, there remains an outstanding balance due and owing by Aetna to Plaintiff and the Class.

Although Merkle alleges that Aetna "agreed to pay" Merkle's billed charges, the remaining allegations and the attached Explanation of Benefits plainly show that Aetna has not agreed to pay Merkle's billed charges. *See W.R. Townsend*, 728 So. 2d at 300. *See also Shumrak v. Broken Sound Club, Inc.*, 898 So. 2d 1018, 1020 (Fla. 4th DCA 2005) ("If an exhibit facially negates the cause of action asserted, the document attached as an exhibit controls and must be considered in determining a motion to dismiss.") (citations omitted). Because Merkle's allegations and the exhibit attached to the Complaint negate Merkle's action for account stated and show that there has been no mutual agreement, this Court must dismiss Merkle's Count III. *See Braun v. Noel*, 188 So. 2d 564, 565 (Fla. 3d DCA 1966) (affirming dismissal of complaint for failure to state a cause of action for account stated; "There can be no liability on an account stated if there has been no mutual agreement, and the mere presentation of a claim and its retention without objection cannot of itself create a liability.").

Although this Court normally would grant a plaintiff leave to amend its complaint when dismissed for failure to state a cause of action, doing so here would be futile. *See Torrey v. Leesburg Regional Medical Ctr.*, 769 So. 2d 1040, 1044 n.4 (Fla. 2000) ("As a general rule, leave to amend should not be denied unless the privilege has been abused, there is prejudice to the opposing party, or *amendment would be futile*.") (italics added here). Granting Merkle leave to amend Counts I and IV fail would be futile because no private right of action exists for an alleged violation of Section 641.513(5). Granting Merkle leave to amend Count II would be futile because the lack of any benefit conferred by Merkle upon Aetna will not change. Granting Merkle leave to amend Count III would be futile because the very essence of Merkle's action is that the parties disagree on the amount which Merkle claims Aetna owes.

Conclusion

Based on the foregoing, it is ORDERED AND ADJUDGED that Defendant's Motion to Dismiss is GRANTED WITH PREJUDICE. This Court enters final judgment in favor of Defendant, Aetna Health, Inc., and against Plaintiff, Peter F. Merkle, M.D., P.A. Merkle shall take nothing by its action, and Aetna shall go hence without day. This Court finds that Aetna is the prevailing party in this action and is entitled to recover its taxable costs, for which this Court reserves jurisdiction to determine the amount, if any.

DONE AND ORDERED at Palm Beach County, Florida, this 7th day of November, 2005.

Jonathan D. Gerber
Circuit Court Judge

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