IN THE FOURTH DISTRICT COURT OF APPEALS

CASE NOS. 4D05-4552, 4D05-4553, 4D05-4554 & 4D05-4555 (CONSOLIDATED)

PETER F. MERKLE, M.D., P.A., Etc.

Appellants,

vs.

HEALTH OPTIONS, INC., Etc.

Appellees.

On Appeal From Final Orders of the
Fifteenth Judicial Circuit In And For Palm Beach County, Florida

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BRIEF OF *AMICI CURIAE* FLORIDA HOSPITAL ASSOCIATION, FLORIDA COLLEGE OF EMERGENCY PHYSICIANS, FLORIDA MEDICAL ASSOCIATION, the AMERICAN MEDICAL ASSOCIATION, the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, and the FLORIDA ORTHOPAEDIC SOCIETY

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STATEMENT OF IDENTITY AND INTEREST OF *AMICI*

The Florida Hospital Association (the "FHA") is a not-for-profit association representing all types of hospitals throughout the state. Through advocacy, education, research, representation, and service, the FHA carries out its mission "to promote the ability of member hospitals and healthcare systems to effectively and efficiently serve the healthcare needs of their communities." Currently, FHA's membership includes over 200 hospitals, 20 professional membership groups and councils, and over 1,800 professional members.

The Florida College of Emergency Physicians ("FCEP") is a state chapter of the American College of Emergency Physicians and represents more than 1,100 emergency physicians in the State of Florida. FCEP member physicians represent the health care safety net of Florida's residents and visitors. More than seven million patients seek care annually in Florida emergency departments. FCEP was founded on October 15, 1971, and is headquartered in Orlando.

The Florida Medical Association (the "FMA") is a not-for-profit corporation which is organized and maintained for the benefit of the approximately 16,000 licensed Florida physicians who comprise its membership. The FMA was created and exists for the purpose of securing and maintaining the highest standards of practice in medicine and to further the interests of its members. One of the primary purposes of the FMA is to act on behalf of its members by representing their

common interests before the courts of the State of Florida. Members of the FMA are substantially affected by state or national statutes, rules, regulations, and policies applicable to health care claims.

The American Medical Association ("AMA"), an Illinois non-profit corporation, is an association of approximately 250,000 physicians, residents, and medical students. Its members practice in every state, including Florida. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.[1]

The Florida Orthopaedic Society (the "FOS") was founded in 1947 to raise the standards of orthopaedic practices by providing ongoing education, networking, recognition, and certification. The FOS is a Florida corporation currently representing over 1,100 orthopaedic surgeons. As an independent organization it is recognized as a state affiliate of the American Academy of Orthopaedic Surgeons and American Association of Orthopaedic Surgeons. Its membership includes surgeons all over the State of Florida, of all

[1] The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

musculoskeletal specialties and practices that range in size from solo-practitioners to large institutions. Membership in the organization is reserved for surgeons who have completed an orthopaedic residency training program.

The primary legal issues raised in this appeal (namely, whether Florida's Emergency Services Statute is enforceable by providers and what the appropriate level of reimbursement should be under Florida's Emergency Services Statute) are of significant importance to the instant *amici* and their members since the Emergency Services Statute (sometimes referenced as the "Statute"), Florida Statute § 641.513, is the primary means by which the Florida Legislature sought to guarantee that health care providers were compensated promptly and fully for having to render emergency care and services to HMO subscribers. The hospitals represented by the FHA and the physicians represented by the FCEP, the FMA, the AMA, and the FOS are required, by law, to provide emergency care to HMO subscribers and to submit those claims to HMOs for reimbursement. Moreover, the appropriate level of reimbursement under the Emergency Services Statute has long been a contentious issue between HMOs and medical providers that now requires judicial resolution. Hence, the instant *amici* and their members have an important stake in the outcome of this case and also have significant expertise and knowledge on the issues raised by this appeal.

SUMMARY OF ARGUMENT

The trial court below granted the HMOs' motions to dismiss with prejudice (the "Order") because it found that Florida Statute § 641.513 did not contain a private right of action. The Circuit Court's decision should be reversed because it contravenes the very text and premises of the Statute and because it directly conflicts with binding precedent from this Court in Westside EKG Assoc. v. Foundation Health, 2005 WL 1026183 (Fla. 4th DCA May 4, 2005).[2] The Florida legislature clearly intended that medical providers be able to enforce the "Emergency Services" statute (the "Statute"). The clearest proof is the very text of § 641.513 itself. Under the explicit mandates of that Statute, a provider ***has*** to render certain emergency services to HMO subscribers who seek their help. In return, HMOs are required, in the absence of a negotiated agreement discounting the provider's charges, to pay the medical provider the usual and customary charges for the emergency services rendered. The Statute is very explicit in both requiring payment and in setting the parameters for reimbursement. To preclude providers from enforcing the Emergency Services Statute would not only be contrary to the text of the statute and the legislative intent behind it, but would completely eviscerate it and would amount to an unconstitutional confiscatory

[2] The Westside EKG case decided by this Court is currently on appeal to the Florida Supreme Court. Oral argument is scheduled to take place on February 10, 2006.

taking of property for public purposes. Without a private right of action under that Statute: 1) § 641.513 would require that claims for emergency services "shall be paid," but would not empower providers to actually collect those claims from HMOs who do not pay emergency claims; 2) the same statute would even set the reimbursement level for those claims, but would not allow providers to collect those monies or to seek redress for any underpayments made by the HMOs for emergency services rendered; and, 3) although the terms of the Statute are specifically mandatory, providers would not be able to invoke its protections. Clearly, the Florida legislature did not intend § 641.513 to be unenforceable by health care providers. In addition, with respect to an unjust enrichment claim, it is clear that providers do confer a benefit upon the HMOs when they render emergency services to their insureds. Hence, the lower court's dismissal of the unjust enrichment claims also constitutes legal error.

ARGUMENT

I. The Emergency Services Statute Mandates Payment Of Billed Charges

A. The Statute

The issue of what amount health insurers owe health care providers for rendering emergency medical services to their insureds is answered clearly and unequivocally in the Florida Statutes. By way of background, the Emergency Medical Transfer and Act of Labor Act ("EMTALA")(42 U.S.C. § 1395dd) and

Florida Statute § 395.1041 (entitled "Access to emergency services and care") generally require that hospital emergency departments and emergency room physicians provide necessary medical care, screening, and treatment to stabilize a potential emergency medical condition prior to requesting any insurance or HMO information from a presenting patient. Florida's Emergency Services Statute, § 641.513, establishes the appropriate reimbursement procedures and level for such emergency health care treatment when the provider does not have a contract with the HMO to which the patient belongs.

When a doctor or hospital provides services to an HMO member, the statute generally prohibits the medical provider from collecting payment from the insured— other than a specified co-payment — for the emergency services rendered. See Fla. Stats. §§ 641.3154(4) and 641.513(4). The HMO, in turn, is obligated to pay the provider's claim regardless of whether the provider has a contract with the HMO to pay a previously-negotiated, lower rate. See Fla. Stats. §§ 641.3154(1), 641.3155(3)(e) and 641.513(5). More specifically, Florida Statute § 641.513 states unequivocally that:

> 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 same 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.
>
> Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

Despite the explicit text of the Statute calling for the payment of "charges," Florida HMOs (including the HMOs here) have unilaterally set their payment rates for emergency claims at 120 percent (or so) of Medicare "reimbursement" rates. The arbitrary reimbursement rate set by the HMOs continues despite the fact that the Statute does not tie reimbursement levels to Medicare rates and even though attempts to tie reimbursement rates to a percentage of Medicare have been repeatedly rebuffed by the Florida Legislature in recent years). [3]

B. Legislative Intent

As the Florida Supreme Court has noted, "[i]t must be assumed that a provision enacted by the legislature is intended to have some useful purpose." Smith v. Piezo Tech. and Prof'l Adm'rs, 427 So. 2d 182, 184 (Fla. 1983). This means that

> [w]here a statute requires an act to be done for the benefit of another or forbids the doing of an act which may be to his injury, though no action be given in express terms by the statute for the omission or commission, the general rule of law is that the party injured should have an action; for where a statute gives a right, there, although in

[33] See, e.g., Senate Bill 2350 (2004)(draft of bill would have limited hospital reimbursement for emergency services to 120 percent of the Medicare rate, but bill was not even voted on during the legislative session).

> express terms it has not given a remedy, the remedy by law which is properly applicable to that right follows as an incident.

Girard Trust Co. v. Tampashores Dev. Co., 117 So. 786, 788 (1928). See also Moyant v. Beattie, 561 So. 2d 1319 (Fla. 4th DCA 1990)(quoting 49 Fla. Jur.2d, Statutes § 223 (1984)("If a statute grants a right or imposes a duty, it may be construed as conferring by implication the power necessary for the exercise of the right or the performance of the duty.")

"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." Murthy v. N. Sinha Corp., 644 So. 2d 983, 986 (Fla. 1994). Here, it must be clear that the Statute was not enacted merely to secure the safety or welfare of the public as an entity. Rather, § 641.513 was clearly enacted to require HMOs to pay for emergency services and care and to require HMOs to pay for those services at the amounts set forth in § 641.513(5). In exchange for requiring healthcare providers (who are generally precluded from billing the patient) to provide emergency care to HMO patients with whom the health care provider has not contracted, the legislature required HMOs to pay the statutorily required amount. The terms of the Statute regulate only the conduct of health care providers and HMOs, and not the public in general. If health care providers cannot collect the HMOs' payment obligation under § 641.513, in effect they would truly be without a legal remedy to recover full

payment for emergency medical services they were obligated to perform by law. This is clearly not what the Florida Legislature intended in passing a Statute that specifically mandates HMO payments to providers for emergency services and specifically mandates an enumerated payment formula. To force health care providers to provide services without fair compensation would render the Statute unconstitutional and would amount to a confiscatory taking of property for public persons and would be a right without a remedy. Moreover, the statutory payment formula in the Emergency Services Statute was specifically set at "usual and customary charges" by the Florida legislature to ensure that providers were reimbursed fully by health insurance companies so long as they were charging their standard rates.

C. Legislative History

By this statutory scheme, the Florida Legislature intended "that subscribers will receive needed services for which hospitals and emergency room physicians ***will*** receive reimbursement." See S.B. 886 (May 4, 1996), Final Bill and Economic Impact Statement at p. 4 (emphasis supplied). Indeed, the legislative history confirms that providers have every right to seek full payment from HMOs for emergency services and care rendered to their subscribers so long as they charge their standard rates. According to one pertinent Senate Staff Analysis referencing § 641.513:

> Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral... The HMO ***must*** compensate the provider for screening, evaluation, and examination reasonably calculated... [and] the HMO ***must also*** compensate the provider for emergency services and care.

See Fla. S. Comm. on Fiscal Policy, CS for SBs 1508, 706 & 2234 (2000) Staff Analysis at p. 4 (April 26, 2000)(emphasis supplied)(available online at http:/www.flsenate.gov/data/session/2000/Senate/bills/analysis/pdf/SB1508.fp.pdf) Thus, even these brief excerpts from the relevant legislative history confirm that § 641.513 was specifically intended to mandate full HMO payments to health care providers for emergency services, screening, evaluation, examination, and care. The terms of the Statute are mandatory ("shall") and it is clear that the legislature intended that such payments be obligatory. Hence, it can only follow that health care providers be allowed to collect such obligatory payments and that they be able to collect their full, billed (and standard) charges.

D. No Administrative Alternative

The HMOs' argument that the authority to enforce the Statute lies in the hands of Florida regulators is not correct. Neither the Florida Department of Insurance (n/k/a the Office of Insurance Regulation or the "OIR") nor AHCA have the power to pursue civil claims against HMOs requiring HMOs to reimburse providers when the HMOs fail to make full and proper payments under § 641.513. Indeed, AHCA has already acknowledged two things relevant to the interpretation

of § 641.513 and this appeal. First, it determined that the HMOs' practice of paying non-contracting providers 120% of the Medicare allowable rate "appears to be in violation of section 641.513(5), Florida Statutes" because the calculation is based on amounts "paid" and not, as required, the "usual and customary provider charges for similar services in the community where the services were provided." Second, AHCA also acknowledged that, in a letter dated November 4, 2003, it did not have the power to interpret § 641.513(5):

> During the past year the Agency, members of the HMO industry, various provider groups and their representatives have been having some very detailed discussions regarding certain payment practices by HMOs for the provision of emergency services. Section 641.513, Florida Statutes specifies the amount of payment a non-contracted provider must be paid when providing services to an HMO member in emergency situations.
>
> At issue specifically is section 641.513(5)(b), Florida Statutes that reads as follows:
>
> * * *
>
> The members of the HMO industry that have met with the Agency have established payment policies such that they pay percentages of the Medicare Allowable Charges for emergency services, which, they represent comply with section 641.513(5)(b), Florida Statutes. In these situations the HMOs are paying between 100% and 120% of Medicare allowable charges for emergency services rendered to commercial (non-Medicare and non-Medicaid) subscribers. The provider community involved with these discussions has taken exception to that practice.
>
> ***As the Agency does not have specific rule making authority to determine what specific payment amounts would comply with Section 641.513(5)(b), Florida Statutes,*** we suggest that a court of competent jurisdiction or the provider dispute resolution program as outlined in section 408.7057, Florida Statutes, is the appropriate venue

> for the parties to such disputes to settle this issue in those situations in which the parties involved cannot reach an agreement on their own.

(emphasis added).

If AHCA does not have the authority to interpret that statute, it is respectfully submitted that MAXIMUS does not either. Hence, the HMOs cannot point to any statutory mechanism whereby any governmental body can force HMOs to pay providers the amounts they have been underpaid or not paid under Florida Statute § 641.513. The possible imposition of penalties and fines payable to the government does not provide a monetary remedy to individual providers injured by violations of the Emergency Services Statute. Accordingly, the only way providers can recover damages for the HMOs' routine underpayment or non-payment of emergency services claims under § 641.513 is to bring civil actions against them.

E. Other Statutory Analogies

A statutory scheme analogous to the one at issue in this case is the statutory scheme relating to payment for personal injury protection ("PIP") benefits under automobile insurance policies. The issue in this case relates to emergency services and care. Similarly, almost all of the claims arising under PIP sections of automobile insurance policies are for emergency services and care. Florida Statute § 627.736 requires automobile insurance companies to pay for services provided in

accordance with that Chapter. Until § 627.736 was amended in 2003, there was no specific private right of action for violating that statutory section. Notwithstanding the fact that there was no language in that statute specifically authorizing a private suit, numerous lawsuits have been litigated over insurance carriers' failures to properly pay in accordance with the terms of § 627.736. See Allstate Ins. Co. v. Kaklamanos, 843 So. 2d 885 (Fla. 2003); Gurney v. State Farm Mut. Auto. Ins. Co., 795 So.2d 1118 (Fla. 5th DCA 2001); and Reg'l MRI of Orlando, Inc. v. Nationwide Mut. Fire Ins. Co., 884 So.2d 1102 (Fla. 5th DCA 2004).

Under this analogous statutory scheme, Florida courts have readily determined that there is a private right of action for violating § 627.736. The only difference between § 627.736 and § 641.513 is that § 641.513 is much more specific and narrowly focused as it applies only to emergency services and care and only between providers and HMOs. Despite the numerous contingencies and factors that exist under § 627.736, the only required determination under § 641.513(5) is whether the HMOs paid the proper amounts thereunder. Clearly, if the Florida Supreme Court has allowed a private right of action under § 627.736, providers must also be able to similarly enforce § 641.513 for analogous types of health care claims.

The HMOs have argued previously that the PIP Act is distinguishable, because there are two references to lawsuits in that statute. However, it should be

noted that the HMO Act contains numerous references to lawsuits to enforce its terms, see § 641.28 (expressly recognizing civil remedy); § 641.282 (payment of judgment by HMO); § 641.3154(4)(b) (acknowledging that court of competent jurisdiction can determine that organization is liable for payments to provider); § 641.3917 (recognizing rights under general, civil and common law, and that no action of the department "shall abrogate such rights to damage or other relief in any court"). Additionally, the dispute resolution statutes relied upon by the HMOs as providing the "exclusive" administrative remedy specifically state that they do not apply if the claim "is the basis for an action pending in state or federal court," see § 408.7056(2)(f) and § 408.7057(2)(b)(6). Therefore, healthcare providers must be able to enforce the express terms of § 641.513 to obtain full reimbursement for any emergency services and care rendered to HMO subscribers.

II. The Villazon Cases Is Inapposite And The Westside EKG Is Controlling.

In granting the HMOs' motion to dismiss, the Circuit Court relied directly on the case of Villazon v. Prudential Healthcare Plan, Inc., 843 So. 2d 842 (Fla. 2003) for the argument that there is no private right of action under § 641.513. Order, p. 2. But, Villazon is wholly distinguishable. Villazon involved a claim of negligence against an HMO subscriber's healthcare providers and also against the subscriber's HMO. In this case, Dr. Merkle has not asserted a claim for negligence or any other tort. Moreover, and perhaps most importantly, Villazon found that a

private right of action for damages did not exist under Florida's "Health Maintenance Organization Act" (the "HMO Act"). The HMO Act is specifically defined as Florida Statutes §§ 641.1-641.3923. Villazon does not apply to **provider** claims for emergency services, which do not arise under the HMO Act, but under Florida Statute § 641.513 (which lies in Part III of Chapter 641). Hence, the Villazon case is flatly irrelevant to this appeal.

The trial court below should have relied on Westside EKG Assoc. v. Foundation Health, 2005 WL 1026183 (Fla. 4th DCA 2005), since that case is directly on point, deals with the same statute and is controlling authority from this very Court. In the Westside EKG case, this Court held that the provisions of Florida's prompt payment statute (§ 641.3155) were enforceable through the HMOs' subscriber agreements. The Emergency Services Statute should, at the very least, be enforceable in the very same manner and to the same extent.

III. Section 641.513's Unambiguous Terms Provide That HMOs Must Pay Providers Their Usual and Customary Charges In the Absence of A Contract

Section 641.513(5) sets out the specific rates by which HMOs must reimburse providers for rendering of emergency services and care to their members. That subsection provides that:

> 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 same 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.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

Fla. Stat. § 641.513(5).

In response to a provider complaint, on December 24, 2002, AHCA sent a letter to Appellee Health Options, Inc. regarding its practice of paying non-participating providers 120% of the Medicare allowable rate. See AHCA Letter dated December 24, 2002. In the letter, AHCA stated that the policy of paying 120% of Medicare "appears to be in violation of section 641.513(5), Florida Statutes." Id. AHCA reasoned that using 120% of Medicare is a calculation based on amounts "paid" and not, as required, the "usual and customary provider charges for similar services in the community where the services were provided." Id.

The phrase "usual and customary provider charges" is unambiguous, and clearly means "charges" and not, as the HMOs has contended, some unilaterally-determined percentage of Medicare reimbursement rates. Thus, under the express terms of the statute, the reimbursement formula mandated by § 641.513(5) is clearly unambiguous. As the Florida Supreme Court has explained:

> when the language of a statute is clear and unambiguous and conveys a clear and definite meaning, there is no occasion to resorting to the rules of statutory construction; the statute must be given its plain and obvious meaning.

A.R. Douglass, Inc. v. McRainey, 102 Fla. 1141, 1144 (1931). Here, the Emergency Services Statute requires HMOs to pay providers their "usual and customary charges" or to pay them the "usual and customary provider charges for similar services in the same community where the services were provided." See also Florida Statute § 409.9128 (also containing the same "usual and customary provider charges" phrase).

Moreover, the phrase "usual and customary charges" occurs at least ten different times in the Florida Statutes, and always in the context of billed "charges" (and never as some notion of discounted charges or fees, as suggested by the HMOs). Lastly, the Florida Legislature has chosen to tie reimbursement rates to Medicare rates in other contexts. See, e.g., Florida Statute § 440.13. This means that its decision not to tie provider reimbursement for emergency services to some percentage of Medicare rates must have been a purposeful one. Indeed, the Florida Legislature specifically rebuffed the HMOs' recent attempts to amend the Statute along those very lines. See footnote 1 above. It is clear, then, that the HMOs' unilateral decision to reimburse providers at 120 percent of Medicare rates is not in compliance with § 641.513 (which requires that providers be paid their usual and

customary charges or that the parties negotiate a mutually acceptable reimbursement rate). The HMOs are not free to arbitrarily establish their own reimbursement formula (at a lesser amount) when the Statute clearly calls for higher payments to providers. The HMOs are free to negotiate with providers for a lesser amount, but they are not free to simply pay a lower rate by fiat, and the Florida courts are not free to conclude otherwise. The Florida Legislature has already precluded this, and the parties are bound by the terms of the Emergency Services Statute.

IV. Providers Do Confer An Actionable Benefit Upon HMOs.

In addition to a claim for breach of the Emergency Services Statute, Dr. Merkle asserted a claim for unjust enrichment/quantum meruit against the HMOS for their failure to fully pay for the emergency services he was forced to render to their insureds. The elements of such a claim are well-accepted. In order to assert a claim for unjust enrichment, a plaintiff must allege that: (1) plaintiff has conferred a benefit upon the defendant who has knowledge thereof; (2) defendant voluntarily accepts and retains the benefits conferred; and (3) the circumstances are such that it would be inequitable for the defendant to retain the benefit without paying for the value therof to the plaintiff. Hillman Constr. Corp. v. Wainer, 636 So. 2d 576, 577 (Fla. 4th DCA 1994). The trial court below dismissed Dr. Merkle's unjust enrichment claim against the HMOs for non-payment and under-payment of its

claims on the grounds that "any benefit from services rendered by Merkle flowed to emergency room patients, not" the [HMOs]. Order, p. 5. The trial court's conclusion was erroneous for several reasons.

Under Florida law, HMOs agree to provide medical services to their subscribers for a fixed, monthly premium. Thus, HMOs owe a legal duty to provide medical services. F.S. §§ 641.19(12) & 641.31(1). The provision of medical services by providers, then, actually discharges part of the legal obligation owed by the HMOs to provide medical services to its subscribers and, thus, confers a direct benefit upon the HMOs. This should be more than enough to satisfy the "benefit" element of the claim. Moreover, in Shands Teaching Hospital and Clinics, Inc. v. Beech Street Corp., 899 So. 2d 1222, 1227-1228 (Fla. 1st DCA 2005), the Court held that a provider could state a cause of action for unjust enrichment by alleging that it had conferred a benefit upon the HMO. The same result is demanded here since, at the motion to dismiss stage, Dr. Merkle should be allowed to pursue his claim and eventually prove that it has conferred the type of benefit contemplated by the claim.

CONCLUSION

WHEREFORE, for all the foregoing reasons, *amici curiae*, the Florida Hospital Association, the Florida College Of Emergency Physicians, the Florida Medical Association, the American Medical Association, and the Florida

Orthopaedic Society respectfully request that this Court reverse the decision of the Circuit Court. Interpreting the Emergency Services narrowly to deny a private remedy to providers injured by violations thereof would not serve the Statute's purpose or give effect to its provisions and, indeed, would render the Statute meaningless. The instant *amici* also request that this Court find that the HMOs are required to reimburse providers their full, billed charges on any claim for emergency services rendered pursuant to Florida Statute § 641.513(5) since the Emergency Services Statute unambiguously requires that health insurers pay health care providers their full, billed charges or the billed charges of other providers in the same community for similar services. Lastly, *amici* also ask this Court to find that the obligatory rendering of emergency services to the HMOs' insureds confers a benefit upon the HMOs sufficient to support a claim for unjust enrichment.

If providers cannot enforce the very statute that the Florida legislature passed to ensure that providers' emergency claims would be paid, the Statute would be left a nullity. The Florida legislature clearly never intended that the Emergency Services Statute be a proverbial right without a remedy. Providers are only asking that they be fairly compensated for services that Florida law requires they provide.

CERTIFICATE OF SERVICE

We hereby certify that a true and correct copy of the foregoing was furnished via electronic means to the persons on the attached service list, this 8th day of February, 2006. Hard copies followed by U.S. Mail.

CERTIFICATE OF COMPLIANCE

We hereby 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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