OA 11-6-95

IN THE SUPREME COURT OF FLORIDA

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION, and STATE OF FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

Appellants, Cross-Appellees

vs.

CASE NO. 86,213

ASSOCIATED INDUSTRIES OF FLORIDA, INC., PUBLIX SUPERMARKETS, INC., NATIONAL ASSOCIATION OF CONVENIENCE STORES, INC., and PHILIP MORRIS, INC.,

Appellees, Cross-Appellants.

STATE OF FLORIDA'S CONSOLIDATED ANSWER AND REPLY BRIEF TO PLAINTIFFS' CROSS-APPEAL AND ANSWER BRIEF

On Direct Review from a Decision of the
Second Judicial Circuit, Certified for Immediate Resolution

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PRELIMINARY STATEMENT

Appellants/cross-appellees, State of Florida, Agency for Health Care Administration ("AHCA") and State of Florida Department of Business and Professional Regulation ("DBPR") will be referred to collectively as "Florida" or "the State." Since appellees/cross-appellants, Associated Industries of Florida, inc. ("AIF"), Publix Supermarkets, Inc. ("Publix"), National Association of Convenience Stores, Inc. ("NACS"), and Philip Morris Incorporation ("Philip Morris") and the State are both appellants and appellees, they will be referred to as they appeared below: as the "State" and the "plaintiffs."

References to the record on appeal will be indicated as "(R. ____.) Or "(R. Supp. _____.)." Each record citation will be to the specific pages of the record on which the referenced material appears. An appendix is attached directly to this brief and includes the 1990 Medicaid Third-Party Liability Act at Tab 1 (A.1) and the 1994 Amendment at Tab 2 (A.2). Other materials referenced in this brief are reproduced in the Appendix and are cited as "(A. ____.)."

STATE OF FLORIDA'S CONSOLIDATED ANSWER AND REPLY BRIEF TO PLAINTIFFS' CROSS-APPEAL AND ANSWER BRIEF

SUMMARY OF ARGUMENT

Effect and Application of 1994 Amendments. The 1990 Medicaid Third-Party Liability Act was an extensive, comprehensive exercise of the State's inherent power and federally mandated obligation to recover all Medicaid expenditures from any and all liable third-parties and available third-party resources. The 1990 Act expressly abrogated any and all common law or equitable principles as "necessary to ensure full recovery" of Medicaid expenditures; required existing principles of law to be "construed together to provide the greatest recovery; and unequivocally recognized the State's independent right of action to sue and recover all Medicaid expenditures from "any" liable third-party. The 1990 Act gave fair warning to potential third-party defendants that they could be directly liable to the State for Medicaid payments attributable to the harm caused by defective or dangerous products.

The 1994 Amendments did not make "innocent" prior acts culpable. They did not create a new cause of action; establish new theories of liability; or designate new potential defendants. Therefore, the Amendments did not create a new legal burden that was substantial. They apply to Medicaid payments made within five years of filing suit, and at the very least to all payments made on or after July 3, 1990 -- the effective date of the Medicaid Third-Party Liability Act. *See* Ch. 90-295, Laws of Fla.

Separation of Powers. The aggregate damages (so-called "joinder"), liberal construction and market share provisions of the 1994 Amendments do not encroach upon this Court's rulemaking power or the judiciary's duty to interpret statutes. These provisions establish the conditions under which the State may maintain its cause of action for aggregate damages. Liberal construction and market share liability are remedial matters within the Legislature's domain. To the extent the aggregate damages provisions have procedural implications, those aspects are integral to the judicial process contemplated by the 1994 Amendments. There is no conflict with this Court's procedural rules. Separation of powers is not violated.

Statute of Repose. The hypothetical possibility that the 1994 Amendments could revive a time-barred claim did not posit jurisdiction in the trial court for purposes of declaratory relief. The trial court's holding was an advisory opinion that must be vacated.

AHCA. Declaring AHCA to be a *de facto* department results in a constitutional construction of § 20.42, Fla. Stat. (1992), and gives effect to the 25 department limit of Art. IV, § 6. Even if AHCA were improperly structured, its authority would revert to HRS through revival of earlier statutes designating HRS as the State's Medicaid agency.

Access to Courts. Florida's constitutional guarantee of access to courts does not require that all affirmative defenses be preserved forever. The provision as to disclosing individual Medicaid recipients has nothing to do with access to courts; rather, it is a condition under which the State may bring a lawsuit. Nothing in the 1994 Amendments requires an unconstitutional application of this provision. Market share liability, already adopted by this Court, adjusts the State's remedy. It does not relieve the State from proving its case.

Relevancy and Admissibility of Evidence. The 1994 Amendments do not affect the court's ability to determine the admissibility of evidence. They do not affect the fact-finder's weighing of evidence. They declare, consistent with the Florida law of evidence, that causation may be proven statistically.

Due Process. Based on the arguments above, the 1994 Amendments do not offend due process. They do not relieve the State from proving causation and damages, or prevent a defendant from rebutting the State's case. A wrongdoer is not prevented from seeking contribution from other wrongdoers. The 1994 Amendments do not violate due process.

ARGUMENT

Plaintiffs "Statement of the Case and Facts" is argumentative and concludes with a parade of imaginary-horribles as to applications of the 1994 Amendments and irrelevant commentary about legislators not knowing what they were doing when they passed the subject legislation. It is true that in 1990, Florida moved to the forefront in enacting a statutory scheme consistent with the purposes of the Federal Medicaid Act and in 1994 defined its specific application in the product liability context. The ball is now in the domain of the courts; not the political halls of the legislature where the multi-billion dollar tobacco industry has previously enjoyed such success in protecting, indeed, enhancing its interests. In the part of their brief labeled "Argument," plaintiffs misleadingly argue "no case has held" when they should say, "no case has addressed the issue" and attempt to turn statutory and constitutional principles on their heads in order to create a constitutionally infirm strawman. At a time when the citizens of this state and nation demand their government protect the public pocketbook because there simply are not enough resources, there is no constitutional, legal or moral support for continuing a multi-billion

dollar subsidy for one of the most wealthy, powerful (and we would submit undeserving) industries in this nation.

1. Plaintiffs Misapply Fundamental Principles of Statutory Construction

Although giving lip service to axioms that statutes are presumed to be constitutional and that "[W]hen a statute is amended, it is presumed that the Legislature intended it to have a meaning different from that accorded to it before the Amendment" [Plaintiffs' Answer Brief (Pl. Br.), p.31], plaintiffs' arguments are premised on the notion that trial courts will eschew their legal and constitutional obligations and give the 1994 Amendments the most improbable, radical application. They further ask this Court to ignore well-established, pre-existing statutory and case law upon which the Amendments rest and on that basis, ask this Court to hold its strawman unconstitutional. Rather than trying to conjure up some extreme application or attenuated interpretation of the Amendments that might render them unconstitutional, this Court has repeatedly viewed legislation in the light most favorable to its constitutionality. For example, in *State ex rel. Pittman v. Stanjeski*, 562 So. 2d 673 (Fla. 1990), this Court refused to give a provision of the AFDC statutes the unconstitutional construction chosen by the district courts; considered the federal and state purposes and policy behind the Act (562 So. 2d at 677); recognized that the law was passed "in an attempt to bring Florida into full compliance with . . . congressional acts and implementing federal regulations, thus avoiding a loss of federal funds . . . ." (562 So. 2d at 678); interpreted the statute "as doing no more than codifying the existing law of this state" (562 So. 2d at 679); and construed the arguably offending provisions of the statute so as to comply with due process requirements (562 So.2d at 679). The statute in issue on this appeal should be given the same deference.

2. Plaintiffs Misrepresent The Scope And Underlying Purpose of The Medicaid Third-Party Liability Act And Ignore The Broad Power of The State to Carry Out Federally Mandated Recovery of Taxpayer's Monies From Wrongdoers Who Have Caused The Expenditures of Tax Funds.

Plaintiffs would have this Court ignore the fundamental right of the State to act in behalf of its taxpayers and its federally mandated obligation to pursue every reasonable avenue to recoup federal and state Medicaid expenditures incurred as a result of wrongfully caused injuries to Florida citizens.[1] The 1994 Amendments clearly do not in any respect contravene federal constitutional law. Indeed, failure to give the 1990 and 1994 laws their intended application potentially violates the Supremacy clause of the Federal Constitution. Once all the rhetoric is stripped away, the 1990 and 1994 laws are simply a rational attempt by the State of Florida to carry out the obligations imposed upon it by federal law to recoup federal funds from parties proved to be tortfeasors who have caused the expenditure of taxpayer's money for medical care necessitated by their tortious conduct.

Anything in the Florida Constitution that may be construed so as to obstruct the State's rational and good faith effort through its Legislature and Executive Department to comply with

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[1]As a condition of participating in the Federal Medicaid program, the State must seek recovery of Medicaid expenditure from all liable third parties to the extent the reimbursement can be reasonably expected to exceed the costs of such recovery. 42 U.S.C. § 1396a(a)(25)(B). As stated in 50 Fed. Reg. 46,652, 46,658 (1985) (comments on revisions to 42 C.F.R. § 433.138) (emphasis supplied):

> [T]he Act requires that . . . where the amount the State can reasonably expect to recover exceeds the cost of recovery, the State must seek recover to the extent of liability. This section contains no exceptions, hence all third-party resources, including workers' compensation and tort liability, must be pursued to the limit of liability.

the federal Medicaid mandate would be in jeopardy of violating the Supremacy clause of the United States Constitution. Accordingly, given every court's obligation to construe state law, including provisions of the state Constitution, in a way that avoids conflict with the supreme federal law, it would be respectfully suggested that this Court should, if anything, apply a double dose of the presumption of constitutionality in this case.

3. There Is No Statutory or Constitutional Impediment to The State's Recovering Its Unique Aggregate Damages From Wrongdoers Who Are Proved to Have Caused The Expenditure of Taxpayer Monies.

To say there is something in the Florida Constitution that requires the State Legislature to proceed as though Florida stood in the shoes of every individual patient is basically to say that the Florida Constitution prevents the State from carrying out the mandate of the Federal Medicaid Act. The Florida Constitution clearly does not so provide. The equities, if any, between the tortfeasor and the Medicaid recipient have absolutely no bearing or logical relationship to the equities that may obtain in a lawsuit against the tortfeasor in behalf of the taxpayers who, as a matter of moral and legal obligation, have been required to pay for the damages caused by the wrongdoer. Whether the State's claim be founded on common law principles, or principles of equity such as restitution or indemnity or some other similar theory fashioned by equity to provide a remedy, or upon the 1990 Medicaid Third-Party Liability Act which clearly and unequivocally created a right of direct action by the State to recover its full damages from third-party tortfeasors, there is no constitutional right of a tortfeasor to interject the alleged fault of another to diminish its responsibility.

The nature of the State's claim involves the harm of a thousand cuts, . . . or more accurately millions. The State and its taxpayers have been injured in the aggregate because they

have been required to expend millions of dollars to pay for damages caused by the wrongful conduct of the Tobacco Industry. The State will have to prove that at trial. Proving the State's unique aggregate harm by competent, scientific statistical evidence and utilizing concepts of market share liability is a reasonable, responsible and appropriate method of matching the nature of the cause of action with the proof of the claim. Unquestionably, the federal mandate contemplates that the states have the right to and should pursue such remedies.

When viewed in the proper light, the 1990 Medicaid Third-Party Liability Act[2] as amended in 1994 is a proper and necessary exercise of the State's power to recoup tax dollars expended within the five year statute of limitations. The exercise of that right should not be emasculated by hypertechnical and unnecessary constructions of the law and the State Constitution.

PLAINTIFFS-APPELLEES' BRIEF

Plaintiffs argue that the 1994 Amendments violate the separation of powers doctrine and that the 1994 Amendments cannot be applied retroactively. Underlying such arguments is a basic misconstruction of the 1990 Act and the effect of the 1994 Amendments.

I. PLAINTIFFS MISCHARACTERIZE THE EFFECT AND APPLICATION OF THE 1994 AMENDMENTS.

Plaintiffs' arguments rise or fall on their premise that prior to the 1994 Amendments, the State only had two very limited "statutory remedies against potential third-party tortfeasors: assignment and subrogation;" and that prior to the 1994 Amendments, "the State stood in the shoes of the Medicaid recipient." (Pl. Br., p.28) Plaintiffs thus accuse the State of "historic

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[2]Plaintiffs have raised no issue regarding the constitutionality of the 1990 Act.

revisionism," recognizing that if the State previously enjoyed the substantive rights underlying the 1994 Amendments, their constitutional attack fails. For without question, the State has the right to legislatively establish new remedies to further the public interest, *Department of Environmental Regulation v. Goldring*, 477 So.2d 532 (Fla. 1985); *State v. Hamilton*, 388 So.2d 561, 563 (Fla. 1980), particularly when it is under a federal mandate to do so.

Thus, accepting arguendo plaintiffs' contentions regarding non-retroactive application of laws permitting the State a direct action to recover full damages incurred as a result of paying for wrongfully caused injuries to its citizens, if the State's rights preexisted the 1994 Amendments, then plaintiffs' arguments regarding retroactivity fail. Similarly, if the "procedural" aspects of the Amendments do not adversely impact on the Court's rulemaking power and are integral to the statutory scheme, they are not violative of the separation of powers doctrine. *Leapai v. Milton*, 595 So.2d 12 (Fla. 1992); *Van Bibber v. Hartford Accident & Indemnity Ins. Co.*, 439 So. 2d 880 (Fla. 1993); *Williams v. Campagnulo*, 588 So. 2d 983 (Fla. 1991).

A. Plaintiffs Ignore And Misconstrue The Changes in Florida Statutory Law Culminating in The 1990 Medicaid Third-Party Liability Act.

Although it should be clear that the State enjoys historical common law and equitable rights and remedies (*see* State's Initial. Br., pp. 26-32 and discussion *infra*, pp. 27-32), when properly viewed there can be no legitimate question but that as of the effective date of the 1990

Medicaid Third-Party Liability Act (July 3, 1990),[3] the State was entitled to recover all Medicaid expenditures caused by wrongful injuries to Florida Medicaid recipients.

In order to best dispel plaintiff's rhetoric, we append the session laws for the 1990 Act and the 1994 Amendments for the Court's consideration. *See* Ch. 90-295, App. 1 and Ch. 94-251, App. 2. Taking nothing out of context and simply reading the words of the statutes, this Court can readily see the effect of the 1994 Amendments on the pre-existing statutory law, thus debunking plaintiffs' claims that, "The 1994 Amendments rewrite this law from top to bottom" [Pl. Br., p.1]. Indeed, probably the most compelling answer to plaintiffs' mischaracterization of the 1990 Act vis-a-vis the 1994 Amendments is that the 1990 Act for the first time established a Florida "Medicaid Third-Party Liability Act"; the Act encompassed some twelve (12) pages of session law and supplanted section 409.266(4), Florida Statutes, a one page section of the "Medical Assistance" statute. In contrast, the 1994 Amendments, which if stacked on end yield less than two pages, simply fine-tune the 1990 vehicle to make it more efficient in carrying out the federal and state policy of full recovery from all liable third-party sources. Statutes are indeed intended to do something. *Sunshine State News v. State,* 121 So.2d 705, 707 (Fla. 3d DCA 1960). The 1990 Act was a major revamping of a previously limited, recipient dependent - subrogation oriented right of recovery. (*See* App. 3 for prior statutory provisions.) The 1990 Medicaid Third-Party Liability Act (note the name is not "Recipient Subrogation Act") established new and comprehensive rights and remedies for the State on behalf of its taxpayers.

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[3]The 1990 Act was enacted by two nearly synonymous session laws, Chapter 90-232, section 4, and Chapter 90-295, section 33, with effective dates that differ by three months. Ch. 90-295 (July 3, 1990); Ch. 90-232 (October 1, 1990). In its Initial Brief, p.3, the State referenced October 1, 1990, whereas the July 3, 1990 date controls.

A comparison of relevant provisions of the 1990 Act and 1994 Amendments shows the fallacy of plaintiffs' arguments:

1990 Enactment of the "Medicaid Third-Party Liability Act", Chapter 90-295, Laws of Florida	**1994 Amendments to the Medicaid Third-Party Liability Act, Chapter 94-251, Laws of Florida**
(1) It is the intent of the Legislature that Medicaid be the payor of last resort . . . . If benefits of a liable third-party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program or entity. Medicaid is to be paid in full from and, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien and subrogation, are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third-party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.	(1) It is the intent of the Legislature that Medicaid be the payor of last resort . . . . If benefits of a liable third-party are available, ~~discovered or become available after medical assistance has been provided by Medicaid~~, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien and subrogation, comparative negligence, assumption of risk, and all other affirmative defenses normally avail-able to a liable third-party, are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources; such principles shall apply to a recipient's right to recovery against any third-party, but shall not act to reduce the recovery of the agency pursuant to this section. The concept of joint and several liability applies to any recovery on the part of the agency. It is intended that if the resources of a liable third-party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources. Common law theories of recovery shall be liberally construed to accomplish this intent.
(7) When the department provides, pays for, or becomes liable for medical care . . ., it shall have the following rights, as to which the department may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits. . . .	

Comparing the statutes, it is clear that as of 1990, the Legislature unequivocally stated that Medicaid was to be payor of last resort; Medicaid was to be repaid in full and prior to any other person; principles of common law and equity as to assignment, lien and subrogation were abrogated to the extent necessary to ensure full recovery from third-parties ("Third-Party" was defined in 1990 as any party "that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid"). Ch. 90-295 (3)(p). The State was given the right to assert "independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits". Ch. 90-295(7). The 1990 Act is clear and unambiguous that the State had the right unfettered by any common law or equitable defenses to obtain all, full, 100% of Medicaid benefits from liable third-parties. Furthermore, under the established jurisprudence of the State of Florida, a jointly and severally liable party could not assert the comparative fault of another tortfeasor to reduce the claim of a damaged plaintiff. *Walt Disney World v. Wood*, 515 So.2d 198 (Fla. 1987) (leaving to the legislature whether, and how, to change joint and several liability); *Moore v. St. Cloud Utilities*, 337 So.2d 982, 984 (Fla. 4th DCA 1976); *Travelers Ins. Co. v. Ballinger*, 312 So.2d 249 (Fla. 1st DCA 1975). Although the Comparative Fault Act modified the doctrine of joint and several liability, it expressly retained joint and several liability for economic damages "when the percentage of fault of a defendant equals or exceeds that of a particular claimant". § 768.81(3), Fla. Stat. (1993). Thus, even under the Comparative Fault Act, in this uniquely and wholly economic damages action in which the innocent State is the "particular claimant", a tortfeasor would not be entitled to assert affirmative defenses that it might have against some third-party (such as the recipient) to reduce the State's claim.

It is thus clear that the 1994 Amendments did not change the obligations of any class of tortfeasors' that existed after the passage of the 1990 Act. The 1994 Amendments to Section (1) did "do something": they restated the effect of the 1990 Act in specific terms as to its impact on affirmative defenses. However, they neither created nor destroyed substantive rights.

Contrary to plaintiffs' assertions that the State had no independent right of recovery, stood in the shoes of the Medicaid recipient, and had only two avenues of recovery until the 1994 Amendments (Pl. Br., p.28), under the 1990 Medicaid Third-Party Liability Act the State had **four** statutorily established methods of recovery **in addition to** "independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits." Ch. 90-295(7). Indeed, plaintiffs would apparently have this Court overlook or ignore the statutory remedies plainly expressed in subsection (12) of Ch. 90-295 (emphasis supplied):

> The department may, as a matter of right, in order to enforce its rights under this section, **institute**, intervene in, or join any legal proceeding **in its own name** in one or more of the following capacities: **individually**, as **subrogee** of the recipient, as **assignee** of the recipient, or as **lien holder** of the collateral.

Since plaintiffs simply say "it ain't so" and pretend the 1990 enactment of the Medicaid Third-Party Liability Act did nothing to change the nominal rights afforded under prior law, we would ask this Court to consider the relevant provisions of the 1990 Act that established four (4) expansive rights of recovery for the State in addition to "independent principles of law."

1. Statutory Subrogation Right. The first remedy in the 1990 statutory scheme is a subrogation right:

> (7)(a) The department is automatically subrogated to any rights that an applicant, recipient or legal representative has to any third-party benefit for the full amount of medical assistance . . . .

> Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the department from any and all third-party benefits. Equities of a recipient, his legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recoveries . . . .

Ch. 90-295(7)(a). This provision thus created an exceptional statutory right of subrogation that superseded the rights of any third-parties. The plaintiffs are correct, however, that the language of the subrogation provision deals primarily with placing the State in front of innocent creditors and health care providers. (As a matter of common sense, one might ask why the State would supersede the contractual, legal and equitable rights of innocent third-parties but, according to plaintiffs, not provide itself a similar remedy against the wrongdoer who caused the harm in the first place). However, there is no arguable basis to suggest that the second remedy furnished by the 1990 Act - statutory assignment - was limited in any respect.

2. Statutory Assignment. The 1990 Act created a new statutory assignment right whereby the recipient "automatically assigns to the department any right, title and interest such person has to any third-party benefit . . . ." Ch. 90-295(7)(b). Although this wording is similar to the old law, the 1990 Act expanded the assignment language to provide, "The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the department . . . ." Ch. 90-295(7)(b)1. Banishing any doubt as to the breadth of the State's right to full recovery under its statutory assignment, the 1990 law further provided that the "department is a bonafide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person." Ch. 90-295(7)(b)2. Thus, by virtue of its statutory assignment, the State was expressly <u>not</u> <u>burdened</u>

with any of the legal or equitable liabilities that may have inhered in the recipient. The State became a "bonafide assignee," thus cutting off the right of any third-party to assert defenses it might have against the recipient.[4]

3. Statutory Lien. The third vehicle for recovery was "an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient . . . for which a third-party is or may be liable . . . ." Ch. 90-295(7)(c). Such lien created a 100% payback, regardless of any rights a third-party might have against the recipient. Indeed, the 1990 law provided that if the third-party paid a recipient or obtained a release, that the state "may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid." Ch. 90-295(7)(c)7.

4. Direct Action Recovery From Any Third-Party. The fourth right of full recovery provided that the "department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits. (a) Recovery of such benefits shall be collected directly from: (1) any third-party . . . ." Ch. 90-295(8).

None of the foregoing provisions were altered or changed by the 1994 Amendments. However, the 1994 Amendments contained a reiteration of the independent right and remedy of the State established in 1990 by providing that "The agency has a cause of action against a liable

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[4]The Legislature's use of the term "bona fide assignee for value" is clearly a legal term of art confirming that the State takes the assignment free and clear of any claims that may be made against the recipient - assignor. Similarly, for example, under the Uniform Commercial Code, "a bona fide purchaser in addition to acquiring the rights of a purchaser (§ 678.301) also acquires his interest in the security free of any adverse claim."; § 678.301, Fla. Stat. (1993), Florida Code Comments (emphasis supplied). *See The First National Bank of Florida Key v. Rosasco*, 622 So. 2d 554, 555 (Fla. 3rd DCA 1993).

third-party to recover the full amount of medical assistance provided by Medicaid, and such cause of action is independent of any rights or causes of action of the recipient." Ch. 94-251(6)(a). [Compare similar provisions, 90-295(1), (8) and (12).] Plaintiffs' primary focus is on the foregoing provision and the other words in the 1994 Amendments which refer to the State's independent cause of action. Understandably, plaintiffs would prefer to ignore the 1990 Act which established this right so as to argue that the State can only recoup its payments after 1994. However, plaintiffs cannot erase the written words of the 1990 Act and their histrionic rhetoric regarding the 1994 Amendments should not be permitted to mislead this Court.

It is thus indisputable from the plain language of the 1990 statute that, as of the passage of that law, the State had a superior statutory subrogation right which placed its claim above all others; a statutorily created assignment right which it took without any liabilities inhering in the recipient and which was exercisable directly against any third-party; a lien right which, if not satisfied by a third-party, gave it a right of 100% recovery from the third-party; and a statutory independent right to directly recover full payment from "any third-party." Ch. 90-295(8). The four statutorily created rights to recover full benefits were in addition to any "independent principles of law" which were to be "construed together to provide the greatest recovery." Ch. 90-295(7). (This was of course mirrored by the 1994 Amendments provision that "common law theories of recovery shall be liberally construed to accomplish this intent" and "the evidence code shall be liberally construed regarding the issue of causation and of aggregate damages.")

B. The Cases Cited by Plaintiffs Support the State of Florida's Independent Right to Recover Taxpayers' Medicaid Expenditures

Rather incredibly, plaintiffs suggest that the decision in *Underwood v. Department of HRS*, 551 So. 2d 522 (Fla. 2d DCA 1989), *rev. den.*, 562 So. 2d 345 (Fla. 1990), confirms their assertion that prior to 1994, the State had no rights greater than the Medicaid recipient. Indeed, they argue that if the State had an "independent cause of action" the District Court in *Underwood* "would never have held that the 'principles of subrogation' governed the State's claim." (Pl. Br., p. 30). Unquestionably, the *Underwood* holding that the limited subrogation provisions of the "Medical Assistance" law precluded the State from making 100% recovery of Medicaid funds was a major impetus for enactment of the comprehensive Medicaid Third-Party Liability Act. Although it is true there are no appellate court decisions construing the 1990 Act[5], plaintiffs are plainly wrong when they argue no case has held that the 1990 Act created new and independent causes of action in the State.

Appended (App. 4) is the Circuit Court decision in *Underwood v. Fifer*, 50 Fla. Supp. 2d 199 (Fla. 10th Cir. Ct. 1991), which came on remand from the Second District's decision in *Underwood v. Department of HRS*. Although *Underwood* involved the State's attempt to recover Medicaid benefits from a settlement received by the recipient, as opposed to bringing a direct action against the tortfeasor, the court's review of the law on remand cogently rejects the

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[5]Implicit in plaintiffs' sophistic argument is a suggestion that if the State previously enjoyed these rights, why did it wait until 1994 to exercise them. The fact that the State previously chose not to exercise its political prerogative does not negate the existence of the power to do so. The extraordinary alignment of special interests in these proceedings is ample proof of the drain on the State's resources to prosecute such a claim. Indeed, it is because had Florida voters re-elected Governor Chiles' in 1994, that this political prerogative continues to be exercised in the State's pending lawsuit against the Tobacco Industry.

arguments made here by plaintiffs. First, the court notes that the former "Medical Assistance" recovery provisions were "superseded" by the Medicaid Third-Party Liability Act, which is "part of a complex state and federal regulatory framework. " (50 Fla. Supp. 2d at 201). The court also observed that the 1990 Act was passed not only to correct the problems raised by the *Underwood* decision, but to bring Florida law into "closer compliance with federal requirements" and "to clarify the historic intent of the Legislature as to full recovery by the State." 50 Fla. Supp. 2d at 202. The court found that under the new Medicaid Third-Party Liability Act, the State "has multiple independent rights of recovery, which are to be construed together to provide the greatest recovery to the state from third-party resources, without reduction based on equitable remedies . . . " and that this "clearly complies with federal interpretations of governing federal law requiring full reimbursement to the State Medicaid Agency and federal government from amounts paid or payable by liable third parties . . . ." 50 Fla. Supp. 2d at 203. The court went on to hold,

> "While statutory changes in law are normally presumed to apply prospectively, procedural or remedial changes may be immediately applied to pending cases . . ." *Heilman v. State*, 310 So. 2d 376, 377 (Fla. 2d DCA 1975). "If a statute is found to be remedial in nature, *it can and should be retroactively applied* in order to serve its intended purposes *City of Orlando v. Desjardins*, 493 So. 2d 1027, 1028 (Fla. 1986), (emphasis added)." "By definition, a remedial statute is one which confers or changes a remedy; a remedy is the means employed in enforcing a right or in redressing an injury." *St. Johns Village I, Ltd. v. Dept. of State, Division of Corporations*, 497 So. 2d 990, 993 (Fla. 5th DCA 1986).

50 Fla. Supp. at 203-04. Although the District Court had determined that the State could only receive partial recovery on the basis of equitable distribution under the old law, the trial court applied the 1990 assignment provisions of the new Act (which abrogated the "latent equities" of

third persons or the recipient) and held the State entitled to full recovery of all Medicaid benefits paid to the recipient. In short, the very case cited by plaintiffs for their myopic view of the 1990 Act refutes their arguments.[6]

Plaintiffs simply have sought to mislead this Court as to the scope of the State's remedies and its right to proceed independently under the 1990 Medicaid Third-Party Liability Act. They erroneously assert that the State's "only" statutory remedies of subrogation and assignment are limited by traditional common law and equitable principles, arguing that: "In the Medicaid context, courts around the country have recognized that the statutory remedies of subrogation and assignment in state Medicaid statutes should be given their ordinary meaning, unless expressly modified by statute." (Pl. Br., p.29, emphasis supplied.) [citing *Kittle v. Icard*, 185 S.E.2d 126 (W. Va. 1991); *Smith v. Alabama Medicaid Agency*, 461 So.2d 817 (Ala. Civ. App. 1984); *State v. Cowdell*, 421 N.E.2d 667, 671 (Ind. Ct. App. 1981); and *White v. Sutherland*, 585 P.2d 331 (N.M. Ct. App. 1978), *cert. denied*, 582 P.2d 1292 (N.M. 1978)]. However, the exception is the rule in Florida because, unlike in the cases cited by plaintiffs, the Florida legislature "expressly modified" the statutory remedies available to the State by passage of the 1990 Act.

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[6]Similarly, *O'Melveny & Meyers v. Federal Deposit Ins. Corp.*, 512 U.S.____, 114 S.Ct. 2048, 129 L.Ed. 2d 67 (1994) provides no support to plaintiffs' position, for it turns not on any supposed principle against construing statutes to afford the Government a monetary remedy against wrongdoers [as plaintiffs suggest (Pl. Br., p.30, n.31)], but rather on the absence of a general federal common law, which precluded the judicial creation of a federal-law duty of liability. *See* 114 S. Ct. at 2053. More fundamentally, however, *O'Melveny & Meyers* proves precisely the opposite of what plaintiffs believe. The Court explained that it would not "adopt a *judge-made* rule to supplement federal statutory regulation that is comprehensive and detailed" because "matters left unaddressed in such a scheme are presumably left subject to the disposition provided by *state law*." 114 S. Ct. at 2054 (emphasis added). That is exactly what the Florida Third-Party Medicaid Liability Act does.

A review of the state statutes addressed in the foreign cases cited by plaintiffs reflects laws similar to the limited Florida provisions which predated the comprehensive 1990 Act. A comparison of the West Virginia, Alabama, Indiana and New Mexico statutes with the 1990 Act highlights that the legislature did in fact establish a much broader, independent right of recovery for the State of Florida. In plaintiffs words, in 1990, the Florida law was "expressly modified by statute," as plaintiffs' argue must occur (Pl. Br., p.29) so as to establish the remedies which are in issue on this appeal. In sum, plaintiffs compare apples with oranges. When viewed against the West Virginia, Alabama, Indiana and New Mexico statutes, it is clear that the remedies of subrogation and assignment were expressly modified by the 1990 Florida Medicaid Third-Party Liability Act and principles of common law and equity were "abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources." Ch. 90-295 (1).

Similarly, plaintiffs misconstrue *Waldron v. Miami Valley Hosp.*, 1994 WL 680152, at 19-20 (Ohio Ct. App. 1994), *appeal denied*, 72 Ohio St.3d 1415 (1995), as supporting their argument that under the Florida Medicaid Third-Party Liability Act, the State is limited to the rights of an injured Medicaid recipient. (Pl. Br., p.31, n.33) The reason the *Waldron* court refused to interpret the Ohio statute in accord with case law interpreting federal law [7] was that

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[7]The federal Act under discussion in *Waldron* was the Federal Medical Care Recovery Act which has been interpreted by several courts, including a Florida decision, as providing the United States with an independent cause of action not limited to the subrogation rights of the injured party. *United States v. Merrigan*, 389 F.2d 21, 23 (3rd Cir. 1968) (allowing separate cause of action against tortfeasor even though injured recipient had already sued and recovered for his injuries); *United States v. Moore*, 469 F.2d 788, 792 (3rd Cir. 1972) (Medical Care o recovery Act confers on the United States an independent right of recovery unimpaired by the vagaries of state family immunity laws); *United States Automobile Ass'n v. Holland*, 283 So.2d 381, 385 (Fla. 1st DCA 1973) (allowing for recovery of medical expenses paid by the United States even though state no-fault insurance law immunized the tortfeasor from liability to the

Ohio's statute (unlike Florida's) only adopted a right of subrogation derived from the Medicaid recipient and did not provide for "an independent right of recovery." 1994 WL 680152, at 19.

A closer reading of *Waldron* shows that the case supports the validity of Florida's Medicaid Third-Party Liability Act. The decision in *Waldron* implies that if Ohio's Medicaid statute[8] had provided for an independent right of recovery, the court would have enforced it. In short, when *Waldron* is properly construed, it stands for the proposition that if Ohio had a recovery statute like the 1990 Florida Medicaid Third-Party Liability Act which provided for abrogation of "[p]rinciples of common law and equity as to assignment, lien, and subrogation . . . to the extent necessary to ensure full recovery by Medicaid from third-party resources," [Ch. 90-295(1)] and provided that the State may "assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits," [Ch. 90-295(7)] then the State of Ohio would not have been fettered with the recipient's baggage.

The language of Florida's 1990 Medicaid Third-Party Liability Act is similar to the language in the Federal Medical Care Recovery Act which allows for an independent right of recovery. Therefore, the distinction made in *Waldron* under Ohio's rudimentary statute is inapplicable to Florida's law.

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recipient of medical services).

[8]The limited Ohio law is probably most comparable to Florida's law as it existed back in 1978. (App. 4). Section 5101.58, Ohio R.C. provides:

> The acceptance of aid . . . gives a right of subrogation to the department of human services and the department of human services of any county against the liability of a third party for the cost of medical services and care arising out of the injury, disease, or disability of the recipient.

Furthermore, when this Court has had occasion to consider other statutory public welfare schemes, it has repeatedly allowed the State broad latitude in enforcing its rights against third parties. Just as plaintiffs try to narrow the vision of the Court to prevent it from reading the 1990 Medicaid Third-Party Liability Act to accomplish its purposes, an absent, non-supporting father argued for a restrictive reading of a statutory term ("debt") in *Lamm v. Chapman*, 413 So.2d 749 (Fla. 1982). Dealing with AFDC, also a Chapter 409 program, this Court insisted on complying with legislatively announced public policy and held that the use of civil contempt did not violate the constitutional guarantee against imprisonment for debt:

> The error in the argument that the legislature intentionally used the term "debt" in section 409.2561(1) to restrict the state's use of civil contempt becomes clear upon **examination of the entire statutory scheme** for Aid to Families with Dependent Children. In sections 409.235-.2597, Florida Statutes (1979), the legislature created a comprehensive program to furnish financial and rehabilitative assistance to dependent children and established guidelines for program entitlement and payment. **The legislature also expressed the intention to limit the expenditure of public funds for this program by stating: "It is declared to be the public policy of this state that this act be construed and administered** to the end that children shall be maintained from the resources of responsible parents, **thereby relieving, at least in part, the burden presently borne by the general citizenry through public assistance programs.**" § 409.2551, Fla. Stat. (1979).

Lamm, 413 So.2d at 751-52 (emphasis supplied). The Court then noted that:

> Section 409.2561 is **designed to implement this policy** by laying out a procedure whereby the state is authorized **to fulfill its responsibilities** both to dependent children and **to the taxpayers**.

413 So.2d at 752 (emphasis supplied). Completing its review, the Court declared:

> After considering all of the provisions of section 409.2561, together with **the declared public policy** regarding child support, we conclude the legislature did not intend to prohibit the state from

> using civil contempt as **one means of securing repayment of public moneys** and of ensuring that responsible parents fulfill their obligation to provide continuing reasonable child support.

413 So.2d at 752 (emphasis supplied). Accordingly, as the Court should do in interpreting the means of securing Medicaid repayment under the 1990 Medicaid Third-Party Liability Act, this Court interpreted the AFDC statute in line with the announced public policy:

> In our view, the term **'debt'** in section 409.2561(1) was **used in the broad sense to indicate** that a responsible parent who has the ability to pay child support **will not be allowed to avoid this obligation solely because the state, through necessity, has provided public assistance.**

413 So.2d at 752 (emphasis supplied).

Following *Lamm*, the legislature continued to enhance the ability to obtain support for dependent children and to protect the public treasury. It adopted section 61.17(3), Florida Statutes (1989) which, according to this Court in *Gibson v. Bennett*, 561 So.2d 565, 569 (Fla. 1990), provides for the use of contempt proceedings to enforce a judgment for support arrearages. Importantly for the 1990 Medicaid Third-Party Liability Act (as well as the 1994 Amendments), the *Gibson* court went on to observe:

> **While section 61.17(3) took effect after the events in this case, the statute merely embodies the preexisting public policy** that equitable remedies, including contempt, are available to enforce a judgment for support arrearages.

561 So.2d at 569 (emphasis supplied). The Court also noted a change in the Revised Uniform Reciprocal Enforcement of Support Act for collecting arrearages after a child is no longer dependent, and said:

> This amendment is further evidence of **the general legislative intent, apparent from the statute even before the amendment,**

> **that** custodial parents and **the general citizenry** of the state through public assistance programs **be relieved of the burden** imposed by a nonpaying parent.

561 So.2d at 572 (emphasis supplied).

Thus, in *Lamm* and *Gibson*, the Court demonstrated the depth of its understanding of the public policy of the State of Florida to protect the public treasury from those who would shift to the taxpayers responsibility for their own acts. The same consideration should be accorded the State's efforts under the Medicaid Third-Party Liability Act and the 1994 Amendments.

II. THE TOBACCO INDUSTRY AND AFFECTED WRONGDOERS HAD "FAIR NOTICE" OF THE CONSEQUENCES OF THEIR ACTS AND CANNOT LEGALLY COMPLAIN ABOUT BEING HELD ACCOUNTABLE FOR THE STATE'S DAMAGES CAUSED BY THEIR WRONGFUL CONDUCT

It is true that there is a bias against retroactive application of substantive legislation. This "bias" is generally not controlling when considering legislation such as the 1994 Amendments which are clearly remedial and designed to further the public interest. *City of Orlando v. Desjardins*, 493 So.2d 1027, 1028-29 (Fla. 1986). In any event, as stated by plaintiffs, citing *Landgraf v. U.S. Film Products*, 511 U.S. ____, 114 S. Ct. 1483, 128 L.Ed. 2d 229 (1994), retroactive considerations are to "insure that persons receive 'fair warning' of what conduct may give rise to liability and prevents the legislature from taking 'retribution against unpopular groups or individuals' *Landgraf*, 114 S. Ct. at 1497." [Pl. Br., p. 25]. However, the Tobacco Industry and plaintiffs have had "fair warning" for decades that they may be held accountable for not only medical expenses, but other damages caused by sale of their defective products. *Green v. American Tobacco Co.*, 154 So. 2d 169 (Fla. 1963). Since the 1968 amendments to the Federal Medicaid Act, 42 U.S.C. § 1396a(a)(25), they have had "fair warning" that they may be held

accountable for 100% of the taxpayers' money spent to pay for the medical care of their victims. (See n.2 *supra*). Clearly, they have had "fair warning" since the 1990 enactment of the Medicaid Third-Party Liability Act that "any" third-party is subject to direct suit by the State of Florida to recover 100% of Medicaid expenditures for indigent citizens who are injured by defective products. As noted by the U.S. Supreme Court in *Landgraf*,

> A statute does not operate 'retrospectively' merely because it is applied in a case arising from conduct antedating the statutes enactment. . . [citations omitted], or upsets expectations based on prior law. Rather, the Court must ask whether the new provision attaches new legal consequences to events completed before its enactment.

114 S. Ct. at 1499. There can be no question but that tortfeasors and manufacturers of defective products have been on "fair notice" of the consequences to pay damages arising out of their tortious conduct. The fact that the procedures for enforcing the general consequences may change from time to time is irrelevant. "Because rules of procedure regulate secondary rather than primary conduct, the fact that a new procedural rule was instituted after the conduct giving rise to the suit does not make application of the rule at trial retroactive." *Landgraf*, 114 S. Ct. at 1502.[9] Indeed, after passage of the 1990 Act, there can be no question but that tortfeasors were on "fair notice" of the specific consequence of being sued by the State of Florida for recoupment

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[9]"Modification of remedy merely adjusts the extent, or method of enforcement, of liability in instances in which the possibility of liability previously was known." *Hastings v. Earth Satellite Corp.*, 628 F.2d 85, 93 (D.C. Cir. 1980), *cert. denied*, 449 U.S. 905, 101 S.Ct. 281 (1980). *See also, Ratner v. Hensley*, 303 So.2d 41, 45 (Fla. 3rd DCA 1974) (alteration or modification of remedies to provide basis for "obtaining redress for breach of preexisting duties" is not retroactive legislation).

of all medical payments incurred by the State as a result of the proven fault of a party who caused or contributed to causing the injury to the Medicaid recipient.

A. The 1994 Amendments Do Not Violate Constitutional Rules Against Retroactivity

The Federal Constitution plainly does not bar retroactive application of the 1994 Amendments. The only requirement for such application is a showing "that the retroactive application of the statute is itself justified by a rational legislative purpose." *Pension Benefit Guaranty Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 730, 104 S. Ct. 2709, 81 L.Ed. 2d 601, (1984). The Act is a curative provision,[10] designed to alleviate the unfair burdens placed on Florida taxpayers by their forced subsidization of the enormous health costs that rightfully should be paid by the Tobacco Industry. "It is surely proper for Congress to legislate retrospectively to ensure that costs of a program are borne by the entire class of persons that Congress rationally believes should bear them." *United States v. Sperry Corp.*, 493 U.S. 52, 65, 110 S. Ct. 387, 396, 107 L.Ed. 2d 290 (1989). The rules of primary conduct are unaffected. The period of retroactivity is only a "modest" one, *Carlton,* 114 S. Ct. at 2022, designed to allow the State to sue within five years of Medicaid expenditures. he Supreme Court has upheld other, much more dramatic, retroactive laws. *See, e.g., Usery v. Elkhorn Turner Mining Co.*, 428 U.S. 1, 96 S. Ct.

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[10]Plaintiffs cite *State Dept. of Revenue v. Zuckerman-Vernon Corp.*, 354 So.2d 353, 358 (Fla. 1977), for the principle that inclusion of an effective date rebuts any argument that the legislature intended retrospective application of the law. *Zuckerman* cites no authority for this point, and the State has found no other Florida case that ascribes such significance to an effective date. The fact that Ch. 94-251(7), Laws of Florida, provides for an effective date of July 1, 1994, indicates nothing about the legislature's intent with respect to retroactive application. In any event, remedial statutes are presumed to be retroactive irrespective of the fact that they contain an effective date. *See City of Orlando v. Desjardins*, 493 So.2d 1027, 1028 (Fla. 1986).

2882, 49 L.Ed. 2d 752 (1976) (upholding a federal law requiring coal mine operators to compensate former employees disabled by black lung disease, even though the operators had never expected such liability and the employees had long since ended their connection with the industry); *Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust,* 508 U.S. _____, 113 S. Ct. 2264, 124 L.Ed. 2d 539 (1993) (upholding a multiemployer pension statute that vastly (and retroactively) increased an employer's pension liabilities far in excess of what a series of private contracts and labor agreements had provided).

B. The State's Payment of Medicaid Benefits is the Final Element of the Cause of Action

In 1990, the State limited its recovery to payments made five (5) years prior to the date "of discovery of facts giving rise to a cause of action under this section." Ch. 90-295(12)(h). This provision was amended in 1994 to make it clear that for purposes of the five year recovery period, each "item of expense" is to be considered "a separate cause of action." Ch. 94-251(12)(h). It is the payment of Medicaid benefits which is the final component of the State's cause of action, not when the wrongful acts occurred that ultimately resulted in the damage. This is consistent with Florida law construing when a cause of action accrues. *See, e.g., Peat, Marwick, Mitchell & Co. v. Lane*, 565 So.2d 1323 (Fla. 1990); *Throneburg v. Boose*, 1995 WL 455442 (Fla. 4th DCA 1995); *Bierman v. Miller*, 639 So.2d 627 (Fla. 3d DCA 1994); *Whack v. Seminole Memorial Hospital, Inc.*, 456 So.2d 561 (Fla. 5th DCA 1984). Even under the most restrictive application of the Act, payments made within five years of institution of suit under the Medicaid Third-Party Liability Act should be recoverable.

III. THE EQUITABLE RIGHTS OF THE STATE PRE-DATING THE 1990 ACT ARE REQUIRED "TO BE CONSTRUED TOGETHER TO PROVIDE THE GREATEST RECOVERY FROM THIRD-PARTY BENEFITS"

The 1994 Amendments did modify the law; but they did not create new substantive duties or deprive defendants of fundamental rights. The Amendments simply applied the rights of the State established by Florida common law and the 1990 Act in the product liability context. The duty of the defendants long predated the 1990 statute. The wrong has traditionally been recognized by Florida law. The right of the State predated the 1990 statutes and was statutorily recognized and enhanced by the 1990 statutes. The class of wrongdoers represented by the plaintiffs have been on notice of the potential consequences of their acts for decades. Those wrongdoers were also charged with notice that the State of Florida would pay the medical expenses for indigent Floridians.[11] The 1994 Amendments simply facilitate the long-established rightful remedy of the State for redress of the great harm which it has suffered due to the neglect or defective products of third-parties. The Amendments should be applied to any claims falling within the five-year provision of the Act.

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[11]In *United Services Automobile Ass'n v. Holland*, 283 So.2d 381, 385-86 (Fla. 1st DCA 1973), the court, through Judge John Wigginton refused to permit Holland's insurer to avoid reimbursement of losses paid by the United States. And, applying equity reasoning, the court noted that when the insurer there issued the policy, it was charged with knowledge that the medical expenses "would be paid by the Government which under the law had a right to claim reimbursement from the tortfeasor." 283 So.2d at 385. The court then refused to "create a windfall in the [insurer's] favor and bring about an unconscionable and inequitable result. This we are not willing to do." 283 So.2d at 386.

Restitution/Unjust Enrichment/Indemnity

Florida courts have clearly recognized the law of restitution as set out in the Restatement. *See, e.g., Stuart v. Hertz Corp.*, 351 So.2d 703, 705 (Fla. 1977). Under the law of restitution -- which with unjust enrichment shares many equitable features with the law of indemnity[12] -- the State "is entitled to restitution from the other if . . . the things or services supplied were immediately necessary to satisfy the requirements of public decency, health, or safety." *Restatement of Restitution*, § 115. Plaintiffs simply beg the question by arguing that the State will have to prove a breach of a duty prior to being entitled to restitution. That is what the State's law suit will rise or fall upon: proof that the defendant was negligent or sold defective products (the breach of a duty) which required the State to incur the medical expenses.

The Plaintiffs suggest there needs to be some particular kind of "special relationship" for indemnity to apply. In fact, all that is necessary is that the indemnitor be in such a position, as regards the indemnitee (the State), to be "vicariously, constructively, derivatively or technically liable" to pay the damages caused by the indemnitor. *Houdaille Industries, Inc. v. Edwards*, 374 So.2d 490, 493 (Fla. 1979) (clarifying that terminology can obscure the real question: fault or no fault?). The Tobacco Industry's assertion that the State cannot use the law of indemnity to recover Medicaid benefits because the State was under no duty to provide Medicaid benefits cannot be squared with the facts. (Pl. Br., p.40, n 39.) With the passage of the Florida Medicaid

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[12]Hence, the directive of the 1990 Medicaid Third-Party Liability Act that the State "may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits. . . ."

program in 1969, the law obligated the State[13] to provide financial assistance for medical care of the Florida poor. *See Florida v. Mathews*, 526 F.2d 319, 326 (5th Cir. 1976) ("Once a state chooses to participate in a federally funded program, it must comply with federal standards."). A legal relationship thus was born.

Despite knowledge of this ongoing legal relationship, the Tobacco Industry has continued to market and sell its tobacco products to the citizenry of Florida and, moreover, to use this legal relationship to its benefit and advantage. The Tobacco Industry does so with full knowledge that (1) its tobacco products are a leading cause of health problems, and (2) the State is legally obligated to pay the health care costs of the poor.[14] The plaintiffs' "volunteer" argument against indemnity is sophistry. It also overlooks *West American Ins. Co. v. Yellow Cab Co.*, 495 So.2d 204, 207 (Fla. 5th DCA 1986), which applied "legal" or "equitable" subrogation, also known as

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[13]To characterize undertaking this legal obligation to provide health care to the poor as "voluntary" is meaningless, as all legislation is voluntary.

[14]For example, the legal obligation of the State to provide medical care for its indigents compares to the legal obligation of a shipowner to provide maintenance and cure for its crew. When a crewman is tortiously injured and the shipowner provides maintenance and cure, the law of indemnity allows the shipowner to obtain full indemnity from the tortfeasor even if the crewman was contributorily negligent himself. *Adams v. Texaco, Inc.*, 640 F.2d 618, 620 (5th Cir. 1981); *Savoie v. Lafourche Boat Rentals, Inc.*, 627 F.2d 722 (5th Cir. 1980); *Richardson v. St. Charles-St. John the Baptist Bridge & Ferry Authority*, 284 F.Supp. 709 (E.D.La 1968). Although *Adams* and *Savoie* were decided before the adoption of comparative fault in such cases, the law has recently been comprehensively reviewed and remains the same - it shifts the whole loss from the innocent shipowner to the wrongdoer. *Bertram v. Freeport McMoran, Inc.*, 35 F.3d 1009 (5th Cir. 1994). Citing *Richardson*, the Fifth Circuit in *Adams*, 640 F.2d at 620, n. 2, set out the philosophy underlying the application of equitable indemnity: "[I]mposition of liability on the tortfeasor for maintenance and cure is not too 'indirect' a consequence of his negligence to allow recovery. The shipowner's obligation--imposed by the law itself--is not so unforeseeable by a tortfeasor as to bar recovery. This is not a private contractual obligation undertaken by the shipowner."

indemnity [*Allstate Ins. Co. v. Metropolitan Dade Co.*, 436 So.2d 976 (Fla. 3d DCA 1983)], to allow recovery notwithstanding the absence of any pre-accident relationship between the blameless indemnitee and the tortfeasor-indemnitor. Moreover, the State payment of these health care costs inures to the Tobacco Industry's benefit inasmuch as the incentive for the poor to sue the Tobacco Industry in order to obtain health care has been removed.

The plaintiffs take the unsupported position (Pl. Br., p.40) that, even though the affirmative defenses of parent/child immunity or workers' compensation immunity have been held not to defeat indemnity actions, for some unarticulated reason comparative fault is different. The plaintiffs assert that the courts "with substantial unanimity" allow the defenses of comparative fault or assumption of risk against an indemnity claim. However, they erroneously cite foreign cases dealing , not with indemnity, but with limited statutory subrogation claims by employers who did step only into the shoes of their employees. Plaintiffs did not need to go out of state to make that unremarkable, but wholly irrelevant point. *Maryland Casualty Co. v. Smith*, 272 So.2d 517 (Fla. 1973); *Fidelity & Cas. Co. of N.Y. v. Bedingfield*, 60 So.2d 489 (Fla. 1952).

Similarly, in a curious footnoted argument (Pl. Br., p.40, n.40), plaintiffs distort the State's position. The State fully expects to prove that for decades the Tobacco Industry engaged in "active, culpably wrong" acts.

The centerpiece of plaintiffs' argument against the pre-existing remedy of equitable indemnity hangs by a thread from *Scott & Jobalia Construction Co. v. Halifax Paving, Inc.*, 538 So.2d 76, 79 (Fla. 5th DCA 1989), *aff'd* 565 So.2d 1346 (Fla. 1990), which stated that one of the ingredients of a claim for indemnity is that "the indemnitor must have a coextensive liability to

the plaintiff." (Pl. Br., p.39, emphasis in original). In light of a number of factors, it is highly questionable if "coextensive liability" is required under Florida equitable indemnity law.

First, it must be pointed out that this ambiguous term -- indeed much of the indemnity analysis -- in *Scott & Jobalia* was dicta, as the decision turned on the issue of immunity from suit under worker's compensation law. *Scott & Jobalia*, 538 So.2d at 80-82. Moreover, the derivation of this undefined concept is not to be found. The court in *Scott & Jobalia*, 538 So.2d at 79, n.3, relies upon three authorities for the proposition of "coextensive liability." Neither of the two decisional authorities, *Allstate Insurance Co. v. Metropolitan Dade County*, 436 So.2d 976, 978 (Fla. 3d DCA 1983), *rev. denied*, 447 So.2d 885 (Fla. 1984), and *Houdaille Industries, Inc. v. Edwards*, 374 So.2d 490 (Fla. 1979), make any mention of "coextensive liability" in their treatment of indemnity. *Allstate* states that so long as there is the requisite relationship between the indemnitor and indemnitee and there is no fault on the part of indemnitee, indemnification is proper. 436 So.2d at 978. Indeed, *Houdaille*, in setting out the principles of Florida indemnity law, states that: "Indemnity can only be applied where the liability of the person seeking indemnity is solely constructive or derivative and only against one who, because of his act, has caused such *constructive* liability to be imposed." 374 So.2d at 493. This supports the State's position that while in its recoupment action it must show that the Tobacco Industry committed wrongful acts that caused the State to expend vast resources under the Medicaid program, the State need not document the Tobacco Industry's tort liability on a smoker-by-smoker basis.

Finally, the Corpus Juris Secondum authority relied upon, 42 C.J.S. *Indemnity* § 25 at 603-04 (1944), now at 42 C.J.S. *Indemnity* § 41 at 133-35 (1991), makes no mention of "coextensive liability". Rather, it states, in pertinent part, that "the prospective indemnitor must

also be liable to the third-party, and as between the prospective indemnitee and indemnitor, the obligation ought to be discharged by the indemnitor." 42 C.J.S. *Indemnity* § 41 at 134. Thus, the indemnitor must pay one hundred percent of the obligation discharged by the indemnitee, not that the obligation of the indemnitor to the third-party be identical to the obligation of the indemnitor to the indemnitee. Accordingly, one must conjecture that the court's use of the term "coextensive liability" was inadvertent paraphrasing. Moreover, by virtue of the 1990 Medicaid Third-Party Liability Act, these independent principles of law are required to be construed together to provide the greatest recovery from third-party benefits.

IV. THE AGGREGATE DAMAGES, LIBERAL CONSTRUCTION AND MARKET SHARE PROVISIONS OF THE 1994 AMENDMENTS DO NOT UNCONSTITUTIONALLY VIOLATE THE SEPARATION OF POWERS DOCTRINE

The aggregate damages (so-called "joinder") provisions of the 1994 Amendments do not have the subversive purpose argued by plaintiffs and are a necessary and appropriate legislative exercise to implement the federal and state policy of recovery of Medicaid expenditures. Under the 1990 Act, when the state brought suit to enforce its rights, it was required to give notice to the recipient. Ch. 90-295(12)(a). This section was amended in 1994 so as to eliminate the right of the recipient (not any rights of the Tobacco Industry) to notice when the state determined to bring a claim for its aggregate damages arising out of multiple payments. Thus, the notice section of the 1990 Act was amended by the 1994 Amendments to provide,

> The provisions of this subsection [requiring notice] shall not apply to any actions brought pursuant to subsection (9), and in any such action, no notice to recipients is required, and the recipient shall have no right to become a party to any action brought under such subsection.

Ch. 94-251 (12)(a). Subsection (9) of the 1994 Amendments, rather than being an egregious, unconstitutional "joinder" provision as asserted by plaintiffs, was promulgated to permit the State to bring a claim for its aggregate damages incurred as a result of paying benefits to hundreds or thousands of health care providers. Subsection (9)(a) provided that when the agency seeks recovery from liable third parties "due to actions by third parties or circumstances which involve common issues of fact or law, the agency may bring an action to recover sums paid to all such recipients in one proceeding." Similarly, since the recipients were not entitled to notice or to intervene in such actions, the 1994 Amendments provide that when the number of recipients "is so large as to cause it to be impracticable to join or identify each claim, the agency shall not be required to so identify the individual recipients . . ., but rather can proceed to seek recovery based upon payments made on behalf of an entire class of recipients." Ch. 94-251(9)(a). In a similar vein, the 1994 Amendments permit the State in an aggregate damages case to "proceed under a market share theory, provided that the products involved are substantially interchangeable among brands, and that substantially similar factual or legal issues would be involved . . . ." Ch. 94-251(9)(b).

Thus, rather than being designed to impermissibly impair the rights of liable third-parties, these provisions are essential to and integral to the practical enforcement of the State's rights and are consistent with Rule 1.110, Florida Rules of Civil Procedure, and Florida law. Moreover, and most importantly, application of these provisions is subject to the oversight and discretion of the trial court to determine if there are common issues of fact or law, such a multiplicity of recipients as to make it impracticable to join or identify them in a particular case, and the other preconditions that reasonably assure due process and preserve the Court's ultimate power over its

constitutional domain. *See* Ch. 94-251(9)(a) and (b). It is not uncommon, particularly in highly regulated fields such as health care and welfare, that statutes necessarily have procedural implications. This Court has repeatedly permitted such incidental intrusions or, if necessary, adopted the provisions as special rules of court. *Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976); *Sun Insurance Office, Ltd. v. Clay*, 133 So.2d 735 (Fla. 1961). In all events, such matters, if "procedural" for purposes of separation of power analysis, are clearly not "substantive" and are appropriately applied to pending causes of action. *See discussion infra* at 43-45.

V. THE TRIAL COURT'S RULING REGARDING THE STATUTE OF REPOSE WAS PREMATURE AND SHOULD BE REVERSED

Plaintiffs recognize, as they must, *Overland Construction Co. v. Sirmons*, 369 So.2d 572 (Fla. 1979), *Diamond v. E. R. Squibb and Sons*, 397 So.2d 671 (Fla. 1981), *Pullum v. Cincinnati, Inc.*, 476 So.2d 657, 659, n.* (Fla. 1985), and *Conley v. Boyle Drug Co.*, 570 So. 2d 275 (Fla. 1990), that the products liability statute of repose never was intended to, and could not constitutionally be applied to cut off the rights of victims of latent diseases caused by defective products such as Philip Morris' cigarettes. Now, the remaining plaintiffs, besides Philip Morris, ask the Court to hypothesize about potential products which "may" have been sold by convenience stores or a grocery store chain or unidentified members of a general trade association more than a dozen years before the 1986 repeal of the statute of repose. It is unnecessary for this Court to rule on the ability of the legislature to exclude the long-repealed statute of repose from use against a Medicaid recoupment suit by the State just to soothe concerns about "a hypothetical, state of facts which have not arisen and are only contingent, uncertain and rest in the future." *Martinez v. Scanlan*, 582 So.2d 1167, 1174 (Fla. 1991).

Further, the standing ruling by the trial court (R. 476-77) was general in nature. It made no determination as to any need for a declaration about the statute of repose. In that regard, there is no "actual controversy".

VI. AHCA IS CONSTITUTIONALLY STRUCTURED UNDER ART. IV, § 6 OF THE FLORIDA CONSTITUTION AS EITHER A SEPARATE DEPARTMENT OR AS A UNIT "WITHIN" DBPR

Plaintiffs argue, in essence, that AHCA's structure violates Article IV, § 6, Florida Constitution, simply because it is an autonomous "agency" within a department. As shown in the State's Initial Brief, the legislature made AHCA an agency to avoid the possibility of exceeding the 25 department limit. The Legislature clearly intended to give AHCA full departmental powers and duties, and AHCA should not be deemed unconstitutional simply because the legislature used the word "agency" instead of "department". If a governmental agency is a department in everything but name it should be treated as such, subject to the numerical limit[15] of Art. IV, § 6. This interpretation does not rewrite any statute. It adopts a constitutional construction of § 20.42, Florida Statutes, rather than the literal but unreasonable interpretation suggested by plaintiffs. *See State v. Iacovone*, 20 Fla.L.W. S475, 476 (Fla. Sept.

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[15]As shown in the State's Initial Brief (p.42-4), the court below would have had to find that the Board of Trustees was a department in order to rule that AHCA even temporarily exceeded the limitation of 25 in 1992. Appellees never so argued and the trial court did not find that the Board of Trustees was a department. Appellants do not argue even now that the Board of Trustees is a department, but allude to other independent divisions within departments. However, DOAH and PERC are quasi-adjudicatory and do not perform executive branch functions. *See In re Advisory Opinion*, 223 So.2d 35, 40 (Fla. 1969). The Division of Retirement was not created until 1994, by Chapter 94-249, § 30, Laws of Florida. There is no showing that AHCA, created in 1992, was even temporarily a 26th department.

21, 1995) (rejecting literal interpretation "plainly at variance with the purpose of the legislation as a whole").

Plaintiffs also urge that recognizing AHCA as a department would "rewrite" § 20.42, because AHCA's head is not confirmed by the Senate. Plaintiffs, however, rely on the confirmation requirement of the 1994 version of § 20.05(2), Fla. Stat. AHCA was created in 1992 by Chapter 92-33, Laws of Florida. The statutory requirement for agency head confirmation was not enacted until 1994. Ch. 94-235, § 4, Laws of Fla. Hence, in 1992, AHCA was a proper department in all but name. That the Legislature has not subsequently chosen to make AHCA's head subject to Senate confirmation does not make AHCA "unconstitutional".

Moreover, as a statute establishing a single agency, Chapter 92-33, Laws of Florida, would have been more specific than a confirmation requirement applying to all agencies generally. Hence, AHCA's enabling legislation would control. *See McKendry v. State*, 641 So.2d 45, 46 (Fla. 1994) ("The more specific statute is considered to be an exception to the general terms of the more comprehensive statute.").

Finally, plaintiffs claim they are entitled to relief from a different lawsuit, and seek a declaration that AHCA is "without power to sue plaintiffs/appellees under the Act." (Pl. Br., p.52). This claim arises only if this Court first determines that AHCA is unconstitutionally structured.[16]

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[16]This claim should have been brought in response to an actual suit brought by AHCA, and is not ripe for adjudication here. The trial court was without jurisdiction to consider it. *Santa Rosa County, Fla. v. Administration Comm.*, 20 Fla.L.W. S333 (Fla. July 13, 1995).

The State's Initial Brief and briefs by amici note the potential for disruption caused by the lower court's holding. Plaintiffs acknowledged this when they joined AHCA's suggestion that the First District Court of Appeals pass the appeal directly to this Court. Numerous suits now question AHCA's authority.[17] This Court can take judicial notice of these circumstances, and invoke the *de facto* officer doctrine to uphold AHCA's past actions, including its suit against tobacco companies.

Even if AHCA were held unconstitutionally structured, plaintiffs would not enjoy the relief they seek because the authority to sue would revert to HRS, which had such authority under earlier statutes. *See* § 409.901(6), Fla. Stat. (1991) (defining "department" to mean HRS, and declaring HRS to be the "Medicaid agency for the state"); and § 409.910, Fla. Stat. (1991). The invalidation of AHCA's structure would severely disrupt regulation of health care by creating a hiatus in the law. Therefore, the 1991 statutes authorizing HRS to pursue Medicaid matters would be revived. *See B.H. v. State*, 645 So.2d 987, 995-6 (Fla. 1994) ("revival is proper and does not violate due process when the loss of constitutionally invalid statutory language will result in an intolerable hiatus in the law"). *See also Waldrup v. Dugger*, 562 So.2d 687, 693-4 (Fla. 1990) (striking an unconstitutional part of prisoner gaintime statute and replacing it with earlier statute).

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[17]*Blue Cross and Blue Shield of Florida, Inc. v. AHCA*, Case No. 95-3635 BID (DOAH); *AHCA v. Wingo, et al.*, Case No. 95-1971 (Fla. 1st DCA 1995); *Sanchez v. AHCA*, Case No. 95-2548 (Fla. 1st DCA 1995); *AHCA v. Board of Clinical Laboratories*, Case No. 95-2036 (Fla. 1st DCA 1995).

If AHCA cannot bring suit, HRS can. If this Court finds AHCA unconstitutionally structured, it should also declare that HRS can be substituted as a party plaintiff in any Medicaid-related suit already brought by AHCA.

PLAINTIFFS' CROSS-APPEAL

In their brief on cross-appeal, beginning at page 52 of their consolidated brief, plaintiffs specifically complain that the 1994 Amendments deny them access to the courts, violate the separation of powers doctrine and deny them due process guaranteed by the state and federal constitutions. To the contrary, however, there is nothing in the Florida Constitution that requires the State to pretend it simply represents individual recipients of Medicaid funds as opposed to all the taxpayers of the State of Florida who have been damaged in the process of coming to the aid of those injured individuals. Article I, § 21 of the State Constitution was designed to give ordinary citizens and taxpayers access to justice. It was not intended to be transformed and perverted into an obstacle to the State's representation of its citizen taxpayers. Similarly, the separation of powers doctrine was intended to preserve the integrity of the judicial process, not to arbitrarily impede the legitimate implementation of the State's obligation to protect the public welfare and preserve the public weal. In addition to the arguments set out previously, we further address the points on cross-appeal as follows:

I. THE 1994 AMENDMENTS DO NOT OFFEND THE FEDERAL OR FLORIDA CONSTITUTIONS

A. Having Access to Courts Does Not Mean Having the Guarantee of Any Particular Defense in Every Kind of Case

Plaintiffs' assertion that the Amendments deny access to courts disregards the plain language of both the Florida Constitution and the Medicaid Third-Party Liability Act itself.

Article I, § 21 of the Constitution provides that "[t]he courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." It is "intended to give life and vitality to the maxim: 'For every wrong there is a remedy'." *Swain v. Curry*, 595 So.2d 168, 174 (Fla. 1st DCA 1992), *citing Holland v. Mayes*, 19 So.2d 709, 711 (Fla. 1944). Thus, Article I, § 21 guarantees plaintiffs the opportunity to redress injury. *See, e.g., Swain*, 595 So.2d 168; *Smith v. Department of Insurance,* 507 So.2d 1080 (Fla. 1987).

There is nothing in Article I, § 21 to indicate it was intended to protect wrongdoers from the consequences of their wrongs. The 1994 Amendments, which clarify and affirm existing Florida law as modified by the 1990 Act and enhance the procedures for Medicaid reimbursement, are consistent with the dictates of Article I, § 21 that Florida taxpayers have access to the courts free of unreasonable burdens and restrictions.

The suggestion that the affirmative defense provisions of the 1994 Amendments violate Article I, § 21, is both hyperbolic and inaccurate. Article I, § 21 has *never* been interpreted to guarantee a defendant the right to present any particular affirmative defense. In fact, this Court has held unconstitutional the affirmative defense of statute of repose when it removed the ability to sue before the injury occurred. *Overland Construction Co. v. Sirmons*, 369 So.2d 572 (Fla. 1979); *Diamond v. E. R. Squibb and Sons*, 397 So.2d 671 (Fla. 1981). Moreover, Plaintiffs'

reliance on *Psychiatric Associates v. Siegel*, 610 So.2d 419 (Fla. 1992), *State ex rel. Pittman v. Stanjeski*, 562 So.2d 673 (Fla. 1990), and *State Farm Mutual Auto Ins. Co. v. Hassen*, 650 So.2d 128 (Fla. 2d DCA 1995), for the proposition that the provision protects the right to present particular defenses or to do so in a certain way is based upon a misreading of these cases. *Psychiatric Associates* deals with the right of an aggrieved person to present claims and the others deal with monetary barriers to the right of a party to be heard at all. Indeed, even were a defendant to have this right, the 1994 Amendments effect no substantive change as to affirmative defenses.

First, affirmative defenses that might be available against a Medicaid recipient do not apply against the State, whose cause of action is not derivative. Moreover, the 1994 language Plaintiffs find so objectionable is merely a more explicit reiteration of the statutory law enunciated by the 1990 Act; (*see* discussion, *supra*, pp. 7-23). Plaintiffs have not challenged the 1990 law and have waived all objection. *See* Plaintiffs' Memorandum in the trial court, page 1 *and* footnote 1 (R. Supp. 1). Secondly, the State's rights have never been limited to the contractual subrogation rights of a private insurance company, as in the cases cited by plaintiffs. See State's Initial Br., p.25, n.9, 10. If insurance is provided by contract, where a risk is assumed for a fee, the insurer is entitled only to be subrogated to the claims of the insured. The remedy is entirely different, however, when the "insurer's" obligation is imposed by law or statute. (*See* discussion of indemnity/legal subrogation, restitution, and unjust enrichment, *supra*, pp. 27-32 and in Initial Brief, pp.26-32).[18]

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[18]Persuasive support for this position can be found in a recent Mississippi decision in which Judge Meyers held that the favorite affirmative defenses of the cigarette manufacturers,

While cases cited by plaintiffs have made references to the applicability of the guarantee of access to courts to defendants in lawsuits, it is clear that it is far from the traditional understanding of the access to courts guarantee: to provide redress for injury.[19] In *State ex rel. Pittman v. Stanjeski*, 563 So.2d 673 (Fla. 1990), but for the saving construction given the statute by this Court, a defendant would have been denied the right even to appear in court and, thus, justice would not have been "administered without . . . denial." Article 1, § 21, Fla. Const. Similarly, in *State Farm Mut. Auto. Ins. Co. v. Hassen*, 650 So.2d 128 (Fla. 2d DCA 1995), the defendant was required to pay the amount of the alleged liability as a prerequisite to defending against it. Seen in context, then, *State Farm* stands for the proposition under Article I, § 21 that justice should be "administered without sale." The application of the "justice shall be administered without sale, denial or delay" aspect of Article I, §21 to protect the ability of a defendant even to come into court and defend is more consistent with procedural due process inasmuch as the defendants were being denied a hearing before suffering judgment (*Stanjeski*) or being deprived of property (*State Farm*).

The circumstances of prospective defendants under the 1994 Amendments to the 1990 Medicaid Third-Party Liability Act are worlds apart from automatic liability through a judgment entered by a clerk (*Stanjeski*) or having to pay the alleged obligation "up front" (*State Farm*).

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assumption of the risk and contributory negligence, could not be asserted against the state in an action to recover Medicaid funds from liable third parties. Order, February 21, 1995, *Mike Moore, Attorney General, ex rel., State of Mississippi v. American Tobacco Co.*, Case Number 94:1429 (Chancery Court, Jackson County, Mississippi). (R. 559)

[19]In *Psychiatric Associates v. Siegel,* 610 So.2d 419 (Fla. 1992), the party protected by Article I, §21, was the plaintiff who was seeking to redress the injury of having been excluded from hospital privileges.

Instead, the State is obligated to prove tortious conduct, prove causation and prove the amount of damages. Those efforts are subject to defensive attack before the defendant faces a judgment directing it to pay damages to the State. Nothing about the cases cited by plaintiffs suggests that tortfeasors in a Medicaid reimbursement suit by the State have any constitutional interest in any particular defense that might have been asserted against an individual Medicaid recipient.

B. The 1994 Amendments Do Not Deny Discovery

As for plaintiffs' shrill arguments that these provisions constitute an extraordinary departure from Florida practice and procedure and are tantamount to absolute liability,[20] this Court should not engage in some hypothetical application projected by the plaintiffs, but construe the provisions as they should be -- in a light most favorable to their constitutional application. These provisions unequivocally require the State to prove a defective product or negligence. These provisions clearly require the State to prove causation, but simply and appropriately permit the use of statistical evidence under the guidance of the trial court. Clearly,

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[20]To the contrary, the Act is similar to other provisions of Florida law that address the State's inherent duty to protect the public welfare. For example, in environmental matters, the State may sue to protect the public interest and recover taxpayer monies. § 376.3071(7)(a) and (b), Fla. Stat. (Supp. 1994). These laws are "necessary for the general welfare and . . . shall be liberally construed to effect [their] purposes . . ." § 376.21, Fla. Stat. (1993). Section 376.205, Florida Statutes, deems any action to remedy pollution violations to be cumulative rather than exclusive. The State's only burden is to prove that a discharge occurred. **Proof of negligence is not required**. § 376.308(1), Fla. Stat. (Supp. 1994). The owner of the facility is presumed liable unless it is established that he did not contribute to the spill. § 376.308(1)(c), Fla. Stat. (Supp. 1994). This statute (enacted in 1986) provides that the limitations period for the State to prosecute an action runs from the last date funds were expended to clean-up spills, rather than the date the spill occurred. § 376.3071(7), Fla. Stat. (Supp. 1994). Similarly, under the Deceptive and Unfair Trade Practice Act, the Department of Legal Affairs may bring an action "on behalf of one or more consumers" § 501.207(1)(c), Fla. Stat. (1993).

as is the case with DNA proof and other statistical evidence, a defendant has more than adequate access to discovery and the ability to defend against such evidence and, if the State fails in its burden, to have it excluded.

C. The Application of Market Share and Joint and Several Liability Does Not Offend the Florida Constitution

Rather inexplicably, plaintiffs argue that the 1994 provision allowing the State to proceed under a market share theory somehow impermissibly impacts on their substantive rights and can only be used to recover payments after the effective date of the 1994 Amendments. First, of course, the market share decision cited by plaintiffs, *Conley v. Boyle Drug Co.*, 570 So. 2d 275 (Fla. 1990), applied market share in a pending case arising out of the use of a defective product several decades before. Thus, contrary to plaintiffs' arguments, it was applied "retroactively." Furthermore, this Court expressly recognized that when "traditional theories of tort law are inadequate to redress the appellant's injuries," the market share approach should be permitted. *Conley*, 570 So. 2d at 280.

The reasons for permitting the application of market share are articulated in *Conley*, i.e., similar and interchangeable products, difficulty in identifying the specific product involved, difficulty in determining exactly when and which defective product caused the harm, and the intervention of time since use of the product. These same considerations apply to suit under the Medicaid Third-Party Liability Act against the Tobacco Industry. Plainly, the legislative adoption of market share for use by the State under such circumstances is a rational, appropriate and necessary device to redress the State's injury. This Court found no "substantive" impediment to applying the then brand new market share approach; nor did it have any reservations about

applying market share to a pending claim that arose out of decades-old wrongdoing. There is no logical or plausible reason for applying a different analysis or application of market share in the legislative context. Indeed, the manufacturer defendants in *Conley* asked this Court to leave the adoption of market share liability to the legislature. 570 So.2d at 283-84.

Furthermore, since this procedure is incidental to and necessary to carry out the policy and purposes of the Medicaid Third-Party Liability Act, there is no constitutionally impermissible intrusion on the court's rulemaking authority. *See* cases cited at 32-34, *supra*, and in State's Initial Br., pp.13-20. Moreover, if this provision were viewed as encroaching on the Court's domain, this Court should adopt such a procedure, as it did in *Conley*. *See, e.g., Avila S. Condominium Ass'n v. Kappa Corp.*, 347 So. 2d 599, 608 (Fla. 1977), where this Court observed "that substantive law includes those rules and principles which fix and declare the primary rights of individuals as respect their persons and their property." (Emphasis supplied.) This Court went on to define practice and procedure as including "the administration of the remedies available in cases of invasion of primary rights of individuals." 347 So.2d at 608. Accordingly, because the Court viewed the statute in *Avila* as impacting on its rule-making authority, the procedural portion of the statute was adopted as a rule of court. *See also Leapai v. Milton*, 595 So.2d 12 (Fla. 1992); *In re Rules of Civil Procedure*, 281 So.2d 204 (Fla. 1973); *Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976).

In regard to plaintiffs' complaints about the joint and several liability provision in conjunction with market share liability, it should be remembered that *Conley* involved a personal injury claim for both intangible and economic losses; losses which invoke both "several" and "joint and several" damages. Indeed, one of the primary reasons for not applying joint and

several liability in *Conley* was that by virtue of the legislature's adopting the Comparative Fault Act in 1986, "joint and several liability is only favored within this state in those limited situations set forth in Sections 768.81(3)(4) and (5), Florida Statutes . . . ." 570 So. 2d at 285. However, the State's claim under the Medicaid Third-Party Liability Act is solely for economic losses which is one of those limited situations "favored" under the law of Florida. Indeed, the law of Florida, § 768.81(3), Fla. Stat. (1993), mandates recovery of such damages under the doctrine of joint and several liability.[21] Thus, plaintiffs are simply wrong in suggesting that this provision impermissibly creates barriers to their right to invoke several liability.

Most importantly, the 1994 Amendments do not direct the trial court or this Court as to how market share is to be applied. As with their other arguments, the plaintiffs presume an imaginary-horrible application of the law. There is nothing in the statutory provision regarding market share that in any way limits or prohibits the courts from determining whether the preconditions for utilizing market share are met in a particular case; nor does the statute in any manner limit the courts' ability to assure that defendant's due process rights are protected. Plaintiffs' arguments about market share are without merit.

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[21]In *Conley*, this Court deferred to the "express legislative pronouncement" regarding the limitation on joint and several liability as a statement of "the policy of this state." 570 So. 2d at 285. The same Act deferred to in *Conley* calls for joint and several liability in a uniquely economic loss claim by the innocent State. The 1994 Amendments are a reiteration of that same policy.

II. THE 1994 AMENDMENTS DO NOT ENCROACH ON THE PROVINCE AND DUTY OF COURTS TO DETERMINE THE RELEVANCY AND ADMISSIBILITY OF EVIDENCE

The use of statistical evidence to prove causation and damages is nothing new; it is merely a codification of existing law. *See* State's Initial Br., pp.19, n.6. So long as evidence comports with the requirements of the law, it should be admissible. Likewise, a liberal construction of the evidence code is the rule rather than the exception. § 90.402, Fla. Stat. (1993). These aspects of the 1994 Amendments, thus, simply state truisms of evidence law.

III. THE 1994 AMENDMENTS COMPLY WITH THE REQUIREMENTS OF DUE PROCESS

Plaintiffs have, or purport to have, a fundamental misconception of the 1994 Amendments. As already demonstrated, under the 1994 Amendments the State must prove liability, prove causation and prove damages. The provisions of the Amendments mirror familiar principles of Florida law. Plaintiffs' challenge rests on exaggeration and outright distortion of the operation of the 1994 Amendments.

The Amendments ensure that those responsible for tobacco illnesses pay their fair share. This is hardly the sort of arbitrary action prohibited by due process. *See, e.g., Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust*, 508 U.S. _____, 113 S.Ct. 2264, 2286-89, 124 L.Ed. 2d 539 (1993); *United States Railroad Retirement Bd. v. Fritz*, 449 U.S. 166, 176-77, 101 S.Ct. 453, 66 L.Ed. 2d 368 (1980). A legislature may abolish defenses or create new liabilities without violating due process. *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 432-33, 102 S.Ct. 1148, 71 L.Ed. 2d 265, (1982); *Martinez v. California*, 444 U.S. 277, 281-83, 100 S.Ct. 553, 62 L.Ed. 2d 481 (1980). Nor can there be any argument that the Amendments create "irrational" or "irrebuttable" presumptions. For one thing, the Amendments

do not control anything about how a defendant may respond to a claim brought by the State; the Amendments merely spell out the affirmative elements of the State's case. On their face and by their terms, the Amendments do not preclude a defendant from rebutting a claim in any way it wishes. A declaratory judgment on plaintiffs' facial challenge is plainly premature.[22]

Finally, the gravamen of appellees' attack seems to be that joint liability is fundamentally unfair, even with the availability of contribution. (Pl. Br., p.62, n.61.) Yet the doctrine of joint liability -- *without contribution* -- has long roots in the common law; in fact, it pre-dated the American Revolution by more than 450 years. *See* William L. Prosser, *Joint Torts and Several Liability*, 25 Cal.L.Rev. 413, 414-18 (1937); *De Bodreugam v. Arcedekne*, YB 30 Edw. I (Rolls Series) 106 (1302). Indeed, present Florida public policy continues to "favor" joint liability in economic damages cases such as the State's claim to recoup its Medicaid expenditures. *Conley, supra*, 570 So.2d at 285.

IV. CONCLUSION

The Medicaid Third-Party Liability Act and 1994 Amendments are an appropriate and reasonable exercise of the State's obligation to recoup federal and state tax monies expended as a result of wrongfully caused injuries to Floridians. Pre-existing Florida law and principles of equity support the State's cause of action free and clear of liabilities inhering in the Medicaid recipient. The 1990 Act, unchallenged by plaintiffs, clearly and unequivocally abrogated any common law or equitable principle that might impair full recovery from any third-party. The

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[22]A facial challenge requires a showing that the statute is invalid in all its applications. *Reno v. Flores*, 507 U.S. ____, 113 S.Ct. 1439, 1446, 123 L.Ed. 2d 1 (1993) (challenger "must establish that no set of circumstances exists under which the Act would be valid."); *see* also, *United States v. Salerno*, 481 U.S. 739, 745, 107 S.Ct. 2095, 95 L.Ed. 2d 697 (1987); *California Coastal Comm'n v. Granite Rock Co.*, 480 U.S. 572, 593, 107 S.Ct. 1419, 94 L.Ed. 2d 577 (1987).

1994 Amendments are a rational application of recognized legal principles in the product liability context and are necessary to provide an adequate remedy for Florida taxpayers. The 1994 Amendments are constitutional and should be applied to actions pursued by the State to recover payments made within the five year limitations period, and at the very least payments made on or after July 3, 1990, the effective date of the Medicaid Third-Party Liability Act.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by hand delivery to **ARTHUR J. ENGLAND, JR.**, Esquire, and **BARRY RICHARD**, Esquire, Greenberg, Traurig, Hoffman, Lipoff, Rosen & Quentel, P.A., 101 East College Avenue, Tallahassee, Florida 32302; and **ALAN C. SUNDBERG**, Esquire, Carlton, Fields, Ward, Emmanuel, Smith & Cutler, P.A., 500 First Florida Bank Tower, 215 South Monroe Street, Post Office Drawer 190, Tallahassee, Florida 32302; this 11th day of OCTOBER, 1995.

CHARLIE MCCOY
Assistant Attorney General

IN THE SUPREME COURT OF FLORIDA

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION, and STATE OF FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

Appellants, Cross-Appellees

vs. **CASE NO. 86,213**

ASSOCIATED INDUSTRIES OF FLORIDA, INC., PUBLIX SUPERMARKETS, INC., NATIONAL ASSOCIATION OF CONVENIENCE STORES, INC., and PHILIP MORRIS, INC.,

Appellees, Cross-Appellants.
_____/

APPENDIX OF SELECTED MATERIALS CITED IN: STATE OF FLORIDA'S CONSOLIDATED ANSWER AND REPLY BRIEF TO PLAINTIFFS' CROSS-APPEAL AND ANSWER BRIEF

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APPENDIX 1

Chapter 90-295, Section 33, Laws of Florida

[FLORIDA MEDICAID THIRD-PARTY LIABILITY ACT AS CREATED BY THE 1990 LEGISLATURE]

Section 33. Section 409.2665, Florida Statutes, is created to read:

409.2665. Responsibility for payments on behalf of Medicaid eligible persons when other parties are liable

(1) It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and

equity as to assignment, lien, and subrogation are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

(2) This section may be cited as the "Medicaid Third-Party Liability Act."

(3) As used in this section, the following words shall have the following meanings:

(a) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under s. 409.266 has been submitted to the department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(b) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, good, or service.

(c) "Collateral" means:

1. Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care which necessitated that Medicaid provide medical assistance.

2. All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

3. Proceeds, as defined in this section.

(d) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.

(e) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.

(f) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(g) "Lienholder" means the department, which has a lien under paragraph (7)(c).

(h) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in Florida by the department.

(i) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

(j) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.

(k) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Florida Medicaid program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, x-ray services, and prescribed drug services, and such other services as are covered by the Florida Medicaid program.

(l) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this paragraph.

(m) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."

(n) "Provider" means any entity, including, without limitation, any hospital, physician, or other health care practitioner, supplier, or facility, providing medical care and related goods or services to a recipient.

(o) "Recipient" means any individual who has been determined to be eligible for Medicaid or who is receiving, or has received, medical assistance, or any medical care, good, or service for which Medicaid has paid or may be obligated.

(p) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(q) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the department, for any Medicaid covered injury, illness, good, or service, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

(4) Third-party benefits for medical services shall be primary to medical assistance provided by Medicaid.

(5) After the department has provided medical assistance under s. 409.266, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the department has a waiver pursuant to federal law; or

(b) Situations in which the department learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(6) An applicant, recipient, or legal representative shall inform the department of any rights the applicant or recipient has to third-party benefits and shall inform the department of the name and address of any person that is or may be liable to provide third-party benefits. When the department provides, pays for, or becomes liable for medical services provided by a hospital, the recipient receiving such medical services or his legal representative shall also provide the information as to third-party benefits, as defined in this section, to the hospital, which shall periodically provide notice thereof to the department in a manner specified by the department.

(7) When the department provides, pays for, or becomes liable for medical care under s. 409.266, it shall have the following rights, as to which the department may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(a) The department is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the department from any and all third-party benefits. Equities of a recipient, his legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the department as to its subrogation rights granted under this paragraph.

(b) By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically assigns to the department any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

1. The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the department, but not in excess of the amount of medical assistance provided by the department.

2. The department is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, his legal representative, his creditors, or health care providers shall not defeat or reduce recovery by the department as to the assignment granted under this paragraph.

3. By accepting medical assistance, the recipient grants to the department the limited power of attorney to act in his name, place, and stead to perform specific acts with regard to third-party benefits, his assent being deemed to have been given, including:

a. Endorsing any draft, check, money order, or other negotiable instrument representing third-party benefits that are received on behalf of the recipient as a third-party benefit.

b. Compromising claims to the extent of the rights assigned, provided the recipient is not otherwise represented by an attorney as to the claim.

(c) The department is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in this section.

1. The lien attaches automatically when a recipient first receives treatment for which the department may be obligated to provide medical assistance under s. 409.266. The lien is perfected automatically at the time of attachment.

2. The department is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the lienholder, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the department. The claim of lien, to the extent known by the department, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 1 year after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the department of the liability of any third party, or the date of discovery of a cause of action against a third party brought by a recipient or his legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 1 year of the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The department may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the department has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the lienholder joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the lienholder shall be entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the lienholder may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the department has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within one year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the department's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, from the date of recording; and shall exist for a period of 7 years from the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the department shall not be required to be paid in advance of filing and recording, but may be billed to the department after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the department shall, within 30 days of satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(8) The department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the department any amount in excess of the actual third party benefits received by the provider from a third party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the department shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph (15)(a).

2. To the federal government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph (15)(a) and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the department for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

(9) The department shall require an applicant or recipient, or the legal representative thereof, to cooperate in the recovery by the department of third-party benefits of a recipient and in establishing paternity and support of a recipient child born out of wedlock. As a minimal standard of cooperation, the recipient or person able to legally assign a recipient's rights shall:

(a) Appear at an office designated by the department to provide relevant information or evidence.

(b) Appear as a witness at a court or other proceeding.

(c) Provide information, or attest to lack of information, under penalty of perjury.

(d) Pay to the department any third-party benefit received.

(e) Take any additional steps to assist in establishing paternity or securing third-party benefits, or both.

(f) Paragraphs (a)–(e) notwithstanding, the department shall have the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

(10) The department shall deny or terminate eligibility for any applicant or recipient who refuses to cooperate as required in subsection (9), unless cooperation has been waived in writing by the department as provided in paragraph (9)(f), provided, however, that any denial or termination of eligibility shall not reduce medical assistance otherwise payable by the department to a provider for medical care provided to a recipient prior to denial or termination of eligibility.

(11) An applicant or recipient shall be deemed to have provided to the department the authority to obtain and release medical information and other records with respect to such medical care, for the sole purpose of obtaining reimbursement for medical assistance provided by Medicaid.

(12) The department may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(a) If either the recipient, or his legal representative, or the department brings an action against a third party, the recipient, or his legal representative, or the department, or their attorneys, shall, within 30 days of filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an action is brought by either the department, or the recipient or his legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his action with the other if brought independently. Unless waived by the other, the recipient, or his legal representative, or the department shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the department shall be sent to an address set forth by rule. Notice to the recipient or his legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his legal representative.

(b) An action by the department to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the department's expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the department.

(d) No judgment, award, or settlement in any action by a recipient or his legal representative to recover damages for injuries or other third-party benefits, when the

department has an interest, shall be satisfied without first giving the department notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the department's claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his legal representative is a party and in which the amount of any judgment, award, or settlement from third-party benefits, excluding medical coverage as defined in subparagraph 4., after reasonable costs and expenses of litigation, is an amount equal to or less than 200 percent of the amount of medical assistance provided by Medicaid less any medical coverage paid or payable to the department, then distribution of the amount recovered shall be as follows:

1. Any fee for services of an attorney retained by the recipient or his legal representative shall not exceed an amount equal to 25 percent of the recovery, after reasonable costs and expenses of litigation, from the judgment, award, or settlement.

2. After attorneys fees, two-thirds of the remaining recovery shall be designated for past medical care and paid to the department for medical assistance provided by Medicaid.

3. The remaining amount from the recovery shall be paid to the recipient.

4. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

(g) In the event that the recipient, his legal representative, or his estate brings an action against a third party, notice of institution of legal proceedings, notice of settlement, and all other notices required by this section or by rule shall be given to the department, in Tallahassee, in a manner set forth by rule. All such notices shall be given by the attorney retained to assert the recipient's or legal representative's claim, or, if no attorney is retained, by the recipient, his legal representative, or his estate.

(h) Except as otherwise provided in this section, actions to enforce the rights of the department under this section shall be commenced within 5 years of the date a cause of action accrues, with the period running from the later of the date of discovery by the department of a case filed by a recipient or his legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph (7)(c)9.

(i) Upon the death of a recipient, and within the time prescribed by ss. 733.702 and 733.710, the department, in addition to any other available remedy, may file a claim against the estate of the recipient for the total amount of medical assistance provided by Medicaid for the benefit of the recipient. Claims so filed shall take priority as class 3 claims as provided by s. 733.707(1)(c). The filing of a claim pursuant to this paragraph shall neither reduce nor diminish the general claims of the department pursuant to s. 409.345, except that the department shall not receive double recovery for the same expenditure. Claims under this paragraph shall be superior to those under s. 409.345. The death of the recipient shall neither extinguish nor diminish any right of the department to recover third-party benefits from a third party or provider. Nothing in this paragraph affects or prevents a proceeding to enforce a lien created pursuant to this section or a proceeding to set aside a fraudulent conveyance as defined in subsection (17).

(13) No action taken by the department shall operate to deny the recipient's recovery of that portion of benefits not assigned or subrogated to the department, or not secured by the department's lien. The department's rights of recovery created by this section, however, shall not be limited to some portion of recovery from a judgment, award, or settlement. Only the following benefits are not subject to the rights of the department:

benefits not related in any way to a covered injury or illness; proceeds of life insurance coverage on the recipient; proceeds of insurance coverage, such as coverage for property damage, which by its terms and provisions cannot be construed to cover personal injury, death, or a covered injury or illness; proceeds of disability coverage for lost income; and recovery in excess of the amount of medical benefits provided by Medicaid after repayment in full to the department.

(14) No action of the recipient shall prejudice the rights of the department under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his legal representative shall impair the department's rights. Provided, however, that in a structured settlement, no settlement agreement by the parties shall be effective or binding against the department for benefits accrued without the express written consent of the department or an appropriate order of a court having personal jurisdiction over the department.

(15) The department is authorized to enter into agreements to enforce or collect medical support and other third-party benefits.

(a) If a cooperative agreement is entered into with any agency, program, or subdivision of the state, or any agency, program, or legal entity of or operated by a subdivision of the state, or with any other state, the department is authorized to make an incentive payment of up to 15 percent of the amount actually collected and reimbursed to the department, to the extent of medical assistance paid by Medicaid. Such incentive payment is to be deducted from the federal share of that amount, to the extent authorized by federal law. The department may pay such person an additional percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, but no more than a maximum percentage established by the department. In no case shall the percentage exceed the lesser of a percentage determined to be commercially reasonable or 15 percent, in addition to the 15-percent incentive payment, of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(b) If an agreement to enforce or collect third-party benefits is entered into by the department with any person other than those described in paragraph (a), including any attorney retained by the department who is not an employee or agent of any person named in paragraph (a), then the department may pay such person a percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, to the extent of medical assistance paid by Medicaid. In no case shall the percentage exceed a maximum established by the department, which shall not exceed the lesser of a percentage determined to be commercially reasonable or 30 percent of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(c) An agreement pursuant to this subsection may permit reasonable litigation costs or expenses to be paid from the department's recovery to a person under contract with the department.

(d) Contingency fees and costs incurred in recovery pursuant to an agreement under this subsection may, for purposes of determining state and federal share, be deemed to be administrative expenses of the state. To the extent permitted by federal law, such administrative expenses shall be shared with, or fully paid by, the Federal Government.

(16) Insurance and other third-party benefits may not contain any term or provision which purports to limit or exclude payment or provisions of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance from Medicaid, and any such term or provision shall be void as against public policy.

(17) Any transfer or encumbrance of any right, title, or interest to which the department has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the department for reimbursement of medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the

department, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the department, but not in excess of the amount of medical assistance provided by Medicaid.

(18) A recipient or his legal representative or any person representing, or acting as agent for, a recipient or his legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (7)(c), or who has actual knowledge of the department's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the department the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the department pending judicial determination of the department's right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the department the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 409.325(4)(b), and acted with the intent set forth in s. 812.014(1).

(a) In cases of suspected criminal violations or fraudulent activity, the department is authorized to take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(b) The department is authorized to investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Auditor General, to the Attorney General, or to any state attorney. Pursuant to s. 409.2664, the Auditor General has primary responsibility to investigate and control Medicaid fraud.

(c) In carrying out duties and responsibilities related to Medicaid fraud control, the department may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(d) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft shall be confidential and exempt from the provisions of s. 119.07(1):

1. Until such time as the department takes final agency action;

2. Until such time as the Auditor General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(19) In recovering any payments in accordance with this section, the department is authorized to make appropriate settlements.

(20) Notwithstanding any provision in this section to the contrary, the department shall not be required to seek reimbursement from a liable third party on claims for which the department determines that the amount it reasonably expects to recover will be less than the cost of recovery, or that recovery efforts will otherwise not be cost-effective.

(21) Entities providing health insurance as defined in s. 624.603, and health maintenance organizations and prepaid health clinics as defined in chapter 641, shall provide such records and information as is necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(a) The secretary of the department and the Insurance Commissioner shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.

1. The department shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter 641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.

2. All information obtained pursuant to subparagraph 1. shall be confidential and exempt from the provisions of s. 119.07(1). This exemption shall be subject to the Open Government Sunset Review Act in accordance with s. 119.14.

3. The cooperative agreement or rules promulgated under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.

(b) The department and the Department of Insurance jointly shall promulgate rules for the development and administration of the cooperative agreement. The rules shall include the following:

1. A method for identifying those entities subject to furnishing information under the cooperative agreement.

2. A method for furnishing requested information.

3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.

(22) The department is authorized to adopt rules to implement the provisions of this section and federal requirements.

APPENDIX 2

Changes Made in the Florida Medicaid Third-Party Liability Act by the 1994 Amendments, Chapter 94-251, Section 4

The changes made in the Florida Medicaid Third-Party Liability Act by the 1994 Amendments (Ch. 94-251) Section 4 were as follows:

Section 4. Section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(1) It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are available ~~discovered or become available after medical assistance has been provided by Medicaid~~, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation, comparative negligence, assumption of risk, and all other affirmative defenses normally available to a liable third party, are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third party resources; such principles shall apply to a recipient's right to recovery against any third party, but shall not act to reduce the recovery of the agency pursuant to this section. The concept of joint and several liability applies to any recovery on the part of the agency. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources. Common law theories of recovery shall be liberally construed to accomplish this intent. . . .

* * * *

(4) . . . (b) Situations in which a third party is liable and the liability or benefits available are discovered either before or ~~the department learns of the existence of a liable third party or in which third party benefits are discovered or become available~~ after medical assistance has been provided by Medicaid. . . .

* * * *

(6) When the department provides, pays for, or becomes liable for medical care under the Medicaid program, it has the following rights, as to which the department may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third party benefits:

(a) The agency has a cause of action against a liable third party to recover the full amount of medical assistance provided by Medicaid, and such cause of action is independent of any rights or causes of action of the recipient.

* * * *

(9) In the event that medical assistance has been provided by Medicaid to more than one recipient, and the agency elects to seek recovery from liable third parties due to actions by the third parties or circumstances which involve common issues of fact or law, the agency may bring an action to recover sums paid to all such recipients in one proceeding. In any action brought under this subsection, the evidence code shall be liberally construed regarding the issues of causation and of aggregate

APPENDIX 3

Chapter 78-433, Section 14, Laws of Florida; and
Chapter 82-159, Section 1, Laws of Florida

Section 14. Section 409.266, Florida Statutes, is amended to read:

409.266 Medical assistance ~~for-the-needy.~~--

(1) The department is designated as the state agency responsible for the administration of Medicaid funds under Title XIX of the Social Security Act and, to the extent moneys are appropriated, ~~of Health-and-Rehabilitative-Services~~ is authorized to provide payment for medical services to any person who:

(a) Is determined by the department to be categorically eligible for Medicaid ~~65-years-of-age-or-older,-or-blind,-or--permanently--and totally--disabled,--or--a--spouse--of-such-a-person,-or-children-that would,-if-needy,-qualify-for-aid-to-families-with-dependent-children, or--relatives--with--whom--such--children--are--living,-including-any dependent-children-required-to-be-included--by--the--Social--Security Act,-or-children-in-foster-home-care,-such-eligibility-as-established by-regulations-of-the-department.~~

~~(b)---Is--a-citizen-of-the-United-States-or-has-been-a-resident-of the-United-States-for-at-least-20-years-and-resides-in-this-state;~~

(b) ~~(c)~~ Has not sufficient income resources or assets, as determined by the department, to provide needed medical care without utilizing his resources required to meet his basic needs for shelter, food, clothing, and personal expenses. Interest on savings accounts of $1,000 or less held in the name of a Medicaid recipient shall not be considered income to be applied toward the monthly cost of institutional care.

(2) The department is hereby authorized to:

(a) Enter into such agreements with appropriate ~~fiscal~~ agents, other state agencies, or any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary or needed to implement the provisions of Title XIX of the Social Security Act pertaining to medical assistance.

(b) Contract with health maintenance organizations, certified pursuant to part II, chapter 641, for the provision of medical services to eligible persons.

(3)(a) Third party coverage for medical services shall be primary coverage and shall be exhausted before any payment authorized under this section shall be made on the behalf of any person eligible for services under this section.

(b) A public assistance applicant or recipient shall inform the department of any rights he has to third party payments for medical services. The department shall automatically be subrogated to any such rights the recipient has to third party payments and shall recover to the fullest extent possible the amount of all medical assistance payments made on the behalf of the recipient. Recovery of such payments shall be collected directly from:

1. Any third party liable to make a medical benefit payment to the provider of the recipient's medical services or to the recipient under the terms of any contract, settlement, or award; or

2. The recipient, if he has received third party payment for medical services provided to him.

(c) In recovering any payments in accordance with this subsection, the department is authorized to make appropriate settlements.

(d) The department shall promulgate rules to implement the provisions of this subsection.

(4) In addition to the federally required Medicaid services, the department shall make available to eligible recipients the care and services of a nurse midwife in accordance with Title XIX of the Social Security Act, 42 U. S. Code ss. 1396-1396j. For the purposes of this subsection, the term "nurse midwife" means an advanced registered nurse practitioner who is a certified nurse midwife pursuant to the provisions of chapter 464.

MEDICAL ASSISTANCE—PRENEED FUNERAL AND BURIAL SUPPLY CONTRACTS

CHAPTER 82-159

SENATE BILL NO. 583

An act relating to social and economic assistance, amending s. 409.266(3), Florida Statutes; providing for recovery of payments; providing for assignment of financial rights; providing for release of medical information; providing for enforcement of subrogation rights; providing for imposition of liens; providing for irrevocable preneed funeral service and burial supply contracts for applicants for, and recipients of, Supplemental Security Income, aid to families with dependent children, or Medicaid; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) of section 409.266, Florida Statutes, is amended to read:

409.266 Medical assistance.--

(3)(a) Third-party coverage for medical services shall be primary coverage and shall be exhausted before any payment authorized under this section shall be made on the behalf of any person eligible for services under this section.

(b) A public assistance applicant or recipient shall inform the department of any rights he has to third-party

payments for medical services. The department shall automatically be subrogated to any such rights the recipient has to third-party payments and shall recover to the fullest extent possible the amount of all medical assistance payments made on the behalf of the recipient. Recovery of such payments shall be collected directly from:

1. Any third party liable to make a medical benefit payment to the provider of the recipient's medical services or to the recipient under the terms of any contract, settlement, or award; or

2. The recipient, if he has received third-party payment for medical services provided to him; or

3. The provider of the recipient's medical services if third-party payment for medical services has been recovered by the provider.

(c) A public assistance applicant or recipient who receives medical care for which the department may be obligated to pay shall be deemed to have made assignment to the department of any right such person has to any payments for such medical care from a third party, up to the amount of medical assistance paid by the department.

(d) A public assistance applicant or recipient who receives medical care for which the department may be obligated to pay shall be deemed to have provided the department the authority to release medical information for such medical care for the sole purpose of obtaining reimbursement for medical assistance payments directly from third parties.

(e) The department may, in order to enforce its subrogation rights under this section, institute, intervene, or join any legal proceedings against any third party against whom recovery rights arise. No action taken by the department shall operate to deny the recipient's recovery for that portion of his damages not subrogated to the department and no action of the recipient shall prejudice the department's subrogation rights.

(f) When the department provides, pays for, or becomes liable for medical care, it shall have a lien for the amount of medical assistance paid upon any and all causes of action which accrue to the person to whom care was furnished, or to his legal representatives, as a result of sickness, injury, disease, disability, or death, due to the liability of a third party which necessitated the medical care. The department shall have 1 year from the date when the last item of medical care relative to a specific accident or spell of illness was paid in which to file its verified lien statement, and the statement shall be filed with the clerk of circuit court in the recipient's county of residence. The verified lien statement shall contain the name and address of the person to whom medical care was furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best knowledge of the department, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

(g)~~(e)~~ In recovering any payments in accordance with this subsection, the department is authorized to make appropriate settlements.

(h)~~(d)~~ The department shall promulgate rules to implement the provisions of this subsection.

APPENDIX 4

Underwood v. Fifer, 50 Fla. Supp. 2d 199 (Fla. 10th Cir. Ct. 1991)

UNDERWOOD v FIFER, et al.

Case No. 88-35-G

Tenth Judicial Circuit, Highlands County

November 8, 1991

HEADNOTE

Classified to Florida Supplement Digest

Insurance § 767; Medicaid benefits — state's statutory right to reimbursement of benefits paid superceded by contract between state and recipient holding recipient harmless for benefits in excess of certain amount — proceeds from recipient's insurance

Through the Medicaid program, the Department of Health and Rehabilitative Services paid medical assistance on behalf of the recipient in the amount of $66,878.40; however, it entered into an agreement with the recipient under which it agreed to hold her harmless for amounts in excess of $7,643.05. Insurance available for the recipient's benefit totaled $105,000. The Second District Court of Appeal remanded the case to the circuit court upon motions of the parties. The circuit court held the Department was contractually limited by the hold harmless agreement to recovery of $7,643.05 from the proceeds of the insurance, despite its entitlement by statute to recover the total amount of Medicaid benefits paid to the recipient.

APPEARANCES OF COUNSEL

Robin Gibson, Esquire, Mark H. Smith, Esquire, Law Offices of Gibson and Lilly, for plaintiff.

Richard L. Rogers, Esquire, Counsel, Medicaid Third Party, for intervenor, Department of Health and Rehabilitative Services.

OPINION OF THE COURT

J. DAVID LANGFORD, Circuit Judge.

THIS CAUSE has come before the Court upon remand from the District Court of Appeal, Second District, in *Underwood v Department of Health and Rehabilitative Services*, 551 So.2d 522 (Fla. 2d DCA 1989) (hereinafter "Underwood"), upon the motion of Plaintiff

JENNIFER UNDERWOOD for the remedy of equitable distribution, and upon the motions of Intervenor, the STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES (the "Department" or "State") for full statutory recovery and for declaratory relief. For the reasons set forth below, we grant the Department full recovery of the amount paid as medical assistance on behalf of Jennifer Underwood by Florida Medicaid, in the amount of $66,878.40, but because the Department has agreed to hold Plaintiff Underwood harmless for amounts in excess of $7,643.05, Plaintiff is held harmless as to amounts in excess of such amount, and the Department shall receive $7,643.05 from the proceeds of this case.

The facts of the case are not in dispute. Insurance available for Plaintiff's benefit totaled $105,000, of which $5,000 is available from medical pay coverage, and $100,000 is available from liability coverage. In the order dated November 21, 1988, this Court ruled that the Department was entitled to recover $55,163.97, the amount of medical assistance the Department had paid at that date as medical benefits on behalf of Plaintiff. The Department continued to pay for Plaintiff's medical care through May 24, 1989, in amounts totaling $66,878.40. On June 29, 1989, the Department filed a lien for $66,878.40 in the Official Records of Polk County, Book 2755, Pages 0792 through 0795. The total damages resulting from Plaintiff's injuries were valued at $3,000,000.

On appeal, in their briefs, both parties presented arguments related the Department's statutory subrogation rights under § 409.266(4)(b), Fla. Stat. (now repealed and superseded). Although briefly mentioned, no issue on appeal was addressed to either the statutory assignment or lien, the Department's other two statutory rights under the former Medicaid third-party liability provision (respectively "TPL" and "former TPL provision") of the medical assistance statute, § 409.266(4), Fla. Stat. (superseded on July 3, 1990 by act of the legislature in 1990, Ch. 90-295, § 33 [as well as Ch. 90-232, § 4, effective October 1, 1990], as amended in 1991, Ch. 91-282, §§ 30 and 38, eff. June 5, 1991, presently §§ 409.901 and 409.910, Fla. Stat.), although arguments were made by the Department as to assignment and lien in post-opinion motions.

In addition to amounts from liability recovery, discussed below, the *Underwood* opinion held that the Department was entitled to full recovery of funds that came solely from medical payments coverage, $5,000 in this case. 551 So.2d at 524.

As to recovery from liability coverage, the *Underwood* case was

determined on the basis of the Department's statutory subrogation right, to which the appellate court applied to state recovery the equitable remedy of equitable prorata distribution in a manner similar to principles of equitable distribution used to reduce recovery pursuant to subrogation rights of insurers that provide workers compensation coverage.

The former TPL provision of the medical assistance (i.e., Medicaid) statute was superseded on July 3, 1990 by the Medicaid Third-Party Liability Act (the "MTPLA"), § 409.2665 (Supp. 1990) (session law cited above). On June 5, 1991, § 409.2665, Fla. Stat. (Supp. 1990) was amended and renumbered §§ 409.901 and 409.910, Fla. Stat. by Ch. 91-282, §§ 30 and 38, Laws of Fla. The MTPLA, Title XIX of the Social Security Act (hereinafter "SSA") (especially SSA §§ 1902(a)(25), 1902(a)(45), and 1912 (42 U.S.C. §§ 1396a(a)(25), 1396a(a)(45), and 1396k)), and federal regulations (42 C.F.R. §§ 433.135-433.154) govern recovery of reimbursement by the state Medicaid agency in Florida.

[1] The Florida medical assistance statutes, §§ 409.901-409.920, as enacted in Ch. 91-282, Laws of Fla., including the MTPLA, and their respective predecessor statutes, are part of a complex state and federal regulatory framework. The overall intent of the medical assistance statutes is set out at the beginning of Title XIX of the SSA at § 1901 (42 U.S.C. § 1396). The intent or purpose is to enable

> each State, as far as is practicable under the conditions for each State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . . 42 U.S.C. § 1396.

Medical assistance is available, however, only when the resources of an individual are insufficient. Medicaid is the final safety net for medical care for the indigent, the last to pay, and, with the exception of Medicare, the first to be repaid if third-party resources later become available. State and federal costs of providing medical assistance are rising sharply. Both Congress and the Florida Legislature have established a framework to limit costs to the public treasury when third parties are, or may be liable. Costs are limited, initially through cost avoidance measures, and, subsequent to payment of medical assistance, by requiring repayment of reimbursement to state and federal governments from the resources of a liable third party. *See,* 42 U.S.C. 1396a(a)(25), 1396a(a)(45) and 1396k; 42 C.F.R. 433.135-433.154; the

MTPLA (and the former TPL provision); and Fla. Admin. Code Rule 10C-7.0301; *see, also,* proposed Fla. Admin Code Chapter 10C-35, 17 Fla. Admin. Code 3997-4019 (Sept. 6, 1991).

In Florida, the legislative history of the MTPLA and the former TPL provision demonstrates legislative intent since 1978 to increase recovery by the state from third party resources. Legislative staff analyses since 1978 pertaining to legislative acts creating or amending the former TPL provision make no mention of intent to reduce state recovery on principles of equitable distribution or other equitable remedy.

The legislative staff analysis prepared in 1990 by the House Committee for Health Care pertaining to the MTPLA provides three primary reasons the legislature passed the MTPLA. The legislature intended (i) expressly to correct problems and significant monetary losses expected to result from the *Underwood* decision; (ii) to bring the former TPL provision into closer compliance with federal requirements, in that the federal government requires that where third-party benefits are discovered, the state Medicaid agency must recover the full amount paid and must return the federal share to the federal Health Care Financing Administration; and (iii) to clarify the historic intent of the Legislature as to full recovery by the state. The staff analysis stated that the language of the MTPLA "clarifies the intent of the legislature (revised 1978, 1982, and 1986) to assure full recovery of Medicaid payments by the state from third party resources, when they are discovered or become available."

In subsection (1) of the MTPLA, the Florida Legislature expressly states its intent as to third-party liability:

> It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, *it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program or entity.* Medicaid is to be repaid in full from, and to the extent of, any third party benefits, *regardless of whether a recipient is made whole or other creditors paid.* Principles of common law and equity as to assignment, lien and subrogation are to be abrogated to the extent necessary to assure full recovery by Medicaid from third party resources. *It is intended that if the resources of a liable third party become available at any time, the public treasury*

should not bear the burden of medical assistance to the extent of such resources. § 409.910(1), Fla. Stat. (emphasis added).

[2] With the MTPLA, the legislature ratified the Department's construction of the former TPL provision in that, under the MTPLA, the Department has multiple independent rights of recovery, which are to be construed together to provide the greatest recovery to the state from third party resources, without reduction based on equitable remedies. With one exception, not applicable in this case, the Department is entitled to full recovery of reimbursement under the MTPLA.

"Subsequent legislation declaring the intent of an earlier statute is entitled to great weight." *Red Lion Broadcasting Co. v FCC,* 395 U.S. 367, 380-381, 23 L.Ed.2d 371, 383, 89 S.Ct. 1794 (1969). While an administrative statutory construction should normally be followed, this is especially true when the legislature refuses to alter the administrative construction, and even more so when the legislature ratifies it with positive legislation. *Red Lion Broadcasting Co., supra,* 395 U.S. at 381-382, 23 L.Ed.2d at 383-384.

The enactment of the MTPLA provided legislative ratification of the Department's administrative construction of the former TPL provision. Having been ratified by the legislature, the department's construction of the statute is entitled to great weight and should be followed unless clearly wrong. Not only is the statutory construction not clearly wrong, but it clearly complies with federal interpretations of governing federal law requiring full reimbursement to the state Medicaid agency and federal government from amounts paid or payable by liable third parties, as discussed more fully below.

[3] The MTPLA substantially reenacted the former TPL provision, eliminating equitable remedies used to reduce recovery by the state. Not only the subrogation right, but the statutory assignment and lien have survived reenactment, with the express elimination of any equitable remedy against full recovery by the state. These reenacted rights have continued as an existing general policy, having ongoing operation, with more limited remedies available against the rights. *See, McKibben v Mallory,* 293 So.2d 48, 53-54 (Fla. 1974). The MTPLA amended and cured defects in the former statute. *Id.* at 55.

"While statutory changes in law are normally presumed to apply prospectively, procedural or remedial changes may be immediately applied to pending cases . . ." *Heilman v State,* 310 So.2d 376, 1377 (Fla. 2d DCA, 1975). "If a statute is found to be remedial in nature, *it can and should be retroactively applied* in order to serve its intended purposes." *City of Orlando v Desjardins,* 493 So.2d 1027, 1028 (Fla.

1986) (emphasis added). "By definition, a remedial statute is one which confers or changes a remedy; a remedy is the means employed in enforcing a right or in redressing an injury." *St. John's Village I, Ltd. v Dept. of State, Division of Corporations,* 497 So.2d 990, 993 (Fla. 5th DCA 1986).

Under governing law, any remedy of equitable distribution against the Department in cases pertaining to third-party liability has been eliminated since the date the MTPLA became effective, July 3, 1990. Each provision of the MTPLA which eliminated equitable remedies is remedial in nature, and applies to cases pending as of the effective date of the MTPLA.

[4] Under § 409.910(6)(a), Fla. Stat. (enacted after the *Underwood* opinion), the Department is automatically subrogated to the rights of the recipient for the full amount of medical assistance paid by Medicaid. Equities of a recipient cannot, under present statute, reduce or prorate recovery by the Department as to the rights to which the Department is subrogated. Statutory subrogation under the MTPLA, unlike equitable subrogation, is analogous to a right of reimbursement, in that the conditions precedent for equitable subrogation need not be met in order for full recovery to be required. *See, e.g., Riera v Finlay Med. Centers HMO Corp.,* 543 So.2d 372 (Fla. 3d DCA 1989).

[5] In light of the doctrine of law of the case, this Court declines to make a determination either as to recovery of reimbursement under the subrogation right or as to the applicability of the current subrogation provision to the present case. Issues as to subrogation were the only issues on appeal in the *Underwood* case. Without violating the doctrine of law of the case, this Court may determine the state's entitlement to recovery of reimbursement based on the issue of statutory assignment. Statutory assignment was neither an issue on appeal nor was it an issue determined by the District Court of Appeal.

[6] Both federal and state law mandate an assignment by an applicant or recipient to the state Medicaid agency as a condition of eligibility for Medicaid. SSA § 1912 (42 U.S.C. § 1396k); 42 C.F.R. § 433.145-146; § 409.910(6)(b), Fla. Stat., § 409.266(4)(c), Fla. Stat. (1989) (repealed). While state participation in Medicaid is optional, once a state decides to participate, it must comply with federal requirements. *Harris v McRae,* 448 U.S. 297, 301, 100 S.Ct. 2671, 2680, 65 L.Ed.2d 784, 794 (1980); *Wilder v Va. Hospital Assn.,* 110 S.Ct. 2510, 2513, 110 L.Ed.2d 455 (1990); *Colo. Health Care Assn. v Colo. Dept. of Social Services,* 842 F.2d 1158, 1164 (10th Cir. 1988). Federal regulations require, as a condition of eligibility, that a Medi-

caid recipient assign his rights to third party payments to the state Medicaid agency and to cooperate with the state Medicaid agency in obtaining such payments. 42 C.F.R. §§ 433.145-433.148, 433.154. Federal regulations set forth the manner in which third party collections must be distributed, with the state to receive an amount equal to the state Medicaid expenditures, the federal government to receive the federal share, and the recipient to receive any remaining amount. 42 C.F.R. § 433.154.

[7] Under the federally mandated assignment, when a recipient has assigned his rights to the state, the recipient has no rights of recovery to any amount from a liable third party until the state Medicaid agency has recovered the amount Medicaid has expended on his behalf. *See, generally,* 42 C.F.R. § 433.154. The federal Health Care Financing Administration ("HCFA") has construed § 1912(b) of the SSA and 42 C.F.R. § 433.154, to the effect that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." *State Medicaid Manual,* HCFA Pub. 45-3, § 3907, Transmittal No. 40 (Feb. 1990), MEDICARE & MEDICAID GUIDE (CCH), paragraph 14,749. Absent a showing that HCFA's construction of the federal statute is clearly wrong, and in light of the Department's corresponding construction of state and federal law, the Florida Legislature's reenactment of the former TPL provision as the MTPLA and the legislature's ratification of the Department's construction of governing law, this Court is not only required to uphold the Department's construction of the statutory assignment provision, but endorses and adopts it as consistent with the intent of Congress and the Florida Legislature to avoid additional public expense when a third party is legally liable to pay. *See, Red Lion Broadcasting Co., supra,* 395 U.S. at 380-382, 23 L.Ed.2d at 383-384; *State ex rel Biscayne Kennel Club v Board of Business Regulation,* 276 So.2d 823 (Fla. 1983).

[8] In a Medicaid case, just as in a Medicare case, "[i]t would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages from a tortfeasor and pocket the windfall." *Holle v Moline Public Hospital,* 598 F. Supp. 1017 (C.D. Ill. 1984), quoting *Gordon v Forsyth County Hospital Authority,* 409 F. Supp. 708 (M.D.N.C. 1976).

[9] Under the state and federal statutory assignment, the Department is entitled to full recovery of reimbursement prior to any person or entity except Medicare. The Medicaid assignment vests in the Department any right a recipient has to recovery from a third party. The

Medicaid assignment is absolute, vesting in the Department whatever right, title and interest the recipient has to recovery from a third party, totally divesting the recipient of any interest therein except for amounts in excess of the total medical assistance after full recovery by the state. § 409.910(1) and (6)(b), Fla. Stat.; SSA § 1912 (42 U.S.C. § 1396k); 42 C.F.R. §§ 433.145-433.146, 433.154. In the present case, under the statutory Medicaid assignment, the Department has a vested right to full reimbursement of the amount paid by Medicaid, i.e., $66,878.40, from the proceeds of this case. By applying for or receiving medical assistance, as a matter of state and federal law, Plaintiff automatically assigned her cause of action and proceeds from the cause of action to the state. By state and federal law, Plaintiff, as a result of her assignment, has no right, title or interest in any proceeds of the present case until the Department has recovered the full amount of medical assistance that the Medicaid program has expended on her behalf, $66,878.40.

[10] In light of the hold harmless agreement which the parties entered between the date of issuance of the *Underwood* opinion and the enactment of the MTPLA, notwithstanding the Department's statutory entitlement to full recovery, the Department's actual recovery has a cap of $7,643.05. Although entitled by statute to recovery of $66,878.40, the Department is contractually limited to recovery of $7,643.05 from the proceeds of this case. Accordingly it is hereby

ORDERED and ADJUDGED that the Department is entitled by state and federal statute and regulation to reimbursement of the full amount of medical assistance provided by Medicaid, $66,878.40, but, pursuant to prior agreement between Plaintiff and the Department, Plaintiff is held harmless for any amounts in excess of $7,643.05, and, accordingly, the Department shall receive $7,643.05 from the proceeds of this cause of action. It is further ORDERED that Plaintiff's motion for equitable distribution is denied.

DONE and ORDERED at Sebring Florida on this 8th day of November, 1991.