No. 20-1263

In The Supreme Court of the United States

GIANINNA GALLARDO, AN INCAPACITATED PERSON, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,

Petitioner,

v.

SIMONE MARSTILLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF AMERICAN JUSTICE ASSOCIATION AND FLORIDA JUSTICE ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICI CURIAE*[1]

The American Association for Justice ("AAJ") and the Florida Justice Association ("FJA") respectfully submit this brief as *amici curiae*.

The AAJ is a national, voluntary bar association founded in 1946 to strengthen the civil justice system, preserve the right to trial by jury, and protect access to the courts for those who have been wrongfully injured. With members in the United States, Canada, and abroad, AAJ is the world's largest plaintiff trial bar. AAJ's members primarily represent plaintiffs in personal injury actions, employment rights cases, and other civil actions. Throughout its 75-year history, AAJ has served as a leading advocate for all Americans seeking legal recourse for wrongful conduct.

The FJA is AAJ's affiliated state association in Florida. FJA's mission is to strengthen and uphold Florida's civil justice system and to protect the rights of Florida's citizens and consumers.

Many of the injured plaintiffs represented by AAJ and FJA members have received or will receive medical treatment for their injuries paid for by Medicaid. As a result, *amici*'s members and their clients are directly affected by the construction of statutory

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[1] All parties have consented to the filing of this brief. As required by Rule 37.6, counsel certifies this brief was not authored, in whole or in part, by counsel to a party, and no monetary contribution to the preparation or submission of this brief was made by any person or entity other than *Amici Curiae*, their members, or their counsel.

provisions in the federal Medicaid Act concerning repayment of medical expenses to state Medicaid agencies out of proceeds obtained from liable third parties through litigation.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

AAJ and FJA submit this *amicus* brief to provide helpful context in three respects. First, we explain that Florida's argument assumes that all of an injured person's future medical expenses will be paid by Medicaid. That is not what happens. It is the experience of our members that injured plaintiffs become ineligible for Medicaid when they receive their settlement funds. And Florida ignores that Medicaid does not cover many of the medical care expenses that are recovered in litigation.

Second, we explain that Florida has successfully adopted the process for allocating tort settlements discussed by this Court in its previous consideration of the relevant Medicaid lien provisions in *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), and *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013).

Third, given the similarities between Florida's position here and the unsuccessful arguments made by the states in *Ahlborn* and *Wos*, we describe the circumstances supporting this Court's conclusion that permitting the state to take an inequitable share of the

settlement funds "might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Ahlborn*, 547 U.S. at 288.

ARGUMENT

I. Florida's argument erroneously assumes that all of the future medical expenses will be paid by Medicaid.

Florida's argument is built, in part, on the assumption of there being no harm, no foul. The assumption goes like this—Why does it matter if Florida takes some of the settlement money that has been allocated to future medical care because the Medicaid program will be paying for those medical expenses anyway? This assumption is disproved by variables ignored by Florida.

Medicaid disqualification upon settlement: Florida ignores that the injured person probably will not qualify for Medicaid in the future. It is the experience of our members that most Medicaid recipients will no longer qualify for Medicaid if they are permitted to receive their proportionate share of the settlement money. This is because the Medicaid program uses the same income and resource testing that is used by the Supplemental Security Income program.[2]

[2] State Medicaid agencies, "must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving [Supplemental Security Income]." 42 C.F.R. § 435.120. If a state provides Medicaid to individuals or couples who are not receiving Supplemental Security Income, it must still use the income and resource criterion of the Supplemental

Medicaid recipients must, therefore, meet stringent financial criteria. For example, they cannot have more than $2,000 in total countable assets. *See* 42 U.S.C. § 416.1205. Most tort action settlements exceed the $2,000 threshold.

There are only two circumstances where a person will stay on Medicaid after receiving a tort settlement. The first is obvious—the rare circumstance where the recipient's share of the settlement money does not push their total countable assets above the $2,000 cap requirement.

The second circumstance is also uncommon. A tort victim can stay on Medicaid if the injury renders them disabled and if they transfer ***all*** of the settlement money received into a statutorily exempted trust account, commonly called a Special Needs Trust. The Special Needs Trust is an exception to Medicaid disqualification that Congress created and has expressly endorsed. The same statute that requires states to comply with the anti-lien and anti-recovery provisions also requires states to follow the federal provisions for Special Needs Trusts. 42 U.S.C. §§ 1396a(a)(18); 1396p(a), (b), (d). As a result, the statutory scheme must be read together. *See Panama Ref. Co. v. Ryan*, 293 U.S. 388, 439 (1935); Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 168 (2012).

Security Income program. *See* 42 C.F.R. § 435.120; 42 C.F.R. § 435.201(a)(1)-(3).

The Special Needs Trust is a limited exception to the rule of Medicaid disqualification, with stringent statutory requirements. *See* 42 U.S.C. § 1396p(d).[3] As a result, few will qualify. For example, even if a trust meets the statutory requirements for a Special Needs Trust, the trust will still be considered a countable asset and, therefore, could trigger Medicaid disqualification if the trust beneficiary retains prohibited control over the trust, like the ability to terminate the trust or to direct use of the trust funds. POMS SI 01120.200D.1.a.[4]

In addition, spending is also tightly controlled, limited to things directly relevant to the recipient's care. The purpose of the Special Needs Trust is to pay those expenses that Medicaid would never pay. For example, Medicaid often covers only part of the home nurse care prescribed by doctors for seriously injured people.[5] Medicaid also will not pay for important daily

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[3] 42 U.S.C. § 1396p(d) provides "This subsection shall not apply to any of the following trusts," and then identifies other statutory provisions that count all other trusts, other than Special Needs Trusts, as available resources.

[4] These trusts are regulated by the administrative rules set out in the Social Security Administration's Program Operations Manual System (POMS). *See Draper v. Colvin*, 779 F.3d 556, 561 (8th Cir. 2015).

[5] While the medical services provided may differ some amongst states, most (if not all states) do not extend full coverage for all prescribed care. *See*, *e.g.*, https://www.nd.gov/dhs/services/medicalserv/medicaid/noncovered.html (last viewed September 20, 2021); https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/ (last viewed September 20, 2021); https://dss.mo.gov/mhd/general/pages/about.htm (last viewed September 20, 2021).

care expenses, like a home ramp for a wheelchair. Each expense must be reviewed and approved by the trustee, who is bound to comply with stringent regulations that limit spending to things directly relevant to the recipient's care. Violating these spending restrictions is another basis for voiding the limited Special Needs Trust exception to the rule of Medicaid disqualification.

Equally important is the fact that many will not want to create a Special Needs Trust because they will not want to deposit their entire settlement recovery (or whatever amount leaves the Medicaid recipient no more than $2,000 in assets), including noneconomic damages for things like the pain and suffering endured as a result of their injuries, into such a restrictively regulated trust account.

Others will object to the price exacted. In exchange for extending Medicaid qualification, the Special Needs Trust creates a powerful tool for Medicaid recovery by extending the Medicaid lien beyond the damages recovered from the tortfeasor. When the recipient dies, the Medicaid program can use the settlement money that was deposited into the Special Needs Trust to pay all of the recipient's medical expenses ever paid by the program, not just those related to the tortious injury.[6] Given this fulsome recovery potential, it is not

[6] The last part of 42 U.S.C. § 1396p(d)(4)(A) requires that "the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter."

surprising that Congress has extended Medicaid qualification in this limited circumstance.

Medicaid disqualification generally: Florida's position also ignores the changing determination of Medicaid eligibility. For example, a Medicaid recipient may experience a change in their financial circumstances which disqualifies them from the program. Florida ignores this too, implicitly assuming that Medicaid recipients are in a permanent state of poverty, unable to rise out of poverty. But the Medicaid program is not intended to be and is not a permanent solution for providing medical care.

Medicaid disqualification can also be occasioned by changes to the Medicaid eligibility requirements. And these changes can vary amongst the states, making any assumption even more uncertain. So, there is certainly no guarantee that the Medicaid program is picking up the tab for the injured person's future medical care.

Limited Medicaid coverage: Florida's assumption also ignores the undisputed fact that Medicaid coverage is limited and so would never cover all of the medical expenses that can be awarded in litigation.

The Medicaid program has the most restrictive guidelines of any third-party payor. *See generally* Armen H. Merjian, *A Choice Between Food and Medicine:* Denning v. Barbour *and the Struggle for Prescription Drug Coverage Under the Medicaid Act*, 13 SCHOLAR 201 (Winter 2010); Jon Donenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance*

with Federal Availability Requirements, 117 Yale L. J. 1498 (May 2008). For example, as we noted above, Medicaid often does not cover the full amount of home nursing care prescribed for seriously injured people.

In litigation, the recovery of future medical expenses is not artificially restricted by Medicaid guidelines. And these expenses include necessary life care items. For people confined to a wheelchair, for example, the tortfeasor must also pay for things like a house ramp and a handicap-accessible vehicle. So, there is no even swap. Being on Medicaid means doing without these things and receiving less care than medically recommended.

These realities expose the gap in Florida's reasoning. And they highlight why it is important for injured people to retain a proportionate share of the settlement funds to pay for future medical expenses.

II. Florida has successfully followed *Ahlborn* and *Wos*.

In support of its position, Florida repeats the unsuccessful argument made in *Ahlborn* and *Wos*—that something sinister is afoot. In *Ahlborn* and *Wos*, this Court held that any risk of settlement manipulation can be avoided by submitting the matter to a court or administrative tribunal for decision. *Wos*, 568 U.S. at 638; *Ahlborn*, 547 U.S. at 288. In support, this Court explained that "some States have adopted special rules and procedures for allocating tort settlements" to determine subrogation rights to settlement payments. *Ahlborn*, 547 U.S. at 288 n.18.

In *Wos*, this Court also observed that "[t]he task of dividing a tort settlement is a familiar one." *Wos*, 568 U.S. at 642. "In a variety of settings, state and federal courts are called upon to separate lump-sum settlements or jury awards into categories to satisfy different claims to a portion of the moneys recovered." *Id*. As an example of how courts have managed to accomplish such allocations, *Wos* cited *Colorado Compensation Ins. Auth. v. Jones*, 131 P.3d 1074, 1077–78 (Colo. App. 2005). In *Jones*, the court noted, in the context of apportioning workers' compensation settlements, that courts "must determine the amount of each category of damages actually suffered by the employee, and based on these findings, allocate the settlement among the categories." *Id*. at 1077.

Time has proven that the risk of manipulation feared by the states in *Ahlborn* and *Wos* has not materialized. Just as the Court predicted in those cases, judges and lawyers have devised a reliable method for properly allocating tort recoveries.

Pertinent here, Florida has developed straightforward, objective criteria for apportioning tort settlements. Florida's administrative law judges are charged with deciding disputes between Florida's Medicaid agency and Medicaid beneficiaries. Fla. Stat. § 409.910(17)(b) (2016). And they are currently bound under principles of stare decisis by the Florida Supreme Court's precedent prohibiting Medicaid from taking from any portion of the settlement other than those portions allocated for past medical expenses.

Giraldo v. Agency for Health Care Admin., 248 So. 3d 53, 56-59 (Fla. 2018).

Chamberlin v. Agency for Health Care Admin., No. 14-1380MTR, 2021 WL 1567111 (Fla. Div. Admin. Hrgs. Apr. 15, 2021), is an example of Florida's procedure. *Chamberlin* involved a series of tort settlements for various damages, including past and future medical expenses. The past medical expenses had been mostly paid by a Medicaid agency.

Relying on testimony and evidence, an administrative law judge allocated the settlements and determined the amount owed to Medicaid for the past medical expenses it had paid. The administrative law judge's process was as follows:

First, pursuant to section 409.910, an evidentiary hearing was conducted, and Florida's Medicaid agency was afforded the opportunity to defend its claimed reimbursement of Medicaid money.

Second, the administrative law judge evaluated the beneficiary's evidence supporting the different damages requested in litigation, and then totaled the values attributed to these buckets:

- Past medical expenses: The judge determined that the past medical expenses totaled $1,689,934.88. Of that, $1,409,615.94 was paid by Medicaid. *Id.* at *2.
- Future medical expenses and future loss of earnings: The judge evaluated: (1) the

expert opinion of an economist; (2) the expert opinion of a life care planner; and (3) the expert opinion of an independent personal injury attorney who did not represent the recipient. The judge found that the range for these future damages was between $27,951,967 and $36,752,806. *Id.* at *4, 6.

- Noneconomic damages: To estimate the amount a jury would award to compensate for the beneficiary's experience of noneconomic damages like pain and suffering, the judge reviewed jury verdicts from comparable cases. The judge also considered the independent attorney's expert opinion. The judge found the value of the beneficiary's claim for noneconomic damages was $19.4 million *Id.* at *6-7.

- Total damages: The beneficiary's evidence had set the total value of the damages at $45 million. Given that the total value of the amounts determined by the judge exceeded that, the judge found that the beneficiary's valuation was "very conservative." *Id.* at *7.

Third, the beneficiary proved that he had settled his claims against multiple tort defendants for $9,449,500. *Id.* at *2. The beneficiary also provided evidence that such a settlement was reasonable. Specifically, his counsel testified that proving liability would have been "difficult because there was medical literature supporting both sides' arguments concerning the standard of care." *Id.* at *5.

Fourth, the judge mathematically determined Medicaid's proportionate share of the settlement recovery. The judge first determined that the settlement ($9,449,500) was twenty-one percent (21%) of the recoverable damages ($45,000,000). *Id.* at *7). The judge then reduced the past medical expenses paid by Medicaid ($1,409,615.94) by the same percentage, which came to $296,019.34 as the allocated amount Medicaid could recover from the settlement proceeds. *Id.*

As *Chamberlin* makes clear, Florida's process ensures a fair and valid apportionment of the settlement monies amongst the various damages, consistent with this Court's directions in *Ahlborn* and *Wos*. An administrative law judge presides over an evidentiary hearing, and the Florida Medicaid agency is afforded the opportunity to contest this evidence and present its own evidence. As with any adversary proceeding, the judge's decision is based on admissible, relevant evidence.

For the future medical expenses, for example, the judge hears from at least one life care planning expert. As explained in the *amicus* brief submitted by the American Academy of Physician Life Care Planners, a life care planner evaluates the medical condition of injured people and conducts an extensive analysis of the care expenses they will incur throughout their lifetimes. This information allows those people to plan for their future, and it allows for care providers charged with their care to do the same. In the context of a tort suit, the information is used to secure payment for that care from the tortfeasor who caused the injury.

However, the analysis done for litigation is limited to only those costs that meet the standard of proof imposed on plaintiffs.

As with all expert testimony, life care planning experts must be sufficiently qualified to survive a *Daubert*[7] challenge and to withstand scrutiny on cross-examination and challenge by an opposing life care planning expert.[8]

For determining the damages recoverable for non-economic damages, the administrative law judge looks at jury verdicts returned in comparable cases, as recommended by this Court in *Wos*, 568 U.S. at 640-41 (stating that "judges and lawyers . . . can find objective benchmarks to make projections of the damages" that an injured person "reasonably could have expected to receive" at trial by using "damages awarded in comparable tort cases"). It does so by applying the procedure used to test the amount of a jury's verdict in post-verdict proceedings—reviewing jury verdicts returned in comparable cases.

The approach implemented in Florida complies with this Court's directions in *Ahlborn* and *Wos* (and principles of equity) to determine the proportionate share of the settlement recovery that is attributable to past medical expenses. The approach advocated by Florida's Medicaid agency does not. Instead, it inappropriately prioritizes the recovery of past medical

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[7] *Daubert v. Merrell Dow Pharm., Inc.*, 516 U.S. 869 (1995).

[8] Florida's Medicaid agency can hire a life care planning expert to contest the recipient's expert.

expenses it paid over the recovery of medical expenses to be incurred in the future.

III. Florida's position will increase the Medicaid program's future expenses and will reduce reimbursements to the Medicaid program.

Our final point is to elaborate on this Court's conclusion in *Ahlborn* that permitting the state to take an inequitable share of the settlement funds "might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Ahlborn*, 547 U.S. at 288.

A. Florida's position increases the program's future expenses.

As explained above, most Medicaid recipients will no longer qualify for Medicaid if they are permitted to receive their proportionate share of the settlement money. The corollary point is that Florida's position increases the program's future expenses by keeping people on Medicaid. Properly allocating the settlement money, therefore, saves the Medicaid program money.

The first aspect of the savings is obvious—the Medicaid program will not be responsible for the injured person's future medical care unless the injured person's assets are later exhausted so that Medicaid qualification is triggered again. What might not be obvious is the extent of that savings. An unfortunate reality for people injured by a tortfeasor is that their

future medical expenses will most likely be more than the amount recovered in litigation.

This scenario is caused by the disconnect between legal principles and medical care. Much of the experience of the injured is uncertain, but the legal system requires reasonable certainty before imposing a legal obligation to pay for future medical care. *See*, *e.g.*, Danny R. Veilleux, *Sufficiency of Evidence to Prove Medical Expenses as a Result of Injury to Back, Neck or Spine*, 26 A.L.R. 5th 401.

The human body is complex, meaning that the path of an injury is unpredictable. Many times, a person's medical condition worsens, requiring more care than identified in the litigation. Other circumstances can also increase the cost of future medical care, like newly available treatments and procedures.

These realities are all ignored in litigation. The determination of damages in litigation is based on a single moment in time, addressing only those medical expenses that are reasonably certain or probable to occur. Therefore, in the years and decades following suit, the injured person almost always incurs medical expenses that were not recovered in litigation. That is particularly true when recovery is pursuant to a settlement because, as explained below, settlement almost always requires accepting less than full compensation. If the injured person no longer qualifies for the Medicaid program, the Medicaid program will avoid some or all of the additional expense that outpaces the amount that had been paid by the tortfeasor.

Medicaid disqualification also saves the Medicaid program the additional expense of all the other medical expenses it would have paid for the recipient, unrelated to the tort injuries. Wellness visits, preexisting injuries, and new injuries or illnesses—the Medicaid program would be off the hook. The former Medicaid recipient would become responsible for all of their medical bills. For parents who are injured, the same is true of their children's medical expenses. 42 C.F.R. § 435.602(a)(2)(i).

B. Florida's position reduces reimbursements to the program.

The Eleventh Circuit's opinion ignores an important concern identified by this Court—settling litigation is important. *Ahlborn*, 547 U.S. at 288. As a rule, public policy favors the settlement of disputes. *See*, *e.g.*, *Marek v. Chesny*, 473 U.S. 1, 10 (1985). In the context of Medicaid, settlements are necessary to reimburse expenses paid by the program.

The Medicaid program pays the healthcare costs of citizens who cannot afford to do so. It is a mostly federally funded program that is managed by states. To offset those costs, the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, creates various liens whereby medical expenses paid by Medicaid monies can be reimbursed. This case involves one of those liens—when a tortfeasor injures a Medicaid recipient, the Medicaid program enjoys subrogation and assignment rights and a lien of reimbursement for medical expenses incurred because

of the tort. 42 U.S.C. § 1396a(a)(25)(A)-(B), (H); § 1396k(a)-(b). However, if there is no recovery from the tortfeasor, there will be no reimbursement to the Medicaid program.

The Medicaid Act empowers states to file tort suits to recover this money. 42 U.S.C. § 1396k. While that authority may occasionally be used in the context of a mass tort case, it is not exercised in typical tort cases. The reason is that states lack the resources to do everything that goes into prosecuting litigation, including things like interview the injured person, interview witnesses, collect relevant documents (like automobile crash reports and medical records), talk with treating physicians, schedule depositions, hire expert witnesses (which can cost thousands to hundreds of thousands of dollars), and determine the care the injured person will need as a result of the injury. So, the states depend on injured people to prosecute their tort cases in order to generate a recovery from which the Medicaid program can obtain reimbursement.

Discouraging settlement of those cases denies the Medicaid program of these reimbursements. If the purpose of the Medicaid lien is to help defray costs to the Medicaid program, then injured people must be encouraged to seek that liability. Florida's position discourages settlements.

Injured people settle cases for two reasons—to avoid the risk of losing at trial, and to avoid the delay of receiving the compensation they need. In exchange, people accept less than full compensation for their

injuries. That is particularly true for many cases, like this one, where the available compensation is capped. Most times, tortfeasors have limited funds to pay for the injuries they cause. And, if there is liability insurance, the policy limits are often small. For example, car insurance liability policy limits can be as low as $10,000 per person injured and $20,000 total for all people injured. There can be statutory limitations on recovery too, like a sovereign immunity statutory cap on the amount of recovery from states, including their agencies and subdivisions. *See*, *e.g.*, Fla. Stat. § 786.28(25).[9]

In these circumstances, the tortfeasor is typically eager to settle claims for the relatively low policy limits or statutorily available damages. It is the injured person who must decide whether to settle for less than their damages. The disincentive in Florida's position is obvious: injured people will have no incentive to pursue claims against the tortfeasor if all or most of the funds available to pay those claims must go to the Medicaid program.

Here, Gianinna Gallardo sustained catastrophic physical injuries and brain damage when she was hit by a truck after her school bus dropped her off in 2008. JA 25 ¶29; Pet. App. 3, 95. She remains in a persistent vegetative state and is unable to ambulate,

[9] A chart of all fifty states' sovereign immunity laws, including those with damages caps, can be found here: https://www.mwl-law.com/wp-content/uploads/2018/02/STATE-SOVEREIGN-IMMUNITY-AND-TORT-LIABILITY-CHART.pdf (last viewed September 17, 2021).

communicate, eat, toilet, or care for herself. Based, in part, on an expert's assessment of her pecuniary losses, Gianinna's damages were estimated to exceed $20,000,000. JA 41-44. But she was only able to recover $800,000. JA 41-44. Florida demands $300,000 of this. JA 41-44. Under these circumstances, there is little or no incentive to settle, let alone bring a lawsuit. And it is not fair.

Just like the rule of full reimbursement might preclude settlement,[10] a rule permitting the state to take from the recipient's future medical expenses would do the same. Knowing that the state will receive full reimbursement of past medical expenses, injured people will likely demand that the tortfeasor pay that sum in full—in addition to the sum necessary to make the injured person forgo trial against the tortfeasor. Introducing this "non-negotiable" element into settlement negotiations "might preclude settlement in a large number of cases, and be unfair to the recipient in

[10] *Ahlborn* emphasized that it would make no sense, and would be "unfair," to allow states to recover reimbursement for past medical expenses by taking funds paid to compensate for *other* injuries borne by the recipient. *Ahlborn*, 547 U.S. at 288. In a footnote attached to that statement, this Court favorably cited a Washington Supreme Court decision that held that a state agency "could not 'share in damages for which it has provided no compensation' because such a result would be 'absurd and fundamentally unjust.'" *Id.* at n.18 (citing *Flanigan v. Dep't of Labor & Indus.*, 869 P.2d 14, 17 (Wash. 1994)). *See also Denekas v. Shalala*, 943 F. Supp. 1073, 1080 (S.D. Iowa 1996) ("avoidance of contrived apportionments do not allow the government to take settlement proceeds to which others are entitled").

others," as this Court recognized in *Ahlborn*, 547 U.S. at 288.

Other practical results of Florida's position include injured people: (1) not bringing suit because the burden of litigation is not worth the limited recovery Medicaid would permit them; (2) not pursuing claims for future medical expenses; and (3) not requesting medical expenses at all, including past medical expenses.

Whichever way this plays out, Florida's position will reduce reimbursements for the Medicaid program.

CONCLUSION

For the foregoing reasons, *Amici Curiae*, the American Association of Justice and the Florida Association of Justice, urge this Court to reverse the decision of the Eleventh Circuit Court of Appeals in this case.

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