No. 06-2447

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

UNITED SENIORS ASSOCIATION, INC.,

Plaintiff – Appellant,

v.

PHILIP MORRIS USA, ET AL.,

Defendants – Appellees.

APPEAL FROM THE JUDGMENT
OF THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* SUPPORTING DEFENDANTS–APPELLEES AND URGING AFFIRMANCE

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INTEREST OF THE *AMICUS CURIAE*

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation. With a substantial presence in all fifty States and the District of Columbia, the Chamber represents an underlying membership of more than three million businesses and organizations of every size and kind. As the principal voice of American businesses, the Chamber regularly files *amicus* briefs in federal and state courts throughout the country in cases raising issues of national concern.

This is such a case. Plaintiff is seeking to recover billions of dollars based on a far-reaching and countertextual interpretation of the Medicare as Secondary Payer statute (the "MSP"), 42 U.S.C. § 1395y(b), that has been rejected by every one of the many courts to consider it, including the Eleventh Circuit in *Glover v. Liggett Group, Inc.*, 459 F.3d 1304 (2006). *See* Brief for Defendants-Appellees, at 2, 4-5 & nn. 1, 3. If this Court were to disagree with those decisions and reverse the district court, the impact would extend far beyond the tobacco industry to every business that is or might be the subject of a tort claim involving medical expenses. Indeed, if plaintiff's sweeping interpretation of the MSP were accepted, practically any business would be subject to unwarranted double liability in an enormous range of cases based purely on the fact that some alleged victim – and not necessarily even the MSP plaintiff herself – happened to be a Medicare beneficiary. Accordingly, the Chamber's

members have a very substantial interest in the proper resolution of the issue of statutory interpretation raised by this appeal.

All parties to this action have consented to the filing of this *amicus* brief.

STATEMENT OF THE ISSUE

The MSP, 42 U.S.C. § 1395y(b), authorizes a private cause of action to recover double damages when an insurance company or self-insured entity has failed to reimburse Medicare for health care costs for which that insurer or entity is legally responsible. The issue presented by this appeal is whether a private MSP action may be used to subject an entity that has *not* been shown to be legally responsible for the plaintiff's (or other Medicare beneficiaries') health care costs, but against whom the plaintiff (or other Medicare beneficiaries) has an unadjudicated tort claim, to a federal lawsuit for double damages.

STATEMENT OF FACTS

Plaintiff is a non-profit organization proceeding as a "private attorney general" under the MSP. In essence, plaintiff claims that defendants committed a common law battery against smokers by exposing them to nicotine while concealing its addictive properties, that defendants were therefore obligated to pay for the smokers' health care costs, and that, because Medicare paid some of these costs, defendants are liable for twice the amount Medicare paid. Relying on this theory, plaintiff seeks to recover

double the total amount of *all*[1] of Medicare's expenditures since August 4, 1999 for the treatment of diseases attributable to cigarette smoking – expenditures likely totaling billions of dollars. On August 28, 2006, the U.S. District Court for the District of Massachusetts granted defendants' motion to dismiss.

INTRODUCTION AND SUMMARY OF ARGUMENT

In broad outline, the MSP provides that Medicare shall not pay for health care costs for which another payer – the "primary plan" – is responsible. 42 U.S.C. § 1395y(b)(2)(A). The exception to this rule is when a primary plan "has not made or cannot reasonably be expected to make payment . . . promptly," in which case Medicare may pay, subject to a right to reimbursement from the primary plan. *Id.* § 1395y(b)(2)(B).[2]

The statute establishes a private cause of action against "a primary plan which fails to provide for primary payment (or appropriate reimbursement)" in accordance with the substantive provisions of the statute. 42 U.S.C. § 1395y(b)(3)(A). Those

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[1] Excluded from this suit are expenditures for services rendered in Florida for diseases attributable to smoking the cigarettes manufactured by two of the defendants. *See* J.A. 12-13. Those expenditures are the subject of the now-dismissed *Glover* suit.

[2] The statute is named "Medicare as Secondary Payer" not because Medicare pays second – indeed, the statute contemplates that it may well pay first – but because the statute makes Medicare's responsibility for coverage secondary to that of the "primary" plan. *See* 42 C.F.R. § 411.21 (2006).

provisions, in turn, state that a primary plan has a duty to reimburse Medicare "for any payment made by" Medicare "with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." *Id.* § 1395y(b)(2)(B)(ii). The statute also provides that "[a] primary plan's responsibility for [primary] payment may be demonstrated by a *judgment*, a *payment conditioned upon the recipient's compromise, waiver, or release* (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." *Id*. (emphasis added).

As defendants persuasively demonstrate, and as the Eleventh Circuit (along with every district court to have considered the issue) recognized, the language of the statute requires that "an alleged tortfeasor's responsibility for payment of a Medicare beneficiary's medical costs . . . be demonstrated *before* an MSP private cause of action for failure to reimburse Medicare can correctly be brought under section 1395y(b)(3)(A)." *Glover*, 359 F.3d at 1309; *see also Glover v. Philip Morris USA*, 380 F. Supp. 2d 1279, 1289-95 (M.D. Fla. 2005). We do not intend here to repeat the persuasive analysis of the MSP's text and structure contained in defendants' brief and the *Glover* opinions.

Instead, the Chamber submits this brief to supplement that analysis by making three points. First, the implementing agency regulations, when read together with the MSP's text, confirm the correctness of the district court's view that there can be no double-damages liability for failing to make payment under the MSP if there has been no prior determination that the defendant is responsible for those payments.

Second, plaintiff's interpretation and use of the MSP statute would authorize unwarranted double-damages recovery against an enormous number of new defendants by an equally large number of potential plaintiffs. Yet such double-damages liability would be unwarranted because a defendant that has had no established legal responsibility for a plaintiff's injuries cannot possibly have wronged the Medicare program in not reimbursing it for covering those injuries. If plaintiff is correct, however, then every time an injured party believes that a commercial defendant is liable to it in tort, the injured party can use the fact of a Medicare payment to threaten that defendant with double damages, despite the absence of any prior dealings between the defendant and plaintiff. With close to 40 million Medicare beneficiaries in the United States and practically every commercial entity arguably qualifying as a "primary plan" under the statute, there would no meaningful limits on the number and extent of such potential lawsuits. It is no exaggeration to say that the economic impact on American business would be enormous. Congress would not

have brought about such a radical change in the law without making its intention to do so clear in the statute's text, legislative history, or both.

Third, and relatedly, plaintiff's sweeping interpretation would have far-reaching, negative implications for federal-state relations and the workload of the federal courts. Plaintiff's regime would dramatically reshape the federal-state balance by encouraging a massive migration of tort claims from state into federal court. The effect on the federal docket would be tremendous – not just because of the sheer number of claims likely to be filed, but also because tort cases involving effects on health tend to be time-consuming and fact-intensive. Had Congress intended such a significant expansion in the workload of federal judges, it would have made a clear statement in the statute. This it did not do. For all of these reasons (and those set forth in defendants' brief), this Court should uphold the dismissal of plaintiff's MSP lawsuit.

ARGUMENT

I. The Implementing Regulations Confirm What The Statutory Text Says – A Private Lawsuit Under The MSP For Double Damages May Not Be Initiated Without A Prior Demonstration Of A Payment Obligation

As defendants persuasively show, plaintiff's construction of the statute would make a key part of the statute utterly redundant. *See, e.g.*, *Gustafson v. Alloyd Co.*, 513 U.S. 561, 574 (1995) ("the Court will avoid a reading [of a statute] which renders

some words altogether redundant"). The key sentence in Section 1395y(b)(2)(B)(ii) lists ways of demonstrating responsibility for payment. If "by other means" really can mean, as plaintiff would have it, "by a finding of liability *in* the lawsuit initiated to collect double damages for non-payment," as opposed to "by some kind of definitive demonstration *before* the initiation of that suit," then no purpose would be served by the language providing that responsibility for payment "may be demonstrated by a judgment [or] [settlement] payment . . . ."

By the same token, the judgment below finds strong support in "the established interpretative canons of *noscitur a sociis* and *ejusdem generis*," according to which "where general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words." *Wash. State Dep't of Social and Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 384 (2003). Under these well-settled principles, the residual phrase "by other means" *must* refer to the same class of objects referred to in the preceding examples – in other words, to *other instances* "where there is a previously established requirement or agreement to pay for medical services for which Medicare is entitled to be reimbursed." *Glover*, 380 F. Supp. 2d at 1291; *accord Brockovich v. Sharp Healthcare*, 2006 U.S. Dist. LEXIS 82202, at *15-*18 (S.D. Cal. Nov. 7, 2006). Otherwise, the phrase "by other means"

would be so broad as to swallow up and render superfluous the preceding examples that are specified.

That plaintiff's reading would render some of the words of the statute superfluous or inoperative is true not simply by virtue of the canons of statutory construction. It is equally true as a matter of practical realities. According to plaintiff, the critical sentence in Section 1395y(b)(2)(B)(ii) allows an MSP plaintiff to demonstrate the defendant's responsibility for covering the plaintiff's injuries for the first time in the MSP lawsuit itself. But if that were true, why would Congress have bothered to specify several ways of demonstrating that responsibility? Surely, if plaintiff's position is accepted, plaintiff would have the opportunity during its MSP lawsuit to demonstrate the reimbursement obligation using *any* piece of admissible evidence and any legal theory it chooses. And if that is so, then there was no need for Congress to specify that an MSP plaintiff could rely on a particular type of evidence – such as a judgment or a settlement – as a basis for establishing the defendant's responsibility. Thus, the key sentence in the statute makes sense *only* if it is understood as providing that the obligation to reimburse or make primary payment – the failure to fulfill which gives rise to liability for double damages – is not

complete until there has been a prior demonstration of responsibility along the lines of, although not limited to, a judgment or settlement.[3]

This interpretation is strongly confirmed by the agency regulations implementing the statute. "[T]he well-reasoned views of the agencies implementing a statute . . . 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Santiago Clemente v. Executive Airlines, Inc.*, 213 F.3d 25, 30 n.2 (1st Cir. 2000).

First of all, the Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") recently issued a regulation interpreting "by other means" as "including but not limited to a settlement, award, or contractual obligation." 42 C.F.R. § 411.22 (2006). Thus, the agency's own elaboration on "by other means," to the extent it is at all specific, identifies only situations in which "there is a previously established requirement or agreement to pay for medical services for which Medicare is entitled to be reimbursed." *Glover*, 380 F. Supp. 2d at 1291.

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[3] Although there is no need for this Court to reach the issue, "by other means," unlike the terms that precede it, could refer to determinations of responsibility by an arbitrator or administrative agency, or indeed any evidence that definitively establishes responsibility, including, for example, a sworn affidavit or statement of a tortfeasor recounting the underlying events giving rise to the injury, unequivocally acknowledging the tortfeasor's fault, and promising future compensation.

Second, the regulations dealing with the United States' right to double damages in a suit for reimbursement, *see* 42 U.S.C. § 1395y(b)(2)(B)(iii), establish a procedure that is highly instructive. CMS "may *initiate recovery* as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan." 42 C.F.R. § 411.24(b) (2006) (emphasis added). Next, "[i]f it is not necessary for CMS to *take legal action* to recover," then CMS collects simply the amount of the Medicare payment (or the full amount of the primary payer's obligation, if it is less). *Id*. § 411.24(c)(1) (emphasis added). On the other hand, "[i]f it *is* necessary for CMS to take legal action to recover from the primary payer," CMS is entitled to twice the amount of its payment, regardless of whether the primary payer's obligation is in fact less. *Id*. § 411.24(c)(2) (emphasis added).

The crucial feature of this procedure is the distinction between initiating recovery and taking legal action. Initiating recovery must mean taking some kind of meaningful measures *short of* filing suit – for example, sending an invoice or a written demand for reimbursement. The government may file a claim for double damages only *after* the initial recovery measures fail, thus making legal action "necessary." That is, in order for the government to collect double damages, there

must have been a demand or other notice by the government and a refusal to pay on the part of the "primary plan."

Moreover, the regime specifies when the government can make its initial, pre-litigation demand: after "it learns that payment has been made or could be made under . . . any liability or no-fault insurance, or an employer group health plan." 42 C.F.R. 411.24(b). This provision must be read against the statute and regulations, which of course tell us that "a primary plan's responsibility for such payment may be demonstrated by a judgment, a payment . . . , or by other means," including "a settlement, award, or contractual obligation." 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.22 (2006). In other words, when the government receives information – whether through a judgment, a payment, or "other means" – that the insurance plan is responsible for payment, the government initiates recovery, and then, if that fails, initiates a double-damages suit.

These agency regulations strongly confirm the correctness of the lower court's interpretation of the MSP. If plaintiff's reading of "by other means" were accepted, the result would be a logical absurdity, because the demonstration of responsibility would be only a potential outcome of the suit and therefore could not possibly serve, as the statute and regulations require, as a precondition to filing that suit. Put differently, the government cannot know that it is owed payment before a finding of

liability in a suit brought to demonstrate that it is owed payment. To avoid this problem, the statute is properly understood to mean that the government cannot claim double damages for non-payment before the liability determination has been made.

And if all of this is true for government-initiated actions, then it must be true for the private cause of action as well. The private cause of action cannot be broader than the government-initiated suit for which it is effectively a substitute. Therefore, for a private MSP action just as for a government-initiated suit, the demonstration of responsibility that is a precondition to liability for double damages must occur prior to, not in, the very lawsuit in which those damages are sought.

II. Under Plaintiff's Interpretation, The MSP Would Expose Every American Business to Unwarranted Double Liability In Every Tort Case In Which A Medicare Payment Can Be Alleged

Under plaintiff's view, the MSP permits a lawsuit against an alleged tortfeasor for double damages based on the failure to make a payment that would be required only if the defendant were ultimately held liable for the underlying tort. That unprecedented interpretation automatically converts every tort claim involving a health expense covered by Medicare into a potential federal lawsuit for double damages. According to plaintiff, any aggrieved person who believes that his or her injuries (the costs of which were or might have been covered by Medicare) were

caused by tortious conduct need only allege that, plus a failure to make primary payment; instantly, the plaintiff has initiated a viable lawsuit for double damages.

But that interpretation unfairly penalizes the MSP defendant. The purpose of an MSP action, as plaintiff and Senator Grassley emphasize, is to compensate the Medicare program for the wrong done to *it* when it paid for health care costs for which a primary payer was responsible. Double damages are acceptable in this context because, among other things, "double damages are necessary to compensate the Government completely for the costs, delays, and inconveniences occasioned by fraudulent claims." *United States v. Bornstein*, 423 U.S. 303, 314-15 (1976).

A defendant, however, cannot possibly be said to have committed any wrong *against Medicare* for failing to make a payment that it disputes and for which it has never been shown to be responsible. Indeed, not even plaintiff argues that the mere allegation of liability under state tort law creates any obligation to pay.[4] The failure to make payment in these circumstances therefore cannot be a wrong against Medicare, and should not subject a defendant to double damages. As the Eleventh

[4] Plaintiff does argue that "'the rights and liabilities of the parties are fixed at the moment of the accident with respect to a cause of action sounding in tort.'" Brief for Appellant, at 26 (quoting *In re Reading Co.*, 404 F. Supp. 1249, 1251 (E.D. Pa. 1975)). This highly metaphysical point – assuming without conceding that it is even correct – is essentially irrelevant here. The issue is not when the underlying tort liability arises, but the conditions under which a failure to reimburse Medicare gives rise to liability for double damages under the MSP.

Circuit explained in *Glover*: "[U]nder Plaintiffs' interpretation, an alleged tortfeasor that is sued under the MSP (instead of under state tort law) could not contest liability without risking the penalty of double damages: defendants would have no opportunity to reimburse Medicare *after* responsibility was established but before the penalty attached." 459 F.3d at 1309.

Nor is this unfairness likely to be limited to a small number of cases. The MSP broadly defines a "primary plan" (*i.e.*, a potential defendant in an MSP action) as:

> a group health plan or large group health plan . . . [or] a workmen's compensation law or plan, an automobile or *liability insurance policy or plan (including a self-insured plan)* or no fault insurance . . . . *An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan* ***if it carries its own risk*** *(whether by a failure to obtain insurance, or otherwise) in whole* ***or in part****.*

Id. § 1395y(b)(2)(A) (emphasis added).

This definition encompasses practically every potential commercial defendant. Some large organizations have a self-insurance program under which they pool the exposure of their component units and set aside reserves to cover potential losses. *See* EMMETT J. VAUGHAN AND THERESE M. VAUGHAN, FUNDAMENTALS OF RISK INSURANCE 42-43, 63, 65-67 (9th ed. 2003); MARK S. DORFMAN, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 55-57 (7th ed. 2002). Such firms obviously come within the statutory definition of a "primary plan."

More importantly, even when a business purchases liability insurance, it bears part of its own risk and therefore becomes a "primary plan" for purposes of the MSP. Nearly all liability insurance policies include deductibles and policy limits. *See, e.g.*, SCOTT E. HARRINGTON AND GREGORY R. NIEHAUS, RISK MANAGEMENT AND INSURANCE 175 (1999) ("Policy limits always are used in liability insurance policies."); *id*. at 239 (noting that "policies almost always require the policyholder to bear some risk" through "the use of policy provisions like deductibles and limits"). The insured carries its own risk to the extent of the deductible and liability in excess of the coverage limits. Indeed, the regulations implementing the statute spell this out; they define "liability insurance payment" to include not only "payment by a liability insurer" but also "an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan." 42 C.F.R. § 411.50(b) (2005).

Even if some hypothetical business carried none of its own risk, however, it would still be subject to an MSP suit based on ordinary tort claims if plaintiff has its way. The statute does not specify who is to be named as a defendant in a private MSP suit. If plaintiff is right, any time any person comes to believe that any Medicare beneficiary has been injured by any business at all – whether a large

manufacturer or a small family-owned store – the person with the belief could sue the business under the MSP on the theory that the business either has an insurance policy that will cover the relevant liability (in which case the underwriter of the policy would be the primary plan) or does not have such an insurance policy, in which case the business itself is a primary plan.

Either way, the plaintiff could allege that the relevant "primary plan" has failed to make payment and thereby instantly state a claim for double damages. If the primary plan were an outside insurer, it might be a necessary party in any such action, *see* FED. R. CIV. P. 19, but that would not necessarily prevent the MSP plaintiff – who initially has no way of knowing whether and by whom a particular defendant is insured – from suing the alleged tortfeasor under the MSP.

Finally, even if, on plaintiff's view, the MSP does not go so far as to permit a direct suit against a hypothetical fully insured business, it makes little economic difference. To accept plaintiff's view of the statute is to force businesses in the aggregate to bear the costs of the potential for routine double liability in the form of higher premiums under liability insurance policies.

Nor are the numbers of potential *plaintiffs* limited in any meaningful way. In 2005, close to 40 million persons were enrolled in Medicare, and the number is only increasing. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE

ENROLLMENT: NATIONAL TRENDS 1966-2005.[5] Any injury suffered by any one of these people could become the basis of a double-damages suit. Indeed, under the sweeping interpretation offered by plaintiff's counsel (here as well as in *Glover*), an MSP plaintiff need not even be an injured person or Medicare beneficiary herself; *anyone* is authorized to sue as a private attorney general for double damages. This case illustrates the point. Plaintiff is not a Medicare beneficiary; it has no connection to the injuries on which it bases its MSP claims; it has suffered no harm from the defendants. Plaintiff is nonetheless seeking double damages likely in the many billions of dollars based on alleged torts committed against many millions of Medicare beneficiaries.

Accordingly, under plaintiff's interpretation of the MSP, every American business would be subject to vastly increased costs, in the form either of payments pursuant to settlements and judgments wrought in a double-damages regime, or at the very least higher premiums for liability insurance policies. If Congress had intended such a vast expansion of the private cause of action under the MSP, it would have made its intentions clear. The complete absence of any evidence of such intentions

[5] At http://www.cms.hhs.gov/MedicareEnRpts/Downloads/SMI05.pdf (last visited January 16, 2006).

in the text of the statute and its legislative history provides further confirmation that plaintiff's reading is mistaken.

III. Plaintiff's Novel Construction Of The MSP Has The Potential To Flood The Federal Courts With Tort Claims Arising Under State Law, A Circumstance Never Intended By Congress

As if the foregoing were not enough, plaintiff's position, if accepted, would federalize all manner of garden-variety tort litigation hitherto pursued in the state courts and therefore potentially impose vast new burdens on the federal courts. As the Eleventh Circuit recognized, to convert every underlying tort claim involving an injury suffered by a Medicare beneficiary into a potential federal suit is to "drastically expand federal court jurisdiction." *Glover*, 459 F.3d at 1309. Here again, if Congress had intended such a dramatic change, one would expect to see a clear indication in the statutory text or legislative history. *Id*. But there is none. On the contrary, the available evidence of Congress's intent squarely refutes plaintiff's interpretation.

In the modern era, federal courts adjudicate tort claims arising under state law only when there is the requisite diversity of citizenship between the parties and the amount in controversy exceeds $75,000. 28 U.S.C. § 1332(a).[6] Plaintiff, by contrast,

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[6] To be sure, there is pendent jurisdiction, *see* 28 U.S.C. § 1367, but it is discretionary and used only to adjudicate state claims founded on the same case or controversy as a claim that comes within original federal jurisdiction. Plaintiff's theory would not simply allow courts to hear state claims in addition to federal ones based on the same facts; it would effectively *convert* all manner of garden-variety

would open the federal courts to routine adjudication of underlying tort claims arising under state law regardless of the citizenship of the parties or the amount in controversy. So long as the plaintiff (who, just as here, might be a complete stranger to the controversy) can allege an injury to one of the nearly 40 million Americans enrolled in Medicare, the plaintiff would be entitled to a federal forum for a health-related tort dispute. In fact, this point is not disputed either by plaintiff or by Senator Grassley, who goes so far as to say that a tectonic shift in the workload of the federal courts is "precisely what Congress intended." *Amicus* Br. 22. Yet as explained above, in defendants' brief, and in *Glover*, everything about the statute's text and structure – to say nothing of common sense – points in exactly the opposite direction.

Beyond that, as this Court is well aware, modern tort suits involving health-related injuries can be exceedingly time-consuming and would be no less so if smuggled into federal court in the Trojan Horse of an MSP action. Indeed, every MSP lawsuit based on unacknowledged tort liability would require the court to resolve fact-intensive issues like negligence, causation, statute of limitations, contributory negligence, federal preemption, and so on. Individual MSP actions therefore would consume great amounts of time on the part of federal judges.

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state claims into federal ones because an MSP claim based on alleged tort liability could not be resolved without first adjudicating the underlying tort claim.

Plaintiff in effect is asking for precious federal judicial resources to be expended for the resolution of embedded tort claims that do not arise under federal law, do not necessarily involve diverse parties, and do not necessarily involve the requisite amount in controversy.[7]

Because plaintiff's novel interpretation of the MSP would create federal jurisdiction over "any state tort claim in which a business entity allegedly injured a Medicare beneficiary," *Glover*, 459 F.3d at 1309, it would significantly alter the balance of work between the state and federal courts. Ordinarily, if Congress wishes to bring about such a significant change in the federal-state relationship, it must make its intentions "unmistakably clear." *Raygor v. Regents of the Univ. of Minn.*, 534 U.S. 533, 543 (2002) (citations and quotation marks omitted); *accord Gregory v. Ashcroft*, 501 U.S. 452, 462 (1991); *BFP v. Resolution Trust Corp.*, 511 U.S. 531, 544 (1994). As explained above, nothing in the text or structure of the MSP or its legislative history comes close to satisfying that exacting standard. There is simply no reason

[7] As this case makes clear, the important limitations on diversity jurisdiction are not the only restrictions that can be readily circumvented under plaintiff's view. If plaintiff is correct, then many of the essential requirements of FED. R. CIV. P. 23 for class actions can also be easily avoided through the simple expedient of repackaging tort claims as private attorney general claims for double damages under the MSP. As the Eleventh Circuit recognized, if Congress had wished to permit such an end run around established legal protections, it surely would have said so clearly. *Glover*, 459 F.3d at 1309.

to believe that Congress intended the mere fact of a Medicare payment made in good faith to transform any health-related tort claim into federal litigation for quasi-punitive double damages. *See Glover*, 459 F.3d at 1309 ("We are confident that, if Congress intended such radical innovations in jurisdiction, federal-state relations, and tort liability, it would have more clearly expressed its intent.").

CONCLUSION

For the foregoing reasons and those set forth in defendants' brief, the district court's judgment should be affirmed.

Dated: January 18, 2007

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation set forth in Federal Rules of Appellate Procedure 29(b) and 32(a)(7)(B) because this brief uses a proportionally spaced font and contains 4971 words (including footnotes but excluding the cover page, the tables of contents and authorities, and the certificates of counsel), as reported by WordPerfect.

This brief complies with the typeface requirements of Federal Rules of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rules of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using WordPerfect 12 in 14-point Times New Roman.

Dated: January 18, 2007

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Counsel for *Amicus Curiae*

CERTIFICATE OF SERVICE

I hereby certify pursuant to Rule 25(d) of the Federal Rules of Appellate Procedure that on January 18, 2007, the original and ten copies of this brief, including one in a WordPerfect file on CD-ROM, were sent via Federal Express overnight delivery to the clerk of this Court, and that one copy of this brief was served, via First Class Mail, on each of the following counsel of record:

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