No. 03-1341

In the Supreme Court of the United States

BAXTER INTERNATIONAL INC., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

The Medicare Secondary Payer (MSP) statute, 42 U.S.C. 1395y(b)(2), was amended after the court of appeals issued its decision in this case. The petition presents the following questions concerning the proper interpretation of the version of the MSP statute that was in effect at the time the court of appeals ruled:

1. Whether the court of appeals correctly held that the statutory term "self-insured plan" included entities that self-insure only in part, by purchasing excess insurance that is triggered after a liability threshold is met.

2. Whether the court of appeals correctly held that an entity could maintain a "self-insured plan" within the meaning of the MSP statute without establishing formal procedures by which funds were set aside and then could be drawn upon to cover claims.

3. Whether the court of appeals correctly held that petitioners could be held liable under the MSP statute as entities that "received payment" from products liability insurers that were responsible for reimbursing the Medicare program.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-70a) is reported at 345 F.3d 866. The opinion of the district court (Pet. App. 71a-108a) is reported at 174 F. Supp. 2d 1242.

JURISDICTION

The judgment of the court of appeals was entered on September 15, 2003. The petition for rehearing was denied on December 23, 2003 (Pet. App. 110a-112a). The petition for a writ of certiorari was filed on March 22, 2004. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. This action was brought by the United States pursuant to the Medicare Secondary Payer (MSP) statute, 42 U.S.C. 1395y(b)(2). In December 2003, after the court of appeals issued the decision that petitioners would have this Court review, Congress amended the MSP statute in a manner that largely codifies the interpretation given the statute by the Secretary of Health and Human Services and sustained by the court of appeals. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301, 117 Stat. 2221. Those amendments apply as if included in the MSP statute in 1980, and therefore will now govern the proceedings on remand. The following description refers to the version of the statute that was in effect at the time the court of appeals issued its decision.

The MSP statute was enacted in 1980 to reduce the Medicare program's rising costs. H.R. Rep. No. 1167, 96th Cong., 2d Sess. 352 (1980); *Zinman* v. *Shalala*, 67 F.3d 841, 843, 845 (9th Cir. 1995). The statute makes the Medicare program secondary to other plans that cover the costs that Medicare would otherwise absorb. The statute was designed to lower overall federal Medicare disbursements by requiring Medicare beneficiaries to exhaust all available insurance coverage before resorting to their Medicare coverage. *United States* v. *Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996).

Toward that end, the MSP statute establishes two principal directives. First, it sets out the circumstances under which Medicare should withhold payment. If payment has been made by a "liability insurance policy or plan (including a self-insured plan) or under no fault

insurance" for the same medical care, or if such payment can reasonably be expected to be made "promptly," Medicare may not pay. 42 U.S.C. 1395y(b)(2)(A)(ii). That prohibition "is intended to keep the government from paying a medical bill where it is clear an insurance company will pay instead." *Evanston Hosp.* v. *Hauck*, 1 F.3d 540, 544 (7th Cir. 1993), cert. denied, 510 U.S. 1091 (1994).

Second, the statute sets out the circumstances under which Medicare must be reimbursed for the payments it does make. If Medicare cannot reasonably expect payment (or prompt payment) from another insurance plan, Medicare is authorized to pay. 42 U.S.C. 1395y(b)(2)(A)(ii). The statute specifies, however, that such Medicare payments are conditional and must be repaid to Medicare if another insurance plan's responsibility to pay is established. 42 U.S.C. 1395y(b)(2)(B)(i).

To further the goal of reducing Medicare costs, Congress defined broadly the kinds of insurance that are deemed primary to Medicare. The statutory definition of "primary plan" expressly includes liability insurance plans that are self- insured. 42 U.S.C. 1395y(b)(2)(A) ("the term 'primary plan' means * * * a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance").

If the Medicare program is not reimbursed for its payments as required under the MSP statute, the United States may bring suit to obtain reimbursement. The MSP statute authorizes the United States to bring an action against "any entity which is required or responsible * * * to make payment * * * under a primary plan" and against "any other entity (including any physician or provider) that has received payment from that entity." 42 U.S.C. 1395y(b)(2)(B)(ii).

The MSP statute also gives the United States a right of subrogation, in addition to the direct right of action just described. 42 U.S.C. 1395y(b)(2)(B)(iii). Under the subrogation provision, if an entity that should have reimbursed the Medicare program pays a different party (such as a tort victim) instead, that entity remains liable to the government as long as it knew or should have known of Medicare's conditional payment. *Health Ins. Ass'n of Am., Inc.* v. *Shalala*, 23 F.3d 412, 418 (D.C. Cir. 1994) (*HIAA*) ("If a third party payer wants to avoid having to make two payments for the same service, it should refrain from paying someone whom it knows or should know that [Medicare] already has paid."), cert. denied, 513 U.S. 1147 (1995); Pet. App. 55a-56a (following *HIAA* and observing that "the constructive knowledge standard is fully consistent with the intent of the MSP statute, and indeed necessary if the statute is to fulfill its purpose," because "the insurer that pays second is in the superior position to prevent an erroneous or misdirected payment").

2. a. This case arises out of the 1995 settlement of mass tort litigation against the manufacturers of breast implants. In 1994, the federal government informed the settling parties that, to the extent the government had made Medicare payments for the victims' implant-related medical care, the MSP statute required that Medicare be reimbursed. Pet. App. 3a. The 1995 settlement (known as the Revised Settlement Program, or RSP) established a mechanism by which breast implant recipients could obtain compensation from a fund created pursuant to the settlement. *Id.* at 152a-153a (Compl. ¶¶ 15-20). The RSP did not, however, provide for reimbursement of the federal government's Medicare payments, and the manufacturers made settlement payments or caused settlement payments to be made to

claimants from the settlement fund without regard to whether Medicare had paid their implant-related medical expenses. *Id.* at 156a-157a (Compl. ¶¶ 37-42); *id.* at 3a n.1. The manufacturers likewise made settlement payments to implant recipients who opted out of the settlement class, without regard to whether Medicare had paid for their implant-related expenses. *Id.* at 153a-154a, 157a (Compl. ¶¶ 20-22, 39-40).

Beginning in 1995 and continuing through March 2000, the United States entered into a series of tolling agreements with the manufacturers while it attempted to negotiate a resolution of its claims. Pet. App. 5a. After settlement discussions proved unsuccessful, the United States brought this action for monetary and injunctive relief under the MSP statute, naming as defendants the manufacturers that are petitioners here: Baxter International Inc.; Baxter Healthcare Corporation; Bristol-Myers Squibb Company; Minnesota Mining and Manufacturing Company; and Union Carbide Corporation.[1]

The complaint alleges that the United States, through the Medicare program, has paid for implant-related medical care on behalf of thousands of women, including women receiving compensation from the petitioners. Pet. App. 154a, 159a (Compl. ¶¶ 26, 55). The complaint in two respects seeks reimbursement from the petitioners for those Medicare payments (as well as prospective relief) under the MSP statute. First, the complaint alleges that petitioners were liable to the Medicare beneficiaries under a "primary plan" because they were "self-insured" (42 U.S.C. 1395y(b)(2) and (b)(2)(B)(ii)), at least in part, against the risk of

[1] The complaint also named the settlement fund's escrow agent as a defendant. The escrow agent is not a petitioner here.

products liability claims by breast implant recipients. Pet. App. 157-158a, 160a-161a (Compl. ¶¶ 43-44, 58-59, 67-68). Second, the complaint alleges that petitioners alternatively or additionally were responsible for reimbursing the Medicare program as entities that "received payment" (42 U.S.C. 1395y(b)(2)(B)(ii)) from their products liability insurers with respect to implant-related claims. Pet. App. 158a, 161a (Compl. ¶¶ 45-46, 64-65).

b. The district court dismissed the complaint for failure to state a claim. Pet. App. 71a-108a. Although the court offered various grounds for its ruling, only two are relevant to the petition.

First, in dismissing the "self-insurance" counts, the court declared that the statutory term "self-insured plan" does not encompass entities that self-insure only in part, by purchasing excess insurance that is triggered after a liability threshold is met. Pet. App. 84a & n.12. The court opined, further, that a "self-insured plan" necessarily requires "some type of formal arrangement by which funds are set aside and accessed to cover future liabilities," *id.* at 84a, factors that the government had not specifically alleged in its complaint.

Second, the court concluded that petitioners could not be held liable as entities that "received payment" from another insurance plan responsible for reimbursing Medicare, notwithstanding petitioners' alleged receipt of the proceeds of their products liability insurance. In the court's view, petitioners must be regarded as mere "pass-through" entities between their own insurers and the implant recipients. Pet. App. 95a-100a.

c. A unanimous panel of the Eleventh Circuit reversed in relevant part, remanding the case for dis-

covery and other further proceedings. Pet. App. 1a-70a.

Addressing the district court's "self-insurance" rulings, the court rejected the conclusion that the statutory term "self-insured" could not apply to entities that self-insure only in part, by carrying their own risk up to a certain amount and procuring insurance policies to cover the excess. Pet. App. 42a-47a. The court observed that, to prevent responsible parties from eluding MSP liability, the Secretary's regulations defined the statutory term "self-insured" broadly as a plan under which an entity "carries its own risk instead of taking out insurance with a carrier." *Id.* at 45a (quoting 42 C.F.R. 411.50(b)). The court explained that there was "nothing in the plain meaning of the statute which might preclude the agency's interpretation to include within the self-insured concept the commonly occurring circumstances of an individual or entity planning ahead of time to assume responsibility and liability for certain risks up to a designated amount, and to procure an insurance policy to cover the excess." *Id.* at 47a. To the contrary, the court reasoned, while some authorities interpret the term "self-insured plan" rigidly, it "is interpreted by other authorities to include precisely such a combination of self-insurance up to a certain amount with the excess to be covered by an insurance policy." *Ibid.*; see, *e.g.*, *id.* at 48a n.23 (noting that the 1979 edition of *Black's Law Dictionary* (at 1220) explained, in defining self-insurance, that "[a] common practice of businesses is to self-insure up to a certain amount, and then to cover any excess with insurance").

The court of appeals similarly rejected the district court's conclusion that the term "self-insured plan" requires proof of a formal arrangement by which funds were set aside and providers were made to use them to

cover future liabilities. Pet. App. 42a-52a. The court noted that the agency's regulations define the term "plan" to include "any arrangement, oral or written, by one or more entities, to . . . assume legal liability for injury or illness," *id.* at 45a (quoting 42 C.F.R. 411.21), and that the inclusion of the term "oral" suggested "an intent to reach informal, ad hoc arrangements in addition to traditional insurance policies." *Ibid.* The court held that the agency's view was "especially persuasive in the absence of a universally accepted and authoritative definition of 'self-insured plan' which Congress might have contemplated in drafting the statute." *Ibid.*; see, *e.g.*, *id.* at 47a ("Even the sparse legal authority which suggests that there usually will be a reserve for losses, also indicates that 'self-insurance' has no precise legal meaning."). Although the court disagreed with *dicta* in the Fifth Circuit's decision in *Thompson* v. *Goetzmann*, 315 F.3d 457 (2002), opinion withdrawn and reissued as amended on other grounds, 337 F.3d 489 (5th Cir. 2003), suggesting that a formal set-aside of funds was required, the court "fully agree[d] with the Fifth Circuit that the term 'plan' in the statutory term 'self-insured plan' clearly contemplates an *ex ante* arrangement." Pet. App. 49a.

In its "received payment" ruling, the court of appeals remanded to allow the government an opportunity to prove that petitioners may be held liable, based on their alleged receipt of the proceeds of their products liability insurance policies, under the statutory provision allowing the government to recover from "any other entity (including any physician or provider) that has received payment" from any primary plan. Pet. App. 64a (quoting 42 U.S.C. 1395y(b)(2)(B)(ii)). The court explained that it could assume that "Congress intended the term 'any other entity' to be understood with reference to

'physician' and 'provider,' and to encompass only entities of like kind." *Id.* at 65a. The court further observed that, although the record is "devoid of detail about the role of [petitioners'] liability insurance carriers," it appears that petitioners "initially financed the settlement, then filed claims with their insurers, which will provide reimbursement based on their independent evaluation of the class members' claims." *Id.* at 68a. The court explained that, if so, the district court's description of petitioners as "mere intermediaries between their insurance companies and the class members is not accurate." *Ibid.* The court remanded to allow the government to develop evidence relevant to this aspect of the suit. *Id.* at 68a-69a.

d. The court of appeals denied the petitions for rehearing and rehearing en banc, no active judge having asked for a vote on the en banc petition. Pet. App. 111a-112a.

3. On December 8, 2003, after the panel issued its decision in this case, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066. Section 301 of that Act amends the MSP provisions in a manner that largely codifies the interpretations of the Secretary of Health and Human Services on the issues raised by the petition. The title of Section 301(b) reflects that Congress regarded these amendments as "[c]larifying" the MSP statute. 117 Stat. 2221. Section 301(d) further provides that the amendments in Section 301(b) are effective as if included in the MSP statute as originally enacted in 1980. 117 Stat. 2222.

As particularly relevant here, Section 301(b)(1) provides that "[a]n 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 failure to obtain insurance, or otherwise*) *in whole or in part.* 117 Stat. 2222 (emphases added). That provision accordingly makes clear that the existence of a self-insured plan does not depend upon a formal set aside of funds or formal claims procedures, and that an entity that has procured liability insurance may nonetheless be considered to be self-insured for any amount for which the entity carries its own risk.

Additionally, Section 301(b)(3) of the 2003 Act also deletes the parenthetical phrase "including any physician or provider" from the "received payment" provision of the MSP statute, and provides that "the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." 117 Stat. 2222; accord *ibid.* (Section 301(b)(2) amends the MSP statute to provide that "[a] primary plan, and an entity that receives payment from a primary plan, shall reimburse" the Medicare program for the payments it has made). Those amendments leave no doubt that the Secretary has a cause of action to seek reimbursement from entities such as petitioners that are alleged to have received payment from a primary plan, including a traditional liability insurance plan.

ARGUMENT

The interlocutory decision of the court of appeals interpreting the prior version of the MSP statute is correct and does not squarely conflict with the decision of this Court or of another court of appeals. To the extent that there is tension between the decision below and *dicta* from other courts of appeals concerning that prior version, the issues have been resolved by the

December 2003 amendments to the Medicare Secondary Payer statute. Accordingly, the petition for writ of certiorari should be denied.

1. Petitioners do not dispute that the 2003 amendments confirm the positions of the Secretary on the questions raised by the petition and that those amendments—not the provisions in effect when the court of appeals decided the case—will now govern the further proceedings in this case. Moreover, petitioners expressly do not present a constitutional challenge to the 2003 amendments (see Pet. 29). The petition nonetheless seeks review of the court of appeals' interpretation of prior law because petitioners assert that the law of the case doctrine will bar them from later raising a constitutional challenge to the amendments. Pet. 29-30. The court of appeals' decision, however, is purely interlocutory, and nothing would prevent petitioners from raising in this Court any issue—including a constitutional challenge and any issue concerning the prior law that might be relevant to such a challenge—after the entry of final judgment. There is, moreover, no reason at the present time to conclude that the questions petitioners seek to raise now will warrant the Court's review even after entry of a final judgment —assuming that petitioners are found liable in proceedings on remand, that they raise a constitutional challenge to their liability under the 2003 amendments in these proceedings, and that an interpretation of propr law appears relevant to their challenge at that time. Congress has expressed its view that the 2003 amendments clarify, rather than change, the MSP statute. Pub. L. No. 108-173, § 301(b), 117 Stat. 2221 (title describes the provisions in Section 301(b) as "Clarifying Amendments To Conditional Payment Provisions"). Such a congressional declaration about the

meaning of an earlier statute is itself given great weight. *Loving* v. *United States*, 517 U.S. 748, 770 (1996) ("[s]ubsequent legislation declaring the intent of an earlier statute is entitled to great weight") (quoting *Consumer Prod. Safety Comm'n* v. *GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13 (1969), and *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 380-381 (1969)). Moreover, if the Court concluded that review were warranted at that time, it would have the benefit of a more fully developed factual record, and would be able to consider the constitutional challenge in that context.

In any event, petitioners are manifestly incorrect in arguing (Pet. 26) that the 2003 amendments have "unsettled the expectations" of parties who either receive or make a payment relating to medical expenses for which the Secretary has previously made payment under Medicare. Petitioners do not (and cannot) dispute that the payment of products liability insurance proceeds on the basis of implant-related claims is precisely the sort of insurance coverage that triggers the MSP statute's obligation to reimburse Medicare. To the contrary, petitioners' contention in this litigation has largely been that the government may proceed only against the implant recipients. Cf. Pet. App. 52a n.28 (declining to address the argument that the government must attempt to recover from the class members before it may seek reimbursement from the manufacturers).

Petitioners' contention that the 2003 amendments unconstitutionally upset their own settled expectations is also incorrect. The government put petitioners on notice in 1994 (before they entered into the RSP) that, to the extent the government had made Medicare payments for the victims' implant-related medical care, reimbursement was required under the MSP statute.

Petitioners nonetheless thereafter chose at their own risk to make or direct settlement payments to implant recipients without regard to whether Medicare had paid for their medical care.

2. Petitioners argue (Pet. 17-22) that they cannot be regarded as maintaining self-insured plans because they are alleged to have conventional liability insurance for amounts in excess of those for which they carry their own risk. The court of appeals correctly rejected petitioners' contention that they cannot be regarded as having "self-insured" plans within the meaning of the MSP statute unless they carry their *entire* risk. As the court of appeals explained, ample authority supports the agency's interpretation that an entity may combine "self-insurance up to a certain amount with the excess to be covered by an insurance policy." Pet. App. 47a; see also *Black's Law Dictionary* 1220 (5th ed. 1979) ("A common practice of businesses is to self-insure up to a certain amount, and then to cover any excess with insurance.").

Contrary to petitioners' assertion (Pet. 15), the court of appeals' decision does not conflict with the Second Circuit's decision in *Mason* v. *American Tobacco Co.*, 346 F.3d 36 (2003), cert. denied, No. 03-1270 (May 17, 2004), or the Fifth Circuit's amended decision in *Thompson* v. *Goetzmann*, 337 F.3d 489 (2003). As the court of appeals observed, there was no suggestion in *Mason* that the tortfeasor had purchased any insurance. Pet. App. 46a n.22. Nor was there any such indication in *Goetzmann*, as petitioners acknowledge. See Pet. 17 ("The record in *Goetzmann* demonstrated that Zimmer had elected not to purchase product liability insurance[.]").

In any event, the December 2003 amendments to the MSP statute leave no doubt that a business entity shall

be deemed to have a "self-insured plan" if it carries its own risk "in whole or *in part*." Pub. L. No. 108-173, § 301(b)(1), 117 Stat. 2222 (emphasis added). Congress has thus resolved the issue that petitioners ask this Court to decide.

3. Petitioners also argue (Pet. 17-22) that they cannot be understood to have a "self-insured plan" within the meaning of the MSP statute unless they have formal procedures by which funds are set aside and then subject to claims to cover future liabilities. As the court of appeals explained, however, the Secretary has interpreted the statutory term "self-insured plan" broadly to include oral and other informal arrangements to assume liability. Pet. App. 45a; 42 C.F.R. 411.21. To be sure, under the Secretary's regulation interpreting the prior version of the MSP statute, "the mere absence of insurance purchased from a carrier does not necessarily constitute a 'plan' of self-insurance." 54 Fed. Reg. 41,727 (1989). As the court of appeals observed, both the statute and the regulation contemplate some form of "*ex ante* arrangement," and a tortfeasor's discrete settlement payment in a particular case does not by itself establish that it has a self-insured plan. Pet. App. 49a. As the court of appeals further explained, however, neither the statute nor the regulation imposes the additional requirement of a set-aside of funds or other formal procedures. *Id.* at 47a-48a; cf. 29 U.S.C. 1081(a)(1) (exempting welfare benefit plans from ERISA's funding requirements).

Although there are *dicta* in *Goetzmann* suggesting that a formal set-aside of funds is required, any tension between that decision and the decision below does not warrant this Court's review, particularly in light of the December 2003 amendments. As amended, the MSP statute provides that "[a]n 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 failure to obtain insurance, or otherwise*) in whole or in part. Pub. L. No. 108-173, § 301(b)(1), 117 Stat. 2222 (emphasis added). The amendment thus makes clear that no set-aside of funds or formal mechanism for payment of claims is required.

Moreover, the holding of *Goetzmann* is narrow. As the court of appeals in this case explained (Pet. App. 49a & n.24), the Fifth Circuit perceived the government's complaint in *Goetzmann* to allege that the tortfeasor was self-insured merely by virtue of its payment in settlement of a single tort claim. See, *e.g.*, *Goetzmann*, 337 F.3d at 495 ("In this case, the 'self-insurance plan' is alleged by the government to exist by virtue of Zimmer's payment to Medicare recipient Loftin under the terms of their products-liability settlement agreement."). *Goetzmann* thus stands for the unremarkable proposition that "an alleged tortfeasor who settles with a plaintiff is not, *ipso facto*, a 'self-insurer' under the MSP statute." *Id.* at 497.[2] The court of appeals in this case "fully agree[d]" with that aspect of the Fifth Circuit's decision. Pet. App. 49a.

In *Mason*, the Second Circuit expressly distinguished the court of appeals' decision in this case. 346 F.3d at 41-42. *Mason* was a private suit under the MSP statute; the government was not a party. The Second Circuit stressed that the private plaintiffs in *Mason* had

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[2] The government's rehearing petition in *Goetzmann* explained that the panel had misunderstood the government's argument. Pet. for Reh'g En Banc at 14-15, *Thompson* v. *Goetzmann*, 337 F.3d 489 (5th Cir. 2003) (No. 02-10198); Pet. for Panel Reh'g at 1, 12-13, *Goetzmann*, *supra* (No. 02-10198). The panel nonetheless chose to reissue the self-insurance portion of its decision unchanged.

not even established that the defendants were responsible to pay for anyone's medical care. *Id.* at 42. The court explained that, by contrast, the RSP settlement in this case left no doubt about the breast implant manufacturers' responsibility to pay. *Ibid.*

4. Petitioners also argue that they cannot be held liable based on their alleged receipt of payments under product liability insurance plans because they are simply pass-through entities who received payment under a primary plan. Pet. 22-25. The court of appeals assumed, however, that mere "pass-through" payers would not be covered by the MSP statute. Pet. App. 65a. Indeed, the court of appeals affirmed the district court's judgment insofar as it dismissed the damages count against the escrow agent who administers settlement funds, observing that the "uncontested evidence is that the Escrow Agent acts in a purely ministerial role serving the district court." *Ibid.*

By contrast, however, the court observed that the district court's characterization of petitioners as "mere intermediaries" might well prove inaccurate, with the benefit of discovery. Pet. App. 68a. That interlocutory ruling does not warrant this Court's review. Although petitioners allege a conflict with the D.C. Circuit's *HIAA* decision, *HIAA* merely held that a third-party administrator of an employer group health plan could not be held liable based on its receipt of payment from the plan. 23 F.3d at 415-417. The *HIAA* decision has no bearing on the government's claims against petitioners, whose right to the proceeds of their insurance policies cannot plausibly be equated with a third-party administrator's temporary possession of funds intended to pay liabilities for which the administrator has no personal liability. Petitioners would have received any of the funds at issue in their capacities as *insureds*

under policies that were intended to cover the very sort of injuries that led to Medicare payments, and would have received them precisely because of their responsibility for the injuries to the victims. Petitioners are not mere intermediaries, or like a bank that is clearing a check.

Moreover, the December 2003 amendments delete the parenthetical phrase "including any physician or provider," and thus make clear that there is no basis for narrowly interpreting the category of entities liable to reimburse Medicare when they receive payment from their liability insurance carriers. Pub. L. No. 108-173, § 301(b)(3), 117 Stat. 2222 (the federal government may recover "from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity"); Pub. L. No. 108-173, § 301(b)(2), 117 Stat. 2222 ("[a] primary plan, and an entity that receives payment from a primary plan, shall reimburse" the Medicare program for the payments it has made). The government is accordingly entitled to the proceeds allegedly received by petitioners under any primary plan which unquestionably includes a product liability insurance plan. 42 U.S.C. 1395y(b)(2).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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