

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

_____)	
BRIAN HALL, et al.,)	
)	
Plaintiffs)	CIVIL ACTION
)	NO. 1:08-cv-01715-RMC
)	
v.)	
)	
KATHLEEN SEBELIUS,¹ Secretary,)	
Department of Health and Human Services,)	
et al.,)	
)	
Defendants.)	
_____)	

**PLAINTIFFS’ MEMORANDUM OF POINTS AND AUTHORITIES
IN SUPPORT OF PLAINTIFFS’ MOTION FOR SUMMARY JUDGMENT**

MAY IT PLEASE THE COURT:

NOW COME THE PLAINTIFFS, BRIAN HALL, JOHN J. KRAUS and RICHARD K. ARMEY, by and through counsel, and for their Memorandum of Points and Authorities in Support of Plaintiffs’ Motion for Summary Judgment, state as follows:

STATEMENT OF FACTS

I. INTRODUCTION

The three (3) Plaintiffs in this case – all former Federal employees - do not want to be enrolled in Medicare, Part A; rather, they want to keep their Federal Employee Health Benefits (“FEHB”) health insurance plans. They do want to receive the Social Security monthly benefits to which they are entitled. None of the Plaintiffs seek repayment of any of the Medicare taxes they have paid. *Plaintiffs’ Statement of Material Facts as to Which There is No Genuine Issue* (“SMF”) ¶¶9, 33, 35, 50 and 52. The “policies” of the Defendants challenged herein, however,

¹ Pursuant to FRCP 25(d), Kathleen Sebelius was substituted as Secretary for her predecessor, Michael D. Leavitt.

barred them from not enrolling in, and now bar them from disenrolling from, Medicare, Part A, while also receiving their Social Security monthly benefits. In fact, if the Plaintiffs disenrolled from Medicare, Part A, now, they would not only be barred from continuing to receive their Social Security monthly benefits, they would be forced to repay to the Defendants all of the Social Security monthly benefits they have received to date. Those “policies” are the *POMS (“Program Operations Manual System”) HI (“Hospital Insurance”) 00801.002, Waiver of HI Entitlement by Monthly Beneficiary, POMS HI 00801.034, Withdrawal Considerations, and POMS GN 00206.020, Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved* (at times collectively referred to herein as the “POMS”).

A Verified Complaint for Declaratory Judgment, a Restraining Order and Preliminary and Permanent Injunctive Relief was filed on October 9, 2008. *A Verified Amended and Substituted Complaint for Declaratory Judgment, a Restraining Order and Preliminary and Permanent Injunctive Relief (“Complaint”)* was filed on December 15, 2008, adding two (2) plaintiffs, and alleging six (6) causes of action challenging the lawfulness of the POMS.

The *Complaint* sets forth with particularity how the enforcement by the Defendants of the aforesaid POMS harms the Plaintiffs. *Complaint*, ¶¶ 12, 29, 34, 35, 40, 44, 48, 52, 56 and 60. It seeks a declaration of rights, alleging that the challenged POMS are contrary to the Social Security Act, 42 U.S.C. §§ 401 *et seq.*, and, specifically, 42 U.S.C. §§ 402 and 426(a), and the Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, and, specifically, 42 U.S.C. §§ 1395, 1395a, 1395b, 1395i-2 and 1395o, and, are contrary to the properly-promulgated regulations of the Defendants, namely, 20 C.F.R. Part 404 and 42 C.F.R. Parts 406 to 408. The *Complaint* further seeks a declaration of rights, alleging that the challenged POMS are violative of the Administrative Procedure Act (“APA”), 5 U.S.C. §§ 551 to 553 and 558, and Article I, Section 1, of the

Constitution of the United States. Plaintiffs seek injunctive relief, pursuant to 5 U.S.C. §§ 702 to 706, enjoining the enforcement of the POMS and further mandatorily enjoining the Defendants to allow the Plaintiffs to not enroll in, or to disenroll from, Medicare, Part A, without the loss of their Social Security monthly benefits.

II. WHAT MANDATE THAT THE PLAINTIFFS ENROLL IN MEDICARE, PART A, AS A CONDITION OF RECEIVING THEIR SOCIAL SECURITY MONTHLY BENEFITS ARE THE THREE CHALLENGED POMS OF THE DEFENDANTS

The POMS challenged in this case are statements created by the Defendants in 1993 and 2002 and incorporated into the Social Security Operating Manual. They were not promulgated in accordance with the APA, but, nonetheless, they are being applied as system-wide rules. *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary*, reads, in pertinent part:

A. INTRODUCTION

Some individuals entitled to monthly benefits have asked to waive HI Entitlement because of religious or philosophical reasons, or because they prefer other health insurance.

B. POLICY

Individuals entitled to monthly benefits which confer eligibility for HI may not waive HI Entitlement. The only way to avoid HI Entitlement is through withdrawal of the monthly benefit application. Withdrawal requires repayment of all RSDI and HI benefit payments (emphasis added).

The foregoing policy thus links opting-out of Federal hospital insurance entitlement (Medicare, Part A) with withdrawal of Social Security benefits and repayment of all monthly benefits paid.

POMS HI 00801.034, Withdrawal Considerations, reads, in pertinent part:

A. POLICY

To withdraw from the HI program, an individual must submit a written request for withdrawal and must refund any HI benefits paid on his/her behalf as explained in GN00206.095B.I.c. An individual who filed an application for both monthly benefits and HI may:

- Withdraw the claim for monthly benefits without jeopardizing HI

entitlement; or

- Withdraw the claim for both monthly benefits and HI.

The individual may not elect to withdraw only the HI claim (emphasis added).

POMS GN 00206.020, Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved, reads, in pertinent part:

B. POLICY

The claimant can withdraw an application for:

- RSI [Retirement or Survivors Insurance, i.e., Social Security] cash benefits only;
- RSI cash benefits and HI [Hospital Insurance, i.e., Medicare, Part A] insurance coverage..., or
- Medicare [Part B] only

However, a claimant who is entitled to monthly RSI benefits cannot withdraw HI [Medicare, Part A] coverage only since entitlement to HI [Medicare, Part A] is based on entitlement to monthly RSI benefits...(emphasis added).²

III. THE PLAINTIFFS DO NOT WANT TO BE ENROLLED IN MEDICARE, PART A, BUT THEY WANT TO RECEIVE THEIR SOCIAL SECURITY MONTHLY BENEFITS

The three (3) Plaintiffs, BRIAN HALL, JOHN J. KRAUS and RICHARD K. ARMEY, were Federal employees.³ Each of them entered into a health insurance plan pursuant to the Federal Employee Health Benefits (“FEHB”) program, 5 U.S.C. §§ 8907 *et seq.*⁴ Two of them, HALL and KRAUS, signed up for health insurance plans that included Health Savings Accounts (“HSAs”) and high-deductible health insurance policies in lieu of Medicare. HALL selected the

² The foregoing POMS may be found on the web at <https://secure.ssa.gov/apps10/poms.nst/lnx0200206020> open document.

³ HALL was an employee of the United States Department of Housing and Urban Development; KRAUS was an employee of the United States Department of the Navy; ARMEY was an eighteen-year member of the United States House of Representatives. *SMF*, ¶¶ 5, 32 and 49.

⁴ The FEHB program is an entirely separate program from Social Security and Medicare, established by Congress pursuant to 5 U.S.C. § 8901 *et seq.*

“Mail Handlers Benefit Plan – Consumer Option,” a lifetime-long high-deductible health insurance plan that is complemented with an HSA. *SMF*, ¶¶ 6, 7 and 8. KRAUS selected the Aetna Health Fund with an HSA for the rest of his life. *SMF*, ¶ 34. ARMEY, as a former Congressman, enrolled in the United States House of Representatives’ Blue Cross Group Plan for life in lieu of Medicare. *SMF*, ¶ 49.

When HALL, KRAUS, and ARMEY applied for their Social Security monthly benefits they were informed by the SSA representatives that they could not waive their enrollment in Medicare, Part A, unless they gave up their Social Security monthly benefits. All of them questioned the lawfulness of that requirement. All of them had been assured of health care coverage for life under the FEHB program in lieu of Medicare.⁵ They were told by the SSA representatives, however, that they either had to sign the application tendered to them – which required the applicant to be enrolled in Medicare, Part A, as a condition of receiving his Social Security monthly benefits – or suffer not receiving their Social Security monthly benefits at all. *SMF*, ¶¶ 13-17 (HALL), 37-49 (KRAUS), 54 (ARMEY). The application read: **“I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.”** *SMF*, ¶ 65. None were provided with any means by which they could question or appeal the requirement. They either signed the application or they would have been denied their Social Security monthly benefits to which they were entitled. *SMF*, ¶¶ 12-20 (HALL), 36-39, 41-44 (KRAUS), 54-55 (ARMEY).

When KRAUS was informed of the requirement, he asked for its justification. In

⁵ According to HALL’S FEHB Mail Handlers health care plan, enrollment in Medicare, Part A, is wholly voluntary. The Mail Handlers Plan 2008 program booklet reads: “The decision to enroll in Medicare is yours....If you do not apply for one or more parts of Medicare, you can still be covered under the FEHB program.” <http://www.mhbp.com/web/groups/public/documents/webcontent/a034028.pdf>, p. 125. The Mail Handlers Plan 2008 program booklet was “authorized for distribution by the United States Office of Personnel Management.” Federal employees, like Plaintiffs HALL, KRAUS and ARMEY, are covered under the FEHB program.

response, he was actually handed a copy of the *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary*, one of the policies challenged herein, by the representative of the Social Security Administration (“SSA”) on February 9, 2005. *SMF*, ¶ 38. KRAUS attempted to appeal that decision through the offices of his Congresswoman. When a reconsideration decision was finally made by SSA (after much prodding) that the aforesaid policy was in conformity with the Social Security Act, KRAUS demanded a hearing before an Administrative Law Judge (“ALJ”). His formal request was sent by certified mail, return receipt requested, and was signed by a representative of SSA as having been received on February 13, 2006.⁶ As of the date of KRAUS’S Declaration (March 6, 2009), the SSA had failed and refused to ever respond to his demand. *SMF*, ¶¶ 37-44.

After discovering that HHS and SSA relied upon the POMS in forcing enrollment in Medicare, Part A, and that those policies were completely beyond the scope of the Social Security Act, 42 U.S.C. § 426(a), HALL sought legal counsel. HALL knew there were no administrative remedies available to him on this issue, and his only recourse was to appeal to this Court. *SMF*, ¶¶ 9-20. RICHARD K. ARMEY joined this case because he never wanted to be enrolled in Medicare, Part A, in the first place. *SMF*, ¶ 50. He wants to disenroll. Like KRAUS and HALL, ARMEY wants to keep his Social Security monthly benefits. *Id.* None of the Plaintiffs seek any of their Medicare taxes paid over the years refunded. *SMF*, ¶¶ 35, 52.

All of the Plaintiffs share common reasons for not wanting to be enrolled in Medicare, Part A. All of them recognize that if they cannot get out of Medicare, they will give up control over their own health care decisions. *SMF*, ¶¶ 10-11, 32, 34. They will give up control over their providers – institutional and individual – they are able to use. *SMF*, ¶¶ 11, 32, 34, 49 and

⁶ The return receipt to the Request for Hearing by an Administrative Law Judge, Form HA-501-US, was signed, as received, by Janice Garvey of the Social Security Administration, Norristown, PA, on February 13, 2006. *SMF*, ¶ 44.

50. They will be forced to use only those providers who participate in Medicare – an ever-dwindling number. 42 USC § 1395cc. They will be provided only those health care services allowed by Medicare under circumstances Medicare will allow them. 42 USC § 1395k, 1395l, 1395m and 1395u. In the process, they believe they will be denied care they otherwise would obtain if they paid for it themselves. *SMF*, ¶ 11.

For Plaintiffs, HALL, KRAUS and ARMEY, the Defendants' enforcing the POMS has led to the loss of the FEHB programs they entered into upon retirement. **Unless the POMS are voided, they will endanger the FEHB programs for all Federal employees.** For HALL and KRAUS, who had HSAs, the enforcement of the POMS has rendered those HSAs useless and moribund; HALL and KRAUS cannot contribute to their HSAs anymore, and their insurance carriers cannot contribute to them either. Both of their high-deductible insurance carriers are no longer able to adjudicate or pay any of their claims for Medicare, Part A. *SMF*, ¶¶ 7, 8 and 26 (HALL), 36 (KRAUS), 49 (ARMEY). Since this Court denied HALL'S *Motion for a Temporary Restraining Order*, his FEHB health insurance carrier has "taken back" all of its 2009 deposits to HALL'S HSA. *SMF*, ¶ 26. Whatever decisions are now made about the health care provided to HALL, KRAUS and ARMEY are made by Medicare in accordance with what it deems is allowable.

In sum, the Plaintiffs have been effectively denied the health insurance programs they had selected as Federal employees. They selected those health insurance programs because of the freedom given them in those programs to select the providers and the health care services they desired. Two of the Plaintiffs have completely lost their HSAs that allowed them to pay themselves, for the health care services they wanted and to select the providers who offered those services.

ARGUMENT

I. THE CHALLENGED POMS ARE TOTALLY CONTRARY TO THE SOCIAL SECURITY AND MEDICARE ACTS AND REGULATIONS PROMULGATED THEREUNDER

A. The POMS Are Contrary To The Language Of The Social Security Act, 42 U.S.C. §§ 401 *et seq.*, And The Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, And Thus Represent Policies Or Rules For Which There Is No Statutory Basis

1. The Statutory Entitlement to Social Security Monthly Benefits Makes It Clear Such Is Voluntary

The Social Security and Medicare Acts are entirely voluntary and neither incorporate sanctions against an individual who does not enroll in, or disenrolls from, the other. In the first place, “entitlement” to Social Security benefits is statutory. *Flemming v. Nestor*, 363 U.S. 603, 80 S.Ct. 1367, 4 L.Ed.2d. 1435 (1960). The only route one may pursue to become “entitled” to Social Security monthly benefits is found in the Social Security Act, 42 U.S.C. §§ 401 *et seq.* Specifically, § 402 of Title 42 U.S.C. reads, in pertinent part, as follows:

(a) Old-age insurance benefits

Every individual who --

- (1) is a fully insured individual (as defined in § 414(a) of this title),
- (2) has attained age 62, and
- (3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in § 416(l) of this title), ***shall be entitled to an old-age insurance benefit for each month***, beginning with –
 - (A) in the case of an individual who has attained retirement age (as defined in § 416(l) of this title), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or
 - (B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in § 416(l) of this title), the first month throughout which such individual

meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

and ending with the month preceding the month in which he does. Except as provided in subsection (q) and subsection (w) of this section, such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in § 415(a) of this title) for such month.

....

(j) Application for monthly insurance benefits

(1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of this section for any month after August 1950 had he filed application therefor prior to the end of such month ***shall be entitled to such benefit for such month if he files application therefor prior to –***

(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f) of this section, and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) of this section on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or

(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.

42 U.S.C. § 402(a)(j) (emphasis added).

The law relative to “entitlement” to Social Security monthly benefits is clear. One must be a “fully insured individual” who “has attained age 62” and “has filed an application for old-age benefits or was entitled to disability insurance benefits.” Every individual who meets those requirements “**shall be entitled to old-age insurance benefits for each month**” Subsection (j) sets forth when the application must be filed. Nowhere does the Social Security Act in general, or 42 U.S.C. § 402 in particular, predicate “entitlement” to Social Security monthly benefits upon enrollment in Medicare, Part A. An individual “entitled” to Social Security

monthly benefits does not have to access or accept them; the receipt of those benefits is not mandatory. “Shall be entitled” in 42 U.S.C. § 402 does not mean “must be enrolled.” There are no other conditions in 42 U.S.C. § 402, save for special requirements for spouses, children, mothers and fathers, parents, widows and widowers, aliens and “simultaneous” benefits which have no bearing on the questions discussed herein. See 42 U.S.C. § 402(b)-(i) and (k)-(l).

2. The Statutory Entitlement to Medicare, Part A, Benefits Makes It Clear Such Is Voluntary

“Entitlement” to receive Medicare, Part A, benefits is much the same as “entitlement” to Social Security monthly benefits. Title 42 U.S.C. § 426 reads as follows:

(a) Individuals over 65 years

Every individual who –

- (1) has attained age 65, and
- (2)(A) *is entitled to monthly insurance benefits under § 402 of this title*, would be entitled to those benefits *except that he has not filed an application therefor* (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, *files an application for hospital insurance benefits under part A of subchapter XVIII of this chapter*,
- (B) is a qualified railroad retirement beneficiary, or
- (C) (i) would meet the requirements of subparagraph (A) *upon filing application for the monthly insurance benefits involved if medicare qualified government employment* (as defined in § 401(p) of this title) *were treated as employment* (as defined in § 410(a) of this title) for purposes of this subchapter, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII of this chapter.

shall be entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2)

42 U.S.C. § 426(a) (emphasis added).

An individual must attain the age of sixty-five (65) years and be entitled to Social Security monthly benefits to be “entitled” to Medicare, Part A. He or she must, nevertheless, request that those benefits be accessed. It is clear that Congress did not make the obtaining of Medicare, Part A, benefits mandatory. It may have made Medicare, Part A, benefits automatically available upon the filing of an application for Social Security benefits, but the individual would still be accessing only that to which he was “entitled.” “Shall be entitled,” for purposes of Medicare, Part A (42 U.S.C. § 426(a)), cannot have a different meaning from “shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402).

Clearly, Medicare, Part A, is completely voluntary. Likewise, the receipt of Social Security monthly benefits is fully voluntary; it is not contingent upon enrolling in Medicare, Part A. The statutes are positively clear.

3. The Medicare Preamble Statutes Protect The Individual’s Choice of Health Insurance Plans

If the foregoing statutes are not enough to illustrate the voluntariness of Medicare, Congress actually made it clear in a “preamble” statute. Title 42 U.S.C. § 1395b reads:

Nothing contained in this subchapter shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services (emphasis added).

Congress asserts that nothing in the Medicare Act “shall be construed to preclude...any individual from purchasing or otherwise securing protection against the cost of any health care services.” Nothing in the Medicare Act, as amended, has ever undermined that important guarantee. **Moreover, Congress has never included in the Medicare Act, or the Social Security Act, any provision mandating that every individual apply for coverage under**

Medicare, Part A, or his/her Social Security monthly benefits, to which he/she would otherwise be entitled, would be denied. Why would Congress guarantee the free choice of health insurer if it intended to “force” everyone into Medicare, Part A? Once in Medicare, Part A, there is no other coverage, save a secondary carrier under Part B.

4. Where Congress Dictated How Individuals May Lose Social Security Monthly Benefits, It Did not Include Refusing To Enroll In Medicare, Part A

If all of the foregoing is not enough, Congress actually enacted a statute dictating how and under what circumstances an individual may lose his or her Social Security monthly benefits. Those benefits may be “terminated” upon the “primary beneficiary being deported.” 42 U.S.C. § 402(n). Benefits may be “suspended” if the beneficiary who is an alien is residing outside of the United States, or is a citizen of a foreign country that has in effect social insurance similar to Social Security. 42 U.S.C. § 402(t) and (y). A court of competent jurisdiction may deny an individual Social Security monthly benefits if that individual has been convicted of “subversive activities.” 42 U.S.C. § 402(u). Obviously, an individual who files a waiver, pursuant to § 1402(g) of the Internal Revenue Code, and is granted a tax exemption, will waive his or her Social Security monthly benefits. 42 U.S.C. § 402(v). Social Security monthly benefits will also not be paid to individuals who are “confined in jail, prison, or other penal institution or correctional facility.” 42 U.S.C. § 402(x). **No provision for the termination of benefits, much less the repayment of benefits to the Secretary, is found for individuals who simply do not want to become Medicare, Part A, beneficiaries.**

5. The Fact That Medicare Is An “Entitlement” Does Not Make Enrollment In It Mandatory

The word “entitlement” is not synonymous with “required” or “mandatory.” “Entitle,” in its usual sense, “is to give a right; to qualify for; to furnish with proper grounds for seeking.”

“Entitle” is synonymous with “eligible,” meaning “capable of being chosen” or “legally qualified.” *Black’s Law Dictionary*, Revised 4th Ed. Put another way, “entitlement” has been defined as “to give one a right to do or have something; allow; qualify.” *The American Heritage Dictionary of the English Language*, New York: American Heritage Pub. Co., 1970. “Require,” on the other hand, means “to direct, order, demand, command, compel or exact.” *Black’s Law Dictionary*, Revised 4th Ed; *The American Heritage Dictionary of the English Language*.

The only case uncovered that directly addresses the meaning of “entitlement” to Medicare, Part A, is *Giove v. Weinberger*, 380 F.Supp. 364, 367-368 (D.C.Md. 1974), where the following was written: “Entitlement in [Section 426]...is used as a term of art. As such, entitlement is a necessary, *but not sufficient*, prerequisite to the receipt of benefits under Part A.” One, of course, must apply for or access his/her benefits.

The United States Court of Appeals for the Ninth Circuit followed *Webster’s Third New International Dictionary* in interpreting the word “entitlement.” Construing entitlement under § 1127 of the Social Security Act, the Ninth Circuit has held:

In the ordinary use of English, “entitled” means “to give right or legal title to, qualify [one] for something; furnish with proper grounds for seeking or claiming something.” *Webster’s Third New International Dictionary*, 758 (1976).

Fagner v. Heckler, 779 F.2d 541, 543 (9th Cir. 1985); *Pent v. Social Sec. Dist. Office*, 1997 U.S. App. LEXIS 22775 (9th Cir. 1997). The United States Court of Claims held similarly in *Merrill v. United States*, 338 F.2d 372, 374 (1964) and *Hurt v. United States*, 309 F.2d 404, 406 (1993). The Supreme Court of Minnesota held the term “entitled” to be “equivalent” to “eligible.” *State v. Jansen*, 290 N.W. 557 (1940).

Jewish Hospital, Corp. v. Secretary of Health and Human Services, 19 F.3d 270 (6th Cir. 1994) is also instructive. There, the Court considered a Medicare reimbursement provision

allowing the Secretary of HHS to adjust Medicare Prospective Payment System (“PPS”) payments to hospitals. The Court considered the word “eligible” with respect to Medicaid patients and “entitlement” with respect to Medicare patients. There, the Court asserted that “[t]o be entitled to some benefit means that one possesses the right or title to that benefit.” That definition is exactly the same as found in *Black’s Law Dictionary*, *The American Heritage Dictionary of the English Language* and *Webster’s Third New International Dictionary* aforementioned. The Defendants cannot sustain an argument that the POMS properly define the term “entitlement.” “Shall be entitled” means nothing more than “having a right to do or have something.” It does not mean that an individual entitled to Medicare, Part A, **must** accept that to which he is “entitled.”

An individual “entitled” to Social Security monthly benefits under 42 U.S.C. § 402 is not mandated to apply for them; it is wholly voluntary. These very Defendants so argued in *Leverett v. United States Bureau of Health and Human Services*, 2003 WL 21770800 (D.Colo. 2003), and the court agreed, holding: “[N]othing in the Social Security system requires [an individual] to apply for and receive Social Security benefits.” *Id.* at 2. Why would “shall be entitled” mean something different when applied to Medicare, Part A, 42 U.S.C. § 426(a)? It cannot and does not. Even though an individual “shall be entitled” to Medicare, Part A, he/she does not have to accept it. “Shall be entitled,” for purposes of Medicare, Part A (42 U.S.C. § 426(a)), is no different than “shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402).

6. The Challenged POMS Are Contrary To The Social Security And Medicare Acts, And This Court Should Enjoin Them Being Enforced Under 5 U.S.C. §§ 706(2)(A),(B) and (C)

By the very reading of the Social Security Act and the Medicare Act, enrollment is absolutely voluntary for both. For the Secretary of HHS and Commissioner of SSA to make receipt of Social Security monthly benefits conditioned upon applying for Medicare, Part A, is absolutely contrary to 42 U.S.C. §§ 402 and 426(a) and 42 U.S.C. §§ 1395 *et seq.*, and, thus, is invalid. It is “arbitrary, capricious and not in accordance with law.” It is further “in excess of statutory jurisdiction, authority...[and] short of statutory right.” 5 U.S.C. § 706(2)(A),(B) and (C). *Federal Election Comm’n. v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32, 102 S. Ct. 38, 42, 70 L.Ed. 2d 23 (1981); *Red Lion Broadcasting Co. v. F.C.C.*, 395 U.S. 367, 381, 89 S. Ct. 1794, 1802, 23 L. Ed. 2d 371 (1969); *National Ass’n. of Patients on Home Dialysis and Transplantations, Inc., et al. v. Heckler*, 588 F.Supp. 1108, 1127 (D.D.C. 1984).

Executive agencies cannot legislate; any quasi-legislative authority exercised by any agency “must be rooted in a grant of such power by Congress and subject to limitations which that body imposes.” *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, 99 S.Ct. 1705, 1718, 60 L. Ed.2d 208 (1979), *c.f.*, *Batterton v. Francis*, 432 U.S. 416, 425, n. 9, 97 S.Ct. 2399, 2405 n.9, 53 L.Ed.2d. 448 (1977). For any regulation, policy or rule promulgated by any administrative agency to be valid, “it is necessary to establish a nexus between the regulation [policy or rule] and some delegation of the requisite legislative authority by Congress.” *Chrysler Corp. v. Brown*, 441 U.S. at 304, 99 S.Ct. at 1718-1719. “The pertinent inquiry,” wrote the Supreme Court in *Chrysler*, “is whether under any arguable *statutory* grants of authority the [agency’s] requirements are reasonably within the contemplation of that grant of authority.” *Id.*, 441 U.S. at 306, 99 S.Ct. at 1720.

This Court has not hesitated to invalidate executive agency regulations, policies and rules that were inconsistent with the acts of Congress under which they were purportedly promulgated.

Pratt v. Heckler, 629 F.Supp. 1496, *recon. den. sub. nom. Pratt v. Bowen*, 642 F.Supp. 883 (D.D.C. 1986) (regulations and rulings of the Secretary defining severity of impairment found to be inconsistent with Social Security Act); *Duggan v. Bowen*, 691 F.Supp. 1487 (D.D.C. 1988) (part-time intermittent care home health care policies of the Secretary found to be inconsistent with the Medicare Act). It is clear this Court should invalidate the POMS as they are contrary to the Social Security Act and Medicare Acts. As the Supreme Court noted:

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. The reviewing court should not attempt itself to make up for such deficiencies; one may not supply a reasoned basis for the agency's action that the agency itself has not given.

Motor Vehicles Mfrs. Ass'n. v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 2867, 77 L. Ed.2d 443 (1983). The POMS are "arbitrary, capricious....and....not in accordance with law." 5 U.S.C. §§ 706(2)(A), (B) and (C). Accordingly, this Court should grant Plaintiff's Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement.

B. The Properly-Promulgated Regulations of the Defendants Do Not Make Medicare, Part A, Mandatory, Nor Do They Provide For The Stripping Of One's Monthly Social Security Benefits If He or She Elects To Not Enroll In, Or To Disenroll From, Medicare, Part A

Beyond the Social Security and Medicare Acts, the properly-promulgated regulations of the Secretary of HHS and Commissioner of SSA do not make enrollment in Medicare, Part A, mandatory, nor do they penalize or sanction an individual by mandating the loss of his or her monthly Social Security benefits if he or she does not enroll in, or disenrolls from, Medicare, Part A. Rather, the regulations of the Defendants track the statutes.

The regulations governing Social Security are found at 20 C.F.R. 404, *et seq.* Section 404.101 of Title 20 C.F.R., sets forth how one reaches “insured status” for purposes of Social Security. In the subsequent sections the title provides the details for categories of “insured status,” “currently insured” and “disability insured.” The regulations, like the statutes, use the individual’s age and “quarters of coverage” to determine entitlement.

Then § 406 of Title 20 C.F.R. reads:

(a) **Basic provision.** In most cases, **eligibility for Medicare, Part A, is a result of entitlement to monthly social security** or railroad retirement cash benefits or eligibility for monthly social security cash benefits. This section specifies the individuals who need not file an application to become entitled to hospital insurance, those who must file an application, and those who must enroll.

(b) *Individuals who need not file an application for hospital insurance.* An individual who meets any of the following conditions need not file an application for hospital insurance:

(1) *Is under age 65 and has been entitled*, for more than 24 months, to monthly social security or railroad retirement benefits based on disability,

(2) At the time of attainment of age 65, is entitled to monthly social security or railroad retirement benefits.

(3) Establishes entitlement to monthly social security or railroad retirement benefits at any time after attaining age 65.

(c) **Individuals who must file an application for hospital insurance.** An individual must file an application for hospital insurance if he or she seeks entitlement to hospital insurance on the basis of --

(1) The transitional provisions set forth in § 406.13;

(2) Deemed entitlement to disabled widow’s or widower’s benefit under certain circumstances as provided in § 406.12;

(3) A diagnosis of end-stage renal disease, as specified in § 406.13;

(4) Effective January 1, 1981, eligibility for social security cash benefits, as specified in § 403.10(a)(3), if the individual has attained age 65 without applying for those benefits; or

(5) The special provisions applicable to government employment as set forth in § 406.15 (emphasis added).

Nowhere do the properly-promulgated Social Security regulations of the Commissioner of SSA make Social Security or Medicare, Part A, mandatory. The Commissioner does not mandate that Social Security monthly benefits will be denied to any otherwise entitled individual who does not enroll in, or disenrolls from, Medicare, Part A. **In fact, the Commissioner uses**

the term “eligibility” interchangeably with “entitlement.” The Commissioner then defines “entitlement” as nothing more than when an individual “meets all the requirements for entitlement....” 20 C.F.R. § 406.3.⁷ He does not define “entitlement” as being anything similar to what is found in the POMS. He does not predicate the loss of an individual’s monthly Social Security benefits on him/her not enrolling in, or disenrolling from, Medicare, Part A. “Entitlement” and “eligibility” are used to define the availability of Medicare, Part A, for anyone entitled to Social Security monthly benefits.

Likewise, the properly-promulgated regulations of the Secretary of HHS do not make enrolling in, or disenrolling from, Medicare, Part A, mandatory, nor do they predicate an individual losing his or her monthly Social Security benefits upon him or her not enrolling in, or disenrolling from, Medicare, Part A. Thus, 42 C.F.R. § 406.10 reads:

(a) Requirements. An individual is entitled to hospital insurance benefits under section 226 of the Act if he or she has attained age 65 and is:

(1) Entitled to monthly social security benefits under section 202 of the Social Security Act;

(2) A qualified railroad retirement beneficiary who has been certified as such to the Social Security Administration by the Railroad Retirement Board in accordance with section 7(d) of the Railroad Retirement Act of 1974; or

(3) Effective January 1, 1981m eligible for monthly social security benefits under section 202 of the Act and has filed an application for hospital insurance.

(b) Beginning and end of entitlement.

(1) Entitlement begins with the first day of the first month in which the individual meets the requirements of paragraph (a) of this section.

(2) Entitlement continues until the individual dies or no longer meets the requirements of paragraph (a) of this section. An individual is not entitled to railroad retirement benefits and is neither entitled to, nor eligible for, monthly social security benefits in the month in which he or she dies. However, an individual who meets all other requirements for hospital insurance entitlement is entitled to hospital insurance in the month in which he or she dies if he or she --

(i) Would have been entitled to monthly railroad retirement benefits or social security benefits in that month if he or she had not died; or

⁷ This definition is drawn from the original Medicare Act introduced in 1965. *Hearings Before the Committee on Finance, United States Senate, 89th Congress, First Session*, on H.R. 6675, Washington, DC: U.S. Government Printing Office, 1965, p. 4.

(ii) Has filed an application for hospital insurance and would have been eligible for monthly social security benefits in that month if he or she had not died (emphasis added).

The Defendants have often asserted that 20 CFR § 404.640 somehow forms the basis for the POMS. Unfortunately for the Defendants, it does nothing of the sort. All that provision does is set forth how an individual may withdraw from receiving Social Security monthly benefits! **It does not address Medicare at all.** None of the Plaintiffs want to withdraw from receiving their Social Security monthly benefits; they do not want to enroll, or remain enrolled, in Medicare, Part A.

The Defendants have also argued that 42 CFR § 406.6 somehow mandates enrollment in Medicare, Part A. To reach that result they refer the Court to paragraph (e). Paragraph (e), though, refers only to those who “must pay a monthly premium for hospital insurance.” That would not refer to the Plaintiffs because all of them would be “entitled” to Medicare, Part A, and would not pay any premiums for that coverage. The Defendants’ reliance upon 20 CFR § 404.640 and 42 CFR § 406.6 only illustrates that the challenged POMS cannot find support either in 42 U.S.C. § 426(a) or in any of the properly-promulgated regulations of the Secretary of HHS or the Commissioner of SSA.

Clearly, the regulations of the Secretary of HHS and Commissioner of SSA do not make Medicare, Part A, mandatory. The language used in those regulations follows the wording of the statutes. Nowhere is there language in the regulations even close to what is found in the POMS.

Plaintiffs must succeed on the merits of this case because the properly-promulgated regulations of the Secretary of HHS and the Commissioner of SSA underscore the voluntariness of Medicare, Part A, and that the Defendants, statutorily, cannot deny an individual’s monthly Social Security benefits if he or she does not enroll in, or disenrolls from, Medicare, Part A. This

Court should grant Plaintiff's Motion for Summary Judgment and declare the challenged POMS invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

C. The Challenged POMS Should Be Given No Deference Whatsoever

To analyze any agency interpretation of a statute, the Supreme Court has articulated a methodology:

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. **If the intent of Congress is clear, that is the end of the matter**; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction in the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is **whether the agency's answer is based on a permissible construction of the statute.**

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843, 104 S.Ct. 2778, 2781-2782, 81 L.Ed 2d 94 (1984) (emphasis added). The Supreme Court in *United States v. Mead Corp.*, 533 U.S. 218, 121 S.Ct. 2164, 150 L. Ed2d 292 (2001) provided guidelines for reviewing courts to follow in defining the scope of review of agency determinations. The first consideration is the degree of review to be given the decision. This, in turn, depends on whether the Congressional delegation of authority to the agency to implement a statutory scheme is explicit or implicit. In the case of an explicit delegation of authority, the *Mead* court concluded:

When Congress has "explicitly left a gap for an agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation," *Chevron*, 467 U.S. at 843-844, and any ensuing regulation is binding in the courts unless **procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.**

United States v. Mead Corp., 533 U.S. at 227, 121 S.Ct. at 2171, 150 L. Ed2d at 303 [emphasis

added]. Thus, the latitude to be given agency action taken pursuant to an explicit delegation of authority is quite wide. However, this is not the case when Congress merely *implicitly* delegates authority to an agency. The *Mead* court wrote:

Congress, that is, may not have expressly delegated authority or responsibility to implement a particular provision or fill a particular gap. Yet it can still be apparent ... that Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute or fills a space in the enacted law, even one about which "Congress did not actually have an intent" as to a particular result. *Id.*, at 845. When circumstances implying such an expectation exist, a reviewing court has no business rejecting an agency's exercise of its generally conferred authority to resolve a particular statutory ambiguity simply because the agency's chosen resolution seems unwise, *see id.*, at 845-846, but is obliged to accept the agency's position **if Congress has not previously spoken to the point at issue and the agency's interpretation is reasonable**, *see id.*, at 842-845; cf. 5 U.S.C. § 706(2).

United States v. Mead Corp., 533 U.S. at 229, 121 S.Ct. at 2172, 150 L. Ed2d at 305 [emphasis added].

An implicit delegation is not enough to warrant *Chevron* deference. Indeed, the *Mead* court continued:

We hold that administrative implementation of a particular statutory provision qualifies for *Chevron* deference when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority. Delegation of such authority may be shown in a variety of ways, as by an agency's power to engage in adjudication or notice-and-comment rulemaking, or by some other indication of a comparable congressional intent.

United States v. Mead Corp., 533 U.S. at 226-227, 121 S.Ct. at 2171, 150 L. Ed2d at 303.

Although the Defendants are accorded authority to promulgate regulations to administer the Social Security and Medicare statutes, that authority does not extend to promulgating policies that are at variance with the statutes. Wrote the Supreme Court:

We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer [citations omitted]. The fair measure of deference to an agency

administering its own statutes has been understood to vary with the circumstances, and the courts have looked to the degree of the agency's care, its consistency, formality, and relative expertness, **and to the persuasiveness of the agency's position.**

United States v. Mead Corp., 533 U.S. 218, 227-228, 121 S.Ct. 2164, 2171-2172, 150 L. Ed2d 292 (2001) (emphasis added).

Therefore, although the Defendants are granted authority to promulgate regulations to administer the Social Security and Medicare statutes, the "policies" at issue here were not promulgated in exercise of that authority, and, as a result, *Chevron* deference is inapplicable. Rather, this Court is bound only by the narrow deference outlined in *Skidmore v. Swift Co.*, 323 U.S. 134, 65 S.Ct. 161, 89 L.Ed. 124 (1944). *Skidmore* held that:

[Rulings, interpretations, and opinions of administrators], while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.

Skidmore v. Swift & Co., 323 U.S. at 140, 65 S.Ct. at 164, 89 L. Ed. at 129. Under the *Skidmore* standard of review, agency actions are given a more thorough substantive review than a mere "reasonableness" test. Here, the POMS fail the *Skidmore* standard of review. It is clear that there was no thorough consideration given in their formulation, nor are they consistent with the agency's earlier pronouncements in their properly-promulgated regulations, because they were not even promulgated in accord with either the Social Security or Medicare statutes. Rather, they create new rules out of whole cloth that link Social Security entitlement to enrollment in Medicare, Part A. The POMS do not pass muster under *Skidmore* deference.

As the POMS are policies that were not promulgated pursuant to the APA, the threshold

for reviewing what deference, if any, is accorded them is low. *Christensen v. Harris County*, 529 U.S. 576, 587, 120 S.Ct. 1655, 1662, 146 L. Ed.2d 621 (2000) (reviewed opinion letter from U.S. Department of Labor); *Reno v. Koray*, 515 U.S. 50, 61, 115 S.Ct. 2021, 2027, 132 L. Ed2d 46 (1995) (reviewing Bureau of Prisons Program Statement, an “internal agency guideline”); *Martin v. Occupational Safety and Health Review Comm’n.*, 499 U.S. 144, 157, 111 S.Ct. 1171, 1179, 113 L. Ed2d 117 (1991) (reviewing OSHA agency enforcement guidelines). The Supreme Court, however, has also noted: “[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.” For if the intent of Congress is clear and the Secretary’s interpretation of the statute is contrary to that intent, “that is the end of the matter.” *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. at 843, n.9, 104 S. Ct. at 2782, n.9.

Here, the Congressional mandate is clear with respect to 42 U.S.C. §§ 402 and 426(a). Those “entitled” to Social Security monthly benefits are “entitled” to enrollment in Medicare, Part A. They are not required to take it; they simply have a right to it. To say anything else is to deny the plain meaning of the words “shall be entitled.”

The POMS are classic examples of agency overreach; neither SSA nor HHS can come up with a reason why they have taken the words “shall be entitled” and turned them into what is found in the POMS. Deference, indeed, has its limits. Courts must invalidate agency policies that are “inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement.” *NLRB v. Brown*, 380 U.S. 278, 291, 85 S. Ct. 980, 988, 13 L. Ed2d 839, 849 (1965); *Volkswagenwerk v. FMC*, 390 U.S. 261, 272, 88 S. Ct. 929, 935, 19 L. Ed2d 1090, 1097 (1968); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 745-746, 93, S. Ct. 1773, 1784-1785, 36 L. Ed2d 620, 633 (1973); *SEC v. Sloan*, 436 U.S. 103, 118, 98 S. Ct. 1702, 1711, 56 L. Ed2d 148,

160-161 (1978); *Federal Election Comm'n. v. Democratic Senatorial Campaign Comm'n.*, 454 U.S. 27, 32, 102 S. Ct. 38, 42, 70 L.Ed 2d 23 (1981). When a court determines that “there are compelling reasons that [an agency interpretation] is wrong, the court may invalidate the agency’s action. *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381, 89 S. Ct. 1794, 1802, 23 L. Ed 2d 371 (1969); *Zemel v. Rusk*, 381 U.S. 1, 11-12, 85 S. Ct. 1271, 1278, 14 L. Ed2d 179, 187 (1965); *Udall v. Tallman*, 380 U.S. 1, 16-18, 85 S. Ct. 792, 801-802, 13 L. Ed2d 616, 625-626 (1965); *Commissioner v. Sternberger’s Estate*, 348 U.S. 187, 199, 75 S. Ct. 229, 236, 99 L. Ed 246, 256 (1955). Likewise, “a reviewing court should not defer to an agency position which is contrary to an intent of Congress expressed in unambiguous terms.” *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 476, 112 S. Ct. 2589, 2594, 120 L.Ed 2d 379 (1992); *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291, 108 S. Ct. 1811, 1817, 100 L. Ed2d 313, 324 (1988); *International Brotherhood of Teamsters v. Daniel*, 439 U.S. 551, 566, n.20, 99 S. Ct. 790, 800, n.20, 59 L. Ed2d 808 (1979).

This Court has stated law similarly before. Judge Joyce Hens Green concluded in a challenge to Prospective Reimbursement regulations of the End-Stage Renal Disease program:

The agency’s expertise in the complex area of health care regulation entitles it to a large measure of deference from the court. However, deference is not warranted in this instance because, in promulgating these regulations, the Secretary has disregarded the statutory language and has undermined the statutory objective. **If the agency rejects the reasonable interpretation of the statute, the court must honor the clear meaning of a statute, as revealed by its language, purpose and history.**

National Ass’n. of Patients on Home Dialysis and Transplantation, Inc., et al. v. Heckler, 588 F.Supp. 1108, 1127 (D.D.C. 1984) (emphasis added).

Title 42 U.S.C. § 426(a) is unambiguous. It only grants individuals an “entitlement” to Medicare, Part A, nothing more. It does not compel one to enroll in Medicare, Part A, nor does

it compel the defeasance of Social Security monthly benefits if one does not enroll in Medicare, Part A. “Shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402) means it is wholly voluntary; it cannot mean anything different for purposes of Medicare, Part A (42 U.S.C. § 426(a)). This Court should accord the POMS no deference at all. The POMS are plainly contrary to the express intent of Congress.

II. THE POMS AMOUNT TO “LEGISLATING,” A POWER OF GOVERNMENT RESERVED ONLY TO CONGRESS BY ARTICLE I, SECTION I, OF THE CONSTITUTION OF THE UNITED STATES

Because it has been established that Medicare, Part A, is voluntary, the Defendants’ policies or rules set forth in the POMS must be invalid because the Defendants have actually taken it upon themselves to “legislate” by promulgating and enforcing those policies or rules. The Supreme Court has addressed this issue multiple times. In *Chrysler Corp. v. Brown*, the Court restated the fundamental rule of law:

The legislative power of the United States is vested in the Congress, and the exercise of quasi-legislative authority by governmental departments and agencies must be rooted in a grant of such power by the Congress and subject to the limitations which that body imposes.

Id., 441 U.S. at 302-303, 995 S.Ct. at 1718 (emphasis added).

Although Congress granted to the Secretary of HHS and Commissioner of SSA the power to promulgate regulations to carry into effect the Social Security and Medicare Acts (Title 42 U.S.C. § 407), it never accorded them power to actually change the eligibility requirements of Social Security or Medicare from that set forth in the statutes. It never granted to the Secretary of HHS or the Commissioner of SSA the power to make mandatory that which Congress determined to be voluntary. Likewise, Congress did not grant to the Secretary of HHS or the Commissioner of SSA the authority to strip from an individual all of his or her monthly Social Security benefits if he or she did not enroll in, or dis-enrolled from, Medicare, Part A.

The Supreme Court has always regarded any rule promulgated by an executive branch department or agency that does not “conform to the statutory purpose,” or is contrary to the statute under which the department or agency is granted rule-making authority, to be invalid. *Chrysler Corp. v. Brown, supra*; and *Batterton v. Francis, supra*. That invalidity is found in the failure of the rule to properly represent what Congress intended. Such is rooted in Article I, Section 1, of the Constitution of the United States. *Touby v. United States*, 500 U.S. 160, 111 S.Ct. 1752, 114 L.Ed.2d. 219 (1991) and *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 72 S.Ct. 863, 96 L.Ed. 1153 (1952).

Although Congress has the power to vest in executive branch officers of the federal government the authority to promulgate administrative rules, it does not extend to making of rules that go beyond the statute. *United States v. Grimaud*, 220 U.S. 506, 31 S.Ct. 480, 55 L.Ed. 563 (1911); *United States v. Eaton*, 144 U.S. 677, 12 S.Ct. 764, 36 L.Ed. 591 (1892). A distinction exists between delegation of powers to make law that necessarily involves **discretion as to what it shall be**, and conferring authority or **discretion as to its execution**, to be exercised under and in pursuance of law. **The first cannot be done, but the latter clearly can be done.** See *Touby v. United States, supra.*, *Bowles v. Willingham*, 321 U.S. 503, 64 S.Ct. 641, 88 L.Ed 892 (1944). Here, the Secretary of HHS and Commissioner of SSA have subverted the statutes in question. They have exercised “discretion to determine what the law shall be” rather than how the law shall be executed as written by Congress.

The POMS find absolutely no support in the Social Security or Medicare Acts. Both acts provide benefits to individuals who are “entitled” to them. The Defendants have even admitted that “shall be entitled” in 42 U.S.C. § 402 does not mean “must be enrolled.” Clearly, “shall be entitled” in 42 U.S.C. § 426(a) cannot mean “must be enrolled.” Congress provided explicit

statutory provisions governing how and under what circumstances Social Security monthly benefits may be cancelled or withdrawn. None of them include not enrolling in, or disenrolling from, Medicare, Part A. The substantive policies or rules in question, the POMS, must be declared invalid as contrary to the intent of Congress, an exercise of authority not granted by Congress to the Secretary of HHS or the Commissioner of SSA, and a violation of Article I, Section 1, of the Constitution of the United States. *Youngstown Sheet & Tube Co. v. Sawyer, supra*. This Court should grant Plaintiffs' Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

III. AS CONGRESS HAS DELEGATED TO THE DEFENDANTS NO AUTHORITY TO IMPOSE THE SANCTION OF DENYING AND ORDERING REPAYMENT OF MONTHLY SOCIAL SECURITY BENEFITS IF AN INDIVIDUAL DOES NOT ENROLL IN, OR DISENROLLS FROM, MEDICARE, PART A, THE POMS ARE INVALID AND UNLAWFUL UNDER TITLE 5 U.S.C. § 558(b)

According to 5 U.S.C. § 558(b) of the APA, "a sanction may not be imposed....except within jurisdiction delegated to the agency and as authorized by law." Section 558(b) requires statutory authority for all sanctions; it does not distinguish on its face between punitive sanctions and ordinary sanctions. It speaks of "sanctions," period! *American Bus Ass'n v. Slater*, 231 F.3d 1 (D.C. Cir. 2000).

In *American Bus Ass'n.*, the U.S. Court of Appeals for the District of Columbia considered a challenge to a Department of Transportation ("DOT") rule authorizing the imposition of money damages against bus companies for non-compliance with the Americans With Disabilities Act of 1990, 42 U.S.C. § 12188(a)(1) ("ADA"). Striking down the DOT rule, the Court concluded that any fine was a sanction for purposes of Section 558(b) of the APA. "A sanction," wrote the Court, "is a penalty even if only one of its various objects is to punish

wrongful conduct; that is, if it ‘serves *in part* to punish.’” *c.f.*, *Austin v. United States*, 509 U.S. 602, 610, 113 S.Ct. 2801, 125 L.Ed. 2d 488 (1993). Where a penalty is designed to force individuals to “modify their primary conduct,” it is a sanction for purposes of Section 558(b). The DOT was not granted such authority under the ADA or even the agency’s enabling statutes or under its “inherent authority to protect the integrity of its programs.” *American Bus Ass’n. v. Slater*, 231 F.3d at 4-7, distinguishing *Touche Ross R Co. v. SEC*, 609 F.2d 570 (2d Cir. 1979) and *Checkosky v. SEC*, 23 F.3d 452 (D.C.Cir. 1994).

The taking of an individual’s Social Security monthly benefits and forcing him or her to repay all the benefits previously paid, because he or she refused to enroll in, or disenrolled from, Medicare, Part A, is a serious “sanction.” **It is a penalty designed to force an individual to modify his or her conduct.** It is designed to force individuals to take Medicare, Part A, whether they want it or not.

Neither the Social Security Act nor the Medicare Act make enrollment in, or disenrollment from, Medicare, Part A, unlawful, much less sanctionable by the Secretary of HHS or the Commissioner of SSA taking an individual’s Social Security monthly benefits and forcing him or her to repay the benefits previously paid. The Defendants simply have not been delegated the power by Congress to impose such a sanction upon any individual entitled to Social Security monthly benefits. As such, the POMS violate Section 558(b) of the APA and must be declared void and unenforceable. Congress could not speak more clearly than it has in the text of the APA. Wrote the United States Court of Appeals for the District of Columbia: “a sanction may not be imposed **or a substantive rule or order issued** except within jurisdiction delegated to the agency and as authorized by law” (emphasis added). *American Bus Ass’n. v. Slater*, 231 F.3d. at 7. This Court should grant Plaintiffs’ Motion for Summary Judgment and declare the

challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

IV. THE CHALLENGED POLICIES WERE IMPLEMENTED WITHOUT ANY NOTICE AND COMMENT RULE-MAKING AS REQUIRED BY THE ADMINISTRATIVE PROCEDURE ACT

A. The Language of the APA Dictates that the POMS Are Invalid and Unlawful

1. The Challenged Policies Are Agency Rules Under The APA

The APA is codified at Title 5 U.S.C. §§ 551 *et seq.* It was enacted by Congress to establish standards by which the agencies of the executive branch of the federal government may promulgate regulations and rules for the implementation of enactments of Congress. The *Code of Federal Regulations* thus contains all those regulations and rules promulgated by all of the federal executive branch agencies pursuant to the APA.

Section 551 of Title 5 of the United States Code, “Definitions,” reads, in pertinent part, as follows:

For the purpose of this subchapter –

- (1) “agency” means each authority of the Government of the United States, whether or not it is within or subject to review by another agency, but does not include –
 - (A) the Congress;
 - (B) the courts of the United States;
 - (C) the governments of the territories or possessions of the United States;
 - (D) the government of the District of Columbia; or except as to the requirements of § 552 of this title –
 - (E) agencies composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined by them;
 - (F) courts martial and military commissions;
 - (G) military authority exercised in the field in time of war or in occupied territory; or

(H) functions conferred by §§ 1738, 1739, 1743, and 1744 of title 12; chapter 2 of title 41; subchapter II of chapter 471 of title 49; or §§ 1884, 1891-1902, and former § 1641(b)(2), of title 50, appendix;

....

- (4) ***“rule” means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy*** or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing;
- (5) ***“rule making” means agency process for formulating, amending, or repealing a rule***; (emphasis added).

Note that at 5 U.S.C. Section 551(4), a “rule” means the “whole or part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy....” The challenged POMS announce that they are “policies” by name. They do by the word chosen, **“policy.”** They also represent “an agency statement of general or particular applicability and future effect designed to implement” both the Social Security Act, Title 42 U.S.C. §§ 401 *et seq.*, and the Medicare Act, Title 42 U.S.C. §§ 1395 *et seq.* Without question, the POMS are “rules” for purposes of the APA, 5 U.S.C. § 551(4).

2. The Challenged POMS, As “Rules” Under The APA, Must Have Been Promulgated By Means Of “Rule-Making” In Order To Be Enforceable

In order to formulate, amend or repeal a “rule,” an agency must undergo “rule-making,” according to 5 U.S.C. § 551(5). “Rule-making” consists of the agency following the dictates of 5 U.S.C. § 553, which reads:

- (a) This section applies, according to the provisions thereof, except to the extent that there is involved –
- (1) a military or foreign affairs function of the United States; or
 - (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

- (b) General notice of proposed rule-making shall be published in the *Federal Register*, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include –
- (1) a statement of the time, place, and nature of public rule making proceedings;
 - (2) reference to the legal authority under which the rule is proposed; and
 - (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply –

- (A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
 - (B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.
- (c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, §§ 556 and 557 of this title apply instead of this subsection.
- (d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except –
- (1) a substantive rule which grants or recognizes an exemption or relieves a restriction;
 - (2) interpretative rules and statements of policy; or
 - (3) as otherwise provided by the agency for good cause found and published with the rule.
- (e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

5 U.S.C. § 553.

The agency must give thirty (30) days notice of proposed rule-making by publishing the proposed rule in the *Federal Register* with a statement of the time, place and nature of the

proposed rule-making proceeding; refer to the legal authority under which the rule is proposed; and provide the terms or substance of the proposed rule. The agency must then give interested persons an opportunity to participate by providing comment on the proposed rule. It must “incorporate in the rules adopted a concise general statement of their basis and purpose.” *Id.* There is no dispute here that the POMS were not promulgated by means of rule-making; rather, they were simply incorporated into the SSA *Program Operations Manual System* by the agency without informing the public. *SMF*, ¶¶ 171-172.

B. The POMS Are Not Rules Relating to “Benefits” or “Interpretive” Rules

1. The POMS Are Not “Benefit” Rules

The policies or rules at issue here are not related to the calculation of “benefits” so as to be exempted from “rule-making.” The courts have long concluded that the SSA and the Centers For Medicare and Medicaid Services of HHS do not have to conduct “rule-making” over the actual reimbursement or payment calculations under the programs they administer. See *Saint Francis Memorial Hospital v. United States*, 648 F.2d 1305, 227 Ct.Cl. 207 (1981); *Good Samaritan Hospital, Corvall’s v. Matthews*, 609 F.2d 949 (9th Cir. 1979); *Humana of South Carolina, Inc. v. Matthews*, 419 F.Supp. 253 (D.D.C. 1976), *aff’d in part, rev’d in part on other grounds*, 590 F.2d 1070 (D.C. Cir. 1977). In every one of the foregoing cases, “rule-making” was exempted because the determination of the agency related to the **actual reimbursement** a provider would or would not receive. None related to whether an individual must enroll in Medicare, Part A, or lose all of his or her monthly Social Security benefits, an entirely different matter. The policies challenged here on their face, were not established for purposes of calculating the amount of benefits.

2. The POMS Are Not “Interpretive” Rules, They Are “Substantive” or “Legislative” Rules

There are three general categories of rules: (1) legislative (sometimes referred to as substantive rules); (2) interpretive; and (3) procedural. Only legislative or substantive rules require notice and comment. See *Chrysler Corp. v. Brown*, 441 U.S. at 301, 99 S.Ct. at 1717. What distinguishes a “substantive” rule from an “interpretive” rule has been addressed by the Supreme Court. In *Batterton v. Francis*, the Supreme Court noted:

Legislative, or substantive, regulations are issued by an agency pursuant to statutory authority and.... implement the statute, as, for example, the proxy rules issued by the Securities and Exchange Commission Such rules have the force and effect of law.

Id., 432 U.S. at 425, n.9, 97 S.Ct. at 2405 n.9.

In *Chrysler Corp. v. Brown*, the Court reviewed all of its prior holdings on the issue. The *Chrysler* court noted that in *Morton v. Ruiz*, 415 U.S. 199, 232-235, 94 S.Ct. 1055, 1073-1074, 39 L. Ed.2d 270 (1974) a “characteristic inherent in our concept of a ‘substantive rule’ was that it was one affecting individual rights and obligations.” That, it claimed, “is an important touchstone for distinguishing those rules that may be ‘binding’ or have the ‘force of law.’” *Chrysler Corp. v. Brown*, 441 U.S. at 302, 99 S.Ct. at 1718. It goes without saying that because an agency regulation is “substantive” does not give it the force of law; rather, “the legislative power of the United States is vested in the Congress, and the exercise of quasi-legislative authority by governmental departments and agencies must be rooted in a grant of power by the Congress and subject to limitations which that body imposes.” *Id.*

Historically, the Supreme Court looked to the *Attorney General’s Manual on the Administrative Procedure Act* (1947) (“the *Manual*”) to assist it in distinguishing between “substantive” rules and “interpretive” rules, because neither the House nor Senate Reports on the

APA discussed the distinction. See *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, n.31, 99 S.Ct. 1705, 1717; *Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc.*, 435 U.S. 519, 546, 98 S.Ct. 1197, 1213, 55 L. Ed.2d 460 (1978); *Power Reactor Co. v. Electricians*, 367 U.S. 396, 408, 815 Ct. 1529, 1535, 6 L. Ed.2d 924 (1961); *United States v. Zucca*, 351 U.S. 91, 96, 76 S.Ct. 671, 674, 100 L. Ed. 964 (1956). That *Manual* refers to “substantive” rules as rules that “implement” the statute. “Such rules,” it reads, “have the force and effect of law.” *Manual, supra*, at 30, n.3. In contrast, it suggests that “interpretive” rules and “general statements of policy” do not have the force and effect of law. Interpretive rules are “issued by an agency to advise the public of the agency’s construction of the statutes and rules which it administers.” *Id.* General statements of policy are “statements issued by an agency to advise the public *prospectively* of the manner in which the agency *proposes* to exercise a discretionary power,” reads the *Manual. Id.* (emphasis added). See also, *Final Report of Attorney General’s Committee on Administrative Procedure* (1941), p.27.

The Supreme Court has gone so far as to opine that an “interpretive” rule is contrasted with a “substantive” rule by the fact that a court “is not required to give effect to an interpretive regulation.” *General Electric Co. v. Gilbert*, 429 U.S. 125, 141-145, 97 S.Ct. 401, 410-412, 50 L.Ed.2d 343 (1976); *Morton v. Ruiz*, 415 U.S. 199, 231-237, 94 S.Ct. 1055, 1072-1075, 39 L.Ed.2d 270 (1974); *Skidmore v. Swift Co.*, 323 U.S. at 140, 65 S.Ct. at 164, 89 L.Ed. 124 (1944). The POMS, though, are not “interpretive” rules; rather, they have the “force and effect of law,” and are meant to “implement” the Social Security and Medicare Acts. Without question, they “affect individual rights and obligations.” Because there are no similar rules in the *Code of Federal Regulations* – and 42 U.S.C. § 426(a) does not provide similar language – the POMS are the **only** rules mandating Medicare, Part A, enrollment as a condition of receiving

Social Security monthly benefits. As the United States Court of Appeals for the District of Columbia held:

If an agency acts as if a document issued at its headquarters is controlling in the field, if it treats the document in the same manner as it treats a legislative rule....if it leads private parties....to believe they [must] comply with the terms of the document, then the agency's document is, for all practical purposes, "binding."

Appalachian Power Co. v. EPA, 208 F.3d at 1021.

This Court examined a "Transmittal" issued by the Secretary that amended the *Home Health Agency Manual*. It prohibited home health providers from representing a beneficiary in appealing claims under the Medicare program. Judge Stanley Sporkin found the Transmittal to be a "substantive" ruling and voided it as not having been promulgated under the procedures of the APA. Judge Sporkin wrote that it was:

a substantive change in existing law by preventing all beneficiaries from designating home health agencies as their non-attorney representative in the administrative appeals process. Neither the underlying statute, nor the duly promulgated regulation governing non-attorney representation [] contains even a hint that home health agencies should be prohibited from representing beneficiaries. Significantly, the Transmittal contained no reference to any interpretation of any statute or regulation concerning the representation of beneficiaries by non-attorney and describes no pre-existing policy on providing representation.

In Home Health Care, Inc. v. Bowen, 639 F.Supp. 1124, 1126-1127 (D.D.C. 1986).

In the case at bar, the Secretary of HHS and the Commissioner of SSA are actually using the POMS to "force" individuals to accept Medicare, Part A, even though the Social Security Act and Medicare Act – and the properly-promulgated regulations of the Secretary and Commissioner - do not. As *In Home Health Care*, there are no references in the challenged policies or rules to any statute that is being interpreted, much less, 42 U.S.C. § 426(a). If those entitled to Social Security monthly benefits do not accept Medicare, Part A, the rules are being used to strip them of all their Social Security "savings." These are not "interpretative" rules;

they are “substantive” or “legislative” rules. As such, they are “final” agency actions. *Appalachian Power Co. v. EPA*, supra.; *Yale-New Haven Hospital, et al. v. Leavitt*, 470 F.3d 71 (2nd Cir. 2006); *In Home Health Care, Inc. v. Bowen*, supra.

C. **Substantive Rules Are Invalid and Unenforceable If Not Promulgated By Means Of Rule-Making**

The purpose of “rule-making,” particularly the “notice and comment” requirements, is “to allow public participation in the promulgation of rules which have a substantial impact on those regulated.” *National Retired Teachers Ass’n. v. U.S. Postal Service*, 430 F.Supp. 141 (D.D.C. 1977), *aff’d* 593 F.2d 1360 (D.C. Cir. 1978); *Saint Francis Memorial Hospital v. Weinberger*, 413 F.Supp. 323 (D.C. Cal. 1976). Those requirements of “rule-making” have been deemed “fundamental to due process.” *Bell Lines, Inc. v. United States*, 263 F. Supp. 40 (D. W.Va. 1967).

Administrative rules that are “substantive” in nature, which are not promulgated in accordance with the dictates of 5 U.S.C. § 553, are void. *Yale-New Haven Hospital, et al. v. Leavitt*, supra.; *Appalachian Power Co. v. EPA*, supra.; *Louisiana Federal Land Bank Ass’n., FLCA v. Farm Credit Admin.*, 336 F.3d 1075 (D.C.Cir. 2003); *Spirit of the Sage Council v. Norton*, 294 F.Supp. 2d 67 (D.D.C. 2003) *amended* 2004 WL 1326279, *appeal dismissed, vacated in part*, 411 F.3d 225 (D.C.Cir. 2004); *In Home Health Care, Inc. v. Bowen*, supra. Accordingly, the POMS must be declared void and invalid. These policies literally “affect individual rights and obligations,” implement two (2) major congressional enactments and are administered as though they have “the force and effect of law,” yet they were promulgated without any rule-making, thus denying the public the opportunity to participate and comment on their appropriateness and legality. This Court should grant Plaintiffs’ Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5

U.S.C. § 706(2)(D), as they were implemented “without observance of procedure required by law.”

V. **PLAINTIFFS ARE BEING DENIED A FUNDAMENTAL RIGHT TO DETERMINE THEIR OWN HEALTH CARE OR THEIR PROPERTY INTEREST IN THEIR SOCIAL SECURITY IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT**

A. **Plaintiffs Are Being Denied Their Fundamental Right of Privacy By Being Forced to Enroll in Medicare or Being Denied The Right to Get Out of Medicare Pursuant to The Challenged Policies**

The rights asserted in this case are not only important, they are fundamental and protected by the Constitution. The right to choose one’s health care and health care providers is one which has been taken for granted in this society especially as it is historically committed to civil liberties. Furthermore, these rights are inextricably linked to the acts sought to be enjoined, which, in this case, serve to restrict such freedoms. Therefore, the policies sought to be enjoined are important under this analysis due to their restriction on fundamental Constitutional rights.

Plaintiffs HALL, KRAUS and ARMEY have suffered the complete disruption of their FEHB health care insurance programs. HALL, KRAUS and ARMEY are now not allowed to pay privately for their own health care services. They are having to choose physicians only from a pool of those who actually participate in Medicare, an ever-dwindling number. They have lost control over their own health care decision-making. HALL and KRAUS have had to cease making contributions to their HSAs. Their HSAs have become moribund. HALL’S FEHB insurance carrier has actually “taken back” its 2009 contribution to his HSA after the Court denied his Motion for Temporary Restraining Order. If HALL, KRAUS or ARMEY had refused to accept Medicare, Part A, when they applied for Social Security, they would have been denied their Social Security monthly benefits.

The present claims rest, in part, upon a violation of the First, Fourth, Fifth, Ninth, and

Fourteenth Amendment privacy rights of the Plaintiffs to exercise their freedom to choose their own health care and health care provider free from governmental interference. Such “privacy” has been viewed by the Supreme Court as emanating from all of those amendments to the Constitution, particularly the First Amendment. *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 15 L. Ed.2d 510 (1965) (holding state law barring contraceptive devices unconstitutional as violative of the First, Third, Fourth, Fifth, Ninth and Fourteenth Amendments). Wrote Justice Douglas: “various guarantees [in the Bill of Rights] create zones of privacy...[The marriage relationship] concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees.” *Id.*, 381 U.S. at 485, 85 S.Ct. at 1682. Privacy was subsequently found by the Court to include the abortion decision. *Roe v. Wade*, 410 U.S. 113, 43 S.Ct. 705, 35 L. Ed.2d 147 (1973). Whether the right of privacy is founded upon the First, Third, Fourth, Fifth, Ninth or Fourteenth Amendments, wrote the Court, it is “broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.” *Id.*, 420 U.S. at 152, 153, 935 S.Ct. at 726-727. Certainly, one’s decision-making as to **all** health care matters is intensely personal and private; the right of privacy is broad enough to include that as well. Congress made the Social Security Act and Medicare Act voluntary for that very reason. The Plaintiffs are suffering – and will suffer - irreparable harm here as a matter of law.

To deny the exercise of the basic right to choose one’s health care and health care providers undermines Plaintiffs’ fundamental rights under the Constitution. This Court should grant Plaintiffs’ Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

B. Plaintiffs Are Being Denied Their Property Interest In Their Social Security By The Challenged Policies

Whether a wage earner has a property interest in monthly Social Security benefits has

been addressed by the Supreme Court. In *Flemming v. Nestor, supra*, the Court considered an action brought by an alien whose benefits were terminated by an Act of Congress that amended the Social Security Act. The Court concluded that one's interest in his Social Security cannot be seen as an "accrued property right" because Congress reserved for itself the right to "alter, amend or repeal any provision of the Act." *Id.*, 363 U.S. at 610-611, 80 S.Ct. at 1372. The Court concluded that one did not have such a right to benefit payments as would make every defeasance of "accrued" interest by Congress violative of the Due Process Clause of the Fifth Amendment. *Id.* 363 U.S. at 611; 80 S.Ct. at 1373. But, Congress could not act arbitrarily; the Due Process Clause, it wrote, could "interpose a bar...if the statute manifests a patently arbitrary classification, utterly lacking in rational justification." *Id.*

Although one's Social Security benefits are not "vested" due to the fact that they are subject to defeasance by Congress, they are "property" with respect to their defeasance by any other institution of government. Courts will examine a defeasance of such benefits by the Secretary of HHS and/or Commissioner of SSA to determine whether it was arbitrary, capricious, and thus, violative of the Due Process Clause of the Fifth Amendment. *Therrin v. Schneiker*, 795 F.2d 2 (2nd Cir. 1986) and *Collins v. Finch*, 311 F.Supp. 301 (W.D. Pa. 1970); 5 U.S.C. §§ 558(b), 706(A), (B) and (C)..

In the case at bar, the challenged POMS are clearly arbitrary, capricious and not provided by law. Only Congress can "alter, amend or repeal" any provision of the Social Security or Medicare Acts. It has never done so in order to force an individual to forego his or her Social Security monthly benefits if he or she did not want to participate in Medicare, Part A. The POMS are patently arbitrary and capricious; they have been promulgated and are being enforced completely contrary to the statutes and without authority. Accordingly, the POMS violate the

Due Process Clause of the Fifth Amendment to the Constitution of the United States. This Court should grant Plaintiffs' Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

CONCLUSION

For all the foregoing reasons Plaintiffs pray that this Court grant Plaintiffs' Motion For Summary Judgment, declaring the *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary, POMS HI 00801.034, Withdrawal Considerations, and POMS GN 00206.020, Withdrawal Considerations When Hospital Insurance is Involved* void as contrary to law and of no effect, and enjoining the Defendants, permanently and mandatorily, to permit the Plaintiffs to not enroll in, or disenroll from, Medicare, Part A, and retain their Social Security monthly benefits.

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Respectfully submitted,

/s/ Frank M. Northam

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