

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIAN HALL, et al.,)
)
 Plaintiffs,)
)
 v.) Civil Action No. 08-01715 (RMC)
)
 KATHLEEN SEBELIUS, et al.,)
)
 Defendants)
 _____)

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Defendants, by their undersigned attorneys, hereby move, pursuant to Rule 56, Federal Rules of Civil Procedure, for summary judgment.

The grounds for this motion are that defendants are entitled to judgment as a matter of law and that there are no genuine issues of material fact with respect to defendants' entitlement. (Defendants are also opposing plaintiffs' motion for summary judgment, and there are genuine issues of material fact with respect to issues on which plaintiffs would be required to bear a burden of proof in order to be entitled to summary judgment.)

In support of defendants' motion for summary judgment the Court is respectfully referred to:

- the memorandum of points and authorities 1) in opposition to the plaintiffs' motion for summary judgment; and 2) in support of defendants' motion for summary judgment;
- defendants' statement of material facts as to which there is no genuine issue, filed herewith;

- the declaration of Terry D. Stradtman, filed herewith; and
- the declarations of plaintiffs Richard K. Armey, Brian Hall, and John J. Krause, filed by plaintiffs with their motion for summary judgment.

In support of defendants' opposition to plaintiffs' motion for summary judgment, the Court is respectfully referred to:

- the memorandum of points and authorities 1) in opposition to the plaintiffs' motion for summary judgment; and 2) in support of defendants' motion for summary judgment;
- defendants' statement of genuine issues of material fact with respect to plaintiffs' motion for summary judgment;
- the declaration of Terry D. Stradtman, filed herewith;
- the declarations of plaintiffs Richard K. Armey, Brian Hall, and John J. Krause, filed by plaintiffs with their motion for summary judgment;
- the declaration of Brian G. Kennedy pursuant to Rule 56(f), Federal Rules of Civil Procedure, filed herewith; and
- the first set of interrogatories served on plaintiffs Armey, Hall, and Krause, which are filed herewith as exhibits to the Kennedy declaration.

Respectfully submitted,

TONY WEST
Assistant Attorney General

RONALD C. MACHEN
United States Attorney

SHEILA M. LIEBER
Deputy Branch Director

/s/ Brian G. Kennedy
BRIAN G. KENNEDY (D.C. Bar No. 228726)
United States Department of Justice
Civil Division
Federal Programs Branch
20 Massachusetts Ave., N.W.
Washington, D.C. 20530
Tel.: (202) 514-3357 Fax: (202) 616-8470
Email: Brian.Kennedy@usdoj.gov

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIAN HALL, et al.,)
)
 Plaintiffs,)
)
 v.) Civil Action No. 08-01715 (RMC)
)
 KATHLEEN SEBELIUS, et al.,)
)
 Defendants)
)
 _____)

DEFENDANTS' STATEMENT OF GENUINE ISSUES
OF MATERIAL FACT WITH RESPECT TO
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Defendants, by their undersigned attorneys, pursuant to Local Civil Rule 7(h) and Rules 56 and 56(f), Federal Rules of Civil Procedure, hereby identify the portions of plaintiffs' summary judgment motion as to which either 1) there is a genuine issue of disputed fact, or 2) defendants are entitled to discovery pursuant to Rule 56(f), or both.

Most of the alleged facts in plaintiffs' statement ("Pls' SMF") are simply not material. Defendants do not seek to set out every dispute or potential dispute that may involve non-material facts. (Defendants have not, for example, double-checked whether plaintiff Hall does indeed live in Catlett, Virginia, as alleged in paragraph 1.) Defendants do not concede the accuracy of such facts in general, but understand that, where defendants do choose to rest on their view that a fact is immaterial and therefore do not dispute it as a matter of fact, the fact is deemed admitted for the limited purpose of considering plaintiffs' instant summary judgment motion.

Other assertions in plaintiffs' statement are either assertions of law or assertions of fact about what plaintiffs believe is the law. *E.g.*, ¶ 10. Defendants do not concede the accuracy of plaintiffs' legal contentions or of the ostensibly factual assertion of what plaintiffs believe is the law, but also do not, in this document seeking to focus the Court on disputed factual issues, seek to identify each instance in which plaintiffs' legal conclusion is mistaken. That is generally left for the briefs.

On the other hand, in some instances where defendants view an assertion as either or both immaterial or legal rather than factual, out of an abundance of caution they nevertheless indicate that and why that assertion is disputed. Thus, the identification below of a particular dispute should not, without more, be taken as an assertion or admission by defendants that the responded-to assertion by plaintiffs is either or both material or factual.

Responses to Plaintiffs' Numbered Paragraphs

The paragraph numbers below correspond to the paragraph numbers of Plaintiffs' Statement of Material Facts As To Which There Is No Genuine Issue. Paragraphs not so indicated are not material, not disputed, and/or not factual.

3. Plaintiff Hall did not become "eligible to enroll" and thereupon "entitled to" Medicare, Part A (hospital insurance), on January 3, 2009. He became entitled to such hospital insurance benefits on that date without regard to any separate step of eligibility or requirement to enroll for the hospital insurance benefits.

9. Whether Hall does or does not "believe" that "enrollment" for hospital benefits is voluntary might literally be a fact, but the question whether it is

voluntary is one of law and Hall's belief is wrong as a matter of law. While defendants do not dispute that Hall did not wish to (what he calls) "enroll" for hospital insurance benefits when he signed his declaration more than a year ago, defendants are entitled to discovery pursuant to Rule 56(f) to determine whether he does and will continue to maintain that desire. Hall's alleged determination not to participate in the hospital insurance program seems based in significant part on misapprehensions of how the hospital insurance program works and how it interacts with the FEHB program. The process of briefing and discovery in this case could dispel those misapprehensions for a reasonable person, and it is therefore reasonable to expect that Hall's desire not to "enroll" has been or will be dispelled. *Cf. United Seniors Ass'n v. Shalala*, 182 F.3d 965, 970 (D.C. Cir. 1999) (plaintiffs noting that, if their fears about Medicare were based on a misunderstanding of the statute, their case would be at an end).

11. Plaintiff Hall's legal assertion that he will be "forced to limit his choice of providers and physicians to only those who participate in the Medicare program" is unsupported by any citation to the record, and it is disputed. First, plaintiff's participation in a hospital insurance plan has no effect on which physicians or other non-hospital providers he may use. Second, the vast majority of hospitals (and likely every accredited hospital) do participate in Medicare, *see, e.g.*, American Hospital Directory, http://www.ahd.com/state_statistics.html (last visited, May 17, 2010) (private list of hospitals has Medicare data for each hospital) and/or accept patients who have Medicare coverage, so plaintiff's choice of hospitals is not

restricted. At a minimum, defendants should be entitled to discovery on this point pursuant to Rule 56(f). Defendants tendered interrogatories to ask plaintiff Hall for facts within his knowledge and control on precisely the points addressed by this allegedly undisputed fact, for example, whether plaintiff has chosen a hospital for care, and, if so, whether that hospital in fact participates in Medicare. *See* Hall Interrogatories #3, attached to Declaration of Brian G. Kennedy. It would be fundamentally unfair for plaintiff Hall to prevail by merely alleging that there is some undisclosed hypothetical hospital that he cannot patronize if he is in Medicare Part A without at least identifying that hospital and answering other simple related questions.

32. In this paragraph, plaintiff Kraus makes factual assertions about the amount in his health insurance account and about the amount of his medical expenses over the last few years. Defendants are unable to dispute that assertion because the information is solely in plaintiff Kraus's control and Kraus has declined to date to respond to defendants' interrogatory addressed to these precise factual contentions. Kraus Interrogatory # 1, attached to declaration of Brian G. Kennedy. Pursuant to Rule 56(f), Fed. R. Civ. Proc., defendants should be entitled to discovery on this allegedly undisputed fact that plaintiffs contend would be material to a decision on their motion for summary judgment.

33. While defendants do not dispute that Kraus did not want to be (what he calls) "enrolled" for Medicare (Part A) hospital insurance benefits when he signed his declaration more than a year ago, defendants are entitled to discovery pursuant

to Rule 56(f) to determine whether he does and will continue to maintain that desire. Kraus's alleged wish not to participate in the hospital insurance program seems based in significant part on misapprehensions of how the hospital insurance program works and how it interacts with the FEHB program. The process of briefing in this case and of participating in discovery could dispel those misapprehensions for a reasonable person, and it is therefore reasonable to expect that Kraus's desire not to "enroll[]" has been or will be dispelled. *Cf. United Seniors Ass'n v. Shalala*, 182 F.3d 965, 970 (D.C. Cir. 1999) (plaintiffs noting that, if their fears about Medicare were based on a misunderstanding of the statute, their case would be at an end).

36. The assertion that Kraus may not keep an FEHB plan because he is entitled to Medicare Part A is an assertion of law and is neither supported nor correct. To the extent that Kraus contends that he could not stay in his particular Aetna plan, that too is incorrect, although the nature of one aspect of the plan varies depending on whether an annuitant is or is not entitled to Medicare. *See* Aetna Health Fund, 2010 FEHB Brochure at 70 (available at <http://custom.aetna.com/fehbp/index.php>) ("If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead.") Defendants have sought to begin discovery on the very points that Kraus contends are material and undisputed, Kraus's participation in the FEHB, Kraus Interrogatories ## 3-4, and should be able to obtain such discovery pursuant to Rule 56(f), Federal Rules of Civil Procedure.

49. Defendants are unaware of a “United States House of Representatives” Blue Cross Plan distinct from the Blue Cross plans available to other federal employees and annuitants (defendants have sought discovery on that very point, Arney Interrogatory # 1, but the discovery has not been answered). The further assertion that the FEHB Blue Cross Plan “will cover all health care costs” is disputed. Like most health care plans, Blue Cross does not cover “all” health care costs, but excludes certain kinds of costs from coverage altogether; and it does not pay “all” the costs of everything it does cover, requiring instead co-pays, deductibles and the like. *See* Blue Cross Blue Shield, Federal Employee Benefit Program, 2010 Service Benefit Plan Brochure at 18, 111 (available at <http://www.fepblue.org/index.html>).

55. In this paragraph it is alleged that plaintiff Arney “cannot afford to pay back” the monthly old-age insurance benefits he has received to date, citing Arney Declaration ¶ 18. This assertion is disputed by paragraphs 3, 8, and 17 of the same declaration and paragraph 49 of plaintiffs’ statement of material facts. According to paragraphs 3 and 17 of the declaration, Arney was 68 years old at the time of the declaration and had applied for his Social Security benefits when he turned 65. According to paragraph 8 of the declaration and paragraph 49 of the statement of material facts, those Social Security benefits are “meager” and Arney has both two pensions (one from the House and a “smaller pension from his years teaching”) and “significant” savings. These facts asserted by Arney himself belie any contention

that he could not pay back three (now four) years of “meager” Social Security retirement benefits.

57. Plaintiffs’ contention that the POMS are “freestanding” is a contention of law rather than fact, and it is wrong. As explained more fully in defendants’ memorandum of points and authorities, the POMS are consistent with and interpret the underlying statutes and regulations.

Facts Essential To Plaintiffs’ Motion That Either
Are Disputed Or For Which Discovery Is Necessary

Defendants are cross-moving for summary judgment and, on defendants’ view of the law and because defendants do not bear a burden of disproving standing, very few facts are material and none of those is in dispute. In the event, however, that defendants’ motion for summary judgment is denied, a number of factual issues would arise with respect to standing, an issue on which plaintiffs bear the burdens of proof and production and on which defendants have not yet had discovery. Because these disputed facts and facts on which discovery is needed are not necessarily keyed to plaintiffs’ paragraph numbers, we set forth those issues below.

A. Plaintiffs have argued that they will be injured in fact if they remain entitled to hospital insurance benefits under the Social Security Act because their choice of hospitals and doctors will be restricted.

There is no basis for that argument. Indeed, as shown in defendants’ motion to dismiss, it should be undisputed that plaintiffs’ choice of both hospitals and

doctors is not restricted by plaintiffs' entitlement to Medicare hospital insurance benefits.

However, in the event that defendants' motion is denied, plaintiffs' unsupported assertion that their choice will be restricted is in genuine dispute. At the very least, the Court should permit defendants to take discovery on the point. As detailed in the declaration of Brian G. Kennedy, defendants have sought to begin discovery to determine what hospitals, if any, that plaintiffs would otherwise use will become unavailable if plaintiffs remain in the hospital insurance program.

B. In a related point, plaintiffs seem to contend that they have sustained injury in fact because, if they are hospitalized, Medicare will limit the amount they can pay and, they theorize, this will hurt their care. No evidence is cited for either of these propositions. Defendants are entitled to summary judgment on this point because, as a matter of law, the hospitals can charge no more to plaintiffs and their FEHB plans if plaintiffs are outside Medicare than they could charge to plaintiffs if they were in Medicare. 5 U.S.C. § 8904(b)(1)(A).

However, to the extent plaintiffs survive defendants' motion for summary judgment, at the very least defendants would be entitled to discovery on what factual basis, if any, there is for plaintiffs' hitherto unsupported assertions that they will receive better care if they leave Medicare. The interrogatories plaintiffs have not yet answered address this specific point. Kraus Interrogatory #8, Hall Interrogatory # 7, Arney Interrogatory #5.

C. Plaintiffs assert in their brief that “privacy” is an interest, but fail to explain how it is at issue here. For the reasons stated in defendants’ summary judgment motion, there is no genuine issue that such an interest is not materially affected by anticipating plaintiffs’ participation in Medicare given their voluntary participation in the FEHB.

As for plaintiffs’ motion, their statement of material facts notably does not contend that any facts establishing a privacy injury are undisputed. To the extent that plaintiffs do seek to rely on privacy interests to support standing, at the very least defendants would be entitled to discovery to determine why plaintiffs object to Medicare Part A on that basis but not to participating in the FEHB program, which they do voluntarily. The interrogatories plaintiffs Hall and Krause have not yet answered address this specific point. Kraus Interrogatory # 10, Hall Interrogatories 8-9. (Arney did not raise such privacy concerns in his declaration, so no such question was addressed to him.)

D. Plaintiffs Hall and Kraus (though not Arney) also allege that they are losing a tax deduction in connection with a high deductible FEHB plan with HSA that they allegedly still wish to participate in. It is impossible, however, to evaluate whether they have any net loss (given the possibility of using other FEHB plans and taking into account the financial value of Part A coverage itself) without further information on their HSA and on their FEHB plans that those two plaintiffs did not provide. The interrogatories plaintiffs Hall and Krause have not yet

answered begin the process of seeking such discovery. Hall Interrogatories ## 1-2, 10-11; Krause Interrogatories ## 1-4.

Respectfully submitted,

TONY WEST
Assistant Attorney General

RONALD C. MACHEN
United States Attorney

SHEILA M. LIEBER
Deputy Branch Director

/s/ Brian G. Kennedy _____
BRIAN G. KENNEDY (D.C. Bar No. 228726)
United States Department of Justice
Civil Division
Federal Programs Branch
20 Massachusetts Ave., N.W.
Washington, D.C. 20530
Tel.: (202) 514-3357 Fax: (202) 616-8470
Email: Brian.Kennedy@usdoj.gov

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIAN HALL, et al.,)
)
 Plaintiffs,)
)
 v.) Civil Action No. 08-01715 (RMC)
)
 KATHLEEN SEBELIUS, et al.,)
)
 Defendants)
 _____)

DEFENDANTS' STATEMENT OF MATERIAL FACTS
AS TO WHICH THERE IS NO GENUINE ISSUE

Defendants, by their undersigned attorneys, pursuant to Local Civil Rule 7(h) and Rules 56 and 56(f), Federal Rules of Civil Procedure, hereby identify the material facts with respect to defendants' summary judgment motion.

The Stradtman declaration cited and relied upon below is filed herewith. The Arney, Hall, and Kraus declarations cited and relied upon below were filed by plaintiffs with their motion for summary judgment.

1. Plaintiff Arney has attained the age of 65. Arney Declaration ¶ 3.
2. Plaintiff Hall has attained the age of 65. Hall Declaration ¶ 3.
3. Plaintiff Kraus has attained the age of 65. Kraus Declaration ¶ 3.
4. Plaintiff Arney is entitled to old-age insurance benefits under section 202 of the Social Security Act. Arney Declaration ¶¶ 8, 17-18.
5. Plaintiff Hall is entitled to old-age insurance benefits under section 202 of the Social Security Act. Hall Declaration ¶ 17.

6. Plaintiff Kraus is entitled to old-age insurance benefits under section 202 of the Social Security Act. Kraus Declaration ¶ 9.

7. Plaintiff Armev has voluntarily chosen to participate in a health plan under the Federal Employees Health Benefit program. Armev Declaration ¶ 8, 11.

8. The Federal Employees Health Benefit plan voluntarily chosen by plaintiff Armev does not have a health savings account component. Armev Declaration ¶¶ 8, 11 (identifying Armev's FEHB plan as Blue Cross);

<http://www.fepblue.org/benefitplans/index.html> (describing Blue Cross FEHB plans).

9. Plaintiff Hall has voluntarily chosen to participate in a health plan under the Federal Employees Health Benefit program. Hall Declaration ¶¶ 8-10.

10. Plaintiff Kraus has voluntarily chosen to participate in a health plan under the Federal Employees Health Benefit program. Kraus Declaration ¶¶ 8,10.

11. Plaintiff Armev has not identified a single hospital or other provider 1) that he would choose to use and that would treat him if he did not participate in Medicare Part A but 2) that will not treat him if he does participate in Medicare Part A. *See* Armev Declaration ¶ 16 (alleging that such providers exist without naming any).

12. Plaintiff Hall has not identified a single hospital or other provider 1) that he would choose to use and that would treat him if he did not participate in Medicare Part A but 2) that will not treat him if he does participate in Medicare

Part A. *See* Hall Declaration ¶ 16 (alleging that such providers exist without naming any).

13. Plaintiff Kraus has not identified a single hospital or other provider 1) that he would choose to use and that would treat him if he did not participate in Medicare Part A but 2) that will not treat him if he does participate in Medicare Part A. *See* Kraus Declaration ¶ 10 (arguably implying that such providers exist, but not naming any).

14. Plaintiffs contend that creating the program they seek to permit disenrollment would save the government money.

<http://www.medicarelawsuit.org/background.html> (last visited, May 18, 2010)

("the plaintiffs also believe the rules are self-defeating from a financial perspective. Why? Because if even a small percentage of Medicare-eligible retirees were to opt out of the program it could save taxpayers . . . **\$3.4 billion** or more per year by 2017") (emphasis original).

15. The administrative costs of creating a system to allow for plaintiffs and those similarly situated to enroll or disenroll would exceed \$100 million. Stradtman Declaration. [N.B.: This statement of an undisputed fact relates to administrative costs only. It makes no contention about whether there are or would be net program and tax costs or savings and/or whether net program/tax savings, if any, would be greater or less than the administrative costs (*cf.* ¶ 14, *supra*, noting as undisputed fact that plaintiffs contend that there would be net program savings to

the federal fisc, and not asserting as undisputed fact whether plaintiffs' view is correct or incorrect).]

Respectfully submitted,

TONY WEST
Assistant Attorney General

RONALD C. MACHEN
United States Attorney

SHEILA M. LIEBER
Deputy Branch Director

/s/ Brian G. Kennedy _____
BRIAN G. KENNEDY (D.C. Bar No. 228726)
United States Department of Justice
Civil Division
Federal Programs Branch
20 Massachusetts Ave., N.W.
Washington, D.C. 20530
Tel.: (202) 514-3357 Fax: (202) 616-8470
Email: Brian.Kennedy@usdoj.gov

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIAN HALL, et al.,)
)
 Plaintiffs,)
)
 v.) Civil Action No. 08-01715 (RMC)
)
 KATHLEEN SEBELIUS, et al.,)
)
 Defendants)
 _____)

DEFENDANTS' MEMORANDUM 1) IN OPPOSITION TO
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT; AND 2) IN
SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

INTRODUCTION

Because they meet two conditions – being entitled to “monthly insurance benefits” under section 202 of the Social Security Act and having attained age 65 – plaintiffs are entitled to hospital insurance (“HI”) benefits under the Social Security Act. 42 U.S.C. § 426(a). Plaintiffs will continue to meet those two conditions. They allegedly do not want to relinquish monthly insurance benefits. They probably will not become younger than 65 again.

Although plaintiffs do not purport to challenge any provision of the Social Security Act – including the one creating their entitlement to HI benefits – plaintiffs do not want the free hospital insurance benefit that follows as a consequence of those two facts. Instead, they want this Court to order defendants to create some process by which plaintiffs can have their names stricken from some roll of those entitled to the hospital insurance benefits to which plaintiffs are

entitled. They are already, of course, free not to use the benefit. But not using the benefit is not enough, they say

Plaintiffs have not carried, and cannot carry, their burden at the summary judgment stage to show that they have standing to have the Court order defendants to create such a process.

Plaintiffs cannot plausibly claim to be pursuing this case to advance their financial interests because they instead claim that their suit to relinquish their hospital insurance benefits will save the defendants money. *See*

<http://www.medicarelawsuit.org/backgrounder.html> (last visited, May 18, 2010).

Being forced to become entitled to financial benefits from the government that one may choose whether to use is no injury in fact.

Plaintiffs make vague claims that being entitled to this free benefit will nevertheless harm them by restricting their choice of hospitals to the supposedly “ever dwindling” ranks of hospitals that participate in the hospital insurance program. Pls’ SJ Mem. at 7.¹ In fact, the overwhelming majority of hospitals in this country participate in the HI program. Plaintiffs have not named a singled

¹ In addition to inpatient hospital care, the hospital insurance benefit also covers some hospice care, post-hospital extended-care for limited periods in a skilled nursing facility, and some home health care for persons who choose not to enroll in Medicare Part B. *See* 42 U.S.C. § 1395d. Plaintiffs make no contentions specific to such non-hospital care, however and no better or different showing of standing with regard to the other types of care covered by the hospital insurance program. Accordingly, subject to this understanding that hospital insurance also does cover other limited care, this brief generally refers to hospitals care in discussing the hospital insurance benefit.

provider that would refuse to treat them as a patient merely because they are entitled to hospital insurance benefits. If anything, plaintiffs will have a wider selection using their HI benefits than they would under the many private plans that feature “preferred provider” or similar networks. Plaintiffs also seem to hope or suppose that, if unleashed from the yoke of the free HI benefit, they would be free to have their Federal Employee Health Benefit (“FEHB”) insurance pay more money to hospitals than the hospital insurance program will pay and thereby maybe receive better care. The first premise (that their FEHB insurance could pay more if they were not in the HI program) is wrong as a matter of law, *see* 5 U.S.C. § 8904(b)(1)(A), and the second premise (that more money necessarily means better care) is unsupported as a matter of fact.

Plaintiffs also argue that privacy is important in medical matters, Pls’ SJ Mem. at 37-38. And so it is. But plaintiffs nowhere explain how any real privacy interest is at stake in this case. They willingly participate in another federal program, the FEHB program, that features exactly what one would otherwise guess plaintiffs might be opposed to: a large insurance company administering a program under the direction of a federal agency and subject to the same federal privacy laws.

Plaintiffs’ claim also fails on the merits. Unlike the HI program with respect to these plaintiffs, many federal insurance programs require premium payments. Where that is the case – as with the FEHB, as with Medicare Parts B, C, and D, as with even HI itself for those who do have to pay premiums – Congress knows how to, and typically does, establish the terms under which one can enroll, disenroll, and

(if ever) re-enroll. *E.g.*, 42 U.S.C. § 1395i-2. For this no-premium insurance benefit, on the other hand, Congress set forth no provision for enrolling, disenrolling, or re-enrolling. The Court should decline plaintiffs' invitation to legislate such terms out of thin air and the more than a hundred million dollars it would take to set up such a program to accommodate the desires of a handful of individuals who do not want the now premium-free benefits their taxes have already earned them.

Moreover, a system that would make it easier for a few people to forgo participation in the HI program could perversely make it too easy not to participate for the vast majority of individuals who have every reason to want the benefit if they are entitled to it but who may fall through the cracks of a system that suddenly requires a separate application or enrollment.

STATEMENT OF THE CASE

1. Enrollment Provisions, And Absence Of Enrollment Provisions, For Hospital Insurance Benefits Under The Social Security Act

Some persons, including plaintiffs, become "entitled" to hospital insurance benefits under the Social Security Act and are not required to pay any premiums to secure or maintain that entitlement. 42 U.S.C. § 426.

Others (*e.g.*, persons who are 65 or over but are not entitled to monthly insurance benefits) are "eligible" for hospital insurance benefits, but must pay premiums in order to "enroll" in the program. 42 U.S.C. §§ 1395i-2, 1395i-2a. While they are so enrolled, but only while they are so enrolled, these persons become "entitled to [HI] benefits . . . pursuant to" that enrollment. 42 U.S.C. §

1395i-2(a). Congress expressly legislated these enrollment provisions with respect to those whose eligibility for hospital insurance can only be converted to entitlement through enrollment and payment of premiums. 42 U.S.C. §§ 1395i-2, 1395i-2a.

There are no comparable statutory provisions setting forth enrollment terms with respect to persons, like plaintiffs, whose “entitlement” (42 U.S.C. § 426 (header)) to the hospital insurance benefit is not conditioned upon paying premiums. Defendants have not created such enrollment provisions by unilateral regulatory action. Plaintiffs cite and challenge internal guidance in the *Program Operating Instruction Manual System* (“POMS”) that notes this absence of enrollment provisions. Pls’ SJ Mem. *passim*.

Shortly after plaintiffs’ suit was filed, defendants created a joint working group to consider what it would cost to create an enrollment process for the non-premium portion of the hospital insurance benefit program in the event that Congress enacted a statute that would permit such a change. The working group estimated that the cost would exceed \$100 million or, in some variations, would exceed \$200 million. *See* Declaration of Terry M. Stradtman, filed herewith.

2. Plaintiffs’ Circumstances or Alleged Circumstances

Plaintiffs are all at least 65 years of age. They are entitled to old-age insurance benefits under section 202 of the Social Security Act. They are “entitled” to hospital insurance benefits under the Social Security Act. 42 U.S.C. § 426. *See* Plaintiffs Statement of Material Facts as to Which There is no Genuine Issue (“Pls’ St. Mat. Facts”) ¶¶ 3, 20, 28-29, 54. All this is undisputed.

Plaintiffs argue as a matter of law that there is, or there is required to be, some sort of process by which they could not enroll in, or disenroll from, the hospital insurance benefit. This question of law is disputed.

Plaintiffs allege that, if such a process were available, they never would have chosen to enroll in the hospital insurance benefit and would now disenroll. Pls' St. Mat. Facts ¶¶ 9, 33, 55. For purposes of defendants' cross-motion for summary judgment, defendants do not dispute those allegations. For purposes of plaintiffs' motion for summary judgment however, as explained below and in the Declaration of Brian G. Kennedy, defendants should be entitled to discovery pursuant to Rule 56(f), Federal Rules of Civil Procedure.

Plaintiffs allege that they are enrolled in health insurance plans issued pursuant to the Federal Employees Health Benefits Program ("FEHB"), 5 U.S.C. §§ 8901-8914. Pls' St. Mat. Facts ¶¶ 6, 32, 49, 51. This is undisputed.

Once Health Savings Accounts ("HSAs") became available to FEHB participants in 2005, *see id.* ¶ 32, plaintiff Hall was enrolled until 2008 in an FEHB plan that would contribute, and allow him to contribute, to an HSA, *id.*, ¶ 6, and plaintiff Kraus enrolled in such a plan from 2005, and does not make it clear whether he is still enrolled, *id.*, ¶ 32. Plaintiff Armev does not allege that he has ever enrolled or wanted to enroll in such a plan. For purposes of defendants' motion for summary judgment and, except to the extent that, if alleged, plaintiff Kraus's post-2008 enrollment in an HSA plan is material, for purposes of plaintiffs' summary judgment motion, these facts are undisputed. If plaintiff Kraus's post-2008

enrollment in an HSA plan is material, defendants should be entitled to discovery pursuant to Rule 56(f), Federal Rules of Civil Procedure.

3. Prior Proceedings In This Action

On January 28, 2009, the Court denied plaintiff Hall's motion for a temporary restraining order to prevent, as Hall put it, being "enrolled" by defendants for HI benefits. *Hall v. Johnson*, 599 F. Supp. 2d 1 (D.D.C. 2009). Hall had begun receiving the old-age insurance benefits to which he was entitled in 2006. *Id.* at 2. Accordingly, as the Court explained in denying the motion, when he satisfied the second entitlement requirement by turning 65, entitlement to HI benefits was "a status that Mr. Hall achieved automatically," with "[n]o 'enrollment] or other action" being required. *Id.* at 6.

On September 29, 2009, the Court granted in part and denied in part defendants' motion to dismiss. *Hall v. Sebelius*, 2009 WL 3088821 (D.D.C. Sept. 29, 2009). The Court held that two plaintiffs lacked standing, and dismissed them from the case. *Id.* at *4. On the other hand, the Court found that plaintiffs Hall, Kraus, and Arney had sufficiently alleged standing to survive a motion to dismiss. *Id.* at *4-5. The Court also disagreed with defendants' argument that the Court lacked jurisdiction because, defendants argued, there was no final agency action. *Id.* at *5-6. Finally, although the Court agreed with defendants that plaintiffs Hall, Kraus,

and Arney had not exhausted administrative remedies, *id.* at *7-8, it also found that exhaustion would be futile and therefore was excused, *id.* at *9.²

On March 24, 2010, the Court denied defendants' motion to reconsider the partial denial of the motion to dismiss. Noting that the plaintiffs, "at least for now," wanted to "avoid participation" in the HI program, March 24 Order at 2, and that it was "not at all clear why" they would not have that choice, *id.* at 3, the Court set the matter for a scheduling conference to sequence summary judgment proceedings.

At the scheduling conference, defendants' counsel noted that defendants had served interrogatories to begin the discovery process of testing the factual claims of standing on which the previously filed motion of plaintiffs for summary judgment was based.³ Plaintiffs' counsel responded by indicating that no discovery would be necessary because plaintiffs could refile a new motion for summary judgment that he said would not depend on facts that might properly be subject to discovery. The Court permitted plaintiffs to file a new motion without prejudice to defendants' opportunity to make a demonstration under Rule 56(f) that discovery is appropriate.

² Defendants continue to maintain that there was no final agency action and that plaintiffs' claims (and the Court's jurisdiction) are barred by plaintiffs' failure to exhaust. However, without waiving those arguments, defendants do not in this motion re-revisit those issues that were fully discussed in defendants' motions to dismiss and to reconsider.

³ Defendants' counsel had agreed that, at plaintiffs' option, any obligation of plaintiffs to respond to these interrogatories could be tolled during the pendency of defendants' motion to reconsider.

ARGUMENT

I. Plaintiffs Lack Standing To Challenge The Absence Of Any Enrollment, Disenrollment, And Re-enrollment Procedures For The Hospital Insurance Benefits To Which They Are Entitled Under The Social Security Act

When this matter was before this Court on the motion to dismiss, the Court held that plaintiffs Hall, Kraus, and Arney had sufficiently alleged standing. After all, they had alleged that they had financial, privacy, and quality of care interests at stake and, as the Court recognized, those are the kinds of injuries that, where they occur, can support standing.

Now that the case has moved forward to the summary judgment stage, however, plaintiffs bear an additional burden of actually supporting such allegations of injury with hard, particularized evidence of actual or imminent injury:

At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we “presum[e] that general allegations embrace those specific facts that are necessary to support the claim.” [*Lujan v.*] *National Wildlife Federation, supra*, 497 U.S. [871], at 889. In response to a summary judgment motion, however, the plaintiff can no longer rest on such “mere allegations,” but must “set forth” by affidavit or other evidence “specific facts,” Fed.Rule Civ.Proc. 56(e)

Lujan v. Defenders of Wildlife, 504 U.S. 555, 561 (1992). Plaintiffs have not even come close to carrying that burden to produce evidence of specific facts demonstrating injury in fact, and cannot do so.

a. Alleged Injury To Privacy Interests

One type of injury on which plaintiffs seem to rely is an injury to a “privacy” interest, which, as they note, can be an important interest and right, particularly in a medical context. Pls’ SJ Mem. at 38. But neither plaintiffs’ memorandum nor their statement of material facts details how any real privacy interest is at stake in this actual case. We guess that plaintiffs may be concerned that, if they remain entitled to hospital insurance, then private medical information concerning their inpatient hospital admissions might be broadcast by the large impersonal insurance companies that administer the hospital insurance program under the supervision of a federal agency and subject to the privacy protections of the Health Insurance Portability and Accountability Act. *See* 42 U.S.C. §§ 1320d(5)(D), 1320d-6.⁴ Yet plaintiffs all willingly participate in the FEHB and have their benefits administered by a large impersonal insurance company under the supervision of a federal agency and subject to the privacy protections of the Health Insurance Portability and Accountability Act. *See* 42 U.S.C. §§ 1320d(5)(M), 1320d-6. If privacy were a real concern and a real injury, plaintiffs could avoid it only by ceasing to participate in both the Social Security Act’s hospital insurance program and the FEHB program.

We wrote above what we “guess” are plaintiffs’ privacy arguments, because plaintiffs Hall and Kraus (the only two plaintiffs who at least alluded to such a concern in their declarations) have not answered interrogatories that were

⁴ The HI program is also subject to the Privacy Act, 5 U.S.C. § 552a, and 42 U.S.C. § 1346, which restricts disclosure of program information.

specifically designed to elicit more information on these very points and to help focus any depositions that might also prove necessary.⁵ While plaintiffs' willing participation in the FEHB is sufficient to allow a conclusion that there is no privacy injury sufficient to support standing even for purposes of defendants' cross-motion for summary judgment, at the very least the Court ought not grant plaintiffs' own summary judgment motion without first requiring them to respond to simple discovery aimed at finding out what the alleged injury even is and to start gathering information to test whether it actually exists. *See* Rule 56(f), Fed. R. Civ. Proc.

b. Alleged Impact On Care And Hospital And Physician Choice

Plaintiffs also argue that being entitled to HI benefits without any opportunity to disenroll will "force[them] to use only those providers who participate in Medicare – an ever dwindling number" and cause them to be "denied care they otherwise would obtain if they paid for themselves." Pls' SJ Mem. at 7. No evidence whatsoever, other than plaintiffs' own unsupported "belief," is provided for these factual assertions.

For one thing, plaintiffs seem to have confused what is involved in this case, the hospital insurance benefit, with the supplemental medical insurance benefit

⁵ The interrogatories served on plaintiffs Kraus and Hall that begin the inquiries on these points are attached to the declaration of Brian G. Kennedy, filed herewith. Hall Interrogatories ## 8-9, Kraus Interrogatories # 9. The interrogatories to Mr. Armev, also attached, did not address this point, because Mr. Armev's declaration did not claim or rely upon any privacy interest or injury in the first place. To the extent that Armev is also belatedly asserting such an interest, defendants should be entitled to discovery on that point from him as well.

program (also known as Medicare Part B) that pays for physician fees and the like and that is established as a “voluntary insurance program,” 42 U.S.C. § 1395j. When plaintiffs argue that they will be “provided only those health care services allowed by Medicare,” they cite only statutory provisions in Medicare Part B. Pls’ SJ Mem. at 7, *citing* 42 U.S.C. §§ 1395k, 1395l, 1395m, 1395u.⁶ Plaintiffs are already free not to enroll in Medicare Part B, a premium-based voluntary supplemental program. Similarly, plaintiffs’ alleged fears that their choice of physicians will somehow be restricted has no logical or factual link to the issue in this case, which involves only the benefit that pays for inpatient hospital services and has no effect on which physicians plaintiffs may choose.⁷ Whether or not plaintiffs participate in the hospital insurance program, they may choose either from among the “ever dwindling” 99% of doctors who will treat patients with Medicare Part B insurance or from the 1% who might not.⁸

⁶ They are wrong about the effect of those provisions even within Part B.

⁷ Which hospital plaintiffs choose might have an impact on which physicians they may use while hospitalized, but that would be a result of the hospitals’ and physicians’ agreement or lack of agreement on whether a particular physician may practice at the hospital (*e.g.*, has privileges at the hospital), not on whether any particular patient is or is not covered by the HI benefit.

⁸ A somewhat larger percentage of physicians do not accept assignment of Medicare Part B benefits as payment in full, but do accept Medicare Part B patients, bill the patient directly, and send claims to Medicare Part B, which then sends a check to the patient. *E.g.*, <http://www.mayoclinic.org/billing-rst/faqs2.html>. Plaintiffs’ participation in Medicare Part B would thus in no way preclude their ability to choose such physicians.

To the extent that plaintiffs' argument has any arguable relevance to this case, it is only with respect to hospitals. Plaintiffs present no evidence to support their assertion that the number of participating hospitals is "dwindling," much less "ever dwindling." Indeed, plaintiffs have not identified a single hospital, let alone a single hospital that they would choose to use, that will not treat them if it learns that they are entitled to hospital insurance benefits. Not one. So comprehensive is hospital participation in the Medicare program that even private hospital directories use Medicare data for all hospitals they list. *See, e.g.*, American Hospital Directory, http://www.ahd.com/state_statistics.html (last visited, May 17, 2010).⁹

Plaintiffs also seem to argue that, even if their choice of hospital were unaffected, *i.e.*, even holding constant the choice of hospital, their care might still suffer if the HI benefit was used compared to the "care they otherwise would obtain if they paid for it themselves." Pls' SJ Mem. at 7. Plaintiffs utterly fail to support this argument. Nothing in the Social Security Act requires persons like plaintiffs who are entitled to the hospital insurance benefit to use that benefit to pay for hospitalization. *See* 42 U.S.C. § 1395f(a)(1). As far as the Social Security Act is

⁹ The most obvious examples of hospitals that do not participate in Medicare are the non-private hospitals the federal government itself operates through the Department of Veterans Affairs and Department of Defense, which are financed by other means. Plaintiffs do allege, let alone prove, that they are entitled to treatment from such hospitals or that, if they were so entitled, their entitlement to hospital insurance under the Social Security Act would somehow interfere with that entitlement.

concerned, whether they are in or out of the hospital insurance program, plaintiffs are free to pay privately for whatever care they want instead of using their hospital insurance benefit.

To be sure, if what plaintiffs mean by “care they otherwise would obtain if they paid for it themselves” is not care they actually pay for out of their own pockets but instead care that is paid for through the FEHB program, then a hospital indeed can charge the FEHB and plaintiffs no more than what it would charge under the Social Security Act’s hospital insurance program. But that limitation has nothing to do with whether plaintiffs are or are not entitled to the HI benefits. As long as plaintiffs are federal annuitants 65 or over, even if they were not entitled to HI benefits or even if they were somehow allowed to disenroll, a hospital could still not charge them and the FEHB plan anything more than what it would charge under the HI program. 5 U.S.C. § 8904(b)(1)(A).¹⁰ Thus, given plaintiffs’ participation in the FEHB, whether plaintiffs are entitled to, eligible for, enrolled in, participating in, or any other adjective in, the HI program is utterly irrelevant to what their hospital will be paid for any inpatient admission. If plaintiffs truly do want to pay “themselves” at a higher rate for their next admission, it is not the HI benefit they need to forswear, but their participation in the FEHB. Yet, despite having the selfsame level of hospital reimbursement, the FEHB program is praised and

¹⁰ There is an exception in this provision for pre-payment FEHB plans (*i.e.*, HMOs and the like), but plaintiffs, who claim to prize free choice of physicians and providers, all claim to have chosen more traditional fee-for-service FEHB plans.

embraced by plaintiffs. Pls' SJ Mem. at 7. As long as plaintiffs are in the FEHB program, on this point it makes no difference whether they're also in the HI program, and thus this alleged interest can provide no actual injury in fact traceable to HI participation.

It is a sufficient answer to plaintiffs' implied syllogism that their care will suffer that their major premise (*i.e.*, that if only there were some process to disenroll from the HI benefit program, more money would be paid to their hospital than what the HI program pays) is wrong as long as plaintiffs are in the FEHB. But plaintiffs' minor premise (*i.e.*, that hospitals would provide better care to private-pay private patients than to otherwise similarly situated HI patients), should not go unremarked, because it defies common sense and common dignity to presume that dedicated hospital nurses and doctors will treat Medicare patients worse than private-pay patients in similar circumstances. Plaintiffs offer absolutely no evidentiary support for that supposition.¹¹

For these reasons, it is undisputed for purposes of defendants' cross-motion for summary judgment that plaintiffs' status as HI entitled does not cause any injury in fact with regard to selecting a hospital, the amount of payment, or the

¹¹ One academic study that did look at data to test whether hospitals "modif[ied] service intensity, in line with the level of reimbursement available for individual payments" is Avi Dor & Dean E. Farley, *Payment Source and the Cost of Hospital Care: Evidence From a Multiproduct Cost Function With Multiple Payers*, 15 J. HEALTH ECON. 1 (1995). The data showed no statistically significant difference in that respect between private insurance patients and Medicare patients (what non-statistically significant differences there were seemed to indicate that Medicare patients received a higher service intensity).

quality of care. However, in the event that the Court does not grant defendants' motion, it should not find on plaintiffs' motion that such injury exists without first permitting discovery. As with plaintiffs' only hazily sketched allegations of an injury to a privacy interest, defendants have sought discovery that would begin to flesh out what basis plaintiffs could possibly have for alleging that their care will suffer if they cannot rain down their own cash on some hitherto undisclosed hospital outside the HI program. Hall Interrogatories # 3-7; Kraus Interrogatories # 5-8, 10; Arney Interrogatories # 3-8.

c. Lack Of Monetary Injury

In many cases, a plaintiff has sustained a monetary or equivalent economic loss that is an injury in fact. But plaintiffs can make no real claim of monetary injury in fact here. The hospital insurance benefit is premium free and costs the plaintiffs nothing beyond the taxes that they have already paid and do not and cannot seek to have refunded. Indeed, plaintiffs themselves seem to proclaim that they are not suing to obtain net monetary benefits for themselves, but are instead suing in order to save the defendants money. *See* <http://www.medicarelawsuit.org/background.html> (last visited, May 18, 2010) ("the plaintiffs also believe the rules are self-defeating from a financial perspective. Why? Because if even a small percentage of Medicare-eligible retirees were to opt out of the program it could save taxpayers . . . **\$3.4 billion** or more per year by 2017") (emphasis original).

Perhaps, as public-minded citizens, plaintiffs feel, perhaps even feel strongly, that the government is throwing away taxpayer dollars that a deficit-ridden nation can ill afford to pay hospital insurance benefits for people like plaintiffs who would happily turn such benefits down if only they could. But the government's spending of money, even when the expenditures are needless or foolish, does not confer at-large standing on anyone and everyone who pays taxes. *Frothingham v. Mellon*, decided with *Massachusetts v. Mellon*, 262 U.S. 447 (1923). "Standing has been rejected in such cases because the alleged injury is not 'concrete and particularized,' *Defenders of Wildlife, supra*, at 560, but instead a grievance the taxpayer 'suffers in some indefinite way in common with people generally,' *Frothingham, supra*, at 488." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 342 (2006).

It is no answer for plaintiffs to say that they are not just any taxpayers challenging an expenditure of money on someone else, but taxpayers challenging expenditure of other taxpayers' money on themselves. "While such altruistic concern . . . may be admirable, it does not rise to the personal stake in the outcome that is required to confer standing." *Quincy Oil, Inc. v. Federal Energy Admin.*, 620 F.2d 890, 896 (Temp. Emer. Ct. App. 1980). If anything, it weakens even further any claim to injury in fact. After all, to the extent the federal government's spending of money on plaintiffs would otherwise be an injury to them (as distinct from the other, non-monetary, effects plaintiffs allege that we address above), plaintiffs already have two alternative and complete remedies for that supposed injury in their own hands. As noted above, they are free not to use their HI benefit,

which will avoid the government expense. If they still feel guilty at having earned entitlement to hospital benefits through years of paying taxes, they may assuage that guilt by writing a corresponding check to the Bureau of Public Debt and sending it to Attn Dept G, Bureau of the Public Debt, P.O. Box 2188, Parkersburg, WV 26106-2188. If the minimal burden of writing a check and finding a stamp is deemed injury, the Bureau accepts gifts online.

<https://www.pay.gov/paygov/forms/formInstance.html?agencyFormId=23779454>
(last visited, May 18, 2010).

Of course, it might be theoretically possible that plaintiffs' website is fibbing when it says that plaintiffs are out to save defendants money and that in reality they are instead seeking somehow to obtain a net monetary advantage at the government's expense. But there is every reason to take at least plaintiff Armev at his word on this point. The monetary value of the HI benefit he wants to relinquish is not even partially offset by any monetary benefit. In terms of money at least, prevailing on the case would be a pure loss for Armev.

The situation is slightly more complicated for plaintiffs Hall and Kraus, but there is good reason to credit, or at least hold them to, their altruistic posturing as well. They argue that, if they were allowed to disenroll from the HI program, then they could resume getting tax deductions by contributing to HSAs. There are at least two reasons, however, why that argument does not demonstrate injury in fact.

First, Hall and Kraus may be wrong about the tax deduction.¹² Section 223 of the Internal Revenue Code disallows any deduction “for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.” 26 U.S.C. § 223(b)(7). Plaintiff Hall’s and Kraus’s first hurdle is that they must read “entitled” in that provision to mean something different than what “entitled” in 42 U.S.C. § 426(a) means, since even under their view they will remain “entitled” within the meaning of section 426. They need to read section 223’s “entitled” to mean something like what plaintiffs call “enrolled.” For present purposes, we assume *arguendo* that Hall and Kraus are right about the tax code at least on this first point.¹³ Even so, plaintiffs have now been within the

¹² Whether they are right or wrong about the tax deduction is not an issue that can or should be definitively determined in this action. To the extent that Hall’s and Kraus’s ability to show injury in fact ends up turning on the ability of this Court to give them a declaratory judgment that they will be entitled to a tax deduction if they prevail in this case, their standing would be precluded because the Court lacks power to grant such relief. The Declaratory Judgment Act is subject to an express “except[ion] with respect to Federal taxes.” 28 U.S.C. § 2201(a); *see Bob Jones University v. Simon*, 416 U.S. 725, 732 n.7 (1974) (tax exception to the Declaratory Judgment Act demonstrates the “congressional antipathy for premature interference with the assessment or collection of any federal tax”). To the extent, if any, that this action is a disguised attempt by plaintiffs Hall and Kraus to obtain a declaratory judgment against the non-party Commissioner of Internal Revenue that those plaintiffs will be entitled to a tax deduction if they prevail against defendants, the tax exception to the Declaratory Judgment Act precludes such relief. By the same token, the government is not seeking a declaratory judgment about what the Internal Revenue Code means or providing in this brief any official construction of the Code by the non-party Internal Revenue Service.

¹³ The heading of 26 U.S.C. § 223(b)(7) refers to “Medicare eligible individuals” (emphasis added), which is worse for plaintiffs’ position than the statutory text’s “entitled.” On the other hand, the IRS has used “enrolled” in referring to this
(continued...)

HI program in both an “entitled” and (to the extent there is a difference) “enrolled” sense, and the text of the statute does not say that this limitation on deductibility can be turned off. The statute prohibits a deduction “for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter,” 26 U.S.C. § 223(b)(7), whereas Hall and Kraus need to interpret the provision as if it continued on with language such as “. . . for each month thereafter that such individual remains entitled to such benefits.”¹⁴ It would hardly be outlandish to take Congress literally on this point that becoming entitled to Medicare (no matter what “entitled” means here) triggers an irreversible change in the landscape of what is, after all, in part a tax-deferred savings plan. Section 223 itself already contains another such trigger expressly linked to the hospital benefit statute, as the tax penalty for distributions not used for qualified medical

¹³(...continued)

limitation, which would be somewhat better for plaintiffs’ position if their merits argument did not so totally discount the value of sub-regulatory agency interpretations. I.R.S. Notice 2004-50, 2004-2 C.B. 196 (“otherwise eligible individual under section 223(c)(1)” who is “eligible” for Medicare but “who is not actually enrolled in Medicare Part A or Part B may contribute to an HSA until the month that individual is enrolled in Medicare”); I.R.S. Notice 2008-59, 2008-29 I.R.B. 123 (taxpayers “eligible for,” but not “enrolled in,” Medicare may take deduction if otherwise eligible to do so). As we note in the merits section of the argument, there are indeed elements of the Medicare program in which persons can be “eligible” for Medicare but not yet “enrolled” in Medicare, *e.g.*, 42 U.S.C. §§ 1395*i*-2, 1395p. Plaintiffs’ entitlement to Part A benefits, however, does not turn on such enrollment.

¹⁴ By contrast, the subsection of section 223 that addresses general eligibility rather than this more specific limitation does allow for resumption of eligibility after a spell of ineligibility because of participation in certain health insurance programs. 26 U.S.C. § 223(c).

expenses becomes permanently and irreversibly inapplicable “after the date on which the account beneficiary attains the age [65] specified in section 1811 of the Social Security Act [42 U.S.C. § 1395d].” 26 U.S.C. § 223(f)(4)(C). It is not unusual with respect to this or any other tax-deferred savings vehicle that Congress would expect that at some age withdrawals will and should begin to predominate over further contributions.

Second, even if Hall and Kraus could regain tax preferred treatment under section 223, the value of a mere tax deferral or even tax deduction is likely dwarfed by the value of the premium-free hospital insurance their prior taxes have already earned them. In any given year, of course, *ex post* the monetary value of hospital insurance may end up being zero (if one is fortunate enough not to enter the hospital), but (and especially for senior citizens) it might also turn out to be worth tens or hundreds of thousands of dollars. Thus, especially in light of plaintiffs’ website, we do not understand plaintiffs Hall and Kraus to be contending that the value of a tax deduction is more than the *ex ante* risk-adjusted expected value of free hospital insurance. They do not claim that they are trying to gain a net monetary advantage at the expense of the federal fisc. Rather they contend that they have other non-monetary injuries from getting the free hospital insurance – the alleged injuries to privacy and choice and quality of care – and that the tax deduction partially offsets the monetary value of the insurance and ought at least be available to them if, for those other reasons, they relinquish the insurance. We have already shown, however, that those other reasons do not supply injury in fact.

A tax deduction that only partially offsets the monetary loss of the value of the hospital insurance does not result in net monetary gain to plaintiffs. Therefore Hall and Kraus have not shown that they have sustained a monetary injury in fact, only that (assuming they are right about the deduction's availability) the monetary benefit in fact they have sustained is not as great as it might appear if tax consequences were not considered.¹⁵

As with the other elements of alleged injury, it is clear enough that there is no financial injury in fact to plaintiffs that defendants' cross-motion for summary

¹⁵ Plaintiffs may contend that they are not so much giving up any hospital insurance as they are in part shifting costs from the Medicare program to the FEHB program. But any such contention would be belied by plaintiffs' boldface argument that it is defendants' position that "will endanger the FEHB program for all Federal employees." Pls' SJ Mem. at 7 (emphasis omitted). Given this assertion, plaintiffs cannot be understood as claiming that they are seeking to secure a net financial advantage from the federal government for themselves by shifting costs to the FEHB and thus, in part, to the very federal employees and annuitants that they instead proclaim themselves to be protecting. As the Aetna plan that plaintiff Kraus uses explains: "When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down." Aetna Health Fund, 2010 FEHB Brochure at 124 (available at <http://custom.aetna.com/fehbp/index.php>).

In any event, having both hospital insurance under the Social Security Act and FEHB coverage can result in greater reimbursement than either insurance would provide standing alone, since the secondary payer (FEHB) may cover the deductibles and co-insurance payments that an insured would incur under only one plan. *See id.* at 123 ("When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor"); Blue Cross Blue Shield, Federal Employee Benefit Program, 2010 Service Benefit Plan Brochure at 119 (available at <http://www.fepblue.org/index.html>) (Armey's Blue Cross FEHB plan waives certain inpatient hospital co-payments for those who have Medicare Part A).

judgment should be granted. However, at the very least, before addressing plaintiffs' motion for summary judgment on this point, the Court should permit defendants to take basic discovery as to any financial injury plaintiffs may be asserting. Neither Hall nor Kraus sets forth even basic facts that would enable a precise calculation of the relative value to them of any deduction and hospital insurance, and defendants' outstanding interrogatories begin to seek information on those points. Kraus Interrogatories ## 1-4; Hall Interrogatories 1-2, 10.

II. Because Plaintiffs Are Both Entitled To Old-Age Insurance Benefits Under The Social Security Act And Are Age 65 Or Older, They Are Also Entitled To Hospital Insurance Benefits Under The Social Security Act

a. Comparison Of Premium And Non-Premium Based Hospital Insurance Benefit Provisions

Section 226 of the Social Security Act provides that anyone who has attained the age of 65 and who is entitled to old-age or survivors insurance benefits under section 202 of the Social Security Act "shall be entitled to hospital insurance benefits." 42 U.S.C. § 426(a). Plaintiffs meet those requirements and are therefore entitled to hospital insurance benefits. Plaintiffs, however, would read section 226 as if those two requirements conferred merely a status of eligibility for hospital insurance benefits that would not bloom into full-fledged entitlement until activated through enrollment or, alternatively, that could be deactivated through disenrollment.

Congress knows how to write such a provision. In fact, with respect to hospital insurance benefits themselves, Congress did write such a provision, section

1818 of the Social Security Act, 42 U.S.C. § 1395i-2. But that's not the provision that applies to plaintiffs, and the contrast with the provision that does apply to plaintiffs is telling and fatal to their claims.

Section 1818 applies to persons who, like plaintiffs, are 65 or over; who, unlike plaintiffs, are not entitled to Social Security benefits and who do not meet any other requirement for being entitled to HI benefits; but who do meet other specified criteria.¹⁶ For those individuals, Congress carefully delineated that they are "eligible to enroll" in the hospital insurance program, and that, if they enroll, then they become "entitled" to hospital insurance benefits. 42 U.S.C. § 1395i-2(a).

Unlike section 1818, the section that applies to plaintiffs does not start by delineating a universe of persons "eligible" for the program, then specify how they may choose or choose not to "enroll," and provide that then and only then are they "entitled" to the benefit. For persons like plaintiffs, section 226 provides that they are entitled to the hospital insurance benefit. Period.

b. What Enrollment Provisions Do
(And Aren't Needed To Do Here)

Defendants recognize that section 226 is unusual as insurance programs go in not having provisions regarding enrollment, disenrollment, and re-enrollment. But it is also unusual in not having any requirement for paying premiums.

¹⁶ The other criteria are 1) enrollment under Part B of Medicare and 2) either citizenship or five years continuous residence in the United States by an alien lawfully admitted for permanent residence.

That is no mere coincidence. Premium requirements and enrollment provisions tend to go together because control over who among those eligible for insurance benefits is actually enrolled secures the insurer (and other fellow or prospective members of the insured pool) against opportunism and adverse selection. It would in many instances defeat the point of insuring against the unknown if persons could defer enrolling in a health insurance program and not pay any premiums until the moment the need for insurance was known; then be able to enroll instantly by calling from the taxi on the way to the doctor's office or the ambulance on the way to the hospital; then disenroll afterwards to avoid ongoing premiums; re-enroll the next time health care is needed; and keep repeating the cycle. The most extreme cases of such behavior would to some degree be deterred by transaction costs, but to a considerable extent many insurance programs requiring premiums could still be plagued by adverse selection or opportunistic behavior if they placed no limits on moving on or off the rolls. At the other extreme from enrollment policies allowing call-from-the-ambulance opportunistic behavior, a decision not to enroll, or to disenroll, at a given age, say age 65, could be made forever binding on the person who makes that choice, so that even thirty years later, the different person one has become would not get a second chance, no matter how life's circumstances have changed, to re-enroll. *See, e.g., Lexington-Fayette Urban County Government v. Johnson*, 280 S.W.2d 31 (Ky. 2009) (sustaining provisions making opting out of health insurance plan irreversible, in part because of plan's interest in avoiding adverse selection).

Some health insurance programs operate between the extremes. They do not offer instantaneous enrollment, disenrollment, and re-enrollment. But nor is a forgone opportunity to enroll or a hasty decision to disenroll eternally preclusive. Programs that adopt a middle-ground approach therefore use such enrollment policies as limited-period “open seasons,” definitions of what life events authorize a new enrollment election, or waiting periods for enrollment or re-enrollment to take effect. *See, e.g., McGowan v. Shalala*, 135 F.3d 531, 532-35 (7th Cir. 1998). As Judge Easterbrook explained in the context of premium-based Medicare Part B, “[t]o prevent people from waiting until they become ill and then seeking immediate coverage without contributing while healthy . . . Congress established waiting periods.” *Id.* at 533. The same basic framework of enrollment provisions used in Medicare Part B applies to persons who, unlike plaintiffs, do have to pay a premium in order to become entitled to HI benefits. 42 U.S.C. § 1395i-2(c).

By contrast, with respect to plaintiffs and others who become entitled to the HI benefit without paying premiums, those concerns do not apply, and a process for enrollment, disenrollment, and re-enrollment is therefore unnecessary. It is no accident that the Secretary’s regulation – regulation, not POMS – about who “must enroll for hospital insurance” ties the requirement for enrollment directly to the obligation to pay a premium. 42 C.F.R. § 406.6(e) (“*Individuals who must enroll for hospital insurance*. An individual who must pay a monthly premium for hospital insurance must enroll”) (italicization of heading original).

The HI benefit program as it applies to plaintiffs and others who do not need to pay a premium may be atypical of insurance programs that usually have both premium requirements and enrollment provisions. But it is like other programs in which protection against unpredictable hazard is provided without regard to whether a premium is paid. No one has to “enroll” to receive police or fire protection from the government. There is no procedure for disenrollment either, not even for anyone whose sensibility recoils at being so warded by the state.¹⁷

c. Costs Of Establishing Enrollment Procedures

While creating an enrollment process for people like plaintiffs who are automatically qualified for hospital insurance benefits has no discernible benefit, it would have considerable costs. It may seem simple to say that people can go about enrolling, disenrolling, and re-enrolling. But, in a program as large as the hospital insurance program, setting up a system for such enrollment and keeping track of who was or was not enrolled at any given moment would add up. To accommodate the handful of people who, like plaintiffs, would want to opt out of the premium-free insurance, defendants would need to disrupt and rearrange their business processes, and make costly changes to their computerized systems.¹⁸ In light of

¹⁷ This lack of any enrollment or disenrollment process is not entirely due to some intrinsic nature of such services rather than to the lack of a premium. Private security firms that charge premiums for services may limit to whom those services are provided through enrollment procedures. *See, e.g.*, <http://www.broadviewsecurity-home.com/?code=789403> (last visited, May 20, 2010).

¹⁸ The facts in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. (continued...))

plaintiffs' lawsuit, defendants created a joint task force to consider the potential cost of creating an enrollment and disenrollment process and concluded that the cost would exceed \$100 million. Declaration of Terry M. Stradtman. Those costs far exceed any conceivable benefit.

d. Plaintiffs' Ahistorical Interpretation Of Section 226

Plaintiffs try to avoid the telling comparison between premium- and non-premium based hospital insurance – between section 226 and 1818 of the Social Security Act – by making a different comparison, between the old-age and survivors insurance benefit and the hospital insurance benefit, between section 226 and section 202.

¹⁸(...continued)

2008), a case involving the same defendants, illustrate how complicated it can be to deal with something that sounds like it ought to be simple, in that case matching up data on entitlement to supplemental security income and data on, what is also at issue here, entitlement to hospital insurance. Given the number of different purposes for which such data needs to be tracked and the number and variety of computer programs that may need to “call” such data, defendants have an interest in not needlessly complicating and changing their processes, databases, and systems. This Court explained, for example, how the Social Security Administration's understandable need to deal with some exceptional cases in its Supplemental Security Income program caused it to make changes in one database for those intended purposes that ended up leading to unintended errors calculating hospital reimbursement. *See id.* at 27-28. Making exceptions for plaintiffs and a few other individuals may similarly create unanticipated errors or problems in other parts of the systems defendants operate. The point is not that such errors cannot possibly be avoided, but that making sure they are avoided may be time consuming and place needless demands on the agencies' finite resources.

Plaintiffs argue, and on this point they are correct, that section 202, 42 U.S.C. § 402, provides that in general one can only become entitled to old-age or survivors insurance benefits by filing an application for them. Pls' SJ Mem. at 8-10.

Plaintiffs then argue that section 226, 42 U.S.C. § 426, likewise requires that one make an application for HI benefits, that what we have been discussing as an entitlement predicated on only two conditions (being entitled to old-age or survivors insurance benefits and turning 65) actually is predicated on a third condition, namely filing an application for HI benefits. Pls' SJ Mem. at 10-11. Plaintiffs' argument ignores the history of how section 226 has been amended over the years and consequently misreads and misunderstands that section.¹⁹

We have to this point been focusing on persons, like plaintiffs, who are entitled to hospital insurance benefits because they are both 65 and entitled to Social Security benefits. But section 226 actually confers eligibility on four other categories of persons as well. In terms of the statutory text, whether an application is required for the fourth and fifth of the five categories is utterly clear. An application is clearly required for the category described in subparagraph (a)(2)(C);

¹⁹ Even if plaintiffs were right that they were required to file an "application," it would not follow that they were either required to enroll or that they are now or ever entitled to disenroll. For the reasons stated in the prior section, only premium-based HI "eligible" persons are required to "enroll" in order to transform their eligibility into entitlement. *See also* 42 C.F.R. § 406.6 (distinguishing among those "who need not file an application"; who "must file an application"; and who "must enroll"). Thus, the requirement of filing an application is simply not synonymous with enrolling and offers no lever at all to create a right of disenrolling.

it is equally clear that no application is required for the category (qualified railroad retirement beneficiaries 65 or over) described in subparagraph (a)(2)(B).

The arguably more difficult question is whether an application is required for three categories of entitlement, of which plaintiffs are in the first, that were enacted into law at different times but are now codified together in subparagraph (a)(2)(A). There is a requirement at the end of subparagraph (a)(2)(A), set off by commas, that one must, *inter alia*, “file[] an application . . .” If -- a big if as it turns out -- one ignores how that provision accreted over time, there might be three possible readings of the provision. The Secretary’s interpretation, 42 C.F.R. § 406.6, is that the comma-set-off “file an application . . .” requirement reaches back to the second category but not to the first. Plaintiffs’ reading is that the application requirement applies to all three of the preceding categories, and thus applies to the first category (which covers plaintiffs). The application requirement might also be thought to apply only to the immediately preceding of the three categories set out in subparagraph (A), but neither side reads the statute that way.

The history of how the statute came into being makes it evident that the Secretary’s interpretation makes the most sense. Here’s how the current statute came to be:

First, in 1965, came the first category, which covers plaintiffs (and the fourth category, which later was moved to its own subsection):

- a) Every individual who —
 - (1) has attained the age of 65, and

(2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary, shall be entitled to hospital insurance benefits under part A of title XVIII 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).

Social Security Amendments of 1965, Pub. L. 89-97, § 101, 79 Stat. 286, 290. There was no requirement (at least no express requirement) for filing an application.

Second, in 1980 Congress added what we have called the second category and the requirement – in the Secretary’s view only with respect to that new category -- for filing the new application. We show the section as amended in 1980 with the new language in italics.

a) Every individual who —
(1) has attained the age of 65, and
(2) is entitled to monthly insurance benefits under section 202, *or would be entitled to those benefits except that he has not filed an application therefor (or an application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor) and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,* or is a qualified railroad retirement beneficiary, shall be entitled to hospital insurance benefits under part A of title XVIII 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).

Pub. L. 96-473, § 2(a), 94 Stat. 2263, 2263.

Third, in 1981, Congress added what we have been calling the third category, the new 1981 language now shown in bold, the 1980 language still in italics, and the original 1965 provision still in plain text:

(a) Every individual who —
(1) has attained the age of 65, and

(2) is entitled to monthly insurance benefits under section 202, *would be entitled to those benefits except that he has not filed an application therefor (or an 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 title XVIII, or is a qualified railroad retirement beneficiary, shall be entitled to hospital insurance benefits under part A of title XVIII 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).

Pub. L. 97-35, tit. XXII§ 2203(e), 95 Stat. 357, 835.

Finally, in 1982, Congress again amended section 226(a)(2), redesignating the existing provisions as subparagraph (A); striking “or is a qualified railroad beneficiary” from subparagraph (A) and moving it to a new subparagraph (B); and also creating the new subparagraph (C). Pub. L. 97-248, § 278(b)(2)(A), 96 Stat. 324, 560.

With that history in mind, the good common sense of the Secretary’s construction of the statute becomes quite apparent. The original 1965 provision, which is what applies to plaintiffs, had no requirement to file an application. The 1980 amendment added the italicized category of entitlement for those who would have been entitled but for not having filed an application for “monthly insurance benefits”; the italicized filing requirement was directly relevant to that circumstance, so the Secretary rightly construed it as continuing to apply to the italicized second category even after the 1981 interpolation of the boldfaced third

category. But neither the 1980, nor the 1981, nor the 1982 amendments give any reason whatsoever to believe that Congress had, or that the Secretary should, revisit the 1965 decision of Congress not to require a separate application for HI benefits from those who were entitled to old-age or survivors insurance benefits.

Plaintiffs' position that a senior citizen must affirmatively request hospital insurance benefits before he can receive them, Pls' SJ Mem. at 11, also fails the test of practicality. For every rare person who, like plaintiffs, for some reason does not want entitlement to hospital insurance to begin, there are likely a hundred who would want that insurance but who will fall through the cracks because they do not know that an application is even necessary. The contrast here between hospital insurance and old-age insurance benefits is telling. For old-age insurance, someone who does not submit an application as soon as he becomes eligible may lose months or years of benefits, but gains greater per-month benefits by deferring an application. Whether and when to apply is thus a decision that needs to be made by individuals depending on their circumstances. By contrast, missing the earliest opportunity to be entitled for hospital insurance benefits would not result in any greater benefit when one finally did become entitled. Plaintiffs' proposed revision of the statute would do a disservice to senior citizens who would miss the new application requirement plaintiffs would impose.

Given the history and the evident purpose of the statute, the Secretary's is easily the most sensible reading of section 226(a). But, of course, it should be upheld as long as it is at least one permissible reading of the statute:

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 on 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. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984). The Secretary, by regulation, has interpreted the statute as not requiring an application in plaintiffs' circumstances. 42 C.F.R. § 406.6(b), *sort of quoted*, Pls' SJ Mem. at 17.²⁰ The Secretary's interpretation of the statute, as embodied in the regulation, is a permissible reading of the statute that is clearly consistent with the original and abiding intent of Congress.

e. Plaintiffs' Confusion Of Cause And Consequence

Plaintiffs argue that if they wish to avoid being entitled to their hospital insurance benefits, they can do so only by relinquishing their old-age insurance

²⁰ Plaintiffs set out the first three subsections of this section, which they argue is a "regulation[] of the Commissioner of SSA" that they identify as "§ 406 of Title 20 C.F.R." This hits a long-odds trifecta of error. The quoted provision is a regulation of the Secretary; it is in title 42; and the section number is 406.6.

Plaintiffs get much of the text of those three subsections right, although they did insert commas to set off "Part A" in the first line, change a period to a comma at the end of paragraph (b)(1), change the cross-reference in paragraph (c)(1) from § 406.11 to § 406.13, omit italics from two of the three subsection headings, and add italics to the heading of paragraph (b)(1).

benefits, and that that can't be right because "Congress actually enacted a statute dictating how and under what circumstances an individual may lose his or her Social Security benefits," Pls' SJ Mem. at 12, and "refusing to enroll in Medicare, Part A" isn't on that list, *id.* (heading-emphasis and -capitalization omitted); *see also id.* at 9-10, 16-18, 38-39.

That confuses cause and consequence. Being or not being entitled to HI benefits is not a cause, a pre-condition, defeasing condition, or any other requisite of being or not being entitled to retirement benefits. Being entitled to HI benefits is a consequence of being entitled to old-age insurance benefits and having attained age 65, not a means for avoiding or reversing either of those statuses.

Here is a variation of plaintiffs' argument with the same logical structure that may make its flaws more apparent. Suppose a taxpayer wishes to disenroll from filing a married status return and to resume checking single status. He asks the IRS if he can do that, and the IRS tells him, not as long as you're married, sir. The taxpayer argues that this means that the IRS is penalizing him by ending his marriage if he chooses not to participate in filing as married; that there are statutes defining the grounds for dissolving a marriage (desertion, cruelty, irreconcilable differences . . .); that not choosing to file a married return is not on that list; that Congress has not given the IRS any authority whatsoever to dissolve the marriages of single-status-choosing filers; and that, Q.E.D., he must have an option whether to file a married or single return.

That argument does not work. Neither does plaintiffs'. Being married or being entitled to old-age insurance benefits are statuses that have consequences attached, that come with the territory. Those consequences can be avoided by ending the statuses, but the ending of a consequence is not a means of ending the status and would not be expected to be on some list, statutory or otherwise, of the grounds for ending the status.²¹

f. The Unimportance Of The POMS
And The Importance Of The POMS

Plaintiffs discuss some internal agency instructions, the POMS, quite a bit. The POMS say what this brief has been saying, that there is no provision by which someone who has become 65 can become disentitled to HI benefits as long as he is entitled to old-age or survivors insurance benefits.²² Plaintiffs have a string of

²¹ Plaintiffs may respond that having to file a married-status return is a consequence of being married, but that here the question is whether being entitled to HI benefits is a consequence of being 65 or over and entitled to old-age insurance benefits. Quite so. Our point is not that this analogy proves one way or the other whether one entitlement is the consequence of the other. We merely explain why plaintiffs' cause-consequence-reversing argument adds nothing to the analysis. If plaintiffs are wrong about whether one entitlement follows from the other, that argument helps them no more than it would help the taxpayer in the analogy.

²² The POMS also note that in order to successfully withdraw a previously granted application for old-age insurance benefits, one must repay those benefits. The regulation providing that a withdrawal of an application for old-age insurance benefits requires repayment is 20 C.F.R. § 404.640(b). Plaintiffs do not challenge the validity of this regulation. Plaintiffs do say, however, that this regulation "does not address Medicare at all." Pls' SJ Mem. at 19 (emphasis omitted). But one would not expect a Social Security Administration regulation on this point to specifically address plaintiffs' particular motivation for withdrawing their Social Security benefits application any more than it would address any of the other

(continued...)

arguments about why the POMS are invalid, one premise of which is always that the POMS are inconsistent with the statute.

The only point that ultimately matters is whether the POMS are inconsistent with the statute. If plaintiffs are right about the statute, if they can be entitled to old-age insurance benefits without being entitled to hospital insurance benefits (as opposed to merely forgoing using the benefits, which plaintiffs are already free to do), then of course the POMS are invalid.²³

To be sure, the POMS may at least be relevant to that predicate question of what the statute does mean. For the reasons stated above, it is clear from the statute and regulations that entitlement to old-age or survivors insurance benefits automatically entails entitlement to hospital insurance benefits if age 65 has been attained. But if there were otherwise some doubt on the point, the POMS, while perhaps not entitled to full-fledged *Chevron* deference, would at least be entitled to a measure of deference as interpretations of the agencies' own statutory schemes and regulations. *Coeur Alaska, Inc. v. Southeast Alaska Conservation Council*, 129

²²(...continued)

myriad reasons why others might want to withdraw an application. The regulation tells anyone, regardless of their motive for requesting to withdraw a granted application, what conditions they must meet to effectuate a withdrawal.

²³ Other questions about the POMS may be relevant to whether there has been final agency action and whether administrative remedies must be exhausted. If those issues were under consideration, there would be no “of course” about the Court being able to reach out and invalidate any POMS whenever a statutory inconsistency is spotted. But, as noted above, this brief does not seek to revisit those threshold issues that this Court has already decided.

S. Ct. 2458, 2473 (2009); *United States v. Mead Corp.*, 533 U.S. 218, 234-38 (2001); see *United Seniors Ass'n v. Shalala*, 182 F.3d 965, 971-72 (D.C. Cir. 1999).

Plaintiffs' arguments that the POMS should be "given no deference whatsoever," Pls' SJ Mem. at 20 (heading), because they "are at variance with the statutes," *id.* at 21, or "create new rules out of whole cloth," *id.* at 22, beg the questions or presume the answers that, if otherwise doubtful, consideration of the POMS might help the Court resolve.

If the plaintiffs are wrong about the statute – if the Social Security Act does indeed make those 65 and over who are entitled to old-age or survivors insurance benefits also entitled to hospital insurance benefits and does not contain or require any procedure for separate disenrollment from the HI program – then there is no point to, or ground for, invalidating the POMS. The POMS do not cast some impenetrable shadow over the *United States Code* that could hide a statute that actually did require an enrollment and disenrollment process. If the statute plaintiffs seek is not there, removing the POMS will neither reveal it nor confer any other boon on plaintiffs.

It would, however, harm defendants to remove the POMS. These kinds of instructions are vital to agencies that have thousands of employees who must deal with hundreds of thousands of requests for information. See *Schweiker v. Hansen*, 450 U.S. 785, 789-90 (1981). Even where the POMS do not create policies but (as here) merely explain existing statutes and regulations to agency employees, that internal informational purpose is important. The agencies have an interest in

agency employees being able to find the answers they need to provide without “the next man in line growing a beard before being served,” *McGowan v. Shalala*, 135 F.3d 531, 533 (7th Cir. 1998). So agency employees, particularly lower-level employees who are generalists and must answer a wide variety of questions, need to be able to turn to something like the POMS as a resource.²⁴

Two circumstances here make it particularly important that the agencies be able to tell their own employees what the agencies think the statutes mean. First, requests like plaintiffs’ are not likely to be encountered with great frequency by most agency employees. An agency employee who may never before have encountered this question, and who may have had no reason to think she ever would, has a particular need to be able to look up the answer. Second, plaintiffs’ request would send that employee on a snipe hunt. It is a search for something (a way for someone who is entitled to old-age insurance to disenroll from hospital insurance) that cannot be found because it does not exist. It is only fair to the agencies, their employees, and the people behind plaintiffs in line for there to be some way to avoid a long, fruitless search. The POMS accomplish that.

²⁴ Some higher level agency employees, such as administrative law judges, may not need POMS to tell them what the statutes and regulations mean, particularly if there is briefing on those specific issues. The POMS are not binding on such employees.

g. Plaintiffs' Demand For Legislation

In its March 24, 2010, Order the Court noted that plaintiffs “at least for now” wanted to “avoid participation” in the HI program, March 24 Order at 2. That “at least for now” alludes to key unanswered questions about plaintiffs’ position.

If plaintiffs are right and there is a statute that requires a separate act of enrollment and allows disenrollment, what does that statute say? May plaintiffs disenroll, help themselves to an HSA tax deduction for a few months or years, then re-enroll for a few months if it looks like a hospitalization is in the offing, then disenroll and start back up with the tax deduction?²⁵ If someone withdraws at 65 and, when he reaches 75, has changed his mind, may he withdraw his withdrawal? If he changes his mind again at 85, can he re-withdraw? Does he have to wait a year for a change in enrollment to take effect? A month? A minute less than however long the drive to the hospital takes?

Those kinds of questions are not inherently unanswerable. Where Congress did intend to create means to enroll or disenroll in premium-based Medicare, it did address such kinds of questions, in part directly and in part by authorizing the Secretary to issue regulations. *E.g.*, 42 U.S.C. §§ 1395i-2(b), (c); 1395p.

²⁵ As argued above, the Internal Revenue Code seems to take care of the potential problem of taxpayers gaming the system by making the loss of a deduction permanent after one is first entitled to Medicare. But, as also noted above, plaintiffs do not read the Internal Revenue Code that way. On plaintiffs’ view of the Internal Revenue Code, protection against such gaming of the tax system would instead have to be contained in plaintiffs’ hypothetical Medicare enrollment provisions.

But, as there is no premium paid for plaintiffs' coverage, Congress had no need to answer or address those questions here and did not do so. Plaintiffs do not answer those questions either (hence the Court's puzzled "at least for now" in the May 24 Order). The Court would be exceeding its role if it were to legislate answers on such points.

By process of elimination that leaves creating answers to those questions up to defendants. Yet plaintiffs argue that the defendants also cannot "take it upon themselves to 'legislate' by promulgating and enforcing" rules or to "change the eligibility requirements of Social Security and Medicare." Pls' SJ Mem. at 25.

Defendants may predictably take a broader view of their rule-making authority as a general matter. But as a particular matter, 42 U.S.C. § 426 does not set forth a process for enrolling, disenrolling, and re-enrolling, and also does not expressly authorize the Secretary to issue regulations on such points. This is, again, in contrast to other parts of the Medicare program, where Congress not only gave general answers to the questions concerning enrollment periods, but also expressly authorized the Secretary to issue regulations. *E.g.*, 42 U.S.C. §§ 1395i-2(b); 1395p(a). Whether the Secretary could seize upon her more general rule-making authority to create an enrollment process and decide how it would work might best be left for a case presenting that question. At a minimum, the Social Security Act does not require the Secretary to legislate an enrollment system that Congress did not choose itself to enact; that the Secretary has not deemed advisable; that would cost more than a \$100 million to create; and that would serve little

or no discernable purpose (unless creating a means of gaming the tax system counts as a purpose). Creating such a system that required affirmative action to begin entitlement to hospital insurance benefits (Pls' SJ Mem. at 11) would also deprive senior citizens who will fail to comply with that new enrollment requirement of the hospital benefits to which, under the statute that Congress wrote and that the Secretary has faithfully and correctly interpreted, they are entitled.

Conclusion

For the reasons stated above, plaintiffs' motion for summary judgment should be denied and defendants' motion for summary judgment should be granted.

Respectfully submitted,

TONY WEST
Assistant Attorney General

RONALD C. MACHEN
United States Attorney

SHEILA M. LIEBER
Deputy Branch Director

/s/ Brian G. Kennedy
BRIAN G. KENNEDY (D.C. Bar No. 228726)
United States Department of Justice
Civil Division
Federal Programs Branch
20 Massachusetts Ave., N.W.
Washington, D.C. 20530
Tel.: (202) 514-3357 Fax: (202) 616-8470
Email: Brian.Kennedy@usdoj.gov