

- **They have attained age 65 and are entitled to benefits under Medicare, Part A.**
- **They enrolled in health plans under the Federal Employees Health Benefit program that will cover their health care needs for the remainder of their lives.**
- **They want the freedom to determine their own health care choices.**
- **They do not want Medicare, Part A, and want to disenroll from Medicare, Part A.**
- **They wish to continue receiving their monthly benefits from Social Security.**

The Defendants do not contest any of these facts. In their Statement of Material Facts supporting their Motion for Summary Judgment, the Defendants assert the same facts concerning the Plaintiffs' entitlement to Social Security and Medicare, Part A, and the same facts that the Plaintiffs chose FEHB plans.

For purposes of their Motion for Summary Judgment, the Defendants concede that the Plaintiffs do not want Medicare, Part A, **but** the Defendants do not concede that fact for purposes of Plaintiffs' summary judgment motion. *Defendants' 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 ("Def. Mem.")*, 6. The Defendants apparently believe that they can change the Plaintiffs' minds if they are granted discovery.

As to the fact that the Plaintiffs want to continue to receive their Social Security monthly benefits, the Defendants make no comment. The Defendants never mention (and do not contest) the fact that the POMS prohibit the Plaintiffs from avoiding enrollment in, or disenrolling from, Medicare, Part A, unless they forego all future Social Security monthly benefits and repay those they have received to date. Instead, the

Defendants seek to resurrect standing issues that are no longer present in this case. The Defendants also seek to interject policy and financial considerations concerning the administration of the Medicare program in an effort to demonstrate that a ruling in favor of the Plaintiffs would wreak havoc with the system currently in place.

The standing issue was resolved by this Court on September 29, 2009. The potential financial and administrative burdens that allegedly could occur if the POMS are invalidated has no bearing on the standing issue or on the merits of this case.

Neither the DSMF that they claim support their case, nor their quibbles with the *Plaintiffs' Statement of Material Facts To Which There Is No Genuine Issue* ("PSMF"), provide any reason for the Court to avoid the key issue before it – are the POMS valid as being supported by the underlying Social Security and Medicare statutes? The Defendants' policy-based arguments for avoiding that issue must fail.

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

Plaintiffs, by their undersigned attorneys, pursuant to Local Rule 7(h) and Rules 56 and 56(f), Federal Rules of Civil Procedure, hereby respond to *Defendants' Statement of Material Facts As To Which There Is No Genuine Issue* ("DSMF").

Paragraphs 1 through 10 of the Defendants' Statement of Material Facts establish that the Plaintiffs HALL, KRAUS, and ARMEY are all of an age and of a status that "entitles" them to receive Social Security monthly benefits and "entitles" them to participate in Medicare, Part A. Those paragraphs further establish that each of those three Plaintiffs are participants in Federal Employees Health Benefits programs. Plaintiffs have asserted the same facts in support of their Motion for Summary Judgment.

In the brief in support of their Motion for Summary Judgment, the Defendants further concede that each of the Plaintiffs would not have enrolled in, and would disenroll from, Medicare, Part A if a process were available to do so. *Def. Mem.*, 6. While the Plaintiffs agree with the Defendants that the Plaintiffs do not want Medicare, Part A, the Defendants will only concede that issue for purposes of the Defendants' Motion for Summary Judgment and not for purposes of the Plaintiffs' Motion for Summary Judgment. *Def. Mem.*, 6. This, apparently, is due to the Defendants' belief that, if Defendants can engage in discovery, they can convince the Plaintiffs of the "error of their ways" and can "educate" them of their true desire to have Medicare, Part A. *See* DSMF 3 and *passim*. Whether the Plaintiffs need such an education, or can be convinced to change their minds, is not a material fact and is not a genuine issue that needs to be addressed by the Court.

In paragraphs 11 through 13 of the Defendants' Statement of Material Facts, Defendants assert, as to each of the Plaintiffs HALL, KRAUS, and ARMEY, that none of them have identified hospitals which they would choose to treat them, "but [which] will not treat him if he does participate in Medicare, Part A." The Defendants, elsewhere, contend that they need discovery concerning the Plaintiffs' preferred hospitals and concerning the care dispensed by those hospitals. No such discovery is needed. The Plaintiffs' hospital preferences are not material facts that can impact the issue in this case – "Are the POMS valid?" Whether the Plaintiffs or the Defendants are correct on that issue, the facts concerning the Plaintiffs' hospitals of choice will be immaterial.

Similarly immaterial is Defendants' assertion in paragraph 14 of the Defendants' Statement of Material Facts that the Plaintiffs contend that "creating the program they

seek to permit disenrollment would save the government money.” Nowhere in the pleadings in this case have the Plaintiffs ever made such an assertion and, certainly, the Plaintiffs have not sought to “create a program.” The only financial consequences to the Plaintiffs that are material in this case are the consequences that flow from the POMS which dictate that an individual may not withdraw from, or avoid, Medicare, Part A, without sacrificing all Social Security monthly benefits and repaying those benefits that previously have been received. The dictates of the POMS and the Plaintiffs’ desire not to lose their Social Security benefits are the material facts, and the validity of the POMS is the issue presented in this case.

Finally, Defendants assert that “creation” of the “system” that the Plaintiffs seek would cost in excess of \$100 million. DSMF, ¶ 15. Disregarding the fact that this assertion is based on the unsubstantiated Declaration of Terry M. Stradtman concerning the proceedings, deliberations, and conclusions of an unidentified “working group,” any costs to the government that may result from adherence to the law and the proper interpretation of the Social Security and Medicare laws cannot be considered by the Court. If the POMS are invalid, then the cost to the government of properly administering the law has no bearing on the outcome of this case.

The elements of the Defendants’ Statement of Material Facts that actually are material to the issues before the Court are not in dispute. Those are the statements of fact in paragraphs 1-10 of the Defendants’ Statement of Material Facts. The other “facts” propounded by the Defendants, according to Defendants, would establish either that the Plaintiffs are misguided or that a solution is too expensive. Neither of those sets of facts presents an issue that needs to be decided. The resolution (or lack of resolution) of those

sets of facts will not assist the Court in evaluating the validity of the POMS, and will not support the entry of a judgment for either the Plaintiffs or the Defendants.

THE DEFENDANTS' OBJECTIONS TO THE PLAINTIFFS'
STATEMENT OF FACTS MUST BE DISREGARDED

As noted previously, the key facts concerning the Plaintiffs are not in dispute. The Defendants, however, have latched on to some of the background facts recited in the Plaintiffs' Declarations which the Defendants maintain raise issues of fact. The Defendants do not focus on these background facts in order to establish that there are disputed facts that must be resolved before the case is appropriate for summary judgment. Rather, the Defendants suggest that these particular facts, if further explored through discovery, could establish some basis for overturning the Court's ruling on standing.

By referencing the commonly understood rubric that standing must exist at all stages during a case, the Defendants attempt to revisit standing arguments in areas that were not resolved by the Court and did not need to be resolved. The Court's ruling on standing is narrowly focused and recognizes the Plaintiffs' injury-in-fact that will remain throughout the life of this lawsuit:

Conversely, Messrs. Kraus, Armev, and Hall have applied for and are receiving monthly Social Security benefits and wish to continue to do so; however, they wish to opt-out of Medicare Part A. Assuming that the POMS prevent them from declining Medicare Part A while receiving the monthly benefits to which they are entitled, it appears Plaintiffs have a redressable injury and, thus, standing to pursue this claim.

Hall v. Sebelius, 2009 WL 3088821 (D.D.C. Sept. 29, 2009).

The Court did not base its ruling on the Plaintiffs' privacy concerns or financial and quality of care concerns. Nevertheless, the Defendants apparently believe that those concerns still present viable areas of inquiry: "they [Plaintiffs] 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.” *Def. Mem.*, 9.

Ignoring the Court’s clear ruling that the threatened loss of Social Security monthly benefits suffices to establish the Plaintiffs’ standing, the Defendants spend in excess of twenty pages of their brief, and ten pages of their dissection of Plaintiffs’ Statement of Material Facts, in elaborating on what the Defendants perceive as the Plaintiffs’ privacy, financial, and policy bases for pursuing this lawsuit. While doing so, the Defendants never mention the Plaintiffs’ desire not to lose their Social Security benefits. In fact, the Defendants contend that the Plaintiffs have no financial injury: “Plaintiffs cannot possibly claim to be pursuing this case to advance their financial interest...” *Def. Mem.*, 2; “But plaintiffs can make no real claim of monetary injury in fact.” *Def. Mem.*, 16. The only financial injury that the Defendants are willing to recognize is the alleged costs to the government if the POMS are invalidated.

The Defendants’ contentions as to the perceived concerns of the Plaintiffs which would necessitate discovery do not require any response. Those alleged concerns do not present material areas of factual dispute that must be resolved in order to grant summary judgment to the Plaintiffs.

The important financial concern of the Plaintiffs is the loss of their Social Security monthly benefits, not an argument as to whether they will spend their health care dollars better or worse under Medicare, Part A. The Plaintiffs’ desire not to be in Medicare, Part A, stems from a privacy interest based on their desire to control their own health care choices and not have the Government make any determination regarding

those choices. Whether their medical records will be more or less secure from invasion of privacy under Medicare is not a key factual issue. Whether Plaintiff, RICHARD ARMEY, can or cannot afford to repay Social Security benefits certainly is not a key issue in this case.

The Defendants suggest that discovery in all of these areas must be conducted and then the Defendants will have evidence to bolster renewed arguments on the issue of standing. DSMF, 9 and *passim*. Discovery will not alter the Plaintiffs' desire to retain the freedom to make their own health care choices, and discovery will not alter the POMS that mandate the forfeiture of Social Security monthly benefits by anyone who rejects or withdraws from Medicare, Part A. Thus, discovery will not, and cannot, change the factual circumstances that establish an injury-in-fact sufficient to establish standing.

The Defendants do not contest the essential characteristics of the Plaintiffs, as highlighted at the outset of this memorandum.¹ On those essential characteristics, Plaintiffs submit to this Court their Motion for Summary Judgment. Those characteristics establish the essential and material facts upon which the Court can base a ruling. The Defendants finally acknowledge this at the very end of their memorandum:

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.

¹ See pages 1 and 2, *infra*.

Def. Mem., 37 (footnote omitted).²

The Defendants' comments on the Plaintiffs' Statement of Material Facts do not create a dispute as to any material fact and do not establish the need for any discovery. Based on the material facts identified in the Plaintiffs' Statement of Material Facts, the Court can enter a ruling on the Plaintiffs' Motion for Summary Judgment. That ruling should be in favor of the Plaintiffs.

ARGUMENT

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

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

The Social Security and Medicare Acts are entirely voluntary, and neither incorporate sanctions against an individual who does not enroll in, or disenrolls from, the other, as do the POMS. The only route one may pursue to become "entitled" to Social

² The Defendants cite no statutory or regulatory provisions which allow a Medicare beneficiary not to use his or her Medicare benefits in order to obtain health care services. Clearly, a Medicare beneficiary cannot privately pay a physician for health care services under Medicare, Part B, **unless** that physician has filed with the Secretary an affidavit agreeing not to bill Medicare, Part B, for any health care services provided. 42 U.S.C. § 1395a(b)(3). *United Seniors v. Shalala*, 182 F.3d 965 (D.C. Cir., 1999). There are severe civil and criminal penalties for a Medicare provider privately contracting with a beneficiary. 42 U.S.C. §§ 1320a-7a; 1320a-7b. Plaintiffs are at a loss to figure out what Defendants rely upon in regard to Part A. Perhaps Defendants are arguing, once again, that 42 C.F.R. § 489.21 allows a beneficiary to pay for Part A services privately. The Defendants fail to cite that, or any other, regulation. Of course, 42 C.F.R. § 489.21 does not allow for private contracting for Medicare, Part A, health care services. Medicare, Part A, hospital services are "prospectively" paid under 42 U.S.C. § 1395ww; nursing facilities are prospectively paid pursuant to 42 U.S.C. § 1395yy. Part A providers are paid a lump sum based upon what they submit will be their total cost of providing care; they are not paid on a per service basis. Any provider that is prospectively paid and accepts private payments from Medicare beneficiaries will be subject to severe civil – and possibly criminal – penalties. 42 U.S.C. § 1320a-7a and 1320a-7b. As a practical matter, all Medicare beneficiaries sign requests for payment to be made to the provider upon admission to a hospital or other facility. If an individual refuses to sign such a request – or refuses to present his or her Medicare beneficiary card – he or she will be refused admission. To argue that a Medicare beneficiary may "not use the benefit" and still obtain health care services is absolutely absurd and contrary to the law. Medicare beneficiaries must use the benefit if they seek to obtain health care services.

Security monthly benefits is found in the Social Security Act itself, 42 U.S.C. §§ 401 *et seq.*

1. Entitlement to Social Security

According to 42 U.S.C. § 402, one must be a “fully insured individual” who “has attained age 62” and “has filed an application for old-age benefits or was entitled to disability insurance benefits.” Every individual who meets those requirements “**shall be entitled** to old-age insurance benefits for each month” There are no other conditions in 42 U.S.C. § 402. Nowhere does the Social Security Act in general, or 42 U.S.C. § 402 in particular, predicate “entitlement” to Social Security monthly benefits upon enrollment in Medicare, Part A. “**Shall be entitled**” in 42 U.S.C. § 402 does not mean “must be enrolled.”

2. “Entitlement” to Medicare, Part A

“Entitlement” to receive Medicare, Part A, benefits is much the same as “entitlement” to Social Security monthly benefits. An individual must attain the age of sixty-five (65) years and be “entitled” to Social Security monthly benefits; if those conditions are met, the individual “**shall be entitled**” to Medicare, Part A. It is clear that Congress did not make the obtaining of Medicare, Part A, benefits mandatory. “**Shall be entitled,**” for purposes of Medicare, Part A (42 U.S.C. § 426(a)), cannot have a different meaning from “**shall be entitled**” for purposes of Social Security monthly benefits (42 U.S.C. § 402). Those simple words control; no convoluted statutory construction offered by the Defendants saves them. Contrary to the arguments of the Defendants, the 1980 and 1981 amendments to 426 U.S.C. § 426(a) do not alter the meaning of the statute for purposes of the question *sub judice* one iota. *Def. Mem.*, 28-34. The words are still

“shall be entitled,” no matter what convoluted construction Defendants use to assert that they are not there. Congress did not amend those words to read: “must be enrolled.”

3. The Preamble Statute to Medicare

If the foregoing statutes are not enough to illustrate the voluntariness of Medicare, Congress underscored its intentions in a “preamble” statute. Congress asserted that nothing in the Medicare Act “shall be construed to preclude...any individual from purchasing or otherwise securing protection against the cost of any health care services.” 42 U.S.C. § 1395b. Nothing in the Medicare Act, as amended, has ever undermined that guarantee. Moreover, Congress has never included in the Medicare Act, or the Social Security Act, any provision mandating that an individual must apply for coverage under Medicare, Part A, or his/her Social Security monthly benefits, to which he/she would otherwise be “entitled,” would be denied. Why would Congress guarantee the free choice of health insurer if it intended to “force” everyone into Medicare, Part A?

4. Congress Enacted a Statute Governing How Social Security May Be Terminated

Congress actually enacted a statute dictating how and under what circumstances an individual may lose his or her Social Security monthly benefits. 42 U.S.C. §§ 402(n), (t), (y), (u), (v) and (x). No provision for the termination of benefits, much less the repayment of benefits to the Secretary, is found for individuals who simply do not want to become Medicare, Part A, beneficiaries. If Congress intended Social Security monthly benefits to be terminated if an individual chose to withdraw from Medicare, Part A, it would have provided the same explicitly. The Defendants cannot add another provision for the termination of benefits without statutory authority.

5. “Entitled” Does Not Mean “Required”

The word “entitlement” is not synonymous with “required.” “Entitle,” in its usual sense, means “to give a right; to qualify for; to furnish with proper grounds for seeking.” “Entitle” is synonymous with “eligible,” meaning “capable of being chosen” or “legally qualified.” *Black’s Law Dictionary*, Revised 4th Ed. Put another way, “entitlement” has been defined as “to give one a right to do or have something; allow; qualify.” *The American Heritage Dictionary of the English Language*, New York: American Heritage Pub. Co., 1970. Those very definitions have been applied by the courts to define “entitlement” for purposes of Medicare, the same as found in the aforementioned dictionaries. *Pent v. Social Sec. Dist. Office*, 1997 U.S.App. LEXIS 22775 (9th Cir., 1997); *Jewish Hospital Corp. v. Secretary Health and Human Services*, 19 F.3d 270 (6th Cir., 1994); *Fegner v. Heckler*, 779 F.2d 541, 543 (9th Cir., 1985). In *Laverett v. United States Bureau of Health and Human Services*, 2003 WL 21770800 (D. Colo. 2003) the court stated: “[N]othing in the Social Security system requires [an individual] to apply for and receive Social Security benefits.” If “shall be entitled” for purposes of Social Security is voluntary, is not “shall be entitled” as found in Medicare, Part A? To argue, as the Defendants do, that Medicare, Part A, is mandatory – and that Social Security monthly payments are subject to being denied if one does not accept Medicare, Part A – turns the term “entitled” into “required.” The Defendants have offered no argument – and could never develop one – that the word “entitled” means “required.” The POMS require, subject to severe penalty for non-compliance, what Congress made to be purely voluntary.

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

By the very reading of the Social Security Act and the Medicare Act, enrollment is absolutely voluntary for both programs. For the Defendants to make Social Security monthly benefits conditioned upon participating in Medicare, Part A, is absolutely contrary to 42 U.S.C. §§ 402 and 426(a) and 42 U.S.C. §§ 1395 *et seq.*, and, thus, is invalid.

Executive agencies cannot legislate; any quasi-legislative authority exercised by any agency “must be rooted in a grant of such power by Congress and subject to limitations which that body imposes.” *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, 99 S.Ct. 1705, 1718, 60 L. Ed.2d 208 (1979).³ For any regulation, policy or rule promulgated by any administrative agency to be valid, “it is necessary to establish a nexus between the regulation [policy or rule] and some delegation of the requisite legislative authority by Congress.” *Chrysler Corp. v. Brown*, 441 U.S. at 304, 99 S.Ct. at 1718-1719. “The pertinent inquiry,” wrote the Supreme Court in *Chrysler*, “is whether under any arguable *statutory* grants of authority the [agency’s] requirements are reasonably within the contemplation of that grant of authority.” *Id.*, 441 U.S. at 306, 99 S.Ct. at 1720.

This Court has not hesitated to invalidate executive agency regulations, policies and rules that were inconsistent with the acts of Congress under which they were purportedly promulgated. *Pratt v. Heckler*, 629 F.Supp. 1496, *recon. den. sub. nom. Pratt v. Bowen*, 642 F.Supp. 883 (D.D.C. 1986) (regulations and rulings of the Secretary defining severity of impairment found to be inconsistent with Social Security Act); *Duggan v. Bowen*, 691 F.Supp. 1487 (D.D.C. 1988) (part-time intermittent care home

³ See also *Batterton v. Francis*, 432 US 416, 425, n. 9, 97 S.Ct. 2399, 2405, n. 9, 53 L.Ed.2d 448 (1977).

health care policies of the Secretary found to be inconsistent with the Medicare Act). It is clear this Court should invalidate the POMS as they are contrary to the Social Security Act and Medicare Acts. As the Supreme Court noted: “The reviewing court should not attempt itself to make up for [any] deficiencies; one may not supply a reasoned basis for the agency’s action that the agency itself has not given.” *Motor Vehicles Mfrs. Ass’n. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 2867, 77 L. Ed.2d 443 (1983). The POMS are “arbitrary, capricious...not in accordance with law...in excess of statutory jurisdiction, authority [and] short of statutory right.” The POMS should be declared invalid and their enforcement enjoined pursuant to 5 U.S.C. §§ 706(2)(A), (B) and (C).

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

1. The Social Security “Entitlement” Regulation

Beyond the Social Security and Medicare Acts, the regulations do not make enrollment in Medicare, Part A, mandatory, nor do they penalize or sanction an individual by mandating the loss of his or her monthly Social Security benefits if he or she does not enroll in, or disenrolls from, Medicare, Part A. **In fact, the pertinent regulation uses the term “eligibility” interchangeably with “entitlement.”** It then defines “entitlement” as nothing more than when an individual “**meets all the requirements for entitlement....**” 42 C.F.R. § 406.6. “Entitlement” and “eligibility” are used to define the availability of Medicare, Part A, benefits to an individual who meets the requirements. It does not define “entitlement” as being anything close to what is

found in the POMS; it does not predicate the loss of an individual's monthly Social Security benefits on him/her not enrolling in, or disenrolling from, Medicare, Part A.

2. The Medicare, Part A, "Entitlement" Regulation

The regulation governing "entitlement" to Medicare, Part A, benefits is equally clear.

42 C.F.R. § 406.10 (a) reads:

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

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

Like the regulation governing entitlement to Social Security monthly benefits, 42 C.F.R. § 406.10(a) speaks of an individual being "entitled," nothing more.

3. 20 C.F.R. § 404.640(b) Forms No Basis For the POMS

Contrary to Defendants' assertions, 20 C.F.R. § 404.640(b) forms no basis for the POMS. All it does is set forth how an individual may withdraw from receiving Social Security monthly benefits; **it does not address Medicare at all!** None of the Plaintiffs want to withdraw from receiving their Social Security monthly benefits; they simply do not want to remain enrolled in Medicare, Part A.

4. 42 C.F.R. § 406.6 Forms No Basis For the POMS

The Defendants have also argued that 42 C.F.R. § 406.6 somehow mandates enrollment in Medicare, Part A. To reach that result they refer the Court to subparagraph (e). Subparagraph (e), though, refers only to those who "must pay a monthly premium for hospital insurance." *Def. Mem.*, 26. That would not refer to the Plaintiffs because all of them would be "entitled" to Medicare, Part A, and would not pay any premiums for

that coverage. The Defendants' reliance upon 20 C.F.R. § 404.640 and 42 C.F.R. § 406.6 only illustrates that the challenged POMS cannot find support either in 42 U.S.C. §§ 402, 426(a) or 1395 *et seq.* or in any of the Defendants' regulations. The POMS should be declared invalid and their enforcement enjoined pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

5. The Court Should Ignore Defendants' Argument That It Would Cost Too Much To Comply With The Law

Defendants' argument (based upon the Declaration of Terry M. Stradtman) that it would cost too much to "establish enrollment procedures" is laughable. Plaintiffs care not; nor should this Court. Translated, Defendants' argument boils down to nothing more than "it would cost too much to force us to perform as Congress dictated, so let us continue to perform as we please, even though it is completely contrary to the dictates of Congress!" This Court should disregard such an argument.

C. The Challenged POMS Should Be Given No Deference Whatsoever

The Supreme Court has articulated a methodology to analyze an agency interpretation of a statute: "**If the intent of Congress is clear, that is the end of the matter...** the question for the court is **whether the agency's answer is based on a permissible construction of the statute.**" *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843, 104 S.Ct. 2778, 2781-2782, 81 L.Ed 2d 94 (1984) (emphasis added). As well, the Supreme Court in *United States v. Mead Corp.*, 533 U.S. 218, 121 S.Ct. 2164, 150 L. Ed2d 292 (2001) provided guidelines for defining the scope of review of agency determinations. The *Mead* court concluded that if Congress left a "gap for an agency to fill, any ensuing regulation is binding unless it is

procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.” *United States v. Mead Corp.*, 533 U.S. at 227, 121 S.Ct. at 2171, 150 L. Ed2d at 303 [emphasis added].

Because the validity of agency pronouncements [the POMS] are in issue, this Court is bound by the narrow deference outlined in *Skidmore v. Swift Co.*, 323 U.S. 134, 65 S.Ct. 161, 89 L.Ed. 124 (1944); that its judgment that deference is appropriate “depends upon the thoroughness evident in [the agency’s] consideration, the validity of [the agency’s] reasoning, [the rule’s] consistency with earlier and later pronouncements, and all those factors which give [the agency] power to persuade, if lacking power to control.” *Skidmore v. Swift & Co.*, 323 U.S. at 140, 65 S.Ct. at 164, 89 L. Ed. at 129.⁴ The POMS utterly fail the *Mead* and *Skidmore* standards of review. There was clearly no thorough consideration given in their formulation; they are unquestionably inconsistent with the agency’s earlier pronouncements in their regulations, and they were unquestionably not promulgated in accord with either the Social Security or Medicare statutes. Rather, they create new rules out of whole cloth that link Social Security entitlement to enrollment in Medicare, Part A.

The POMS are classic examples of agency overreach; the Defendants cannot come up with a valid, coherent or persuasive reason why they have taken the words “shall be entitled” and turned them into what is found in the POMS. Courts must invalidate agency policies that are “inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement.” *NLRB v. Brown*, 380 U.S. 278, 291, 85 S. Ct.

⁴ Because the POMS were not promulgated pursuant to the Administrative Procedure Act (“APA”) (see Argument, Part IV, hereinbelow), the threshold for reviewing what deference is accorded them, if any, is low. *Christensen v. Harris County*, 529 US 576, 587, 120 S.Ct. 1655, 1662, 146 L.Ed.2d 621 (2000); *Martin v. Occupational Safety and Health Review Comm’n.*, 499 US 144, 157, 111 S.Ct. 1171, 1179, 113 L.Ed.2d 117 (1991).

980, 988, 13 L. Ed2d 839, 849 (1965).⁵ When a court determines that “there are compelling reasons that [an agency interpretation] is wrong, the court may invalidate the agency’s action.” *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381, 89 S. Ct. 1794, 1802, 23 L. Ed 2d 371 (1969). Likewise, “a reviewing court should not defer to an agency position which is contrary to an intent of Congress expressed in unambiguous terms.” *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 476, 112 S. Ct. 2589, 2594, 120 L.Ed 2d 379 (1992); and see *National Ass’n. of Patients on Home Dialysis and Transplantation, Inc., et al. v. Heckler*, 588 F.Supp. 1108, 1127 (D.D.C. 1984) (emphasis added).⁶ This Court should accord the POMS no deference at all.

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

Although Congress has the power to vest in executive branch officers of the federal government the authority to promulgate administrative rules, it does not extend to making of rules that go beyond the statute. *Touby v. United States*, 500 U.S. 160, 111 S.Ct. 1752, 114 L.Ed.2d 219 (1991); *United States v. Grimaud*, 220 U.S. 506, 31 S.Ct. 480, 55 L.Ed. 563 (1911); *United States v. Eaton*, 144 U.S. 677, 12 S.Ct. 764, 36 L.Ed.591 (1892). A distinction exists between delegation of powers to make law that necessarily involves **discretion as to what it shall be**, and conferring authority or **discretion as to its execution**, to be exercised under and in pursuance of law. **The first cannot be done, but the latter clearly can be done.** *Bowles v. Willingham*, 321 U.S.

⁵ See also *FEC v. Democratic Senatorial Campaign Comm.*, 454 US 27, 32, 102 S.Ct. 38, 42, 70 L.Ed.2d 23 (1981); *SEC v. Sloan*, 436 US 103, 118, 98 S.Ct. 1702, 1711, 56 L.Ed.2d 148, 160-161 (1978); *FMC v. Seatrain Lines, Inc.*, 411 US 726, 745-746, 93 S.Ct. 1773, 1784-1785, 36 L.Ed.2d 620, 633 (1973); *Volkswagenwerk v. FMC*, 390 US 264, 272, 88 S.Ct. 929, 935, 19 L.Ed.2d 1090, 1097 (1968).

⁶ “If the agency rejects the reasonable interpretation of the statute, the court must honor the clear meaning of the statute, as revealed by its language, purpose and history,” wrote Judge Joyce Hens Green in *National Ass’n. of Patients on Home Dialysis*, 588 E.Supp. at 1127.

503, 64 S.Ct. 641, 88 L.Ed 892 (1944).⁷ Here, the Defendants have exercised “discretion to determine what the law shall be” rather than how the law shall be executed as written by Congress. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 72 S.Ct. 863, 96 L.Ed. 1153 (1952). The Court must declare invalid and enjoin the enforcement of the POMS pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

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

In *American Bus Ass’n.*, the Court considered a challenge to a Department of Transportation (“DOT”) rule authorizing the imposition of money damages against bus companies for non-compliance with the Americans With Disabilities Act of 1990, 42 U.S.C. § 12188(a)(1) (“ADA”). Striking down the DOT rule, the Court concluded that any fine was a sanction for purposes of Section 558(b) of the APA. “A sanction,” wrote the Court, “is a penalty even if only one of its various objects is to punish wrongful conduct; that is, if it ‘serves *in part* to punish.’” *c.f.*, *Austin v. United States*, 509 U.S. 602, 610, 113 S.Ct. 2801, 125 L.Ed. 2d 488 (1993). Where a penalty is designed to force

⁷ Simply stated, “The legislative power of the United States is vested in Congress, and the exercise of quasi-legislative authority by the government departments and agencies must be rooted in a grant of such power by the Congress and subject to the limitations which that body imposes.” *Chrysler v. Brown*, 441 US at 302-303, 995 S.Ct. at 1718.

individuals to “modify their primary conduct,” it is a sanction for purposes of Section 558(b). The DOT was not granted such authority under the ADA, the agency’s enabling statutes or under its “inherent authority to protect the integrity of its programs.” *American Bus Ass’n. v. Slater*, 231 F.3d at 4-7.

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

Neither the Social Security Act nor the Medicare Act make enrollment in, or disenrollment from, Medicare, Part A, unlawful, much less sanctionable by the Defendants taking an individual’s Social Security monthly benefits and forcing him or her to repay the benefits previously paid. The Defendants simply have not been delegated power by Congress to impose such a sanction upon any individual entitled to Social Security monthly benefits. As such, the POMS violate Section 558(b) of the APA and must be declared void and unenforceable. The POMS are invalid and the Court should enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

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

Without question, the POMS are “rules” for purposes of the APA, 5 U.S.C. § 551(4). In order to formulate, amend or repeal a “rule,” an agency must undergo “rule-making,” according to 5 U.S.C. § 551(5). There is no dispute here that the POMS were

not promulgated by means of rule-making; rather, they were simply incorporated into the SSA *Program Operations Manual System* by the agency without informing the public. PSMF, ¶¶ 171-172.⁸

Only legislative or substantive rules require notice and comment. See *Chrysler Corp. v. Brown*, 441 U.S. at 301, 99 S.Ct. at 1717. The POMS are “legislative” rules; they are not “interpretive” rules. The Defendants are actually using the POMS to “force” individuals to accept Medicare, Part A, even though the Social Security Act and Medicare Act – and the regulations of the Defendants - do not. There are no references in the challenged policies or rules to any statute that is being interpreted, much less, 42 U.S.C. §§ 402, 426(a) or 1395 *et seq.* If those entitled to Social Security monthly benefits do not accept Medicare, Part A, the rules are being used to strip them of all their Social Security “savings.” The POMS literally “affect individual rights and obligations,” implement two (2) major congressional enactments and are administered as though they have “the force and effect of law,” yet they were promulgated without any rule-making, thus denying the public the opportunity to participate and comment on their appropriateness and legality.

The POMS are not “interpretative” rules; they are “substantive” or “legislative” rules. As such, they are “final” agency actions. Administrative rules that are “substantive” in nature, which are not promulgated in accordance with the dictates of 5 U.S.C. § 553, are void. Accordingly, the POMS must be declared void and invalid, pursuant to 5 U.S.C. § 706(2)(D).

⁸ The policies or rules at issue here are not related to the calculation of “benefits” so as to be exempted from “rule-making.”

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

A. **Plaintiffs' Rights to Determine Their Own Health Care Choices – Including Who Pays For Them and How They Are Paid – Are Being Constitutionally Denied by The POMS**

Plaintiffs HALL, KRAUS and ARMEY have suffered the complete disruption of their FEHB health care insurance programs. HALL, KRAUS and ARMEY are now not allowed to pay privately for their own health care services. They are having to choose physicians only from a pool of those who actually participate in Medicare. The Federal Government now determines the healthcare services they will receive. They have lost control over their own health care decision-making. The Government determines the healthcare services provided, the length of stay in a hospital, and even the provider. HALL and KRAUS have had to cease making contributions to their HSAs. Their HSAs have become moribund. HALL'S FEHB insurance carrier has actually "taken back" its 2009 contribution to his HSA after the Court denied his Motion for Temporary Restraining Order. If HALL, KRAUS or ARMEY want to withdraw from Medicare, Part A, they will be denied their Social Security monthly benefits. All of their Social Security "savings" will be taken away from them – and, they will be "forced" to pay back all of the benefits they have received to date!

The present claims rest, in part, upon a violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendment privacy rights of the Plaintiffs **to exercise their freedom to choose their own health care services, health care providers and health care payors (including themselves) free from governmental interference.** Such "privacy" has been

viewed by the Supreme Court as emanating from all of those amendments to the Constitution, particularly the First Amendment. *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 15 L. Ed.2d 510 (1965) (holding state law barring contraceptive devices unconstitutional as violative of the First, Third, Fourth, Fifth, Ninth and Fourteenth Amendments). The right to privacy was subsequently found to include the abortion decision. *Roe v. Wade*, 419 U.S. 113, 43 S.Ct. 705, 35 L.Ed.2d 147 (1973). Certainly, one's decision-making as to **all** health care matters is intensely personal and private; the right of privacy is broad enough to encompass all health care decisions, including who makes the determination to pay, and, what health care service will be provided. Congress made the Social Security Act and Medicare Act voluntary for that very reason.

B. The Defendants Cannot Constitutionally Divest Plaintiffs of Their Social Security Benefits by Means of the POMS

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

In the case at bar, the challenged POMS are clearly arbitrary, capricious and not provided by law. Only Congress can "alter, amend or repeal" any provision of the Social Security or Medicare Acts. It has never done so in order to force an individual to forego his or her Social Security monthly benefits if he or she did not want to participate in Medicare, Part A. The POMS are patently arbitrary and capricious; they have been

promulgated – and are being enforced – completely contrary to the statutes and without the requisite authority. Accordingly, the POMS violate the Due Process Clause of the Fifth Amendment to the Constitution of the United States, and should be declared invalid and their enforcement enjoined. 5 U.S.C. § 706(A), (B) and (C).

CONCLUSION

For all the foregoing reasons Plaintiffs pray that this Court deny Defendants' Motion for Summary Judgment and grant Plaintiffs' Motion For Summary Judgment, declaring the *POMS HI 0081.002, Waiver of HI Entitlement by Monthly Beneficiary*, *POMS HI 00802.034, Withdrawal Considerations*, and *POMS GN 00206.020. Withdrawal Considerations When Hospital Insurance is Involved* void as contrary to law and of no effect, and enjoining the Defendants, permanently and mandatorily, to permit the Plaintiffs to not enroll in, or disenroll from, Medicare, Part A, and retain their Social Security monthly benefits.

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Respectfully submitted,

/s/ Frank M. Northam
D.C. Bar No. 206110
Webster, Chamberlain & Bean
1747 Pennsylvania Avenue, NW, Suite 1000
Washington, DC 20006
Telephone: (202) 785-9500
Fax: (202) 835-0243
Email: fnortham@wc-b.com

/s/ Kent Masterson Brown

Kent Masterson Brown

Law Offices of Kent Masterson Brown

P.O. Box 1208

315 N. Broadway

Lexington, KY 40588-1208

Telephone: (859) 455-9330

Fax: (859) 455-9430

Email: kmb@qx.net