RECORD NO. 11-5076

ORAL ARGUMENT SCHEDULED FOR OCTOBER 13, 2011

In The

United States Court of Appeals

For The District of Columbia Circuit

BRIAN HALL; LEWIS RANDALL; NORMAN ROGERS; JOHN J. KRAUS; RICHARD K. ARMEY,

Plaintiffs – Appellants,

v.

KATHLEEN SEBELIUS, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; MARK J. ASTRUE, COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION,

Defendants – Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

BRIEF OF APPELLANTS

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a) (1), Plaintiffs-Appellants, BRIAN HALL, LEWIS RANDALL, NORMAN ROGERS, JOHN J. KRAUS, and RICHARD K. ARMEY, hereby submit this Certificate as to Parties, Rulings, and Related Cases.

A. Parties and Amici. The parties in the district court were plaintiffs Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus and Richard K. Armey; and defendants Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, and Michael J. Astrue, Commissioner of the Social Security Administration. All parties below are parties before this Court in this appeal.

B. Rulings Under Review. The rulings and decisions under review are:

(1) Judge Rosemary M. Collyer's September 29, 2009 decision and order granting, in part, Defendants' Motion to Dismiss and dismissing the Amended Complaint as to Lewis Randall and Norman Rogers. The opinion is not reported. The ruling under review and order are set forth in the Joint Appendix at JA 73-92.

(2) Judge Rosemary M. Collyer's March 16, 2011 decision and order reconsidering and granting Defendants' Motion for Summary Judgment and denying Plaintiffs' Motion for Summary Judgment. This opinion is not yet reported. The ruling and judgment under review are set forth in the Joint Appendix at pp. JA 223-236.

C. Related Case. The case on review was never previously before this Court or any other court, and counsel for Plaintiffs-Appellants are not aware of any related cases currently pending before this Court or any other court.

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GLOSSARY

APA	Administrative Procedure Act
FEHB	Federal Employee Health Benefits
HHS	U.S. Department of Health and Human Services
HSA	Health Savings Accounts
POMS	Program Operating Manual System
SSA	Social Security Administration

STATEMENT OF JURISDICTION

The district court had jurisdiction over this case under 28 U.S.C. §§ 1331 and 2201 because Plaintiffs-Appellants sought a declaratory judgment on a federal question: Whether various provisions of the Defendants-Appellees *Program Operations Manual System* ("POMS") create procedurally, statutorily and constitutionally invalid bars to the Plaintiffs-Appellants choice to not enroll in, or disenroll from, Medicare, Part A. The district court also had jurisdiction under 42 U.S.C. §§ 405(g) and 1395ff because the Plaintiffs-Appellants challenged the Defendants-Appellees final decisions to reject the Plaintiff-Appellants applications to not participate in, or withdraw from, Medicare, Part A. Finally, the district court had jurisdiction under 5 U.S.C. § 701 *et seq*. because the POMS are final legislative and substantive rules or policies that were not properly promulgated as rules and regulations under the Administrative Procedure Act.

This Court has jurisdiction under 28 U.S.C. § 1291 because this is an appeal from the district court's final judgment granting summary judgment in favor of the Defendants-Appellees against the Plaintiffs-Appellants Hall, Kraus and Armey entered on March 16, 2011. This is also an appeal from the district court's final judgment dismissing the Amended Complaint as to Plaintiffs-Appellants Rogers and Randall for lack of standing, by order dated September 29, 2009. Plaintiffs-Appellants timely filed their notice of appeal on March 22, 2011.

STATEMENT OF THE ISSUES

(1) Whether the district court erred in finding that the words "shall be entitled," set forth in 42 U.S.C. § 426(a), mean a person must be enrolled in Medicare, Part A, as a condition of him or her receiving Social Security Retirement benefits.

(2) Whether the Social Security Administration's Program Operations Manual System ("POMS") HI 00801.002, *Waiver of HI Entitlement by Monthly Beneficiary*; POMS HI 00801.034, *Withdrawal Considerations*; and POMS GN 00206.020, *Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved*, are procedurally, statutorily and/or constitutionally, invalid.

(3) Whether the district court erred in finding that Plaintiffs-Appellants, Lewis Randall and Norman Rogers, lack standing to pursue their claims against Defendants-Appellees.

STATUTES AND REGULATIONS

An Addendum contains the following:

POMS HI 00801.002, *Waiver of HI Entitlement by Monthly Beneficiary*

POMS HI 00801.034, *Withdrawal Considerations*

POMS GN 00206.020, *Withdrawal Considerations When Hospital Insurance is Involved*

5 U.S.C. § 558(b)

42 U.S.C. § 402(a)

42 U.S.C. § 426(a)

20 C.F.R. § 404.640

42 C.F.R. § 406.6

42 C.F.R. § 406.10

INTRODUCTION

This case presents procedural, statutory and constitutional challenges to the validity of three internal rules promulgated by the Social Security Administration ("SSA") and the United States Department of Health and Human Services ("HHS") -- POMS HI 0081.002, *Waiver of HI Entitlement by Monthly Beneficiary*, POMS HI 00801.034, *Withdrawal Considerations*, and POMS GN 00206.020, *Withdrawal Considerations When Hospital Insurance is Involved.*[1] Those internal rules make enrollment in Medicare, Part A, mandatory upon receipt of Social Security monthly benefits, and, further, penalize individuals who seek to disenroll from Medicare, Part A, by requiring that Social Security monthly benefits and Medicare, Part A, benefits previously paid be refunded.

All five Plaintiffs-Appellants want to receive the Social Security monthly benefits to which they are entitled; they believe they have earned those funds and those funds have been set aside for them. All five of the Plaintiffs-Appellants do not want Medicare, Part A. Three of the Plaintiffs-Appellants, Hall, Kraus and

[1] The POMS, as described by the district court, are "an SSA handbook designed for internal use by SSA employees in processing claims." JA at p. JA 230.

Armey, were Federal employees and were completely covered by their Federal Employee Health Benefits ("FEHB") health insurance plans. Two of those Plaintiffs-Appellants, Hall and Kraus, had health savings accounts ("HSA"). When they were required to enroll in Medicare, Part A, their HSA's became moribund; Hall's FEHB health insurer even took back its 2009 contribution to his HSA. Plaintiffs-Appellants Randall and Rogers cannot enroll for their Social Security monthly benefits because to do so would require them also to enroll in Medicare, Part A, according to the POMS. If they did so enroll, they could not get out of Medicare, Part A, without also losing their Social Security monthly benefits.

Plaintiffs-Appellants contend that the POMS are unlawful in that both Social Security and Medicare, Part A, are entitlements, the use of which by individuals is wholly voluntary. The statutes, 42 U.S.C. §§ 402 and 426, read identically. Both statutes state that an individual "shall be entitled" to benefits when the individual satisfies certain qualifying conditions. Neither statute states that an individual, who satisifies those qualifying conditions, *must* accept the benefits. Moreover, neither statute states that acceptance of the benefits available under one of the statutes will require the individual to accept the benefits available under the other statute.

This simple and straightforward statutory construction of the usage of the term "entitlement" is the theory of the Plaintiffs-Appellants case. Were it not for

the POMS, an individual who was eligble for, or already receiving, Social Security retirement benefits could choose to enroll, or not to enroll, in Medicare, Part A, when that individual reached the age of 65. That is what "shall be entitled" means in 42 U.S.C. § 426, in setting forth the qualifications for participation in Medicare.

The district court chose not to accord the same meaning to the term "shall be entitled" in the two statutes and concluded that the Medicare statute created "a different type of entitlement." Under the district court's construction of the identical statutory terms, "entitlement" under Medicare was "automatic" when an individual was 65 years of age and receiving Social Security. By so construing the statutes, the district court was able to uphold the directives of the POMS.

The district court's statutory construction contradicts the plain meaning of the term "entitlement" and disregards the statutory and constitutional underpinnings of the Medicare statute's guarantee that individuals would remain unhindered in their choices to obtain medical care. The district court's decision should be reversed, the POMS should be invalidated, and the Plaintiffs-Appellants should be provided the opportunity to choose whether they wish to participate in Medicare, Part A.

STATEMENT OF FACTS

Plaintiffs-Appellants, Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus and Richard K. Armey, are retirees who "do not want to apply for, or want to disenroll from, Medicare, Part A . . . [but] do want to apply for and/or be paid their monthly Social Security benefits to which they are entitled." (Amended Complaint, JA 18-19). They filed this action pursuant to the Medicare Act, 42 U.S.C. § 1395 *et seq*., the Social Security Act 42 U.S.C. § 401, *et seq*., and the Administrative Procedure Act ("APA"), 5 U.S.C. § 551, *et seq*., alleging that the SSA rules regarding Medicare, Part A, as set forth in the SSA's POMS, are invalid and operate either to deprive them of their right to Social Security benefits or to force them to "enroll in" Medicare, Part A, against their will. JA 14-49.

When they filed their Amended Complaint in December 2008, three of the five Plaintiffs-Appellants – Hall, Kraus and Armey – had been receiving monthly Social Security benefits for several years. JA 16-17. Kraus and Armey were also unwilling participants in Medicare, Part A; both tried to get out of it, but were informed by SSA that they could not. When they applied for Social Security retirement benefits, they were provided an application that mandated they enroll in both Social Security and Medicare, Part A, at the same time, or not receive either benefit. JA 25-26.

Kraus tried to appeal this requirement, but SSA never responded to his request for a hearing before an Administrative Law Judge ("ALJ") until long after the filing of the Amended Complaint herein and more than three years after Kraus's request. The ALJ ultimately held that Kraus could not forego Medicare, Part A, and receive monthly Social Security benefits. Kraus's appeal to the Medicare Appeals Council produced the same result. JA 104-107.

Hall was required to accept Medicare, Part A, beginning in January 2009 when the Court below denied his Motion for a Temporary Restraining Order. JA 4 (Docket Entry No. 11).

Hall, Kraus and Armey had FEHB health insurance as they were all formerly Federal employees. Once they were forced to accept Medicare, Part A, they lost their FEHB insurers as primary carriers; Medicare assumed the role of the primary carrier, adjudicating the provision of all of their health care services and payments. JA 131-163.

Both Hall and Kraus had HSAs with their FEHB health insurers, allowing them the maximum control over their health care decisions. JA 139-163. Once they were forced into Medicare, Part A, they were prohibited from using their HSAs; Hall's insurer actually took back its contribution to his HSA after the Court below denied his Motion for a Temporary Restraining Order to keep from being enrolled in Medicare, Part A. Those HSAs are now moribund. JA 139-163.

Plaintiffs-Appellants, Randall and Rogers, were eligible for monthly Social Security benefits at the time the Amended Complaint was filed, but had not applied for them, because if they had, they would have been required to enroll in Medicare, Part A, which they do not want. If they applied for Social Security benefits and then tried to disenroll from Medicare, Part A, they would not only lose their Social Security monthly benefits, but be required to repay all benefits received from both programs. To date, they have not been able to receive the monthly Social Security benefits to which they are entitled because they do not want to be enrolled in Medicare, Part A. JA 26-27.

All Plaintiffs-Appellants contend that the SSA's policies, as set forth in the POMS, "are patently contrary to the Social Security Act" in that they require them to accept Medicare, Part A, as a condition of receipt of their monthly Social Security benefits. The enforcement of those POMS by the Defendants-Appellees was the sole cause for the Plaintiffs-Appellants, Hall, Kraus and Armey, being forced into Medicare, Part A, as a condition of receiving their monthly Social Security benefits. The POMS are also the sole cause of Plaintiffs-Appellants Rogers and Randall not being able to receive the monthly Social Security benefits to which they are otherwise entitled. JA 26-27.

The POMS contain several provisions relating to Medicare, Part A (a.k.a. "Health Insurance" or "HI"). The POMS challenged by the Plaintiffs-Appellants –

POMS HI 00801.002, POMS HI 00801.034, and POMS GN 00206.020 – all state that a claimant who is entitled to monthly benefits may withdraw from Medicare, Part A, by withdrawing his/her application for monthly Social Security benefits, but he/she may not withdraw only from Medicare, Part A, while retaining his/her monthly Social Security benefits. POMS 00801.002 states, under the heading "Policy," "Individuals entitled to monthly benefits which confer eligibility for HI may not waive HI entitlement. The only way to avoid HI entitlement is through withdrawal of the monthly Social Security benefit application. Withdrawal requires repayment of all RSDI and HI benefit payments." POMS: HI 00801.002 – *Waiver of HI Entitlement by Monthly Beneficiary*. According to the aforesaid POMS, an individual must enroll in Medicare, Part A, as a condition of receiving the Social Security monthly benefits, and he/she cannot escape Medicare, Part A, without repaying all benefits received and foregoing Social Security. The other POMS provisions at issue contain similar language.

Plaintiffs-Appellants have challenged the POMS on the ground that it is the SSA's policy, as expressed in the POMS, and not the Social Security or Medicare Acts, that prevents them from withdrawing from Medicare, Part A, while still receiving Social Security.

Plaintiffs-Appellants, Hall, Kraus, and Armey share the following characteristics:

- They are retired from Federal employment and have attained the age of 65.
- They applied for, and are receiving, Social Security Retirement benefits.
- They are entitled to benefits under Medicare, Part A.
- They had previously been enrolled in health plans under the FEHB program and wish to continue that coverage in full.
- They have lost their FEHB health insurance coverage, save for it being the secondary payer; Medicare, Part A, controls all health care coverage.
- They do not want to be covered by Medicare, Part A, and want to disenroll from Medicare, Part A.
- They want to continue receiving their monthly Social Security Retirement benefits.
- Hall and Kraus have lost the use of their HSAs as Medicare, Part A, controls all health care coverage.

JA 224.

Plaintiffs-Appellants, Rogers and Randall, share the following characteristics:

- They have attained the age of 65.
- They are entitled to Social Security monthly benefits.
- They are entitled to benefits under Medicare, Part A.
- They have enrolled in health plans and wish to continue that coverage in full, and, otherwise, pay for health care services out of their own pockets.

- They do not want to be covered by Medicare, Part A.
- They want to receive their monthly Social Security benefits to which they are entitled.
- Because they do not want to be covered by Medicare, Part A, they cannot apply for their monthly Social Security benefits.

JA 16-30.

Plaintiffs-Appellants filed their initial Complaint in this case on October 9, 2008. In January, 2009, with Brian Hall's sixty-fifth birthday (which made him eligible for Medicare, Part A) about to take place, Hall sought a temporary restraining order and preliminary injunction to prevent his forced participation in Meidcare, Part A. The district court denied Hall's motion on January 28, 2009. JA 4 (Docket Entry No. 11). Thereafter, Defendants-Appellees moved to dismiss as to all of the Plantiffs on the grounds of standing. On September 29, 2009, the district court granted the motion to dismiss as to Norman Rogers and Lewis Randall but also held that Hall, Kraus and Armey did have standing. JA 73-92. On March 24, 2010, the district court reconfirmed its ruling of September 29, 2009 by denying a motion for reconsideration which had been filed by Defendants-Appellees. JA 104-107. Subsequently, both sets of parties filed motions for summary judgment and on March 16, 2011, the district court granted summary judgment in favor of the Defendants-Appellees and upheld the validity of the POMS. This appeal

followed challenging the district court's ruling on the merits and the district court's ruling finding that Randall and Rogers had no standing.

SUMMARY OF ARGUMENT

In 1965, Congress enacted the Medicare laws and utilized declarative terminology, identical to that appearing in the Social Security retirement benefit law, to describe Medicare as an "entitlement." The Medicare law does not mandate that anyone participate in Medicare programs, just as the Social Security laws do not mandate that anyone participate in Social Security. Nevertheless, a policy manual developed for use by Social Security Administration employees ("the POMS") sets forth three provisions which dictate that every individual who reaches the age of 65 and is receiving Social Security retirement benefits *shall* become a participant in Medicare, Part A. Those POMS provisions contradict the Medicare statute's guarantee that individuals will not be "precluded" from making health care decisions of their choosing. One of those decisions would be the choice whether or not to participate in Medicare, Part A, or obtain other coverage.

The Medicare, Part A, statute – 42 U.S.C. § 426(a) – states that an individual "shall be entitled" to participate in Medicare. Nowhere in the Medicare statues does it provide that anyone will be "required" to participate or even that an individual, who satisfies the qualifications to be "entitled" to Medicare, Part A, must accept Medicare, Part A. Under the Social Security statute defining those

who "shall be entitled" to retirement benefits, an individual qualifying for entitlement may decline to accept the benefits to which he/she is entitled.

The POMS, as did the district court, construe the "entitlement" provision under Medicare, Part A, 42 U.S.C. § 426(a), in a manner that is contrary to the clear meaning of that term. Moreover, the POMS improperly conflate a regulatory requirement that one repay all benefits when withdrawing from Social Security with a requirement (created and existing only in the POMS) that one must withdraw from Social Security in order to avoid participation in Medicare, Part A. The Social Security and Medicare statutes do not, however, create such an inextricable relationship. Indeed, one may participate in Medicare without partaking of Social Security benefits to which he/she is entitled. Only the POMS prevent an individual from exercising a complementary option – participating in Social Security but declining participation in Medicare. The POMS represent an impermissible construction of the "entitlement" provision of the Medicare, Part A, statute and, because they are contrary to the statute, must be invalidated.

The POMS were never promulgated with notice-and-comment pursuant to the APA, 5 U.S.C. § 553, even though they are not interpretive rules, but legislative and substantive rules that deeply affect the life, health and financial well-being of every citizen in the United States. The POMS are procedurally defective.

Plaintiffs-Appellants contend that the POMS further violate Article I, Section I, of the Constitution because they amount to "legislating," a power only reserved to Congress. They further violate the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the Constitution because they force individuals into a government-run health care system that is actuarily unsound and subject to constant budget constraints that limit health care choices and providers and even denies to individuals the right to make their own health care decisions with the providers of their choice as they see fit.

Finally, Plaintiffs-Appellants Randall and Rogers challenge their dismissal from the case on the grounds of standing. They cannot enroll in Social Security without also enrolling in Medicare, Part A. If they did enroll in both programs and tried to disenroll from Medicare, Part A, they would be denied their Social Security monthly benefits received, according to the POMS. As a consequence, they are being denied all of their Social Security monthly benefits to which they are entitled. They had standing to bring this case.

Plaintiffs-Appellants ask this Court to reverse the court below and void the POMS and direct the court below to enjoin their enforcement. They further ask this Court to reverse the court below with respect to the standing of Plaintiffs-Appellants Randall and Rogers.

STANDARD OF REVIEW

This Court reviews a district court's grant of summary judgment *de novo*. *Abington Crest Nursing and Rehabilitation Center v. Sebelius*, 575 F.3d 717, 719 (D.C. Cir. 2009), citing *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994) (In reviewing an agency's final action, "the Court addresses the issue *de novo*, without deference to the decision of the district court.").

This Court reviews "a dismissal for lack of standing de novo". *Renal Physicians Ass'n. v. United States Dep't. of Health and Human Services*, 489 F.3d 1267, 1273 (D.C. Cir. 2007); *Information Handling Services, Inc. v. Defense Automated Printing Services*, 338 F.3d 1024, 1029 (D.C. Cir. 2003).

ARGUMENT

I. MEDICARE WAS ENACTED BY CONGRESS IN 1965 AS A VOLUNTARY PROGRAM AND THAT HAS NOT CHANGED SINCE THEN

In 1965 Congress enacted the Medicare Act, 42 U.S.C. §§ 1395 *et seq*., asserting in a preamble statute that "nothing contained in this subchapter 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, 42 U.S.C. §§ 401 *et seq*., as amended, 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.

Social Security and Medicare, Part A, were created by Congress to be voluntary programs. 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." Medicare, Part A, similarly, is completely voluntary as evidenced by the language of the preamble, 42 U.S.C. § 1395b.

II. THE POMS ARE CONTRARY TO THE SOCIAL SECURITY AND MEDICARE ACTS AND REGULATIONS PROMULGATED THEREUNDER

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

1. Entitlement to Social Security Monthly Benefits Is Set Forth In 42 U.S.C. § 402(a), and Enrollment in Medicare, Part A, Is Not a Prerequisite Thereto.

Title 42 U.S.C. § 402 reads, in pertinent part, as follows:

(a) Old-age insurance benefits

Every individual who --

(1) is a fully insured individual (as defined in § 414(a) of this title),
(2) has attained age 62, and

> (3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in § 416(l) of this title), *shall be entitled to an old-age insurance benefit for each month*, beginning with –
>
> (A) in the case of an individual who has attained retirement age (as defined in § 416(l) of this title), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or
>
> (B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in § 416(l) of this title), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),
>
> and ending with the month preceding the month in which he does. Except as provided in subsection (q) and subsection (w) of this section, such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in § 415(a) of this title) for such month.

According to 42 U.S.C. § 402(a), 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 set forth in 42 U.S.C. § 402(a). Nowhere does the Social Security Act in general, or 42 U.S.C. § 402(a) in particular, predicate entitlement to Social Security monthly benefits upon enrollment in Medicare, Part

A. "Shall be entitled," as set forth in 42 U.S.C. § 402(a), does not – and cannot – mean "must enroll."

2. "Entitlement" to Medicare, Part A, Is Set Forth In 42 U.S.C. § 426(a), And That "Entitlement" Is Not a Prerequisite to Receiving Monthly Social Security Benefits.

Title 42 U.S.C. § 426 reads as follows:

(a) Individuals over 65 years

Every individual who –

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

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

Entitlement to receive Medicare, Part A, benefits is virtually identical to entitlement to receive Social Security monthly benefits. An individual must attain the age of sixty-five (65) years and be entitled to Social Security monthly benefits, and, if those conditions are met, he/she "shall be entitled" to the benefits created by Medicare, Part A. 42 U.S.C. § 426(a).

Congress did not make 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(a)). None of the subsequent amendments to 42 U.S.C. § 426(a) – or in the Medicare Act, 42 U.S.C. § 1395 *et seq*., in general – alter the meaning of the statute for purposes of the question *sub judice*. The words are still "shall be entitled."

3. Congress Enacted Provisions Governing How Social Security May Be Terminated at 42 U.S.C. § 402, And Not Enrolling In, Or Withdrawing From, Medicare, Part A, Is Not Included Therein

Congress actually enacted provisions dictating how and under what circumstances an individual may lose his/ her Social Security monthly benefits. 42 U.S.C. § 402(n), (t), (y), (u), (v) and (x). Benefits may be "terminated" upon the

"primary beneficiary being deported." 42 U.S.C. § 402(n). Benefits may be "suspended" if the beneficiary who is an alien is residing outside of the United States, or is a citizen of a foreign country that has in effect social insurance similar to Social Security. 42 U.S.C. § 402(t) and (y). A court of competent jurisdiction may deny an individual Social Security monthly benefits if that individual has been convicted of "subversive activities." 42 U.S.C. § 402(u). An individual who files a waiver, pursuant to § 1402(g) of the Internal Revenue Code, and is granted a tax exemption, will waive his/her Social Security monthly benefits. 42 U.S.C. § 402(v). Social Security monthly benefits will also not be paid to individuals who are "confined in jail, prison, or other penal institution or correctional facility." 42 U.S.C. § 402(x).

No provision for the termination of benefits, much less the repayment of benefits to the Secretary, is found for individuals who simply do not want Medicare, Part A, benefits. If Congress intended Social Security monthly benefits to be terminated if an individual chose not to enroll in, or to withdraw from, Medicare, Part A, it would have provided the same in 42 U.S.C. § 402.

4. "Shall Be Entitled" Is Not Synonymous With "Shall Be Required"

The words "shall be entitled" are not the same as "shall be 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 right or legal title to, qualify for something; furnish with the proper grounds for seeking or claiming something." *Webster's Third New International Dictionary* (1993); *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 Social Security and Medicare. *Krishnan v. Barnhart, Comm. of Social Security Adm'n.*, 328 F.3d 685, 693 (D.C. Cir. 2003) ("Entitlement" to benefits requires a claimant to "qualify" for same); *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 275 (6th Cir. 1994) ("To be entitled to some benefit means that one possesses the right or title to that benefit."); *Fagner v. Heckler*, 779 F.2d 541, 543 (9th Cir. 1985) ("In the ordinary use of English, 'entitled' means 'to give right or legal title to, qualify [one] for something; furnish proper grounds for seeking or claiming something.' In legal parlance, the same type of usage can be found.").[2]

[2] This Court has often used *Webster's Third New International Dictionary* for defining the terms set forth in statutes. *Friends of the Earth v. EPA*, 446 F.3d 140, 144 (D.C. Cir. 2006), *cert. denied*, 549 U.S. 1175 (2007) (use of the Webster's dictionary to define the term "daily.") The Supreme Court used that same dictionary to discern the meaning of "injury." *Brown v. Gardner*, 513 U.S. 115, 117, 115 S. Ct. 552, 555, 130 L. Ed. 2d 462 (1994).

If "shall be entitled," for purposes of Social Security monthly benefits, makes those benefits subject to an individual's voluntary enrollment, then "shall be entitled," as found in Medicare, Part A, must be the same. Wrote the Supreme Court: "There is a presumption that a given term is used to mean the same thing throughout a statute." *Brown v. Gardner*, 513 U.S. 115, 118, 115 S. Ct. 552, 555, 130 L. Ed. 2d 462 (1994) ("injury" as set forth in 38 U.S.C. § 1151 means the same as in 38 U.S.C. §§ 1110, 1131 and 1701, and does not imply "fault"); *Atlantic Cleaners & Dryers, Inc. v. United States*, 286 U.S. 427, 432-433, 52 S. Ct. 607, 608-609, 76 L. Ed. 1204 (1932) (whether words "trade or commerce" in section 1 of the Sherman Anti-Trust Act have same meaning in section 3).

5. The Challenged POMS Are Contrary To The Social Security And Medicare Acts, And This Court Should So Find, Reverse the District Court Below And Direct It to Enjoin Defendants-Appellees From Enforcing the POMS Under 5 U.S.C. §§ 706(2)(A),(B) and (C)

By the very reading of the Social Security and Medicare Acts, enrollment is voluntary for both programs. The POMS require, subject to severe penalty for non-compliance, what Congress made to be purely voluntary. To condition Social Security monthly benefits upon the individual participating in Medicare, Part A, is contrary to 42 U.S.C. §§ 402(a) and 426(a) and 42 U.S.C. §§ 1395 *et seq.*, and, thus, invalid. Title 42 U.S.C. § 426(a) does not, by its very words, create a

"different type of entitlement" than 42 U.S.C. § 402(a), as stated by the court below. There is no "different type of entitlement."

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) (the regulations of the Office of Federal Contract Compliance Programs requiring disclosure of trade secrets and confidential business information were not authorized by any legislative grant of authority). 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." *Id.*, 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. If the regulation is not contemplated by that grant of authority, it is void. A regulation or rule "which operates to create a rule out of harmony with the statute is a mere nullity." *Manhattan Gen. Equip. Co. v. Comm'r of Internal Revenue*, 297 U.S. 129, 134, 56 S. Ct. 397, 400, 80 L. Ed. 528 (1936) (amended Article 1599 of the Treasury Regulations 69 could not lawfully be made retroactive).

This Court has not hesitated to invalidate agency regulations, policies and rules that were inconsistent with the acts of Congress under which they were purportedly promulgated. *Friends of Earth, Inc. v. EPA*, 446 F.3d at 144-146 (EPA cannot deviate from requirement established by Congress in the Clean Water Act that "[e]ach state shall establish….the total maximum daily load for those pollutants which the Administrator identifies….as suitable for such calculation.") This Court held that the EPA may not avoid the congressional intent clearly expressed in the text by asserting that its preferred approach would be better policy. *Id* at 145. Further, it held that "the most reliable guide to congressional intent is the legislation Congress enacted." *Id* at 146. See also: *Sierra Club v. EPA*, 294 F.3d 155 (D.C. Cir. 2002). Thus, "[i]f the relevant statutory language is plain but is inconsistent with the [agency] regulations, [the court] must hold the regulations invalid." *American Federation of Government Employees v. Gates*, 486 F.3d 1316, 1321-1322 (D.C. Cir. 2007), *cert. dismissed*, 552 U.S. 1171 (2008). Put another way, this Court has stated that "[t]he authority to issue regulations is not the power to make law, and a regulation contrary to a statute is void." *Orion Reserves Ltd. Partnership v. Salazar*, 553 F.3d 697, 703 (D.C. Cir. 2009), *cert. denied*, 130 S. Ct. 110 (2009).

The POMS should be invalidated as they are contrary to the Social Security and Medicare Acts. As the Supreme Court has 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) (National Highway Traffic Safety Administration acted arbitrarily and capriciously when it rescinded the crash protection requirements of motor vehicle safety standards and court of appeals erred when it intensified the scope of its review). The POMS are "arbitrary, capricious….not in accordance with law…in excess of statutory jurisdiction, authority [and] short of statutory right." This Court should declare the POMS invalid, as they are in excess of Defendants-Appellees' authority and short of statutory right, and thereby reverse the court below and direct it to enjoin the Defendants-Appellees from enforcing the POMS, pursuant to 5 U.S.C. §§ 706(2)(A), (B) and (C).

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

1. The Social Security Regulation Governing "Entitlement" Thereto Does Not Mandate Enrollment In Medicare, Part A, as a Condition of Receiving Social Security Monthly Benefits

Beyond the Social Security and Medicare Acts, the regulations promulgated by the Defendants-Appellees do not make enrollment in Medicare, Part A, mandatory, nor do they penalize or sanction an individual by mandating the loss of

his/her monthly Social Security benefits if he/she does not enroll in, or disenrolls from, Medicare, Part A. Title 42 C.F.R. § 406.6 reads:

> (a) Basic provision. In most cases, eligibility for Medicare, Part A, is a result of *entitlement* to monthly social security or railroad retirement cash benefits or *eligibility* for monthly social security cash benefits. This section specifies the individuals who need not file an application to become entitled to hospital insurance, those who must file an application, and those who must enroll.
> (b) *Individuals who need not file an application for hospital insurance*. An individual who meets any of the following conditions need not file an application for hospital insurance:
> (1) *Is under age 65 and has been entitled*, for more than 24 months, to monthly social security or railroad retirement benefits based on disability,
> (2) *At the time of attainment of age 65*, *is entitled to monthly social security or railroad retirement benefits*.
> (3) Establishes entitlement to monthly social security or railroad retirement benefits at any time after attaining age 65. (Emphasis added)

This regulation actually uses the term "eligibility" interchangeably with "entitlement." The regulations then define "entitlement" as nothing more than when an individual meets all the requirements for entitlement. 42 C.F.R. § 406.10(b). "Entitlement" and "eligibility" are used to define the availability of Medicare, Part A, benefits to an individual who meets the requirements. The regulation 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.[3]

2. The Medicare, Part A, Regulation Governing "Entitlement" Thereto Does Not Mandate Enrollment In Medicare, Part A, as a Condition of Receiving Social Security Monthly Benefits

The regulation governing "entitlement" to Medicare, Part A, benefits is equally clear. Title 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; it forms no basis for the challenged POMS, and it develops no "different type of entitlement." No other regulations have ever been promulgated by the Defendants-Appellees to make receipt of monthly Social Security benefits dependent upon enrollment in Medicare, Part A. The POMS should be declared invalid as they are in excess of Defendants-Appellees' authority, short of statutory right and contrary

[3] Title 20 C.F.R. § 404.640(b) actually sets forth how a beneficiary of Social Security monthly benefits can withdraw an application for benefits, making it clear "shall be entitled" for purposes of 42 U.S.C. § 402(a) makes Social Security voluntary. Of course, none of the Appellants herein seek to withdraw from receiving their Social Security monthly benefits. They only seek to withdraw from participation, or not participate, in Medicare, Part A.

to Defendants-Appellees' earlier pronouncements, and this Court should so declare, reverse the court below and direct it to enjoin the Defendants-Appellees from enforcing the POMS, pursuant to 5 U.S.C. §§ 706(2)(A), (B) and (C).

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." *Good Samaritan Hospital v. Shalala*, 508 U.S. 402, 409, 113 S. Ct. 2151, 2157, 124 L. Ed. 2d 368 (1993) (quoting *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 694 (1984) ("[T]he question for the court is whether the agency's answer is based on a permissible construction of the statute.")); See also: *Abington Crest Nursing and Rehabilitation Center v. Sebelius*, 575 F.3d at 719; *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d at 1229. As well, the Supreme Court in *United States v. Mead Corp.*, 533 U.S. 218, 121 S. Ct. 2164, 150 L. Ed. 2d 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." *Id.* 533 U.S. at 227, 121 S. Ct. at 2171.

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); a 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." *Id.*, 323 U.S. at 140, 65 S. Ct. at 164.[4]

The POMS fail the *Mead* and *Skidmore* standards of review. There was no thorough consideration given in their formulation; they are inconsistent with the agencys' earlier pronouncements in their regulations, and they were 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 examples of agency overreach. Courts should invalidate agency policies that are "inconsistent with the statutory mandate or that frustrate the congressional policy underlying a statute." *NLRB v. Brown*, 380 U.S. 278, 291,

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[4] Because the POMS were not promulgated pursuant to the Administrative Procedure Act ("APA") (see Argument V, hereinbelow), the threshold for reviewing what deference is accorded them, if any, is low. *Christensen v. Harris County*, 529 U.S. 576, 587, 120 S. Ct. 1655, 1662-1663, 146 L. Ed. 2d 621 (2000); *Martin v. Occupational Safety and Health Review Comm'n.*, 499 U.S. 144, 157, 111 S. Ct. 1171, 1179,113 L. Ed. 2d 117 (1991).

85 S. Ct. 980, 988, 13 L. Ed. 2d 839 (1965).[5] When a court determines that "there are compelling indications 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); See also: *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. at 842-843, 104 S. Ct. at 2781-2782. This Court should accord the POMS no deference at all.

III. 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

[5] See also, *FEC v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32, 102 S. Ct. 38, 42, 70 L. Ed. 2d 23, (1981); *SEC v. Sloan*, 436 U.S. 103, 118-119, 98 S. Ct. 1702, 1711-1712, 56 L. Ed. 2d 148 (1978); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 745-746, 93 S. Ct. 1773, 1784-1785, 36 L. Ed. 2d 620 (1973); *Volkswagenwerk v. FMC*, 390 U.S. 261, 272, 88 S. Ct. 929, 935-936, 19 L. Ed. 2d 1090 (1968).

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. 503, 64 S. Ct. 641, 88 L. Ed. 892 (1944).[6] Here, the Defendants-Appellees have exercised "discretion to determine what the law shall be" rather than how the law shall be executed as written by Congress. "The Constitution did not subject [the] law-making power of Congress to [executive] control." *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 588, 72 S. Ct. 863, 867, 96 L. Ed. 1153 (1952). This Court should declare the POMS invalid, reverse the court below and direct it to enjoin the Appellees from enforcing them, pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

[6] 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 U.S. at 302, 99 S. Ct. at 1718.

IV. AS CONGRESS HAS DELEGATED TO THE DEFENDANTS-APPELLEES 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.*, this 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, this Court concluded that any fine was a sanction for purposes of Section 558(b) of the APA. "A civil sanction," the Supreme Court wrote, "that cannot be said solely to serve a remedial purpose, but rather can only be explained as also serving either retributive or deterrent purposes is punishment as we have understood the term." *Austin v. United States*, 509 U.S. 602, 621, 113 S. Ct. 2801, 2812, 125 L. Ed. 2d 488 (1993). Where a penalty is designed to force individuals to "modify their primary conduct," it is a sanction for purposes of Section 558(b). The DOT was

not granted such authority under the ADA, 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/her to repay all the benefits previously paid because he/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/her conduct. It is designed to force individuals to take Medicare, Part A, whether they want it or not.

Neither the Social Security nor Medicare Acts make enrollment in, or disenrollment from, Medicare, Part A, unlawful, much less sanctionable by the Defendants-Appellees taking an individual's Social Security monthly benefits and forcing him/her to repay the benefits previously paid. The Defendants-Appellees 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 this Court should declare them void and unenforceable, reverse the court below and direct it to enjoin Defendants-Appellees from enforcing them, pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

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. JA 84.[7]

Legislative or substantive rules require notice and comment. See *Chrysler Corp. v. Brown*, 441 U.S. at 301-303, 99 S. Ct. at 1717-1718. The POMS are "legislative" rules; they are not "interpretive" rules. The Defendants-Appellees are actually using the POMS to "force" individuals to accept Medicare, Part A, even though the Social Security and Medicare Acts – and the regulations of the Defendants-Appellees - do not. There are no references in the challenged policies or rules to any statute that is being interpreted, much less reference to 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 "affect individual rights and obligations,"

[7] The policies or rules at issue here are not related to the calculation of "benefits" so as to be exempted form "rule-making."

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, this Court should declare the POMS invalid, reverse the court below and direct it to enjoin Defendants-Appellees from enforcing them, pursuant to 5 U.S.C. § 706(2)(D).

VI. PLAINTIFFS-APPELLANTS ARE BEING DENIED A FUNDAMENTAL RIGHT TO DETERMINE THEIR OWN HEALTH CARE OR BE DENIED THEIR PROPERTY INTEREST IN THEIR SOCIAL SECURITY IN VIOLATION OF THE FIRST, FOURTH, FIFTH, NINTH AND FOURTEENTH AMENDMENTS TO THE CONSTITUTION OF THE UNITED STATES

A. Plaintiffs-Appellants' Rights to Determine Their Own Health Care Choices – Including Who Pays For Them and What Services or Medicals Are Delivered – Are Being Constitutionally Denied by The POMS

Plaintiffs-Appellants Hall, Kraus and Armey have suffered the complete disruption of their FEHB health care insurance programs. Plaintiffs-Appellants Randall and Rogers cannot even apply for their Social Security monthly benefits without being forced to enroll in Medicare, Part A. Hall, Kraus and Armey are

now not allowed to pay privately for their own health care services. They are having to choose physicians only from a pool of those who actually participate in Medicare, an ever-dwindling number. The Federal Government now determines the healthcare services provided to them, the length of stay in a hospital, and even the provider.[8]

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 below denied his motion for temporary restraining order. If Hall, Kraus or Armey want to withdraw from Medicare, Part A, they will be denied their monthly Social Security 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. For Randall and Rogers to even obtain their monthly Social Security benefits, they will be forced into Medicare, Part A.

[8] Medicare beneficiaries must use their Medicare benefits in order to obtain any and all covered health care services. 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. 42 U.S.C. § 1395a(b)(3). *United Seniors v. Shalala*, 185 F.3d 965 (D.C. Cir. 1999). There are civil and criminal penalties for a Medicare provider privately contracting with a beneficiary. 42 U.S.C. §§ 1320a-7a-7b. Medicare, Part A, services are "prospectively" paid under 42 U.S.C. § 1395ww; nursing facilities are prospectively paid pursuant to 42 U.S.C. § 1395yy. Any provider that is prospectively paid and accepts private payments from Medicare beneficiaries will be subject to civil – and possibly criminal – penalties. 42 U.S.C. § 1320a-7a-7b.

The present claims rest, in part, upon a violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendment privacy rights of the Plaintiffs-Appellants 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, 14 L. Ed. 2d 510 (1965) (holding state law barring contraceptive devices unconstitutional as violative of the First, Fourth, Fifth, Ninth and Fourteenth Amendments). The right to privacy was subsequently found to include the abortion decision. *Roe v. Wade*, 410 U.S. 113, 93 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, what health care service will be provided, and what provider to use. The POMS deny Plaintiffs-Appellants their right to make health care choices free from Federal Government interference. The POMS violate the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the Constitution of the United States and this Court should so find and declare them invalid, reverse the court below and direct it to enjoin Defendants-Appellees from enforcing the POMS, pursuant to 5 U.S.C. §§ 706(2)(A), (B) and (C).

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

Although Social Security monthly benefits are not "vested" due to the fact that they are subject to defeasance by Congress (*Flemming v. Nestor*, 363 U.S. 603, 80 S. Ct. 1367, 4 L. Ed. 2d 1435 (1960)), 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-Appellees to determine whether it is arbitrary, capricious, and thus, violative of the Due Process Clause of the Fifth Amendment. *Therrien v. Schweiker*, 795 F.2d 2 (2d Cir. 1986); *Collins v. Finch*, 311 F. Supp. 301 (W.D. Pa. 1970).

In the case at bar, the challenged POMS are arbitrary, capricious and not provided by law. Only Congress can "alter, amend or repeal" any provision of the Social Security or Medicare Acts, and it has never done so in order to force an individual to forego his or her Social Security monthly benefits if he/she did not participate in Medicare, Part A. The POMS are arbitrary and capricious; they have been promulgated – and are being enforced – contrary to the statutes and without the requisite authority. They violate the Due Process Clause of the Fifth Amendment to the Constitution of the United States, and this Court should so find, reverse the court below and direct it to enjoin Defendants-Appellees from enforcing them, pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

VII. PLAINTIFFS-APPELLANTS RANDALL AND ROGERS WERE IMPROPERLY DISMISSED BY THE COURT BELOW

Plaintiffs-Appellants Randall and Rogers were improperly dismissed from the case by the court below. Even though both of them were eligible for Social Security monthly benefits long before they challenged the POMS, they refused to sign the application for Social Security benefits because it, by virtue of the POMS, required them to enroll in Medicare, Part A. Neither Randall nor Rogers want to enroll in Medicare, Part A. They came to court seeking a declaration of rights as they had been put in a position of either losing all of their Social Security monthly benefits or being forced to enroll in Medicare, Part A, and surrendering their control over their health care to the Federal Government. Rogers and Randall have suffered the contining injury of being prevented from receiving the monthly Social Security payments to which they are entitled.

Standing is always evidenced when a challenging party is placed in the dilemma of incurring the disadvantages of complying with a law, regulation or rule or risking penalties for non-compliance. *Whitney v. Heckler*, 780 F.2d 963, 968-969, n.6 (11th Cir.), *cert. denied*, 479 U.S. 813 (1986). See also: *Doe v. Bolton*, 410 U.S. 179, 188, 93 S. Ct. 739, 745, 35 L. Ed. 2d 201 (1973); *Epperson v. Arkansas*, 393 U.S. 97, 100, 89 S. Ct. 266, 268, 21 L. Ed. 2d 228 (1968). Both Randall and Rogers present injuries-in-fact. Those injuries are a direct result of the POMS. Those injuries are "concrete" and "particularized." See: *Lujan v.*

Defenders of Wildlife, 504 U.S. 555, 560-561, 112 S. Ct. 2130, 2136, 119 L. Ed. 2d 351 (1992). Both Randall and Rogers have "a direct stake in the outcome of the litigation." *Diamond v. Charles*, 476 U.S. 54, 66-67, 106 S. Ct. 1697, 1706, 90 L. Ed. 2d 48 (1986). Clearly, the injury to Randall and Rogers is traceable to the Defendants-Appellees and the POMS, not to some independent third party. *Northwest Airlines v. FAA*, 795 F.2d 195, 203-204 (D.C. Cir. 1986).

For Randall and Rogers no administrative mechanisms are available to address their concerns. As they cannot sign the application for Social Security benefits, they cannot proceed through any administrative channel even if the result of same was not a foregone conclusion, which it is. They would have to enroll in Social Security and Medicare, Part A, and then try to disenroll from Medicare, Part A, only. If they were successful, the POMS would mandate that they surrender their Social Security monthly benefits, and return all of the benefits received from both programs while they participated, making the tautology complete. There is no administrative remedy available to Randall and Rogers.

The POMS are "system-wide rules;" they have bound the Plaintiffs-Appellants "with the force of law." *Cement Kiln Recycling Coalition v. EPA*, 493 F.3d 207, 226-227 (D.C. Cir. 2007); *Gen. Elec. Co. v. EPA*, 290 F.3d 377, 382 (D.C. Cir. 2002). As 42 U.S.C. §§ 405(g) and 1395ff apply to final decisions regarding "eligibility" for Social Security, "entitlement" to Medicare and the

amount of benefits available, they do not apply here. Randall and Rogers are both "eligible" for Social Security and "entitled" to Medicare, Part A. They just do not want to enroll in Medicare, Part A, and, because the POMS have linked Medicare, Part A, and Social Security together, they are being denied the Social Security monthly benefits to which they are entitled.

As the POMS are system-wide policies that are inconsistent in critically important ways with established regulations and statutes, and this action does not depend on the particular facts of any of the Plaintiffs-Appellants, the exhaustion requirement should be excused for Randall and Rogers as it was for Hall, Kraus and Armey. *Bowen v. City of New York*, 476 U.S. 467, 484-486, 106 S. Ct. 2022, 2032-2033, 90 L. Ed. 2d 462 (1986). Randall and Rogers were improperly dismissed by the court below, and it should be reversed on that issue.

CONCLUSION

For all the foregoing reasons Plaintiffs-Appellants pray that this Court reverse the court below, reinstate Randall and Rogers as Plaintiffs and declare the *POMS HI 00801.002*, *Waiver of HI Entitlement by Monthly Beneficiary*, *POMS HI 00801.034*, *Withdrawal Considerations*, and *POMS GN 00206.020*, *Withdrawal Considerations When Hospital Insurance is Involved*, void as contrary to law and of no effect, and direct the Court below to enjoin the Defendants-Appellees, permanently and mandatorily, to permit the Plaintiffs-Appellants to not enroll in,

or disenroll from, Medicare, Part A, and retain their Social Security monthly benefits.

Dated: July 26, 2011

Respectfully submitted,

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Dated: July 26, 2011

/s/ Frank M. Northam
Counsel for Appellants

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on this 26th day of July, 2011, I caused this Brief of Appellants and Joint Appendix to be filed electronically with the Clerk of the Court using the CM/ECF System, which will send notice of such filing to the following registered CM/ECF users:

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I further certify that on this 26th day of July, 2011, I caused the required number of bound copies of the Brief of Appellants and Joint Appendix to be hand-filed with the Clerk of the Court, and a copy of the Joint Appendix to be served, via UPS Ground Transportation, upon Counsel for Appellees at the address listed above.

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Counsel for Appellants

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POMS Section: HI 00801.002

Effective Dates: 06/29/2010 - Present
TN 25 (09-93)

HI 00801.002 Waiver of HI Entitlement by Monthly Beneficiary

A. INTRODUCTION

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

B. POLICY

Individuals entitled to monthly benefits which confer eligibility for HI may **not** waive HI entitlement. The only way to avoid HI entitlement is through withdrawal of the monthly benefit application. Withdrawal requires repayment of all RSDI and HI benefit payments made. (See GN 00206.020 for withdrawal consideration and exclusions).

To Link to this section - Use this URL:
http://policy.ssa.gov/poms.nsf/lnx/0600801002

HI 00801.002 - Waiver of HI Entitlement by Monthly Beneficiary - 06/29/2010
Batch run: 06/29/2010
Rev: 06/29/2010

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POMS Section: HI 00801.034

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Effective Dates: 08/30/1993 - Present
TN 25 (09-93)

HI 00801.034 Withdrawal Considerations

A. POLICY

To withdraw from the HI program, an individual must submit a written request for withdrawal and must refund any HI benefits paid on his/her behalf as explained in GN 00206.095 B.1.c.

An individual who filed an application for both monthly benefits and HI may:

- withdraw the claim for monthly benefits without jeopardizing HI entitlement; **or**
- withdraw the claim for **both** monthly benefits and HI.

The individual may **not** elect to withdraw only the HI claim.

An individual who filed an application for HI only may withdraw the claim at any time (see HI 00801.002).

NOTE: Even though a NH may withdraw a claim for monthly benefits and HI or for HI only, the NH's aged spouse (or other aged auxiliary) retains HI entitlement unless the spouse (or auxiliary) also specifically elects to withdraw the application for HI.

B. REFERENCE

See GN 00206.020 for a complete discussion of withdrawal considerations.

To Link to this section - Use this URL:
http://policy.ssa.gov/poms.nsf/lnx/0600801034

HI 00801.034 - Withdrawal Considerations - 08/30/1993
Batch run: 01/27/2009
Rev:08/30/1993

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Effective Dates: 09/11/2008 - Present
TN 12 (05-02)

GN 00206.020 Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved

A. Background

1. Before 1/1/81

Prior to 1/1/81 an individual age 65 or over had to be entitled to monthly retirement or survivors insurance (RSI) benefits to qualify for HI. Therefore, an individual who withdrew his/her application for monthly benefits lost HI entitlement.

2. Effective 1/1/81

P.L. 96-473 modified the law to provide that an individual 65 or over who filed an application for monthly RSI benefits and HI, is deemed to have filed separate applications for cash benefits and HI coverage. In addition, the individual is deemed entitled to HI based on the date of an original application for monthly benefits which was subsequently withdrawn.
P.L. 96-473 applies only to those claimants who are age 65 or over. It does not apply to:

- Disability (i.e., DIB or disability freeze) applicants; or
- Childhood disability beneficiaries (CDBs), disabled widow(er)s (DWBs) or disabled surviving divorced spouses.

NOTE: Once the disability beneficiaries listed above attain age 65, the exclusion no longer applies.

B. Policy

The claimant can withdraw an application for:

- RSI cash benefits only;
- RSI cash benefits and HI coverage (see HI 00801.022 and GN 00204.021 for an explanation of these benefits); or
- Medicare Only (See HI 00801.008, HI 00801.145, HI 00801.197).

However, a claimant who is entitled to monthly RSI benefits cannot withdraw HI coverage only since entitlement to HI is based on entitlement to monthly RSI benefits (see HI 00801.002). If a

numberholder (NH) filed before age 65 so that his/her spouse would be entitled to HI, and later withdraws the application, the spouse will retain HI entitlement regardless of whether the initial entitlement was before or after 1/1/81.

EXAMPLE 1

In 6/96 a NH (age 62) who was working full-time elected benefits so that his wife, age 66, could be entitled to HI based upon RSI cash benefits. In 12/99, the NH withdrew his application. He kept his HI entitlement which began in 6/99 at age 65, and his wife maintained her HI entitlement which began in 6/96.

EXAMPLE 2

A spouse or survivor beneficiary in a Government Pension Offset (GPO) situation may choose to withdraw the cash benefit portion of his/her RSI claim, to establish entitlement as a Medicare only beneficiary; this would permit deduction of the supplementary medical insurance premium (SMI) from his/her Civil Service annuity. (See HI 00801.022, HI 00801.027, HI 00801.032, HI 00805.245 and HI 01001.190 for HI application requirement, taking a HI claim, establishing HI entitlement, SMI enrollment for civil service annuitants, and SMI premiums for a spouse when GPO is involved respectively.)

C. Procedure

Field offices must determine which application(s) the person wants to withdraw. The conditions for approval of the WD request depend upon the specific entitlement the person wants to nullify.

Follow GN 00204.021 and HI 00801.027 if the person wants to withdraw the application for monthly benefits and keep HI coverage. (See GN 00206.145 for notice requirements.) There is no need to repay any HI benefits, which have already been paid on the person's behalf since the person is not withdrawing the application for HI coverage.

Make sure that the WD request clearly states whether the person wants to include HI coverage in the scope of the WD (see GN 00204.020 for scope of the application). If the claimant wishes to withdraw both RSI and HI coverage, specify the person's reasons for withdrawing HI coverage.

Follow GN 00206.095B.1.c. if the person applied for HI coverage **only**, but after effectuation wants to withdraw the application.

To Link to this section - Use this URL:
http://policy.ssa.gov/poms.nsf/lnx/0200206020

GN 00206.020 - Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved - 09/11/2008
Batch run: 01/27/2009
Rev: 09/11/2008

Federal Administrative Procedure Act

5 U.S.C.

§ 558. Imposition of sanctions; determination of applications for licenses; suspension, revocation, and expiration of licenses

- (a) This section applies, according to the provisions thereof, to the exercise of a power or authority.

- (b) A sanction may not be imposed or a substantive rule or order issued except within jurisdiction delegated to the agency and as authorized by law.

- (c) When application is made for a license required by law, the agency, with due regard for the rights and privileges of all the interested parties or adversely affected persons and within a reasonable time, shall set and complete proceedings required to be conducted in accordance with sections 556 and 557 of this title or other proceedings required by law and shall make its decision. Except in cases of willfulness or those in which public health, interest, or safety requires otherwise, the withdrawal, suspension, revocation, or annulment of a license is lawful only if, before the institution of agency proceedings therefor, the licensee has been given -

    - (1) notice by the agency in writing of the facts or conduct which may warrant the action; and
    - (2) opportunity to demonstrate or achieve compliance with all lawful requirements. When the licensee has made timely and sufficient application for a renewal or a new license in accordance with agency rules, a license with reference to an activity of a continuing nature does not expire until the application has been finally determined by the agency.

Compilation of the Social Security Laws

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OLD-AGE AND SURVIVORS INSURANCE BENEFIT PAYMENTS[18]

Old-Age Insurance Benefits

Sec. 202. [42 U.S.C. 402] (a) Every individual who—

(1) is a fully insured individual (as defined in section 214(a)),

(2) has attained age 62, and

(3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 216(l)),

shall be entitled to an old-age insurance benefit for each month, beginning with—

(A) in the case of an individual who has attained retirement age (as defined in section 216(l)), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or

(B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in section 216(l)), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

and ending with the month preceding the month in which he dies. Except as provided in subsection (q) and subsection (w), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 215(a)) for such month.

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ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Sec. 226. [42 U.S.C. 426] (a) Every individual who—

(1) has attained age 65, and

(2)(A) 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 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,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

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 Online **Code of Federal Regulations**

CFR 20 Title Page

Withdrawal of Application

§404.640 Withdrawal of an application.

(a) *Request for withdrawal filed before a determination is made.* An application may be withdrawn before we make a determination on it if—

(1) A written request for withdrawal is filed at a place described in §404.614 by the claimant or a person who may sign an application for the claimant under §404.612; and

(2) The claimant is alive at the time the request is filed.

(b) *Request for withdrawal filed after a determination is made.* An application may be withdrawn after we make a determination on it if—

(1) The conditions in paragraph (a) of this section are met;

(2) Any other person whose entitlement would be rendered erroneous because of the withdrawal consents in writing to it. Written consent for the person may be given by someone who could sign an application for him or her under §404.612; and

(3) All benefits already paid based on the application being withdrawn are repaid or we are satisfied that they will be repaid.

(c) *Request for withdrawal filed after the claimant's death.* An application may be withdrawn after the claimant's death, regardless of whether we have made a determination on it, if—

(1) The claimant's application was for old-age benefits that would be reduced because of his or her age;

(2) The claimant died before we certified his or her benefit entitlement to the Treasury Department for payment;

(3) A written request for withdrawal is filed at a place described in §404.614 by or for the person eligible for widow's or widower's benefits based on the claimant's earnings; and

(4) The conditions in paragraphs (b) (2) and (3) of this section are met.

(d) *Effect of withdrawal.* If we approve a request to withdraw an application, the application will be considered as though it was never filed. If we disapprove a request for withdrawal, the application is treated as though the request was never filed.

[44 FR 37209, June 26, 1979, as amended at 48 FR 21931, May 16, 1983; 51 FR 37720, Oct. 24, 1986]

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Title 42: Public Health
PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT
Subpart A—General Provisions

§ 406.6 Application or enrollment for hospital insurance.

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

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

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

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

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

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

(1) The transitional provisions set forth in §406.11;

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

(3) A diagnosis ofend-stage renal disease, as specifed in §406.13;

(4) Effective January 1, 1981, eligibility for social security cash benefits, as specified in §406.10(a)(3), if the individual has attained age 65 without applying for those benefits; or

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

(d) *When application is deemedto be filed.* (1) An application based on the transitional provisions or on ESRD is deemed to be filed in the first month of eligibility if it is filed not more than 3 months before the first month, and is retroactive to that month if filed within 12 months after the first month. An application filed more than 12 months after the first month of eligibility is retroactive to the 12th month before the month it is filed.

(2) An application for deemed entitlement to disabled widow's or widower's benefits, that is filed before the first month in which the individual meets all conditions ofentitlement for this benefit, will be deemed

a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed. An application validly filed within 12 months after the first month of eligibility is retroactive to that first month. If filed more than 12 months after that first month, it is retroactive to the 12th month before the month of filing.

(3) Effective June 8, 1980, an application based on eligibility for social security benefits at or after age 65, that is filed before the first month in which the individual meets all eligibility conditions for this benefit, will be deemed a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed.

(4) Effective March 1, 1981, an application under §406.10 that is validly filed within 6 months after the first month of eligibility is retroactive to that first month. If filed more than 6 months after that first month, it is retroactive to the 6th month before the month of filing.

(e) *Individuals who must enroll for hospital insurance.* An individual who must pay a monthly premium for hospital insurance must enroll in accordance with the procedures set forth in §406.21.

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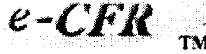

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§ 406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

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

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

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

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

(b) *Beginning and end of entitlement.* (1) Entitlement begins with the first day of the first month in which the individual meets the requirements of paragraph (a) of this section.

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

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

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

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