**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**

## REPLY BRIEF OF APPELLANTS

***Kent Masterson Brown**
**LAW OFFICES OF**
**KENT MASTERSON BROWN, PLLC**
**315 North Broadway**
**Lexington, Kentucky 40508**
**(859) 455-9430**

***Counsel for Appellants***

**Frank M. Northam**
**WEBSTER, CHAMBERLAIN & BEAN**
**1747 Pennsylvania Avenue, N.W.**
**Suite 1000**
**Washington, D.C. 20006**
**(202) 785-9500**

***Counsel for Appellants***

## 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. *Hall v. Sabelius*, 689 F. Supp.2d 10 (D.D.C. 2009). 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. *Hall v. Sebelius*, 770

F.Supp.2d 61 (D.D.C. 2011). The ruling and judgment under review are set forth in the Joint Appendix at 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.

# TABLE OF CONTENTS

**Page**

# TABLE OF AUTHORITIES

*Authorities upon which we chiefly rely are marked with asterisks

**Page(s)**

## CASES



## STATUTES

**OTHER AUTHORITIES**

## GLOSSARY

| | |
|---|---|
| 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 |

## STATUTES AND REGULATIONS

The Plaintiffs-Appellants have no additional statues for inclusion in the Brief.

## SUMMARY OF ARGUMENT

The Defendants-Appellees take the position that "entitlement" to Medicare, Part A, is a mandate that everyone, 65 or older, who applies for Social Security retirement benefits must accept enrollment in Medicare. Proceeding from that premise, the Defendants-Appellees assert that the Plaintiffs-Appellants seek to become "not entitled" by "renouncing" or "abrogating" their Medicare entitlement. That has never been the Plaintiffs-Appellants' position. The Plaintiffs-Appellants acknowledge that they possess a Medicare entitlement which offers them the opportunity to become a Medicare participant (beneficiary). The Plaintiffs-Appellants do not seek to reject that "entitlement," just as they do not seek to reject their Social Security "entitlement."

Defendants-Appellees also complain that the Plaintiffs-Appellants seek to force the Defendants-Appellees Secretary(s) to create an "administrative mechanism" whereby individuals can abrogate their Medicare entitlement and further complain that the Secretary(s) lack the power to do so. Defendants-Appellees' "Statement of the Issue," *Appellees' Brief*, 1. Neither of those concerns needs to be addressed in this case. The issue before the Court is the validity of the POMS. Whatever actions the Secretary(s) may have to take, once the POMS are

invalidated, will be required as a result of the Defendants-Appellees' having to comply with the statutes, not by any request from the Plaintiffs-Appellants that their entitlement to Medicare or Social Security be "abrogated."

Finally, the Defendants-Appellees contend that the Plaintiffs-Appellants have no cognizable injury sufficient to provide them standing in this lawsuit. Defendants-Appellees present the Court with fanciful descriptions of the effects on FEHB insurance plans and HSA accounts resulting from an individual's being forced into Medicare. However, they completely ignore the effects of the invalid POMS which force individuals to relinquish their Social Security retirement benefits in order to escape from Medicare. That threatened loss of a valuable benefit, which is a threat faced by all of the Plaintiffs-Appellants, including Randall and Rogers, is sufficient to confer standing.

## ARGUMENT

### I. Plaintiffs-Appellants Do Not Seek to "Renounce" Their Entitlement to Medicare, Part A

In their opening brief, the Plaintiffs-Appellants never suggested that they sought to "renounce" their entitlement to Medicare, Part A, and they did not contend that the Defendants-Appellees must allow them to "abrogate" that entitlement or somehow declare that the Plaintiffs-Appellants are not entitled to Medicare, Part A. Instead, the Plaintiffs-Appellants ask this Court to read and interpret the term "entitlement," as it is used in 42 U.S.C. § 402(a) (Social

Security) and 42 U.S.C. § 426(a) (Medicare), and apply the normal rules of statutory construction in determining that the Social Security and Medicare "entitlements" are voluntary benefits for which individuals may become qualified when they satisfy the criteria set forth in the statutes.

Throughout their brief, the Defendants-Appellees mischaracterize the Plaintiffs-Appellants' legal position and request for judicial relief by asserting that Plaintiffs-Appellants' seek to "renounce" their entitlement to Medicare, Part A, or that they seek a declaration that they are "not entitled" to Medicare, Part A. The Plaintiffs-Appellants have readily acknowledged to the court below, and to this Court, that they are "entitled" to Medicare, Part A, just as they are entitled to Social Security retirement benefits. Plaintiffs-Appellants do not want to be reclassified as "Not Entitled." Rather, they wish to exercise their rights, as entitled individuals, to decline the proffered Medicare benefits and to be treated as individuals who are not enrolled in Medicare, Part A.[1]

Proceeding upon the mischaracterization of what it is the Plaintiffs-Appellants seek, the Defendants-Appellees present this Court with a Statement of the Issue, *Appellees' Brief*, 1, that need not even be considered by the Court: "This case presents the following issue: whether the Secretary of Health and Human

[1] The Defendants-Appellees object to the Plaintiffs-Appellants' usage of the terms "disenroll" or "not enrolled" but the Plaintiffs-Appellants were forced to create a term to describe their desired status because the Defendants-Appellees' regulations and POMS do not provide any better terminology.

Services is required to provide an administrative mechanism by which persons entitled to Medicare, Part A, benefits pursuant to 42 U.S.C. § 426(a) may abrogate that entitlement without ending their entitlement to Social Security old-age insurance benefits." There are no "administrative mechanisms" before the Court. The only issue is whether "entitlement" under § 426(a) means that a person so entitled must accept Medicare, Part A, benefits as a condition of receiving Social Security retirement benefits.

The Defendants-Appellees' concerns about how the Secretary might or might not be able to establish a framework for handling qualified and "entitled" individuals who decline Medicare, Part A, may be legitimate concerns after the Secretary is ordered to administer the law according to the dictates of the statutes, but those concerns are not presented for decision in this case. The Plaintiffs-Appellants, here, only seek an order to the Secretary(s) to treat "entitlement" as a voluntary status in which the qualified recipient may accept or reject his/her denomination as a Medicare, Part A, enrollee. The Secretary(s) will not need a "mechanism" to "abrogate" "entitlement;" the Secretary(s) will merely need to remove the POMS (to which the Plaintiffs-Appellants object) or revise the POMS to conform to the statutes.

The Plaintiffs-Appellants accept the fact that when they apply for Social Security retirement benefits, they will (as Hall, Kraus, and Armey did) become

entitled to Medicare, Part A. They do not seek to rewrite the statute to somehow eliminate their status as Medicare-entitled. Rather, in accordance with the ordinary meaning of "entitlement," they ask that they be permitted to decline the benefits available under Medicare, Part A, and to be recognized as non-participants in the Medicare program. To remove an administrative roadblock to that course of action, the Plaintiffs-Appellants seek the invalidation of the POMS that are at issue in this case to the extent that those particular provisions prohibit individuals from electing to receive Social Security benefits while declining Medicare benefits.

The Defendants-Appellees, however, assiduously avoid any consideration of the meaning of the term "entitlement" or of the appropriate statutory analysis of the use of that term in the Social Security and Medicare statutes. All of the Defendants-Appellees arguments begin from a premise that "entitlement" in the Medicare statute means "must accept." Such a construction of the term permits them to contend that the Plaintiffs-Appellants want to "renounce" or "abrogate" their entitlement. As just noted, however, that radically misconstrues and wrongly describes the Plaintiffs-Appellants' position.

The Defendants-Appellees' insistence on such a description of the Plaintiffs-Appellants' position enables them to gloss over any analysis of the appropriate interpretation of the term "entitlement." It also enables them to avoid explaining how it is that the Medicare program, guaranteed to be voluntary and not to

preclude individuals from procuring health care services of their choice, becomes mandatory for anyone who applies for Social Security retirement benefits.[2] Similarly, the Defendants-Appellees are able to avoid explaining why someone who wishes to decline the Medicare benefit will only be allowed to do so if he/she relinquishes his/her Social Security retirement benefits, as well as paying back any benefits already received.

Furthermore, only by casting the Medicare benefit as mandatory are the Defendants-Appellees able to contend that this Court should accept the POMS as

---

[2] Defendants-Appellees' contention that Medicare, Part A, is "compulsory" because two members of Congress used the term is of no moment. *Appellees' Brief*, 19. Even if they meant that individuals would be "forced" into Medicare, Part A (which they did not), the comments of two House members do not alter the words of 42 U.S.C. § 426; it still reads, "shall be entitled." What those House members were actually referring to is the fact that Medicare, Part A, is financed by means of a payroll tax, which is compulsory; Medicare, Part B, is not, the beneficiary voluntarily agrees to pay premiums.

Likewise, the use by the Court below (JA 234), and Defendants' use (*Appellees' Brief*, 15) of Justice Stevens opinion in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 674-675, 106 S. Ct. 2133, 2138, 90 L. Ed. 2d 623 (1986), to argue that Medicare, Part A, is "mandatory" is also misplaced. If Medicare, Part A, was mandatory, Justice Stevens would not have quoted 42 U.S.C. § 1395ff, setting forth the appeal rights of an individual dissatisfied with a "determination…as to (A) whether he meets the conditions of Section 426 or Section 426a of this title [which set forth eligibility requirements to be satisfied before an individual is permitted to participate in Part A of the Medicare program]." *Id.* 476 U.S. at 674, n.5, 106 S. Ct. at 2137-2138, n.5. Justice Stevens, like the two aforementioned Congressmen, referred to Medicare, Part A, as "mandatory" only in the sense that individuals must pay a payroll tax to finance it. Part B, on the other hand, is paid for, in part, by premiums paid by those who voluntarily apply for its coverage. In no way did *Michigan Academy* adjudicate the issues raised in this appeal.

"interpretive" rather than "substantive" agency rules. Defendants-Appellees assert that the POMS "reflect outstanding legislative rules" and, therefore, are interpretive. As the Plaintiffs-Appellants demonstrated in their opening brief, however, there are no "legislative rules" that mandate that applicants for Social Security retirement benefits must accept Medicare, Part A, benefits as part of an inseparable package. The statutes contain no such dictate. In fact, the statutes clearly establish (and even the POMS make provision) that one may seek Medicare, Part A, benefits while declining the Social Security retirement benefits to which he/she is entitled. Thus, Medicare and Social Security benefits are not part of an inseparable package. The POMS, by mandating inseparability of Medicare from the receipt of Social Security benefits, contradict that statutory construction and, as a result, are properly viewed as invalid, "substantive" agency rules, which were never promulgated with appropriate notice and comment.

When the Defendants-Appellees' contention that the Plaintiffs-Appellants seek to "renounce" or "abrogate" their Medicare entitlement is properly ignored, the issue in this case can properly be approached as the Plaintiffs-Appellants presented it: Do "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." *Appellants' Brief*, 2. The answer to that question must be "No" when one acknowledges that an entitlement is an

offering that one may accept or reject, without incurring any severe penalty such as the deprivation of Social Security retirement benefits.

## II. All of the Plaintiffs-Appellants Suffer the Cognizable Injury of Loss Of Social Security Retirement Benefits and the Denial of Choice of Health Care Services If the POMS are Enforced

With respect to the standing of Hall, Kraus and Armey, the Court below concluded:

> "Plaintiffs[-Appellants] have standing because they cannot avoid Medicare without foregoing their Social Security Retirement Benefits; they argue that there is no statutory tie between the two. This dispute constitutes a case and controversy without regard to why Plaintiffs[-Appellants] prefer other insurance coverage."

JA 227.

That always has been – and is now – the position of Plaintiffs-Appellants with respect to standing. Simply speaking, by the force of the POMS, and the POMS alone, Social Security Retirement benefits are tied to enrollment in Medicare, Part A, even though there is absolutely no statutory tie between the two. In order for Hall, Kraus and Armey to receive their monthly Social Security Retirement benefits, they were forced, by the POMS, to enroll in Medicare, Part A. JA 3-5, 9-13, 15-16. For Randall and Rogers, they are not able to even receive their Social Security Retirement benefits, according to the POMS, unless they enroll in Medicare, Part A, even though the statutes provide no such requirement. JA 3-4, 7, 12-14, 16-30.

In an effort to avoid discussing standing as the Plaintiffs-Appellants have framed it and the Court below so found, Defendants-Appellees go to great lengths trying to assert that Medicare, Part A, beneficiaries can always refuse to authorize payment from Medicare, thereby paying themselves. *Appellees' Brief*, 29. That, to Defendants-Appellees, makes Medicare, Part A, no different from Hall's, Kraus's and Armey's FEHB health insurance. Presumably, Defendants-Appellees believe it makes Medicare, Part A, no different than Randall's and Rogers's use of their own funds to pay for health care.

There is a difference between FEHB health insurance and Medicare, Part A, that transcends the use of one's own money to pay for health care. One scholar wrote: "FEHB has out-performed Medicare every which way – in containment of costs both to consumers and to the government, in benefit and product innovation and modernization, and in consumer satisfaction." Harry Cain II, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly." 1999 *Health Affairs*, 18(4):25-39. Walton Francis confirmed that finding when he advised FEHB enrollees: "Therefore, if paying both FEHBP and Medicare premiums presses you financially, and you are not sure which program to retain, **the FEHBP alone is a better bargain than Medicare alone.**" Walton Francis, *2011 Guide to Health Plans for Federal Employees*. Washington, D.C.: *Washington Consumer's Checkbook 2010* (hereinafter *2011 Consumer's*

*Checkbook*), 55; http://www.checkbook.org/newhig2/year11/text.cfm or www.guidetohealthplans.org.[3] There is also a difference between the coverage of Medicare, Part A, and the coverage purchased by Randall's and Rogers's use of their own money to pay for all health care services.

The above conclusions that Medicare is an inferior health insurance program reflect the fact that Medicare has been found, in some studies, not to provide its beneficiaries with high quality health care. Stephen F. Jencks, et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association*, 289 (2003): 305-307; Clair Snyder and Gerard Anderson, "Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries?" *Journal of the American Medical Association*, 293 (2005): 2900. See also: David A. Hyman, *Medicare Meets Mephistopheles*. Washington, D.C.: Cato Institute, 2006, 22-25.

Individuals participating in FEHB, like Hall, Kraus, and Armey once did, retain significant freedom of choice that individuals enrolled in Medicare, Part A, do not. FEHB offers eligible individuals a wide range of health plans from which to choose. Beneficiaries of Medicare, Part A, do not have the same access to a

[3] Walton Francis is a consultant who, for many years, served as a policy analyst in the Office of the Secretary of HHS. He has authored the CHECKBOOK's *Guide to Health Plans for Federal Employees* for thirty years.

wide range of health insurance options.[4] Individuals eligible for FEHB are free to choose not to enroll in any given plan or even not enroll at all, freedoms completely denied by the POMS. Randall and Rogers, of course, are completely free to choose and pay for their health care services themselves, but are being denied their Social Security Retirement benefits because they refuse to apply for Medicare, Part A. JA 16-17, 26-27.

Contrary to the assertions of the Defendants-Appellees, Medicare, Part A, beneficiaries lose the freedom to purchase medical services out-of-pocket with their own funds. 42 U.S.C. § 1395cc(a)(1) mandates that a provider (hospital) must be qualified under the Medicare Act in order to participate in Medicare, Part A; and [once qualified] shall be eligible for payments "if it files with the Secretary [of the U.S. Department of Health and Human Services] an agreement (A)(i) **not to charge….any individual or any other person for items or services for which such individual is entitled to have payment made under [Medicare, Part A**]." As a practical matter, no hospital can **ever** charge a Medicare beneficiary, or accept payment from any Medicare beneficiary, except those charges and/or payments explicitly allowed under 42 U.S.C. § 1395cc(a)(1). A Medicare, Part A,

[4] Twenty-nine different FEHB health insurance plans for annuitants between age fifty-five to sixty-five without Medicare are thoroughly outlined in *2011 Consumer's Checkbook*, 57-58, http://www.checkbook.org/newhig2/year11/text.cfm or www.guidetohealthplans.org.

beneficiary must sign a statutorily-mandated form **prior to admission** authorizing the hospital to bill the Medicare intermediary for all items and services provided. 42 U.S.C. § 1395cc(a)(1)(M). If the individual does not sign the form, he or she may not be admitted.[5] That fact disposes of the Defendants-Appellees' contention that Medicare beneficiaries may readily pay for health services of their choice out of their own pockets any time they wish.

No matter how many transmittal letters or circulars Defendants-Appellees parade before this Court claiming a Medicare, Part A, beneficiary may pay "out of his/her own pocket," such events simply cannot and do not occur. Indeed, Medicare has seen so many amendments since 1977, to even use a "Program Circular" from that year as evidence of anything here is pointless. *Appellees' Brief*, 29. No Part A beneficiary will **ever** be in a position to refuse Medicare payment to the hospital and to use his/her own money. The prospective payment is assigned only after discharge. 42 U.S.C. § 1395ww(a). By that time, the beneficiary has already authorized payment; and that authorization had to be signed in order to be admitted. The beneficiary is never presented with the claim.

If the provider (hospital) violates the conditions of participation of Medicare, its agreement with the Secretary will be terminated, pursuant to 42 U.S.C.

[5] 42 U.S.C. § 1395cc(a)(2)(B), a part of the original Medicare enactment in 1965, was actually designed to be a threat against Part A beneficiaries, not an empowerment of them to privately contract with Part A providers.

§ 1395cc(b), the literal economic death for any such institution. Indeed, the provider may be sanctioned for "improper billing." 42 U.S.C. § 1395cc(g). These rigidly-enforced rules effectively deprive Medicare beneficiaries, like Hall, Kraus and Armey, of the freedom to spend their own money on medical care as they see fit.[6] With their FEHB health insurance plans – like all private health insurance – they were completely free to pay for any health care service themselves.

FEHB plans provided Hall, Kraus and Armey comprehensive protection from the costs of a wide range of medical care, including hospital services, physician services, diagnostic tests, mental health services, routine immunizations, emergency care, prescription drugs, nursing services, chemotherapy and radiation, physical therapy and rehabilitation, hearing aids, prosthesis, diabetic supplies, durable medical equipment, vision care, chiropractic care, dental care and preventive services. FEHB plans generally cover many services whether delivered inside or outside of a hospital. *Consumer's Checkbook*, 73-79; http://www.checkbook.org/newhig2/year11/text.cfm or www.guidetohealthplans.org. The protection afforded Randall and Rogers is completely comprehensive, as all decisions and payments are made by them.

[6] Even under Part B of Medicare, for a beneficiary to privately contract with a physician, **he/she must do so with a physician who has completely opted out of the Medicare program**. 42 U.S.C. § 1395cc(a)(b). See *United Seniors v. Shalala*, 185 F.3d 965 (D.C. Cir., 1999).

By contrast, Medicare, Part A, covers only select medical services, generally those provided by health care facilities, including inpatient hospital services, skilled nursing facility services, home health care and hospice care. 42 U.S.C. §§ 1395ww, 1395yy, and 1395bbb; http://www.opm.gov/insure/archive/health/medicare/75-12-FINAL.pdf.

The payment systems that a health insurance plan uses to purchase medical care influence how providers practice medicine. Medicare, Part A, essentially traps beneficiaries in one payment system, leaving them no escape from the perverse incentives that system creates. For example, Medicare, Part A, purchases hospital services using the Prospective Payment System (PPS). 42 U.S.C. § 1395ww. Hospitals receive a fixed amount based on the Medicare, Part A, beneficiaries' Diagnostic-Related Group (DRG), or diagnosis at discharge. 42 U.S.C. § 1395ww(d). Medicare assigns a payment rate to each DRG based on the cost of the average beneficiary with that diagnosis. Hospitals receive the same payment for each Medicare, Part A, beneficiary in a given DRG, irrespective of how many resources (including bed-days) the patient actually consumes. Medicare does allow adjustments for what is called "case mix severity." 42 U.S.C. § 1395ww(d)(5)(C)(ii) and 42 U.S.C. § 1395ww(j)(2); See: CMS "Prospective Payment Systems—General Information," https://www.cms.gov/ProspMedicareFeeSvcPmtGen/. Yet, the incentives to

discharge Medicare, Part A, beneficiaries as quickly as possible, and to avoid follow-up care that might reduce readmissions, remain. That phenomenon has resulted in hospitals being incentivized to discharge Medicare, Part A, beneficiaries as quickly as possible and to avoid follow-up care. A 2006 Rand Corporation analysis, entitled "Effects of Medicare's Prospective Payment System on the Quality of Hospital Care," demonstrated the reality of this statement: http://rand.org/pubs/research_briefs/RB4519.html.

This per-admission payment system encourages hospitals to discharge a Medicare, Part A, beneficiary not only before he/she incurs more than the average amount of charges for his/her DRG – indeed, **it encourages hospitals to discharge Medicare, Part A, beneficiaries as quickly as possible**. Many studies have documented the effect of the DRG system on lengths-of-stay in hospitals. One study found lengths-of-stay for Medicare, Part A, beneficiaries dropped from 10.4 days at the beginning of 1981 (pre-DRG) to 8.8 days at the end of 1984 (post-DRG). K. Davis, *et al*. "Is Cost Containment Working," *Health Affairs,* 4, no.3 (1985): 81-94, http://content.healthaffairs.org/content/4/3/81.full.pdf. Another study found a reduction from 10.0 to 9.1 days in the first year. M.A. Morrisey, *et al.*, "Shifting Medicare Patients Out of Hospital," *Health Affairs*, 7, no. 5 (1988); 52-64, http://content.healthaffairs.org/content/7/5/52.full.pdf. See also HHS's own February 1988 study of lengths of stay for disabled Medicare, Part A,

beneficiaries under the prospective payment system. Korbin Liu and Kenneth G. Maton, "Effects of Medicare's Hospital Prospective Payment System (PPS) on Disabled Medicare Beneficiaries," Final Report, February 1988. http://aspe.dhhs.gov/daltcp/reports/pps.htm. ("Expected reduction in lengths of hospital stays occurred," the report noted.) It is the foregoing phenomenon, more than any other, that causes hospitals to treat Medicare, Part A, beneficiaries differently from those covered by private insurance plans.

In contrast, if Hall, Kraus and Armey could have kept their FEHB health insurance plans they had – or chosen FEHB programs using different payment systems, and therefore different ways of practicing and delivering medical services (which they would have been free to do) – they could have avoided such perverse practices. Many FEHB enrollees, for example, may choose health plans that offer electronic medical records and that coordinate the care that hospitals and other providers deliver to a shared patient as well as high-deductible plans with Flexible Spending Accounts and/or Health Savings Accounts ("HSA"). Hall and Kraus are examples of those who chose FEHB plans with HSAs that allowed them the maximum control over the health care services they would have received by controlling payment themselves to the highest degree possible. JA 19-20, 111, 117; *2011 Consumer's Checkbook*, 93-100, 119-124; http://www.checkbook.org/newhig2/year11/text.cfm or

www.guidetohealthplans.org. Randall and Rogers are completely free of all such perverse practices as they, and they alone, decide how long they remain in a hospital.

The health insurance that all the Plaintiffs-Appellants are being forced to accept (or be denied their Social Security Retirement benefits) – Medicare, Part A – is a fiscal "basket case." It is constantly threatened with bankruptcy, and, to cut costs, it is constantly subject to Congressional and regulatory measures designed to keep it afloat by, among other things, rationing health care and continually addressing the fraud and abuse to which Medicare seems particularly vulnerable. The more newsprint about Medicare going bankrupt, the more fear arises that Medicare beneficiaries will have their health care services further rationed, a concern that has received wide attention recently.[7] In actuality, Medicare already rations care.[8] It is a program that has been

[7] Peter Singer, "Why We Must Ration Health Care," July 19, 2009, *New York Times*. http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html.

[8] See Peter G. Peterson on Charlie Rose – July 3, 2009 – About 17 minutes in http://www.charlierose.com/view/interview/10443. (Peterson, former Secretary of Commerce, indicating that rationing was inevitable considering the state of U.S. finances and the trillions of dollars of unfunded Medicare liabilities.) Individuals on Medicare have been regarded as a "social threat" by some medical ethicists like Daniel Callahan in *Setting Limits: Medical Goals in an Aging Society* (http://books.google.com/books?id=NH1T-sVvEw4C&dq. The Congressional Budget Office reported in June 2008 that: "Further growth in spending per beneficiary for Medicare and Medicaid – the federal government's major health care programs – will be the most important determinant of long-term trends in federal spending. Changing those programs in ways that reduce the growth of

historically wracked with fraud, abuse and financial trouble. Tom Schatz, "Medicare Will Be Bankrupt by 2019," *Budget & Tax News*, May 1, 2004, http://news.heartland.org/newspaper-article/2004/05/01/medicare-will-be-bankrupt-2019; National Public Radio, "Medicare's Looming Bankruptcy," www.npr.org/templates/story/story.php?storyId=1791298; Justin Bank, "Going Out of Business," *Newsweek*, October 7, 2009, www.newsweek.com/2009/10/06/going-out-of-business.html; Smartabouthealth.net, "Medicare, Social Security Funds Diminish, Going Bankrupt," http://smartabouthealth.net/curiosity/2010/08/06/medicare-social-security-funds-diminish-going-bankrupt/; "Is Medicare Going Bankrupt?" http://www.scribd.com/doc/517802/Is-Medicare-Going-Bankrupt; "Medicare Bankrupt in 6-8 Years Without Rationing, True Cost Containment," July 30, 2009, http://truecostblog.com/2009/07/30/medicare-bankrupt-in-6-8-years-without-rationing/; How Do You Squeeze 35 Billion From a System (Medicare) That is Going Bankrupt?" January 25, 2010, http://bankruptcy.hirby.com/how-do-you-

---

costs – which will be difficult, in part because of the complexity of health policy choices – is ultimately the nation's central long-term challenge in setting federal fiscal policy…total federal Medicare and Medicaid outlays will rise from 4 percent of GDP in 2007 to 12 percent in 2050 and 19 percent in 2082 – which, as a share of the economy, is roughly equivalent to the total amount that the federal government spends today. The bulk of that projected increase in health care spending reflects higher costs per beneficiary rather than an increase in the number of beneficiaries associated with an aging population." CBO Testimony (http://www.cbo.gov/ftpdocs/93xx/doc9385/06-17-LTBO_Testimony.pdf).

squeeze-35-billion-from-a-system-medicarethat-is-going-bankrupt/. "The Coming Crisis for Medicare," *Boston Globe*, June 9, 2007, http://www.boston.com/news/globe/editorial_opinion/oped/articles/2007/06/09/the_coming_crisis_for_medicare/. Most recently, Congress cut Medicare by five hundred billion dollars ($500,000,000,000.00) in the Patient Protection and Affordable Care Act!

In an effort to further avoid discussing standing as decided by the Court below, Defendants-Appellees go to great lengths to assert that, for Hall, Kraus and Armey, the Office of Personnel Management requires FEHB carriers follow standard "coordination of benefits rules established by the National Association of Insurance Commissioners. "Those rules," claim the Defendants-Appellees, "make Medicare, Part A, the primary insurer for hospital expenses incurred by individuals 'entitled' to Medicare, Part A, benefits, leaving FEHB carriers secondary payers." *Appellees' Brief*, 31. Defendants-Appellees seem to conclude that FEHB carriers would be second dary payers even if Hall, Kraus and Armey were allowed to disenroll from Medicare, Part A, even though no claim would be filed with Medicare (as it would not be a carrier and Medicare would not even be aware of the insured or of any health care matters relating to him/her), a perfectly unreasonable assertion. The fact of the matter is, Hall, Kraus and Armey could have kept their FEHB insurance and it would have been

the only carrier to adjudicate and pay their claims. http://www.mhbp.com/web/groups/public/documents/webcontent/a034028.pdf, 125-126; JA 19-20, 111, 116-117, 123, 133-135, 140, 147 152-153. For Randall and Rogers, no primary or secondary payor is even in the picture so long as they pay for health care themselves.

The Defendants-Appellees' contentions that the Plaintiffs-Appellants are not injured in regard to the kind of health care available to them, were they not Medicare participants, are simply erroneous. The court below, ultimately, concluded that "[t]his dispute constitutes a case or controversy without regard to why Plaintiffs-Appellants prefer other insurance coverage…" and without regard to "whether Plaintiffs-Appellants' desire to avoid Medicare, Part A is sensible." JA 227. Hall, Kraus and Armey had standing because they faced the loss of their Social Security retirement benefits as the price to be paid for avoiding participant status in the Medicare program. That was a real and substantial injury supporting the Courts' finding that those Plaintiffs-Appellants have standing. Plaintiffs-Appellants Randall and Rogers face the same loss of Social Security retirement benefits to which they would be entitled if they apply for those benefits but refuse to accept Medicare – so long as the POMS are in effect. The fact that Randall and Rogers have not applied for benefits, because of the POMS, has prevented them

from receiving their Social Security payments and their injury is equally real and severe so as to establish their standing to sue.

## CONCLUSION

For all of the foregoing reasons, the district court's September 29, 2009 ruling that Randall and Rogers lack standing should be reversed and the district court's March 16, 2011 ruling, upholding the validity of the POMS, should be reversed.

Dated: September 7, 2011

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
Counsel to Plaintiffs-Appellants, Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus and Richard K. Armey

## CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 28.1(e)(2) or 32(a)(7)(B) because:

   [ X ] this brief contains [*4,728*] words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), *or*

   [ ] this brief uses a monospaced typeface and contains [*state the number of*] lines of text, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because:

   [ X ] this brief has been prepared in a proportionally spaced typeface using [*Microsoft Word 2007*] in [*14pt Times New Roman*]; *or*

   [ ] this brief has been prepared in a monospaced typeface using [*state name and version of word processing program*] with [*state number of characters per inch and name of type style*].

Dated: September 7, 2011

*/s/* Frank M. Northam
*Counsel for Appellants*

## CERTIFICATE OF FILING AND SERVICE

I hereby certify that on this 7th day of September, 2011, I caused this Reply Brief of Appellants 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:

Samantha L. Chaifetz
Mark B. Stern
U.S. DEPARTMENT OF JUSTICE
950 Pennsylvania Avenue, N.W., Room 7248
Washington, D.C. 20530
(202) 514-4621

*Counsel for Appellees*

I further certify that on this 7th day of September, 2011, I caused the required number of bound copies of the Reply Brief of Appellants to be hand-filed with the Clerk of the Court.

*/s/* Frank M. Northam
*Counsel for Appellants*