

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

BRIAN HALL, et al)	
)	
Plaintiffs)	CIVIL ACTION
)	NO. 1:08-cv-01715-RMC
v.)	
)	
MICHAEL LEAVITT, et al)	
)	
Defendants.)	

**PLAINTIFFS’ MEMORANDUM OF POINTS AND AUTHORITIES
IN SUPPORT OF THE MOTIONS FOR A RESTRAINING ORDER
AND PRELIMINARY INJUNCTION**

MAY IT PLEASE THE COURT:

NOW COMES THE PLAINTIFF, BRIAN HALL (and the Plaintiffs, LEWIS RANDALL, NORMAN ROGERS, JOHN J. KRAUS and RICHARD K. ARMEY) by and through counsel, and for their Memorandum of Points and Authorities in Support of the Motions For a Restraining Order and Preliminary Injunction, state as follows:

STATEMENT OF FACTS

I. BRIAN HALL HAS A HEALTH INSURANCE PLAN HE OBTAINED AS A FEDERAL EMPLOYEE HE PREFERS OVER MEDICARE

Plaintiff, BRIAN HALL, will be sixty-five years of age on January 3, 2009 and will, therefore, be statutorily eligible for Medicare, Part A. He has been receiving his monthly Social Security benefits since 2006, the year he reached age sixty-two. *Verified Amended and Substituted Complaint for Declaratory Judgment, A Restraining Order and Preliminary and Permanent Injunction* (“Amended Complaint”), ¶¶3, 12, and 24; *Declaration of Brian Hall* (“Hall Declaration”), ¶¶ 2 and 9.

In accordance with the policies of the Defendants that are challenged in this case, *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*, BRIAN HALL will be *automatically* enrolled in Medicare, Part A, in January, 2009. He will be forced thereby to discontinue his current Federal Employee Health Benefits 5 U.S.C. § 8901, *et seq.* (“FEHB”) health insurance plan, as he will no longer be able to contribute to his Health Savings Account (“HSA”), and his insurance carrier will cease covering his health care costs and expenses as the primary insurer. 26 U.S.C. § 223(b)(7); *IRS Publication 969* at www.irs.gov; *Amended Complaint*, ¶ 13; *Hall Declaration*, ¶ 21. In addition, he will be prohibited from using his own money to pay for his health care services. *Hall Declaration*, ¶ 22; 42 U.S.C. § 1395a(b). BRIAN HALL will lose control over his own health care decision-making, even though that was the whole reason he entered into the FEHB health insurance plan he currently enjoys. If he refuses to accept Medicare, Part A, he will not only lose all of his future, monthly Social Security benefits, according to the aforementioned policies, but he will be required to repay to the Social Security Administration all of the monthly Social Security payments he has received over the past three years. *Amended Complaint*, ¶ 18 (*POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary*); *Hall Declaration*, ¶ 24.

Plaintiff BRIAN HALL was formerly an employee of, and is now retired from, the United States Department of Housing & Urban Development in Washington, DC. *Amended Complaint*, ¶ 13; *Hall Declaration*, ¶ 2. Pursuant to the FEHB program, he chose to participate in the “Mail Handlers Benefit Plan – Consumer Option” upon retirement, a plan that included an HSA and a high-deductible health insurance policy which is, and will be, available for the balance of Plaintiff’s life and will cover his future health care expenses, unless he is compelled to enroll in Medicare, Part A. *Hall Declaration*, ¶ 3, 4, 5, 6, 7 and 8.¹ It gave BRIAN HALL the maximum control over his own health care decision-

¹ BRIAN HALL deposits a portion of his insurance premium each month into his HSA; he also deposits his own funds in his HSA. Those deposits are tax deductible; in 2008, \$3,800.00 will be deductible. His HSA earns interest which is also

making, and that was the whole reason he entered into the FEHB plan currently in force. That plan was designed to cover BRIAN HALL for the remainder of his life in lieu of Medicare. *Hall Declaration*, ¶¶ 3 and 8, and see: <http://www.mhbp.com/web/groups/public/documents/webcontent/a034028.pdf>.

Plaintiff BRIAN HALL refuses to participate in Medicare, Part A; he has already notified the Defendants in writing that he will not enroll in Medicare, Part B. *Hall Declaration*, ¶¶ 8, 9, 10, 11 and 20. He believes the health care services provided to Medicare beneficiaries are inferior to those he could obtain privately; the health care services provided to Medicare beneficiaries are now and will be, in the future, rationed because of budget constraints; Medicare beneficiaries have little control over the health care services provided to them; and the health care services provided under Medicare are not provided with a concern for beneficiaries' privacy; rather, claims are filed with intermediaries and carriers under contract with the Defendant, MICHAEL LEAVITT, Secretary of the United States Department of Health and Human Services (“Secretary”), and are viewed and examined by numerous individuals and shared with multiple federal, state, and even private agencies, pursuant to the Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, and the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1171 *et seq.*, (“HIPAA”), among other statutory provisions. *Amended Complaint*, ¶12; *Hall Declaration*, ¶23.

BRIAN HALL’S concerns about the quality of Medicare coverage are not without foundation. Indeed, Gabrielle M. Kotoski, RN, a Medicare coding specialist and authority in the field of Medicare reimbursement, has articulated why Medicare is inferior to other private health insurance programs; how it restricts payment and restricts health care choices; and, otherwise rations health care. Much of that restricting and rationing of care is due to severe budget constraints in the Medicare system. *Declaration of Gabrielle M. Kotoski, RN (“Kotoski Declaration”)*, *passim*. BRIAN HALL wants to maintain complete control over his own health care decision making; he does not want to be forced into

tax deductible. He is permitted to use his HSA to pay all of the health care expenses not covered by co-insurance and co-payments. *Hall Declaration*, ¶¶ 4 and 5.

a system where a government agency determines the health care services he will receive.²

II. IF BRIAN HALL IS FORCED INTO MEDICARE, PART A, HE WILL NO LONGER BE ABLE TO PAY PRIVATELY FOR HEALTH CARE SERVICES

If BRIAN HALL is automatically enrolled in Medicare, Part A, on January 1, 2009, as the challenged policies dictate, he will lose the right to pay for his own health care services. BRIAN HALL would be considered a “Medicare beneficiary” for all purposes of the Medicare Act. The term “Medicare beneficiary” is defined at 42 U.S.C. § 1395a(5) as “... an individual who is entitled to benefits under Part A of this subchapter or enrolled under Part B of this subchapter.” Title 42 USC § 1395a(b)(1) then provides, in pertinent part:

(b) Use of private contracts by Medicare beneficiaries

(1) In general

Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service-

(A) for which no claim for payment is to be submitted under this subchapter, and

(B) for which the physician or practitioner receives-

(i) no reimbursement under this subchapter directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.

Title 42 USC § 1395a(b)(2)(B), entitled “beneficiary protections,” lists certain provisions that private contracts authorized by §(b)(1) must include:

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate...that by signing such contract the beneficiary-

(i) agrees not to submit a claim (or request that the physician or practitioners submit a claim) under this title for such items or services even if such items or services are otherwise covered by this subchapter;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

(iii) acknowledges that no limits under this title...apply to amounts that may be charged for such items or services;...; and

² This case is not an attack against Medicare; the Plaintiffs do not ask this Court to make any determination regarding the quality of health care services provided under the Medicare program. Rather, Plaintiffs present this testimony to underscore their concerns about the program and why they do not wish to enroll, or be enrolled, in Medicare. This case addresses the voluntariness of Medicare.

(iv) acknowledges that the Medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Title 42 U.S.C. § 1395a(b)(3)(B)(ii) provides that such private contracts are authorized only if the physician signs an affidavit which states that he or she –

will not submit any claim under this title for any item or service provided to any Medicare beneficiary (and will not receive any [Medicare] reimbursement...for any such items or services) during the two-year period beginning on the date the affidavit is signed....

“This means,” wrote the United States Court of Appeals for the District of Columbia, “that a doctor who enters into a [42 U.S.C. § 1395a(b)] private contract with even a single patient is barred from submitting a claim to Medicare on behalf of any patient for a two year period.” *United Seniors Ass’n. v. Shalala*, 182 F.3d 965, 968 (D.C.Cir. 1999). In other words, as a “Medicare beneficiary,” BRIAN HALL would not be able to engage in any private contractual relationships with his physicians and providers because the above provisions effectively prohibit him from paying them privately unless they withdraw from Medicare altogether. If BRIAN HALL were to enter into a private contract with a physician or provider of his choice, notwithstanding the above provisions, that physician or provider would face serious sanctions, including removal from participation in the Medicare program. Thus, BRIAN HALL’S physicians and providers will not provide health care services for him and be paid privately by him so long as he is a “Medicare beneficiary.”

III. IF BRIAN HALL IS FORCED INTO MEDICARE, PART A, HE WILL LOSE HIS HSA AND HIS HEALTH INSURANCE CARRIER AS PRIMARY INSURER

Automatically enrolling Plaintiff, BRIAN HALL, in Medicare, Part A, will bar him from contributing any more funds into his HSA. *Hall Declaration*, ¶¶ 6 and 21. See *IRS Publication 969* at www.irs.gov. Even if he could use the funds in his HSA to pay for some health care services, it would quickly dwindle to nothing. According to 26 U.S.C. § 223(b)(7):

Medicare eligible individuals

The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to

benefits under Title XVIII of the Social Security Act and for each month thereafter.

BRIAN HALL, accordingly, will lose his HSA if he is forced to comply with the challenged policies or rules.

Beyond losing his HSA, BRIAN HALL will lose his insurer as the “primary” insurer. Medicare will become the primary insurance carrier, making all determinations regarding coverage; his current insurer will become only a supplemental carrier. BRIAN HALL will cease enjoying full control over all of his health care choices. Instead, Medicare will control what providers are utilized and what health care services are delivered.

IV. IF BRIAN HALL CHOOSES NOT TO ENROLL IN, OR DISENROLL FROM, MEDICARE, PART A, HE WILL HAVE TO SURRENDER HIS MONTHLY SOCIAL SECURITY BENEFITS

Because BRIAN HALL refuses to participate in Medicare, Part A, he will lose his Social Security benefits according to *POMS (“Program Operations Manual Section”) HI (“Hospital Insurance”) 00801.002, Waiver of HI Entitlement by Monthly Beneficiary,* *POMS HI 00801.034, Withdrawal Considerations,* and *POMS GN 00206.020, Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved.* Indeed, he will also be required to repay to the Social Security Administration all of the Social Security benefits he has received over the past three years. *Amended Complaint, ¶¶ 18, 19, 20, 24 and 25; Hall Declaration, ¶¶ 11 and 24.* That, Plaintiff, BRIAN HALL, cannot afford to do. *Hall Declaration, ¶ 24.*

V. THE POLICIES CHALLENGED HEREIN ARE CLEAR, SYSTEM-WIDE RULES

The policies challenged in this case are clear, unequivocal, system-wide rules. *POMS HI (“Hospital Insurance”) 00801.002, Waiver of HI Entitlement by Monthly Beneficiary,* reads, in pertinent part:

A. INTRODUCTION

Some individuals entitled to monthly benefits have asked to waive HI Entitlement

because of religious or philosophical reasons, or because they prefer other health insurance.

B. POLICY

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

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

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

A. POLICY

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

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

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

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

B. POLICY

The claimant can withdraw an application for:

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

However, a claimant who is entitled to monthly RSI benefits cannot withdraw HI [Medicare, Part A] coverage only since entitlement to HI [Medicare, Part A] is based on entitlement to monthly RSI benefits... (emphasis added).³

³ The foregoing policies may be found on the web at <https://secure.ssa.gov/apps10/poms.nst/lnx0200206020> open

VI. THE EFFECT OF THE CHALLENGED RULES IS TO FORCE BRIAN HALL – AND ALL CITIZENS – TO ENROLL IN MEDICARE, PART A, WHETHER THEY WANT TO OR NOT

The foregoing provisions serve to tie monthly benefits under Social Security and Medicare, Part A, enrollment together and to confiscate an individual's Social Security monthly benefits if he or she attempts to opt out of Medicare, Part A. As noted in the Amended Complaint and in BRIAN HALL'S Declaration, BRIAN HALL contacted representatives of the Defendants more than twelve (12) months ago in order to ascertain the process of avoiding enrollment in Medicare, Part A. Agents of both Defendants informed him that he would be automatically enrolled upon reaching sixty-five years of age (January 2009) and that he could not disenroll. He was informed that if he tried to disenroll, he would have to forfeit his monthly Social Security benefits and to repay those benefits he had received since 2006. When he asked how that might be challenged, the response was "notify your Congressman." BRIAN HALL subsequently discovered *POMS ("Program Operations Manual Section") HI ("Hospital Insurance") 00801.002, Waiver of HI Entitlement by Monthly Beneficiary,* *POMS HI 00801.034, Withdrawal Considerations,* and *POMS GN 00206.020, Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved,* and that the information he had been given by the agents of the Defendants was found therein. There was no mechanism provided by the Defendants to challenge the aforesaid policies. *Amended Complaint*, ¶¶ 24 and 25; *Hall Declaration* ¶¶ 9, 10, 11, 12, 13 and 14.

BRIAN HALL does not want to enroll in, or be enrolled in, Medicare, Part A; he wants to keep his FEHB health insurance plan because he wants complete freedom of choice over his health care decisions. He also wants to keep his monthly Social Security benefits, as they represent his savings which he has been assured by the Federal government over the years was being kept for his retirement, and Congress has never enacted any amendments to the Social Security Act or the Medicare Act authorizing defeasance of one's monthly Social Security benefits if he or she does not want to enroll in,

or wants to disenroll from, Medicare, Part A.

In the absence of a restraining order and a preliminary injunction, BRIAN HALL will be irreparably harmed; he will be forced to make the choice between receiving his monthly Social Security benefits and enrolling in Medicare, Part A, or, disenrolling from Medicare, Part A, and suffering severe consequences. If he is forced to enroll in Medicare, Part A, he will not be able to retain his FEHB health insurance program, including his HSA, which provides him with the liberty to choose his own physicians or health care providers and ensures his right to complete control over and privacy in his health care decisions, treatments and records. He will also lose the freedom to use his own money to pay for health care services. If he refuses to be enrolled in Medicare, Part A, he will lose his monthly Social Security benefits and have to repay to the Social Security Administration all the monthly benefits paid to him since 2006; he cannot afford to do that.

ARGUMENT

I. INTRODUCTION

The usual role of a restraining order and a preliminary injunction is to preserve the *status quo* pending the outcome of litigation. *United Mine Workers v. International Union, United Mine Workers*, 412 F.2d 165, (D.C. Cir., 1969), citing 7 J.W. Moore, *Federal Practice* (2d ed. 1968), ¶ 65.04[1]. Such is entered by the Court in order to protect plaintiffs whose interests are indeterminate during the duration of the action. The role of that intermediate injunctive relief is magnified when the interest at stake is fundamental to the well-being of the party seeking the injunction. Plaintiff BRIAN HALL has been receiving monthly Social Security benefits for nearly three (3) years and desires to continue receiving those benefits. He refuses to be enrolled in Medicare, Part A; rather, he wants to keep his FEHB health insurance plan, including his HSA, in force and maintain control over his own health care decision making. Because the Defendants' policies, which mandate that Social Security monthly benefits and Medicare, Part A, participation are linked, are in dispute, it is appropriate that the *status*

quo be maintained until the Court decides whether those policies are valid.

The Amended Complaint herein seeks, among other forms of relief, a restraining order and a preliminary injunction against the Defendants, barring them from enforcing the aforementioned policies pending a final disposition on the merits. As the litigation of the case *sub judice* is anticipated to extend beyond January 2009, Plaintiffs seek a restraining order and preliminary injunction compelling the Defendants to continue providing Plaintiff, BRIAN HALL, his monthly Social Security benefits and preventing Defendants from automatically enrolling him in, or mandatorily directing the Defendants to disenroll him from, Medicare, Part A, pending a final adjudication of all of the issues raised herein.

II. THE COURTS IN THE DISTRICT OF COLUMBIA CIRCUIT HAVE ESTABLISHED FOUR FUNDAMENTAL REQUIREMENTS FOR THE ISSUANCE OF A PRELIMINARY INJUNCTION

There are four (4) well-known requirements for a court to issue a restraining order and/or preliminary injunction. In the first place, a plaintiff must establish (1) that he possesses a substantial likelihood of success on the merits; (2) that he would suffer irreparable injury if the injunctive relief were not granted; (3) that an injunction would not substantially injure other interested parties; and (4) that the public interest would be furthered by the injunction. *Serono Lab. v. Shalala*, 158 F.3d 1313, 1317-1318 (D.C.Cir. 1998); *City Fed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 746 (D.C. Cir. 1995).

Fundamentally, the "movant must show a substantial likelihood of success on the merits," a requirement the United States Court of Appeals for the District of Columbia Circuit has noted is sometimes phrased as a "reasonable probability of success." *Delaware & H. R. Co. v. United Transp. Union*, 450 F.2d 603, 619 (D.C. Cir. 1971). Moreover, "an assessment of the merits also suffuses the other factors requisite to a preliminary injunction -- the requirement that movant show irreparable harm in the absence of an injunction, and the need of the court to consider damage to the respondent from

granting the injunction, and to consider the public interest involved in both the grant and denial of relief. The accommodation and ‘balancing’ of these considerations often, perhaps typically, depend on underlying premises as to the substantive law defining legal rights.” *Id.*

The first requirement enunciated in *Delaware & H.R. Co. v. United Transp. Union, supra.*, that of “substantial likelihood of success on the merits,” has often been viewed as an estimate of the relative importance of the rights asserted and the acts sought to be enjoined. *Dalmo Sales Co. v. Tysons Corner Regional Shopping Center*, 429 F.2d 206 (D.C. Cir. 1970), *Perry v. Perry*, 190 F.2d 601 (D.C. Cir. 1951). The likelihood of success on the merits that a movant for a restraining order and/or preliminary injunctive relief must demonstrate varies with the quality and *quantum* of harm that he will suffer as a result of the relief sought. "Where it appears that a lack of showing of irreparable damage . . . exists," the United States Court of Appeals for the Second Circuit has pointed out, "the party seeking a preliminary injunction has a burden of convincing [the court] with a reasonable certainty that it must succeed at [the] final hearing." *Dino de Laurentiis Cinematografica v. D-150, Inc.*, 366 F.2d 373, 375 (2d Cir. 1966); see also, *Unicon Mgt. Corp. v. Koppers Co.*, 366 F.2d 199, 204 (2d Cir. 1966) and *United Mine Workers v. International Union, United Mine Workers, supra.* The foregoing indicates that as the potential harm suffered by plaintiff by the denial of the restraining order and/or preliminary injunction decreases, the required showing of success on the merits increases.

It also must be noted that while the probability of success on the merits is a factor to be considered on a motion for a restraining order and/or for a preliminary injunction, such an application "does not involve a final determination of the merits," but, rather, "the exercise of a sound judicial discretion" on the need for interim relief. *Public Service Commission of Wisconsin v. Wisconsin Telephone Co.*, 289 U.S. 67, 70, 53 S. Ct. 514, 315, 77 L. Ed 1036 (1933). Thus, when a motion for a restraining order and/or preliminary injunction is presented to a court in advance of a hearing on the merits, “the court is called upon to exercise its sound discretion upon the basis of a series of estimates:

the relative importance of the rights asserted and the acts sought to be enjoined, the irreparable nature of the injury allegedly flowing from denial of preliminary relief, the probability of the ultimate success or failure of the suit, the balancing of damage and convenience generally...." *Perry v. Perry*, 190 F.2d 601, 602 (D.C. Cir. 1951).

III. THERE IS A SUBSTANTIAL LIKELIHOOD THAT THE PLAINTIFFS WILL SUCCEED ON THE MERITS OF THE CASE SUB JUDICE

A. THE CHALLENGED POLICIES ARE TOTALLY CONTRARY TO THE SOCIAL SECURITY AND MEDICARE ACTS AND REGULATIONS PROMULGATED THEREUNDER

1. ***HI00801.002, WAIVER OF HI ENTITLEMENT BY MONTHLY BENEFICIARY, HI00801.034, WITHDRAWAL CONSIDERATIONS, and GN00206.020, WITHDRAWAL CONSIDERATIONS WHEN HOSPITAL INSURANCE IS INVOLVED, 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***

- a. **The Statutory Entitlement to Social Security Monthly Benefits Makes It Clear Such Is Voluntary**

The Plaintiff, BRIAN HALL, will succeed on the merits in this case because the Social Security and Medicare Acts are entirely voluntary and neither incorporate sanctions against an individual who does not enroll in, or disenrolls from, the other. In the first place, "entitlement" to Social Security benefits is statutory. *Flemming v. Nestor*, 363 U.S. 603, 80 S.Ct. 1376, 4 L.Ed.2d. 1435. The only route one may pursue to become "eligible" for Social Security benefits is found in the Social Security Act, 42 U.S.C. §§ 401 et seq. Specifically, § 402 of Title 42 U.S.C. reads, in pertinent part, as follows:

(a) Old-age insurance benefits

Every individual who --

- (1) is a fully insured individual (as defined in § 414(a) of this title),
- (2) has attained age 62, and
- (3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in § 416(l) of this title),

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

- (A) in the case of an individual who has attained retirement age (as defined in § 416(l) of this title), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or
- (B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in § 416(l) of this title), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

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

....

(j) Application for monthly insurance benefits

- (1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of this section for any month after August 1950 had he filed application therefor prior to the end of such month *shall be entitled to such benefit for such month if he files application therefor prior to –*
 - (A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f) of this section, and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) of this section on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or
 - (B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply (emphasis added).

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

particular, predicate entitlement to Social Security benefits upon enrollment in Medicare, Part A. There are no other conditions, save for special requirements for spouses, children, mothers and fathers, parents, widows and widowers, aliens and “simultaneous” benefits which have no bearing on the questions discussed herein. See 42 U.S.C. § 402(b)-(i) and (k)-(l).

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

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

(a) Individuals over 65 years

Every individual who –

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

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

An individual must attain the age of 65 years and be entitled to monthly Social Security benefits to be eligible. He or she must, nevertheless, request that those benefits be accessed. It is clear that Congress did not make the obtaining of Medicare, Part A, benefits mandatory. It may have made Medicare, Part

A, benefits automatically available, upon the filing of an application for Social Security benefits, but the individual would only be accessing that to which he was entitled or eligible.

The Medicare Act itself also addresses “eligibility” for Medicare, Part A. Title 42 U.S.C. § 1395i-2 reads, in pertinent part, as follows:

(a) Individuals eligible to enroll

Every individual who –

- (1) has attained the age of 65,
- (2) is enrolled under part B of this subchapter;
- (3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and
- (4) is not otherwise entitled to benefits under this part,
shall be eligible to enroll in the insurance program established by this part. Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or § 1395i-2a of this title.

(b) Time, manner, and form of enrollment

An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section (emphasis added)

The foregoing statute – which addresses individuals not eligible by virtue of their entitlement to Social Security monthly benefits - adds a few additional requirements, such as citizenship, or being an alien lawfully admitted for permanent residency to those “eligible to enroll” in Medicare, Part A. It also addresses those individuals who may not otherwise be entitled to Medicare benefits for any other reason.

The Defendants acknowledge publicly that Medicare, Part B, is wholly voluntary. The Centers for Medicare and Medicaid Services (“CMS”) of the United States Department of Health and Human Services actually forwards to everyone eligible to enroll in Medicare a form whereby they may refuse to enroll in Part B. *Hall Declaration*, ¶¶ 15 and 16. Interestingly, though, the statute governing

“eligibility” for Medicare, Part B, reads much like the statutes governing eligibility for Medicare, Part A. Title 42 U.S.C. § 1395o reads as follows:

Every individual who –

- (1) is entitled to hospital insurance benefits under part A of this subchapter, or
- (2) has attained age 65 and is a resident of the United States, and is either (A) a citizen, or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, *is eligible to enroll in the insurance program established by this part* (emphasis added).

In all three of the above statutes, eligibility is, in part, predicated on the individual actually applying for and/or pursuing his or her benefits. Title 42 U.S.C. § 1395i-2 and 42 U.S.C. § 1395o both use the language, “eligible to enroll in the insurance program established by their part,” yet one covers Part A, the other Part B. Title 42 U.S.C. § 402 and 426 use the terms “shall be entitled” and “is entitled” for monthly Social Security benefits and Medicare, Part A, respectively. The terms “eligible” and “entitled” are synonymous. Thus, the statutes contemplate eligibility separately, because Social Security and Medicare, Parts A and B, are three distinctly different programs.

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

It is abundantly clear that Social Security and Medicare, Parts A and B, are “voluntary.” That voluntariness was established by Congress. If the foregoing statutes are not enough to illustrate the voluntariness of Medicare, Congress actually made it clear in a succession of “preamble” statutes.

Title 42 U.S.C. § 1395 reads:

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Title 42 U.S.C. § 1395a reads, in pertinent part, as follows:

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

In addition, Title 42 U.S.C. § 1395b reads:

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

Congress made it clear that Federal officers or employees would not “supervise” medical practice or control the selection of providers. 42 U.S.C. § 1395. To be sure, Medicare has been amended significantly since 1965, and Congress has actually enacted statutes that have extended oversight and supervision by the CMS over some aspects of the practice of Medicare. **Congress has never, though, altered the voluntariness of Medicare, Parts A and B.**

Title 42 U.S.C. § 1395a provides even more assurances of choice; it addresses the free choice of provider of “any individual **entitled** to insurance benefits under this subchapter....” That includes, of course, anyone who has not actually **applied** for Medicare benefits.

The most important of the preamble guarantees to this case is 42 U.S.C. § 1395b. There, Congress asserts that nothing in the Medicare Act “shall be construed to preclude...any individual from purchasing or otherwise securing protection against the cost of any health care services.” That statute has never been amended. Nothing in the Medicare Act, as amended, has ever undermined that important guarantee. **Moreover, Congress has never included in the Medicare Act, or the Social Security Act, any provision mandating that every individual obtain coverage under Medicare, Part A, or, that one’s Social Security benefits, to which he or she would be entitled, could be denied if he or she did not apply for, or disenrolled from, Medicare, Part A.**

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

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

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

The fact that Medicare, Part A, is an “entitlement” does not make enrollment therein mandatory. The word “entitlement” is not synonymous with “required” or “mandatory.” “Entitle,” in its usual sense, “is to give a right; to qualify for; to furnish with proper grounds for seeking.” “Entitle” is synonymous with “eligible,” meaning “capable of being chosen” or “legally qualified.” “Mandate,” on the other hand, means “a command, order or direction...[which a person] is bound to obey.” *Black’s Law Dictionary*, Revised 4th Ed. The only case uncovered that directly addresses the meaning of “entitlement” to Medicare, Part A, is *Giove v. Weinberger*, 380 F.Supp. 364, 367-368 (D.C.Md. 1974) where the following was written: “Entitlement in [Section 426]...is used as a term of art. As such,

entitlement is a necessary, *but not sufficient*, prerequisite to the receipt of benefits under Part A.” One, of course, must apply for benefits. The Defendants cannot sustain an argument that “entitlement” means “mandated.” “Entitlement” means nothing more than “eligible.”

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

Thus, by the very reading of the Social Security Act and the Medicare Act, enrollment is absolutely voluntary for both. For the Secretary and MICHAEL J. ASTRUE, Commissioner of the Social Security Administration (“Commissioner”), to make Social Security benefits conditioned upon applying for Medicare, Part A, is absolutely contrary to 42 U.S.C. § 402 *et seq.* and 42 U.S.C. § 1395 *et seq.*, and, thus, is invalid. It is “arbitrary, capricious and not in accordance with law.” It is further “in excess of statutory jurisdiction, authority...[and] short of statutory right.” 5 U.S.C. § 706(2)(A),(B) and (C).

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.” *Batterton v. Francis*, 423 U.S. 416, 425, n. 9, 27 S.Ct. 2399, 2405 n.9, 53 L.Ed.2d. 448 (1977). For any regulation, policy or rule promulgated by any administrative agency to be valid, “it is necessary to establish a nexus between the regulation [policy or rule] and some delegation of the requisite legislative authority by Congress.” *Chrysler Corp. v. Brown*, 441 U.S. 281, 304, 99 S.Ct. 1705, 1718-1719, 60 L.Ed.2d. 208 (1979). “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 1720.⁴

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

⁴ The challenged policies herein are “substantive” or “legislative” rules. See Argument III D.2, hereinbelow.

Heckler, 629 F.Supp. 1496, *recon. den. sub. nom. Pratt v. Bowen*, 642 F.Supp. 883 (D.D.C. 1986) (regulations and rulings of the Secretary defining severity of impairment found to be inconsistent with Social Security Act); *Duggan v. Bowen*, 691 F.Supp. 1487 (D.D.C. 1988) (part-time intermittent care home health care policies of the Secretary found to be inconsistent with the Medicare Act); and *Tataranowicz v. Sullivan*, 753 F.Supp. 978 (D.D.C. 1990) (Secretary's amendments to Medicare Intermediary Manual construing the transition provisions of the Medicare Catastrophic Coverage Repeal Act regarding additional one hundred (100) days of skilled nursing facility coverage found to be contrary to the act.) It is clear this Court should invalidate POMS ("Program Operations Manual Section") HI ("Hospital Insurance") 00801.002, *Waiver of HI Entitlement by Monthly Beneficiary*," POMS HI 00801.034, *Withdrawal Considerations*, and POMS GN 00206.020, *Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved* as they are contrary to the Social Security Act and Medicare Acts. As such, they are "arbitrary, capricious....and....not in accordance with law." 5 U.S.C. §§ 706(2)(A), (B) and (C). Accordingly, this Court should declare the challenged policies invalid and enjoin their enforcement.

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

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

The regulations governing Social Security are found at 20 C.F.R. 404, *et seq.* Section 404.101 of Title 20 C.F.R., sets forth how one reaches "insured status" for purposes of Social Security. In the subsequent sections the title provides the details for categories of "insured status," "currently insured"

and “disability insured.” The regulations, like the statutes, use the individual’s age and “quarters of coverage” to determine eligibility.

Then § 406 of Title 20 C.F.R. reads:

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

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

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

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

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

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

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

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

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

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

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

Nowhere do the properly-promulgated Social Security regulations of the Commissioner make Social Security or Medicare, Part A, mandatory. The Commissioner does not mandate that Social Security will be denied to an individual who does not enroll in, or disenrolls from, Medicare, Part A. In fact, the Commissioner defines “**entitlement**” as nothing more than when an individual “**meets all the requirements for entitlement....**” 20 C.F.R. § 406.3. He does not define “entitlement” as being synonymous with “mandatory.” He does not predicate the loss of an individual’s monthly Social Security benefits on him or her not enrolling in, or disenrolling from, Medicare, Part A.

Likewise, the properly-promulgated regulations of the Secretary do not make enrolling in, or disenrolling from, Medicare, Part A, mandatory, nor do they predicate an individual losing his or her monthly Social Security benefits upon him or her not enrolling in, or disenrolling from, Medicare, Part A. Thus, 20 C.F.R. § 406.10 reads:

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

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

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

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

(b) *Beginning and end of entitlement.*

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

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

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

Plaintiffs must succeed on the merits of this case because the properly-promulgated regulations of the Commissioner and Secretary underscore the voluntariness of Medicare, Part A, and that the Defendants, statutorily, cannot take an individual's monthly Social Security benefits if he or she does

not enroll in, or disenrolls from, Medicare, Part A. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

Because it has been established that Medicare, Part A, is voluntary, the Defendant’s policies or rules set forth in *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*, must be invalid because they have actually taken it upon themselves to “legislate” by promulgating and enforcing those policies or rules. The Supreme Court of the United States has addressed this issue multiple times. In *Chrysler Corp. v. Brown*, 441 U.S. 281, 302-303, 99 S.Ct. 1705, 1718, 60 L.Ed.2d 208 (1979), the Court restated the fundamental rule of law:

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

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

The Supreme Court of the United States has always regarded any rule promulgated by an Executive Branch department or agency that does not “conform to the statutory purpose,” or is contrary

to the statute under which the department or agency is granted rule-making authority, to be invalid. *Chrysler Corp. v. Brown, supra*; and *Batterton v. Francis, supra*. That invalidity is found in the failure of the rule to properly represent what Congress intended. Such is rooted in Article I, Section 1, of the Constitution of the United States. *Touby v. United States*, 520 U.S. 160, 111 S.Ct. 1752, 114 L.Ed.2d. 219 (1991) and *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 72 S.Ct. 863, 96 L.Ed. 1153 (1952).

Although Congress has the power to vest in Executive Branch officers of the Federal Government the authority to promulgate administrative rules, it does not extend to making of rules that go beyond the statute. *United States v. Grimaud*, 220 U.S. 506, 31 S.Ct. 480, 55 L.Ed. 563 (1911); *United States v. Eaton*, 114 U.S. 677, 12 S.Ct. 764, 36 L.Ed. 591 (1892). A distinction exists between delegation of powers to make law which necessarily involves **discretion as to what it shall be**, and conferring authority or **discretion as to its execution**, to be exercised under and in pursuance of law. **The first cannot be done, but the latter clearly can be done.** See *Touby v. United States, supra*. and see *Bowles v. Willingham*, 321 U.S. 503, 64 S.Ct. 641, 88 L.Ed 892 (1944). Here, the Secretary and Commissioner have subverted the statutes in question. At a minimum, they have exercised “discretion to determine what the law shall be,” rather than how the law shall be executed as written by Congress.

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, find absolutely no support in the Social Security or Medicare Acts. Both acts provide benefits to individuals who are “entitled” to them or who are “eligible” for them. Congress even provided explicit statutory provisions governing how and under what circumstances Social Security benefits may be cancelled or withdrawn. None of them include not enrolling in, or disenrolling from, Medicare, Part A. The substantive policies or rules in question must be declared invalid as contrary to the intent of Congress, an exercise of authority not granted by Congress to the

Commissioner or the Secretary, and a violation of Article I, Section 1, of the Constitution of the United States. *Youngstown Sheet & Tube Co. v. Sawyer, supra*. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

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

In *American Bus Ass’n.*, the District of Columbia Circuit considered a challenge to a Department of Transportation (“DOT”) rule authorizing the imposition of money damages against bus companies for non-compliance with the Americans With Disabilities Act of 1990, 42 U.S.C. § 12188(a)(1) (“ADA”). Striking down the DOT rule, the Court concluded that any fine was a sanction for purposes of Section 558(b) of the APA. “A sanction,” wrote the Court, “is a penalty even if only one of its various objects is to punish wrongful conduct; that is, if it ‘serves *in part* to punish.” C.f., *Austin v. United States*, 509 U.S. 602, 610, 113 S.Ct. 2801, 125 L.Ed. 2d 488 (1993). Where a penalty is designed to force individuals to “modify their primary conduct,” it is a sanction for purposes of Section 558(b). The DOT was not granted such authority under the ADA or even the agency’s enabling statutes or its “inherent authority to protect the integrity of its programs.” *American Bus*

Ass'n. v. Slater, 231 F.3d at 4-7, distinguishing *Touche Ross R Co. v. SEC*, 609 F.2d 570 (2d Cir. 1979) and *Checkosky v. SEC*, 23 F.3d 452 (D.C.Cir. 1994).

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

Neither the Social Security Act, nor the Medicare Act make enrollment in, or disenrollment from, Medicare, Part A, unlawful, much less sanctionable by the Commissioner or Secretary taking an individual's monthly Social Security benefits and forcing him or her to repay the benefits previously paid. The Defendants simply have not been delegated jurisdiction by Congress to impose such a sanction upon any individual entitled to monthly Social Security benefits. As such, *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*, violate Section 558(b) of the APA and must be declared void and unenforceable. Wrote the District of Columbia Circuit: Congress could not speak more clearly than it has in the text of the APA: "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." *American Bus Ass'n. v. Slater*, 231 F.3d. at 7. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

- 1. The Language of the APA Dictates that *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*, Are Invalid and Unlawful**

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

a. The Challenged Policies Are Agency Rules Under The APA

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

For the purpose of this subchapter –

- (1) “agency” means each authority of the Government of the United States, whether or not it is within or subject to review by another agency, but does not include –
 - (A) the Congress;
 - (B) the courts of the United States;
 - (C) the governments of the territories or possessions of the United States;
 - (D) the government of the District of Columbia; or except as to the requirements of § 552 of this title –
 - (E) agencies composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined by them;
 - (F) courts martial and military commissions;
 - (G) military authority exercised in the field in time of war or in occupied territory; or
 - (H) functions conferred by §§ 1738, 1739, 1743, and 1744 of title 12; chapter 2 of title 41; subchapter II of chapter 471 of title 49; or §§ 1884, 1891-1902, and former § 1641(b)(2), of title 50, appendix;

....

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

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

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

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

- (a) This section applies, according to the provisions thereof, except to the extent that there is involved –
 - (1) a military or foreign affairs function of the United States; or
 - (2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.
- (b) General notice of proposed rule-making shall be published in the *Federal Register*, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include –
 - (1) a statement of the time, place, and nature of public rule making proceedings;
 - (2) reference to the legal authority under which the rule is proposed; and
 - (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

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

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

The agency must give thirty (30) days notice of proposed rule-making by publishing the proposed rule in the *Federal Register* with a statement of the time, place and nature of the proposed rule-making proceeding; refer to the legal authority under which the rule is proposed; and provide the terms or substance of the proposed rule. The agency must then give interested persons an opportunity to participate by providing comment on the proposed rule. It must “incorporate in the rules adopted a concise general statement of their basis and purpose.” *Id.* There is no dispute here that *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*, were not promulgated by means of rule-making; rather, they were simply incorporated into the *Social Security Administration’s Program Operations Manual* by the agency without informing the public.

2. ***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, Are Not Rules Relating to “Benefits” or “Interpretive” Rules

- a. ***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 Are Not “Benefit” Rules***

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

- b. ***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 Are Not “Interpretive” Rules, They Are “Substantive” or “Legislative” Rules.***

There are three general categories of rules: (1) legislative (sometimes referred to as substantive rules); (2) interpretive; and (3) procedural. Only legislative or substantive rules require notice and comment. See *Chrysler Corp. v. Brown*, 441 U.S. 281, 301, 99 S.Ct. 1705, 1717, 60 L. Ed.2d 208 (1979). What distinguishes a “substantive” rule from an “interpretive” rule? The Supreme Court of the

United States has addressed that issue. In *Batterton v. Francis*, 432 U.S. 416, 425 n.9, 97 S.Ct. 2399, 2405 n.9, 53 L. Ed.2d 448 (1977), the Court noted:

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

Two years later, the Supreme Court again examined the matter. In *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, 99 S.Ct. 1705, 1717-1718, 60 L. Ed2d 208 (1979), the Court reviewed all of its prior holdings on the issue. It noted in *Morton v. Ruiz*, 415 U.S. 199, 232-235, 94 S.Ct. 1055, 1073-1074, 39 L. Ed.2d 270 (1974) that a “characteristic inherent in our concept of a ‘substantive rule’ was that it was one affecting individual rights and obligations.” That, it claimed, “is an important touchstone for distinguishing those rules that may be ‘binding’ or have the ‘force of law.’” *Chrysler Corp.*, 441 U.S. at 302, 99 S.Ct. at 1718. It goes without saying that because an agency regulation is “substantive” does not give it the force of law; rather, “the legislative power of the United States is vested in the Congress, and the exercise of quasi-legislative authority by governmental departments and agencies must be rooted in a grant of power by the Congress and subject to limitations which that body imposes.” *Id.*

Historically, the Supreme Court of the United States looked to the *Attorney General’s Manual on the Administrative Procedure Act* (1947) (“the *Manual*”) to assist it in distinguishing between “substantive” rules and “interpretive” rules, because neither the House nor Senate Reports on the APA discussed the distinction. See *Chrysler Corp.*, 441 U.S. 281, 302, n.31, 99 S.Ct. 1705, 1717; *Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc.*, 435 U.S. 519, 546, 98 S.Ct. 1197, 1213, 55 L. Ed.2d 460 (1978); *Power Reactor Co. v. Electricians*, 367 U.S. 396, 408, 815 Ct. 1529, 1535, 6 L. Ed.2d 924 (1961); *United States v. Zucca*, 351 U.S. 91, 96, 76 S.Ct. 671, 674, 100 L. Ed. 964 (1956). That *Manual* refers to “substantive” rules as rules that “implement” the statute. “Such rules,” it reads, “have the force and effect of law.” *Manual, supra*, at 30, n.3. In contrast, it suggests

that “interpretive” rules and “general statements of policy” do not have the force and effect of law. Interpretive rules are “issued by an agency to advise the public of the agency’s construction of the statutes and rules which it administers.” *Id.* General statements of policy are “statements issued by an agency to advise the public *prospectively* of the manner in which the agency *proposes* to exercise a discretionary power,” reads the *Manual*. *Id.* (emphasis added). See also, *Final Report of Attorney General’s Committee on Administrative Procedure*, 27 (1941).

The Supreme Court of the United States has gone so far as to opine that an “interpretive” rule is contrasted with a “substantive” rule by the fact that a court “is not required to give effect to an interpretive regulation.” *General Electric Co. v. Gilbert*, 429 U.S. 125, 141-145, 97 S.Ct. 401, 410-412, 50 L.Ed.2d 343 (1976); *Morton v. Ruiz*, 415 U.S. 199, 231-237, 94 S.Ct. 1055, 1072-1075, 39 L.Ed.2d 270 (1974); *Skidmore v. Swift Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944). Thus, even if the Secretary defends this case on the ground that these are “interpretative” rules, they should not be given the force of law, and this Court is not required to give them any effect whatsoever. Thus, the Plaintiff, BRIAN HALL, should be free to not enroll in, or disenroll from, Medicare, Part A, on that ground alone.

Unequivocally, *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*, are not “interpretive” rules; rather, they have the “force and effect of law,” and are meant to “implement” the Social Security Act and Medicare Act. Without question, they “affect individual rights and obligations.” This Court examined a Transmittal issued by the Secretary that amended the Home Health Agency manual. It prohibited home health providers from representing a beneficiary in appealing claims under the Medicare program. Judge Stanley Sporkin found the Transmittal to be a “substantive” ruling and voided it as not having been promulgated under the procedures of the APA. Judge Sporkin wrote that it was:

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

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

In the case at bar, the Commissioner and the Secretary are actually using the rules to “force” individuals to accept Medicare, Part A, even though the Social Security Act and Medicare Act do not. Like *In Home Health Care*, there are no references in the challenged policies or rules to any statute that is being interpreted. If eligible beneficiaries do not accept Medicare, Part A, the rules are being used to strip them of all their Social Security “savings.” These are not “interpretative” rules; they are “substantive” or “legislative” rules.

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

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

Administrative rules that are “substantive” in nature, which are not promulgated in accordance with the dictates of 5 U.S.C. § 553, are void. *Louisiana Federal Land Bank Ass’n., FLCA v. Farm Credit Admin.*, 336 F.3d 1075 (D.C.Cir. 2003); *Spirit of Sage Council v. Norton*, 294 F.Supp. 2d 67 (D.D.C. 2003) *amended* 2004 WL 1326279, *appeal dismissed, vacated in part*, 411 F.3d 225 (D.C.Cir. 2004). Accordingly, *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*, must be declared void and invalid. These policies literally “affect individual rights and obligations,” implement two major congressional enactments and are administered as though they have “the force and effect of law,” yet they were promulgated without any rule-making, thus denying the public the opportunity to participate and comment on their appropriateness and legality. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(D), as they were implemented “without observance of procedure required by law.”

IV. BRIAN HALL WILL BE IRREPARABLY HARMED, AS HE WILL BE DENIED A FUNDAMENTAL RIGHT TO DETERMINE HIS OWN HEALTH CARE OR HIS PROPERTY INTEREST IN HIS SOCIAL SECURITY IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT, IF A PRELIMINARY INJUNCTION IS NOT ENTERED HEREIN

A. BRIAN HALL WILL BE DENIED HIS FUNDAMENTAL RIGHT OF PRIVACY WITHOUT THE RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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

A plaintiff’s harm from the denial of a preliminary injunction is irreparable if it is not completely compensable by monetary damages. *Basicomputer Corp. v. Scott*, 973 F.2d 507 (6th Cir. 1992). Plaintiff BRIAN HALL would suffer the disruption of his health care if this Court denied the restraining order and/or a preliminary injunction. He would not be allowed to pay privately for his health care services; in fact, he would have to locate physicians who have actually opted out of Medicare in order to continue to do so. He would have to choose physicians only from a pool of those

who participate in Medicare. He would lose control over his own health care decision-making. He would also have to cease making contributions to his HSA. Thus, his HSA would be lost altogether. If BRIAN HALL refuses to accept Medicare, Part A, he will be stripped of his monthly Social Security benefits and will be forced to repay to the Social Security Administration all of those benefits he has received since 2006. A monetary amount cannot be affixed to such harm.

It has been held that a denial of an injunction will cause irreparable harm if the claim is based upon a violation of the plaintiff's constitutional rights. *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L. Ed.2d 547 (1976) and *Connection Distrib. Co. v. Reno*, 154 F.3d 281 (6th Cir. 1998) (holding that the loss of First Amendment rights, for even a minimal period of time, constitutes irreparable harm); *Covino v. Patrissi*, 967 F.2d 73 (2d Cir. 1992) (holding that plaintiffs may establish irreparable harm based on an alleged violation of their Fourth Amendment rights); *McDonell v. Hunter*, 746 F.2d 785 (8th Cir. 1984) (finding that a violation of privacy constitutes an irreparable harm). It has also been held that "any delay in the exercise of First Amendment rights constitutes an irreparable injury to those seeking such exercise". *Quaker Action Group v. Hickel*, 421 F.2d 1111 (D.C. Cir., 1969).

The present claim rests, in part, upon a violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendment privacy rights of Plaintiff, BRIAN HALL, to exercise his freedom to choose his own health care and health care provider free from governmental interference. Such "privacy" has been viewed by the Supreme Court as emanating from all of those amendments to the Constitution, particularly the First Amendment. *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 15 L. Ed.2d 510 (1965) (holding state law barring contraceptive devices unconstitutional as violative of the First, Third, Fourth, Fifth, Ninth and Fourteenth Amendments). Wrote Justice Douglas: "various guarantees [in the Bill of Rights] create zones of privacy....[The marriage relationship] concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees." *Id.*, 381 U.S. at 485, 85 S.Ct. at 1682. Privacy was subsequently found by the Court to include the abortion

decision. *Roe v. Wade*, 410 U.S. 113, 43 S.Ct. 705, 35 L. Ed.2d 147 (1973). Whether the right of privacy is founded upon the First, Third, Fourth, Fifth, Ninth or Fourteenth Amendments, wrote the Court, it is “broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.” *Id.*, 420 U.S. at 152, 153, 935 S.Ct. at 726-727. Certainly, one’s decision-making as to all health care matters is intensely personal and private; the right of privacy is broad enough to include that as well. Congress made the Social Security Act and Medicare Act voluntary for that very reason. BRIAN HALL will suffer irreparable harm here as a matter of law.

To deny the exercise of the basic right to choose one’s health care and health care providers would not only undermine BRIAN HALL’S fundamental rights under the Constitution, but also the very amendments upon which such right rests. Here, the “delay” referred to by the Court in *Quaker* is the time between January 1, 2009 and the final adjudication of the action, during which, absent such an injunction, Plaintiff BRIAN HALL would be denied the exercise of his fundamental right of privacy. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

B. BRIAN HALL WILL BE DENIED HIS PROPERTY INTEREST IN HIS SOCIAL SECURITY WITHOUT THE ENTRY OF A RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Whether a wage earner has a property interest in monthly Social Security benefits has been addressed by the Supreme Court. In *Fleming v. Nestor, supra*, the Court considered an action brought by an alien whose benefits were terminated by an Act of Congress that amended the Social Security Act. The Court concluded that one’s interest in his Social Security cannot be seen as an “accrued property right” because Congress reserved for itself the right to “alter, amend or repeal any provision of the Act.” *Id.*, 363 U.S. at 610-611, 80 S.Ct. at 1372. The Court concluded that one did not have such a right to benefit payments as would make every defeasance of “accrued” interest by Congress violative of the Due Process Clause of the Fifth Amendment. *Id.* 363 U.S. at 611; 80 S.Ct. at 1373. But,

Congress could not act arbitrarily; the Due Process Clause, it wrote, could “interpose a bar....if the statute manifests a patently arbitrary classification, utterly lacking in rational justification.” *Id.*

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

In the case at bar, the challenged policies and rules for an individual otherwise entitled to monthly Social Security benefits to surrender them if he or she does not enroll in, or disenrolls from, Medicare, Part A, even though Congress never included such a draconian formula in either the Social Security Act or Medicare Act, are clearly arbitrary, capricious and not provided by law. Only Congress can “alter, amend or repeal” any provision of those Acts. It has never done so in order to force an individual to forego his or her Social Security if he or she did not want to participate in Medicare, Part A. The challenged policies or rules are patently arbitrary and capricious; they have been promulgated and are being enforced completely contrary to the statutes and without authority. Accordingly, *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*, violate the Due Process Clause of the Fifth Amendment to the Constitution of the United States. This Court should declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

V. PLAINTIFF, BRIAN HALL, HAS NO OTHER RECOURSE THAN THE JUDICIAL REMEDY

A. There Are No Administrative Remedies Statutorily Available To The Plaintiff

It also should be considered that Plaintiff, BRIAN HALL, has no other route for relief except

the judicial avenue. No administrative procedure exists to protect his monthly Social Security benefits while he seeks not to participate in Medicare, Part A. BRIAN HALL is afforded relief neither by 42 U.S.C. § 405g nor 42 U.S.C. § 1395ff. Section 405g applies to final decisions of Social Security *eligibility*; BRIAN HALL is eligible for Social Security, and, thus, such is not the issue which he is trying to resolve. Rather, he seeks to opt out of Medicare – an issue about which Section 405g is silent.

Title 42 U.S.C. § 1395ff allows for a regulatory appeal regarding “initial determinations” under Medicare; however, it is necessary to examine subsection (a)(1) in order to know what constitutes an “initial determination.” Section 1395ff(a)(1) reads:

The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A of this subchapter or part B of this subchapter in accordance with those regulations for the following:

(A) The initial determination of **whether an individual is entitled to benefits under such parts.**

(B) The initial determination of **the amount of benefits available to the individual under such parts.**

(C) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1320c-3 (a)(2) of this title, and an initial determination made by an entity pursuant to a contract (other than a contract under section 1395w-22 of this title) with the Secretary to administer provisions of this subchapter or subchapter XI of this chapter (emphasis added).

The above provisions relate to initial determinations of Social Security and Medicare “entitlement” to benefits and initial determinations regarding the amount of benefits under Medicare; as was stated above, BRIAN HALL is entitled to Social Security and Medicare already, but he does not want any Medicare benefits. He seeks to not enroll in, or to disenroll from, Medicare, Part A. No statutory route exists for BRIAN HALL to address the issues raised herein, save that of judicial review.

To underscore the fact that no administrative remedy exists to address BRIAN HALL’S determination to not enroll in, or disenroll from, Medicare, Part A, and not suffer the sanction of losing his monthly Social Security benefits, neither the Commissioner nor the Secretary provide any means by

which BRIAN HALL may notify them of his determination not to enroll in, or to disenroll from, Medicare, Part A. There does exist such a mechanism to enable him to not enroll in Medicare, Part B, and he has exercised that right. *Hall Declaration*, ¶¶ 15, 16 and 17; http://www.coproducer.com/Med_Enroll_Card.pdf.

Those who have attempted to not enroll in, or disenroll from, Medicare, Part A, in the past have had to write letters to the Defendants expressing their intent. In every case, the Defendants have refused to make any determination at all. Plaintiff, JOHN J. KRAUS, applied for his monthly Social Security benefits in February 2005 and informed the Social Security Administration that he did not want to enroll in Medicare, Part A. Like BRIAN HALL, JOHN J. KRAUS, a former employee in the United States Department of The Navy, had obtained health insurance, which included an HSA, through the FEHB program. The Social Security Administration informed him that he could not “waive Medicare entitlement.” By letter dated February 8, 2005, he demanded a hearing. To date, neither the Commissioner, nor anyone in the Social Security Administration, have ever responded to his request. *Amended Complaint*, ¶¶ 6 and 27.

David Nelson also sought to enroll in, or disenroll from, Medicare, Part A. He, like JOHN J. KRAUS, was informed that he could not waive Medicare, Part A, entitlement, and that the Secretary would not make an initial determination. He requested a hearing in 1999. He has received no response thereto in nine (9) years. *Amended Complaint* ¶ 30. The Defendants not only provide no mechanism for any administrative remedy, they will not give one any administrative process if they are asked to do so on this issue.

In reality, there is no administrative remedy for the issues in this case. *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*, are system-wide rules which are explicit: one cannot waive Medicare, Part A, entitlement without losing

his or her monthly Social Security benefits. There are no facts that could be introduced at any hearing; there are no facts for the Commissioner or the Secretary to weigh.

In such an instance, this Court has ruled that one need not pursue administrative remedies before proceeding to a United States District Court. *Tataranowicz v. Sullivan*, 753 F.Supp. 978 (D.D.C. 1990). In *Tataranowicz*, a civil action was filed in this Court against the Secretary for his interpretation of transition rules to take care of individuals who were relying on benefits they received pursuant to the Medicare Catastrophic Coverage Repeal Act, Pub. L.No. 101-234. § 101(b), 103 Stat. 1979 (1989) (“Repeal Act”). Under the Secretary’s construction of the Repeal Act, to obtain the additional one hundred days of Medicare Skilled Nursing Facility (“SNF”) coverage for services provided on or after January 1, 1990, a beneficiary must not only have received extended services—services furnished by an SNF – but Medicare payment for those services on those days. Plaintiffs believed that the Secretary’s construction of the Repeal Act was erroneous.

Judge Stanley Sporkin found the Secretary’s interpretation to be inconsistent with the language of this statute. The Secretary, however, argued that the Plaintiffs failed to exhaust their administrative remedies, citing *Heckler v. Ringer*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984), and contended that the case should be dismissed. Judge Sporkin, overruled the Secretary, holding:

In sum, the [Supreme Court in *Bowen v. City of New York*, 476 U.S. 467, 106 S.Ct. 2022, 90 L.Ed.2d 462 (1986)] held that, notwithstanding its holding in *Ringer*, where a claimant alleges more than deviation from applicable regulations and instead asserts a “systemwide...policy that [is] inconsistent in critically important ways with established regulations: and which does not depend on the particular facts of the claimant’s case, the exhaustion requirement may be excused. *Bowen* at [105 S.Ct.] 2032-33.

The case currently before this Court is squarely governed by the holding in *Bowen*. Plaintiffs in this case do not seek an award of benefits to individual claimants, but rather, a court determination that the Secretary’s policy violates the Repeal Act. The interpretive issue raised by the plaintiffs is clearly collateral to their individual claims for benefits.

Tataranowicz v. Sullivan, 753 F.Supp. at 987.

Indeed, *Tataranowicz* falls within a significant line of cases decided by this Court. In *Bowen v.*

City of New York, supra, the Supreme Court held that the district court had properly included, within a class of claimants it found entitled to relief, individuals who had failed to pursue their own administrative remedies and even those whose time to initiate such remedies had expired. The Court found that exhaustion was excused on equitable grounds, citing *Matthews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d. 18 (1976). The claims for benefits were collateral to the relief sought, i.e., the violation of an unlawful policy, and, the claimants were likely to be irreparably harmed if the exhaustion requirement was not insisted upon. Given the system-wide application of the invalid policies, exhaustion, opined the Court, would have been a “superfluous formality.” The compilation of a factual record was unnecessary to a resolution of the issue, and there was no need for agency expertise.

This Court, in *Pratt v. Heckler*, 629 F.Supp. 1496, *recon. den sub nom, Pratt v. Bowen*, 642 F.Supp. 883 (D.D.C. 1986) held similarly, invalidating certain regulations and rulings promulgated by the Secretary, which required the Social Security Administration to determine disability claims on the basis of a claimant’s inability to do “basic work activity,” as opposed to an inability to do previous work, and prohibited the consideration of multiple non-severe impairments in the aggregate. Judge Thomas Penfield Jackson found against the Secretary’s contention that the Plaintiffs failed to exhaust administrative remedies, concluding:

Plaintiffs....[do] not request an adjudication of individual class members’ entitlement to benefits. Rather [they] seek [] only a determination of the validity of certain administrative regulations and policies which themselves determine eligibility when applied in certain cases.

Pratt v. Heckler, 629 F.Supp. at 1503.

In 1988, Judge Sporkin held similarly in *Duggan v. Bowen*, 691 F.Supp. 1487 (D.D.C. 1988). There, Medicare beneficiaries challenged the Secretary’s interpretation of the “part time or intermittent” care provision which required a person, otherwise entitled to receive coverage for home health care on a less than full-time basis, to establish that such care was both “part-time and intermittent.” The Court found that such interpretation was contrary to the statute. In overruling the

Secretary's contention that the plaintiffs failed to exhaust administrative remedies necessitating dismissal, Judge Sporkin relied on the holding in this Court in *Pratt v. Heckler, supra*. He found that:

Plaintiffs' concerns can be addressed without dealing with the specific merits of any one plaintiff's case – except insofar as that plaintiff's case represents evidence of the unlawful pattern or practice of the agency. Alleged factual differences in plaintiffs' claims are therefore irrelevant. Plaintiffs' shared interest in eliminating HHS policies that are contrary to law is sufficient for class certification.

Duggan v. Bowen, 691 F.Supp. at 1503.

This case is even more compelling than *Tataranowicz, Pratt, Duggan and Bowen v. City of New York*. Neither BRIAN HALL, nor any of his fellow Plaintiffs seek any benefits from Medicare, Part A, whatsoever. There are no facts unique to any of them that are relevant to this case. All of them simply do not want to enroll in, or they seek to disenroll from, Medicare, Part A, and not suffer the loss of their monthly Social Security benefits. The Defendants' policies at issue here, *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*, prohibit them from not enrolling in, or disenrolling from, Medicare, Part A, without also surrendering their monthly Social Security benefits. Their case involves no claims whatsoever; it is a challenge to system-wide rules that all of the Plaintiffs believe are unlawful. No individual facts would make any difference. The judicial remedy is the only remedy available to the plaintiffs.

VI. THE DEFENDANTS WILL NOT BE HARMED BY THE ISSUANCE OF A PRELIMINARY INJUNCTION PRESERVING THE STATUS QUO FOR PLAINTIFF BRIAN HALL

“The power to issue a restraining order and a preliminary injunction, especially a mandatory one, should be ‘sparingly exercised.’” 7 J. W. Moore, *Federal Practice* (2d ed. 1968), para. 6504 [1], p. 1627; *O'Malley v. Chrysler Corp.*, 160 F.2d 35 (7th Cir., 1947). Before issuing such an injunction the court must balance the harm to both parties. *Embassy Dairy v. Camalier*, 211 F.2d 41, (D.C. Cir. 1954). Thus, even where the denial of a restraining order and a preliminary injunction will harm the plaintiff,

the order and injunction should not be issued where it would work a great and potentially irreparable harm to the party enjoined, unless an overwhelming case in the plaintiff's favor is present on the merits and equities of the controversy.” *District 50, United Mine Workers of America v. International Union, United Mine Workers of America*, 412 F.2d 165 (D.C. Cir. 1969); *Dorfmann v. Boozer*, 414 F.2d 1168 (D.C. Cir., 1969).

The foregoing analysis treats the restraining order and preliminary injunction as an equitable tool which must be used sparingly and with wise judicial discretion. However, it is clear that it would be appropriate to enter a restraining order and a preliminary injunction in the present case. Defendants will suffer absolutely no harm from being directed not to distribute Medicare, Part A, benefits to BRIAN HALL. In fact, in being directed to refrain from doing so, Defendants would actually be better off monetarily than they would be to forcibly enroll BRIAN HALL in the Medicare, Part A, program. Therefore, the restraining order and preliminary injunction would certainly not “work a great and potentially irreparable harm to the party enjoined.”

VII. THE PUBLIC INTEREST MANDATES THAT THE PRELIMINARY INJUNCTION SOUGHT HEREIN BE ENTERED

Finally, it is in the interest of the general public that the preliminary injunction sought herein be entered. Social Security beneficiaries comprise an extraordinarily large population of the country. The same holds true for Medicare beneficiaries. It is in the best interest of the citizenry *and* the government itself that the two programs not be intertwined by regulations promulgated unlawfully. If BRIAN HALL is granted this injunction, he will be provided what every United States citizen is statutorily allowed: the freedom to receive his hard-earned Social Security benefits without the needless government intervention into his health care choices. The advancement of such a fundamental right is in the public interest, to be sure.

CONCLUSION

In conclusion, Plaintiffs’ motions for a restraining order and a preliminary injunction, enjoining

the Defendants from automatically enrolling Plaintiff, BRIAN HALL, in Medicare, Part A, and enjoining the Defendants from seizing his monthly Social Security benefits, should be granted. Although the issuance of restraining orders and preliminary injunctions should be sparingly granted, the requirements are clearly met for the issuance of such relief in the present case. There is a substantial likelihood of success on the merits. The relative importance of the rights being asserted here, the right to choose one's health care services, providers and insurance plan, and to receive one's monthly Social Security benefits, is high. The harm suffered by BRIAN HALL if the restraining order and preliminary injunction are not granted would be high; the harm to the Defendants is nonexistent, amounting, in fact, to a financial benefit for them. Finally, the public interest is high. Therefore, all the factors for a restraining order and a preliminary injunction have been duly satisfied, and the court should grant Plaintiff's motions.

Respectfully submitted,

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