



Those “Policies” are the *POMS (“Program Operations Manual System”) 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* (at times collectively referred to herein as the “POMS”).

A *Verified Complaint for Declaratory Judgment, a Restraining Order and Preliminary and Permanent Injunctive Relief* was filed on October 9, 2008. A *Verified Amended and Substituted Complaint for Declaratory Judgment, a Restraining Order and Preliminary and Permanent Injunctive Relief (“Amended Complaint”)* was filed on December 10, 2008, adding two (2) plaintiffs, and alleging six (6) causes of action challenging the lawfulness of the POMS.

The *Amended Complaint* sets forth with particularity how the enforcement by the Defendants of the aforesaid POMS irreparably harms the Plaintiffs. *Amended Complaint*, ¶¶ 12, 29, 34, 35, 40, 44, 48, 52, 56 and 60. It seeks a declaration of rights, alleging that the challenged POMS are contrary to the Social Security Act, 42 U.S.C. §§ 401 *et seq.*, and, specifically, 42 U.S.C. §§ 402 and 426(a), and the Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, and, specifically, 42 U.S.C. §§ 1395, 1395a, 1395b, 1395i-2 and 1395o, and, are contrary to the properly-promulgated regulations of the Defendants, namely, 20 C.F.R. Part 404 and 42 C.F.R. Parts 406 to 408. The *Amended Complaint* further seeks a declaration of rights, alleging that the challenged POMS are violative of the Administrative Procedure Act (“APA”), 5 U.S.C. §§ 551 to 553 and 558, and Article I, Section 1, of the Constitution of the United States. Plaintiffs seek injunctive relief, pursuant to 5 U.S.C. §§ 702 to 706, enjoining the enforcement of the POMS and further mandatorily enjoining the Defendants to allow the Plaintiffs to not enroll in, or to disenroll from, Medicare, Part A, without the loss of their Social Security monthly benefits.

The Defendants have filed a Motion to Dismiss. Plaintiffs respond thereto by this

Memorandum and file herewith their Motion for Summary Judgment that is also supported by this Memorandum.

**II. WHAT MANDATES THAT THE PLAINTIFFS ENROLL IN MEDICARE, PART A, AS A CONDITION OF RECEIVING THEIR SOCIAL SECURITY MONTHLY BENEFITS, ARE THE THREE CHALLENGED POMS OF THE DEFENDANTS**

The POMS challenged in this case are statements created by the Defendants in 1993 and 2002, not promulgated in accordance with the APA, but nonetheless applied as unequivocal, system-wide rules. *Plaintiffs' Statement of Material Facts As To Which There Is No Genuine Issue* ("SMF"), ¶¶ 171 and 174. *POMS HI 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 all monthly 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).**<sup>1</sup>

*SMF*, ¶ 170.

According to the Defendants, the aforesaid POMS are “reasonable interpretations” of the Social Security statutes that address an individual’s “entitlement” to Medicare, Part A, particularly 42 U.S.C. § 426(a), although the POMS do not name any statute that they purportedly interpret whatsoever. *Defendants’ Memorandum in Support of Motion to Dismiss* (“*Def. Mem.*”), pp. 28-34.<sup>2</sup> That statute 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 would be entitled to such benefits but for the failure of another

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<sup>1</sup> The foregoing POMS may be found on the web at <https://secure.ssa.gov/apps10/poms.nst/lnx0200206020> open document.

<sup>2</sup> According to the Defendants, the POMS “explain that ‘entitlement’ to Medicare, Part A, benefits follows automatically for all people who are entitled to monthly Social Security benefits and that under current law there is no mechanism for individuals entitled to monthly Social Security benefits to ‘waive’ this ‘entitlement.’” *Def. Mem.*, p. 29.

individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with the regulations of the Secretary, files an application for hospital insurance benefits under Part A of Subchapter XVIII of this chapter....

....

**shall be entitled to hospital benefits under part A of subchapter XVIII....**  
(emphasis added).

42 U.S.C. § 426(a).

Contrary to the Defendants' assertions, nowhere in 42 U.S.C. § 426(a) is there any mention whatsoever that an individual who applies for monthly Social Security benefits **must** also enroll in Medicare, Part A. Nowhere in 42 U.S.C. § 426(a) is there any mention whatsoever that an individual who applies for Social Security monthly benefits cannot obtain them unless that individual agrees to be enrolled in Medicare, Part A. Nowhere in 42 U.S.C. § 426(a) is there any mention whatsoever that an individual who disenrolls from Medicare, Part A, must also disenroll from receiving Social Security monthly benefits and repay to the SSA all the benefits received to date. In fact, the POMS do not ever refer to the fact that they are "interpretations" of 42 U.S.C. § 426(a) or any other statute. Rather, the POMS are a law unto themselves. SMF, ¶¶ 172-176.

Section 426(a) of 42 U.S.C. also reads just like 42 U.S.C. § 402 which states that individuals who meet the age and contribution requirements "shall be entitled" to Social Security monthly benefits, a statute that has always been construed as voluntary by the Defendants and the courts. All 42 U.S.C. § 426(a) states is that individuals over sixty-five (65) years of age who are entitled to Social Security monthly benefits "shall be entitled to hospital benefits under Part A of subchapter XVIII." It reads just like Section 402. For the foregoing reasons, and others set forth hereinbelow, Plaintiffs challenge the lawfulness of the POMS and the Defendants' enforcement of the POMS.

### **III. THE PLAINTIFFS DO NOT WANT TO BE ENROLLED IN MEDICARE, PART A, BUT THEY WANT TO RECEIVE THEIR SOCIAL SECURITY MONTHLY BENEFITS**

Three (3) of the Plaintiffs, BRIAN HALL, JOHN J. KRAUS and RICHARD K. ARMEY, were Federal employees. Each of them entered into a health insurance plan pursuant to the Federal Employee Health Benefits (“FEHB”) program, 5 U.S.C. §§ 8907 *et seq.* Two, BRIAN HALL and JOHN J. KRAUS, signed up for health insurance plans that included Health Savings Accounts (“HSAs”) and high-deductible health insurance policies in lieu of Medicare. RICHARD K. ARMEY, as all Federal employees, was able to continue his Blue Cross Group plan under the FEHB program in lieu of Medicare. *SMF*, ¶¶ 5-10 (*Hall*); 35, 37 (*Kraus*); 71, 73 (*ArmeY*).<sup>3</sup>

When HALL, KRAUS, and ARMEY applied for their Social Security monthly benefits they were informed by the SSA representatives that they could not waive their enrollment in Medicare, Part A, unless they gave up their Social Security monthly benefits. All of them questioned the lawfulness of that requirement. All of them had been assured of health care coverage under the FEHB program in lieu of Medicare.<sup>4</sup> But, they were told that they either had to sign the application tendered to them – which required the applicant to be enrolled in Medicare, Part A, as a condition of receiving his Social Security monthly benefits – or suffer not receiving their Social Security monthly benefits at all. The application read: **“I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors and**

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<sup>3</sup> HALL was an employee of the United States Department of Housing and Urban Development; KRAUS was an employee of the United States Department of the Navy; ARMEY was an eighteen-year member of the United States House of Representatives. *SMF*, 4 (*Hall*), 35 (*Kraus*), 68 and 70 (*ArmeY*). The FEHB program is an entirely separate program established by Congress pursuant to 5 U.S.C. § 8901 *et seq.*

<sup>4</sup> According to HALL’S FEHB Mail Handlers health care plan, enrollment is wholly voluntary. The Mail Handlers Plan 2008 program booklet reads: “The decision to enroll in Medicare is yours....If you do not apply for one or more parts of Medicare, you can still be covered under the FEHB program.” See *SFM*, ¶ 5 (*Hall*), <http://www.mhbp.com/web/groups/public/documents/webcontent/a034028.pdf>, p. 125. The Mail Handlers Plan 2008 program booklet was “authorized for distribution by the United States Office of Personnel Management.” Federal employees, like Plaintiffs HALL, KRAUS and ARMEY, are covered under the FEHB program.

**Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.”** None were provided with any means by which they could question or appeal the requirement. *SMF*, ¶¶ 15-26 (*Hall*); 40-66 (*Kraus*); 79-81 (*Armey*). They either signed the application or they would be denied their Social Security monthly benefits to which they were entitled. *Id.*

When KRAUS was informed of the requirement, he asked for its justification. In response, he was actually handed a copy of the *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary*, one of the policies challenged herein, by the representative of the Social Security Administration (“SSA”) on February 9, 2005. KRAUS attempted to appeal that decision through the offices of his Congresswoman. When a reconsideration decision was finally made by SSA (after much prodding) that the aforesaid policy was in conformity with the Social Security Act, KRAUS demanded a hearing before an Administrative Law Judge (“ALJ”). His formal request was sent by certified mail, return receipt requested, and was signed by a representative of SSA as having been received on February 13, 2006.<sup>5</sup> The SSA, though, has failed and refused to ever respond to his demand to this date. It has been more than three (3) years. *SMF*, ¶¶ 40-65, Exhibits 1 and 9 (*Kraus*).

JOHN J. KRAUS’S experience is similar to that of witness David Nelson of Junction City, Oregon. Like KRAUS, Nelson wanted no part of Medicare, Part A, but he did want his Social Security benefits. He sought to get out of Medicare, Part A, in June 1999. He attempted, by and through counsel, to exercise the administrative remedies set forth in 42 U.S.C. § 405g and h and § 1395ff. *SMF*, ¶¶ 116-124 (*Nelson*). What he ultimately received was a letter from the Associate General Counsel of HHS, Sheree R. Kanner, dated October 25, 1999, that stated:

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<sup>5</sup> The return receipt to the Request for Hearing by an Administrative Law Judge, Form HA-501-US, was signed, as received, by Janice Garvey of the Social Security Administration, Norristown, PA, on February 13, 2006. *SMF* ¶ 64, Exh. 9 (*Kraus*).

Because Mr. Nelson's entitlement to Medicare, Part A, is a result of his entitlement to Title II retirement benefits, and is not as a result of a successful application for Medicare, Part A, benefits, **the Secretary has not made, and will not make, an initial determination with respect to his Part A entitlement** (emphasis added).

*SMF*, ¶ 123, Exh. D, p. 3 (*Nelson*).

With KRAUS, the Commissioner of SSA simply ignored his demand; with Nelson, the Secretary of the United States Department of Health and Human Services ("HHS") informed him she would not make any determination that he could appeal. The Commissioner of SSA never responded to Nelson's appeal at all. It has been ten (10) years! *SMF*, ¶ 124 (*Nelson*). With both, the Defendants embarked upon a means to frustrate and even prevent KRAUS and NELSON from ever administratively appealing their forced enrollment in Medicare, Part A.

After discovering that HHS and SSA relied upon the POMS in forcing enrollment in Medicare, Part A, and that those policies were completely beyond the scope of the Social Security Act, 42 U.S.C. § 426(a), BRIAN HALL sought legal counsel. He knew there were no administrative remedies available to him on this issue, and his only recourse was to appeal to this Court. *SMF*, ¶ 26 and 29 (*Hall*). RICHARD K. ARMEY has joined this case because he never wanted to be enrolled in Medicare, Part A, in the first place. He wants to disenroll. *SMF*, ¶¶ 73, 81 (*ArmeY*). Like KRAUS and HALL, ARMEY wants to keep his Social Security monthly benefits. *Id.*

The Defendants argue that LEWIS RANDALL and NORMAN ROGERS have never even applied for Social Security monthly benefits and, thus, they have no standing to bring this civil action. The Defendants literally argue out of both sides of their mouths. On the one hand, they claim that HALL, KRAUS and ARMEY signed the application for Social Security monthly benefits, thereby "voluntarily" agreeing to be enrolled in Medicare, Part A, and thus do not have

standing to challenge the POMS. On the other hand, they argue that, because RANDALL and ROGERS refuse to sign the application as it forces them into Medicare, Part A, they have no standing either. *Def. Mem.*, p. 13, n.6. Defendants are positively wrong on both counts; certainly, they cannot have it both ways.

RANDALL and ROGERS want no part of Medicare, Part A. Even though both of them have been eligible for Social Security monthly benefits for five (5) years, neither has sought to obtain those benefits because if they do the POMS and the application for Social Security monthly benefits will mandate that they be enrolled in Medicare, Part A. Both have had to forego a great deal of money because of the challenged policies. They have come to this Court seeking a declaration of rights as they are now put into a position of either losing their Social Security monthly benefits, or being forced to enroll in Medicare, Part A, and losing their freedoms. *SMF*, ¶¶ 93-96 (*Randall*), 109-113 (*Rogers*).

All of the Plaintiffs share common reasons for not wanting to be enrolled in Medicare, Part A. All of them recognize that if they cannot get out of Medicare, or are forced into Medicare, they will give up control over their own health care decisions. They will give up control over their providers – institutional and individual – they are able to use. They will be forced to use only those providers who participate in Medicare – an ever-dwindling number. They will be provided only those health care services “allowed” by Medicare under circumstances Medicare will “allow” them. In the process, they will be denied care they otherwise would obtain if they paid for it themselves. That, of course, will lead to precisely the loss of care described with great authoritativeness by Gabrielle M. Kotoski, RN in her declaration filed heretofore. *SMF*, ¶¶ 125-169 (*Kotoski*). Further, these Plaintiffs will have their medical records subject to exposure that would not occur if they paid privately. *SMF*, ¶¶ 11-13

(Hall); 39 (Kraus); 77-78, 81 (Armey); 90, 91, 95, 96 (Randall); 106, 107, 113 (Rogers).  
*Amended Complaint*, ¶¶ 12, 29, 34, 35, 40, 44, 48, 52, 56 and 60.<sup>6</sup>

None of these harms are based on “unadorned speculation” as claimed by the Defendants. *Def. Mem.*, p. 18. Gabrielle M. Kotoski, R.N. has ably set forth facts illustrating the harm brought about through enrollment in Medicare, Part A, as opposed to paying for one’s own health care needs. Kotoski testifies:

[M]edical services/benefits under Medicare are inferior to medical services/benefits individuals are willing to pay for themselves. [Medicare is] a second tier, government-controlled health care program [in which enrollees are] forced to accept the limitations imposed by the government. [The enrollee] no longer has the freedom to choose the care he/she alone desires and wishes to pay for.

*SMF*, ¶¶ 169 and 125-169 (Kotoski).<sup>7</sup>

There is nothing speculative about the limitations of government, third-party payment; it is well known.

For Plaintiffs, HALL, KRAUS and ARMEY, the Defendants enforcing the POMS has led to the undermining of the FEHB programs they entered into upon retirement. *SMF*, ¶¶ 29 (Hall); 39 (Kraus); 74 and 80 (Armey). **Unless the POMS are voided, they will endanger the FEHB**

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<sup>6</sup> Plaintiffs contend that by being “entitled” to Medicare, Part A, they come within the strictures of 42 U.S.C. § 1395a(b). That statute prohibits “Medicare beneficiaries;” those “entitled to [Medicare], Part A, or enrolled in [Medicare], Part B,” from privately paying for any health care service unless the provider withdraws from participation in Medicare altogether. 42 U.S.C. § 1395a(b)(5)(A). The statute was upheld in *United Seniors v. Shalala*, 182 F.3d 965 (D.C.Cir., 1999) only after the Defendant agency loosened its control over the use of “advance beneficiary notices.” Defendants claim that the Secretary has limited the private contracting restrictions only to Part B. 63 *Fed. Reg.* 58850. *Def. Mem.*, pp. 16-17. Plaintiffs take no solace in that as, once again, the statute the Secretary interprets reads completely differently. In any event, no provider will provide health care services on a private-pay basis to any “Medicare beneficiary” without withdrawing from Medicare participation based on a mere *Federal Register* notice, because he/she will face sanctions if his/her judgment is incorrect. Likewise the Secretary can alter or delete a *Federal Register* notice on a whim. The Defendants then assert the case of *Leverett v. United States Bureau of Health and Human Services, et al.*, 2003 WL 21770810 (D.Colo. 2003) somehow clarifies the matter. That unpublished opinion merely dismisses a *pro se* action of a plaintiff wanting to get out of Social Security and Medicare, Part B, altogether. The court dismissed the action because Social Security and Medicare are “voluntary” programs – and plaintiff need not enroll. The court’s comments about the effects of 42 U.S.C. § 1395a(b) upon the Plaintiff were statements limited only to Plaintiff’s complaint; the court never addressed Part A of Medicare at all. Contrary to Defendants’ assertions, no Medicare beneficiary can pay for any Part A or Part B health care services on a private contract basis outside of 42 U.S.C. § 1395a(b) without the provider facing serious, business-threatening sanctions. Part A services are paid on a “prospective payment” basis, eliminating the Medicare beneficiary from the payment equation altogether. 42 U.S.C. § 1395ww.

<sup>7</sup> Payment mechanisms, including the conditions of and limitations on payment, for Part A health care services are found at 42 U.S.C. §§ 1395f and 1395g, and, 1395ww, 1395xx, 1395yy (Prospective Payment System). Payment mechanisms for Part B may be found at 42 U.S.C. §§ 1395l, 1395m, 1395n and 1395u.

**programs for all Federal employees.** For HALL and KRAUS, who had HSAs, the enforcement of the POMS has rendered those HSAs useless and moribund; HALL and KRAUS cannot contribute to their HSAs anymore, and their insurance carriers cannot contribute to them either. Both of their high-deductible insurance carriers are no longer able to adjudicate their claims; Medicare does. *SMF*, ¶¶ 29 (*Hall*) and 39 (*Kraus*). Since this Court denied HALL’S *Motion for a Temporary Restraining Order*, his FEHB health insurance carrier has “taken back” all of its 2009 deposits to HALL’S HSA. *SMF*, ¶¶ 29 (*Hall*). Whatever decisions are now made about the health care provided to HALL, KRAUS and ARMEY are made by Medicare in accordance with what it deems is “allowable.” Thus, a program which contains trillions of dollars of unfunded liabilities, which will be bankrupt in less than ten (10) years, will decide what it will pay for Plaintiffs’ health care and, consequently, what care will be provided, if any!<sup>8</sup>

The Defendants want to “force” RANDALL and ROGERS to be enrolled in Medicare, Part A, knowing there is no administrative remedy available for them to exercise. The Defendants want to “force” them to sign the application for Social Security monthly benefits that ties those benefits to Medicare, Part A. To do so will immediately force RANDALL and ROGERS to surrender control over their health care decisions and providers and condemn them to accepting only the health care services Medicare deems “allowable.” Because they have resisted filing an application for Social Security monthly benefits until a Court declares their rights, RANDALL and ROGERS have been losing significant amounts of money. *SMF*, ¶¶ 97

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<sup>8</sup> This Court aptly summed up the problem facing the Plaintiffs when it wrote in its *Memorandum Opinion* of January 28, 2009, at p. 8: “It is passing strange that SSA insists that all persons receiving Social Security retirement benefits, a federal program that is running out of money, also must be part of Medicare, Part A, another federal program that overruns budgets.” The Medicare Board of Trustees has established that the Federal Hospital Insurance Trust Fund will be insolvent by 2019. *Status of the Social Security and Medicare Programs, A Summary of the 2008 Annual Reports* (online) Social Security and Medicare Boards of Trustees, Washington, DC, <http://www.ssa.gov/OACT/TRSUM/trsummary.html> (December 6, 2008). Gabriel Kotoski, RN concluded: “The Medicare program is fiscally insolvent. This year (2008) Medicare’s Hospital Insurance (“HI”) Trust Fund [Part A] is expected to pay out more in hospital benefits and other expenditures than it receives in taxes and other dedicated revenues. The Medicare Trustees have estimated that the Federal Hospital Insurance Trust Fund [Part A] will be insolvent by 2019. *SMF*, ¶ 127 (*Kotoski*).

(*Randall*), 107 and 113 (*Rogers*). ROGERS, in fact, is forfeiting \$27,000.00 per year in Social Security monthly benefits because of the POMS. *SMF*, ¶¶ 107 (*Rogers*).

All of the Plaintiffs in this case are highly-educated men: Harvard College; the University of California, Berkeley; the Massachusetts Institute of Technology; University of Maryland and Penn State University, are among the many schools in these Plaintiffs' *curricula vitae*. One of the Plaintiffs holds a Ph.D. in Economics and was a professor of economics at six (6) different universities before he served eighteen (18) years in Congress. *SMF*, ¶¶ 2 (*Hall*); 31-34 (*Kraus*); 67-68 (*Arme*); 83 (*Randall*) and 99 (*Rogers*). All of them understand that the POMS provide completely different requirements than 42 U.S.C. § 426(a). The Plaintiffs present significant, life-and-health-threatening, as well as freedom-threatening and financial, losses if this Court does not void the challenged policies and enjoin the Defendants from enforcing them.

## **ARGUMENT**

### **I. PLAINTIFFS UNEQUIVOCALLY HAVE STANDING TO CHALLENGE THE POLICIES OF THE DEFENDANTS CHALLENGED HEREIN**

#### **A. Introduction**

This Court has articulated the determinants of standing in its decision in *Fox v. Leavitt*, 572 F.Supp. 2d 135, 141 (D.D.C. 2008). Simply, to establish standing, “a plaintiff must show: 1) an actual or imminent injury in fact [that is] 2) fairly attributable to the challenged action of the defendant [and] 3) that is likely to be redressed by a favorable decision.” The elements of standing articulated in *Fox* have been stated by this Court, the U.S. Court of Appeals for the District of Columbia and the Supreme Court over many years. A plaintiff must have a “concrete and particularized” injury. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561, 112 S.Ct.

2130, 2136, 119 L. Ed.2d 351 (1992). See also, *Buckley v. Valeo*, 424 U.S. 1, 96 S. Ct. 612, 46 L. Ed.2d 659 (1976). By “particularized,” the Courts have meant that “the injury must affect the plaintiff in a personal and individual way.” *Lujan* at 504 U.S. at 560, n.1, 112 S.Ct. at 2136, n.1. Stated another way, [a] federal court’s jurisdiction can be invoked only when the plaintiff himself has suffered ‘some threatened or actual injury resulting from the putatively illegal action.’” *Warth v. Seldin*, 422 U.S. 490, 499, 95 S. Ct. 2197, 2205, 45 L. Ed.2d 343 (1975). The Plaintiff must have an “injury in fact,” a “direct stake in the outcome of the litigation, even though small....” *Diamond v. Charles*, 476 U.S. 54. 66-67, 106 S. Ct. 1697, 1706, 90 L. Ed.2d 48 (1986). Too, “a court may act only to redress injury that fairly can be traced to the challenged action of the Defendant, and not injury that results from the independent action of some third party not before the court.” *Northwest Airlines v. FAA*, 795 F.2d 195, 203-204 (D.C.Cir. 1986). See also, *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 41-42, 96 S.Ct. 1917, 1926, 48 L. Ed.2d 450 (1976); *U.S. Ecology, Inc. v. Dept. of the Interior*, 231 F.3d 20, 24 (D.C. Cir. 2000).

Since the Supreme Court’s opinions in *Association of Data Processing Service Organizations, Inc. v. Camp*, 397 U.S. 150, 90 S. Ct. 827, 25 L.Ed. 2d 184 (1970) and *Barlow v. Collins*, 397 U.S. 159, 90 S. Ct. 832, 25 L. Ed.2d 192 (1970), courts have looked to determine “whether the interest sought to be protected by the complainant is arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question.” *Association of Data Processing Organizations, Inc. v. Camp*, 397 U.S. at 153, 90 S.Ct. at 830. Even after those cases, though, courts still require the plaintiff to have a stake in the outcome of the litigation to assure adversarial presentation and to sharpen the issues. “But even a miniscule pecuniary stake of the litigant may be sufficient if [the complainant] provides a suitable and

effective vehicle for vindication of larger issues.” *National Automatic Laundry and Cleaning Council v. Shultz, etc., et al.*, 443 F. 2d 689, 693 (D.C. Cir. 1971) *c.f.* *Flast v. Cohen*, 392 U.S. 83, 99-102, 88 S. Ct. 1942, 1952-1953, 20 L. Ed. 2d 947 (1968).

In addition, the “hardship to the parties of withholding court consideration” must be considered. *Abbott Laboratories v. Gardner*, 387 US 136, 149, 87 S.Ct. 1507, 1515, 18 L. Ed.2d 681 (1967). It is also well established that an issue is ripe for review, and standing is evidenced, when the challenging party is placed in the dilemma of incurring the disadvantages of complying or risking penalties for non-compliance. See, e.g. *Doe v. Bolton*, 410 US 179 188, 93 S.Ct. 739, 745, 35 L. Ed.2d 201 (1974); *Epperson v. Arkansas*, 393 US 97, 100, 89 S.Ct. 266, 268, 21 L. Ed.2d 228 (1968). See also, *Whitney v. Heckler*, 780 F.2d 963, 968-969, n.6 (11<sup>th</sup> Cir. 1986).

These five (5) Plaintiffs present “actual” and “imminent” injuries-in-fact. They tie these injuries directly to the enforcement of the POMS, and, they illustrate that this Court enjoining the enforcement of the POMS and mandatorily directing the Defendants to allow them to disenroll from, or not enroll in, Medicare, Part A, and to allow them to continue to receive their Social Security monthly benefits, will provide them the necessary redress.

**B. The Challenged Policies Are – And Have Been In This Case – Enforced By The Defendants Against Those Who Apply For Their Social Security Monthly Benefits**

The Defendants rest their whole case on the absolutely preposterous argument that the POMS do not prohibit the Plaintiffs from getting out of Medicare, Part A, but rather that the statute, 42 U.S.C. § 426(a), does. *Def. Mem.*, pp. 6-8 and 13-16. The Defendants go on to assert that the challenged policies “track” the statute, but they have “no force of law, and, while warranting respect from the judiciary [citation omitted], [are] not binding on the Defendants or the Court.” *Id.* at 6. The Defendants then cite the “disclaimer” in the *SSA Program Operations*

*Manual System* which states, *inter alia*, that “the POMS states only internal SSA guidance. It is not intended to, does not, and may not be relied upon to create any rights enforceable at law by any party in a civil or criminal action.” *Id.*

The argument is utterly absurd; it is also totally contrary to the facts. In the first place, the challenged POMS do not “track” 42 U.S.C. § 426(a) as Defendants try to assert. In fact, the POMS do not even reference 42 U.S.C. § 426(a), or any other statute, as being interpreted by them at all. All 42 U.S.C. § 426(a) does is “entitle” those entitled to Social Security monthly benefits to Medicare, Part A. It does not make Social Security monthly benefits “conditioned” upon “enrollment” in Medicare, Part A; it does not provide that one’s Social Security monthly benefits will be denied if he/she does not enroll in Medicare, Part A; it does not direct the defeasance of Social Security monthly benefits, plus the repayment of all benefits received to date, if one seeks to disenroll from Medicare, Part A. Only the POMS provide all of those draconian directives.<sup>9</sup> All of the foregoing draconian directives in the POMS are, according to the Defendants, found in the lone words “shall be entitled.” Yet, those same words are used in 42 U.S.C. § 402, and enrollment in Social Security has never been mandatory. The Defendants, of course, offer no definition of the term “shall be entitled.”

Plaintiff JOHN J. KRAUS was actually tendered the *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary*, by the SSA employee in Norristown, Pennsylvania when he questioned the lawfulness of the requirement that he enroll in Medicare, Part A, as he applied for his Social Security monthly benefits. *SMF*, ¶ 41, Exh. 1 (*Kraus*). KRAUS tried to appeal

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<sup>9</sup> Here, it must be stated that Defendants’ contention that no one “enrolls” or “is enrolled” in Medicare is an absolute fabrication. **Individuals actually “enroll,” and “are enrolled,” in Medicare, Part A and Part B. The HHS automatically enrolls individuals in Parts A and B of Medicare if they are 65 years of age and have applied for Social Security.** See, <http://www.medicare.gov/basics/socialsecurity.asp>. There, it states individuals can “disenroll” from Part B. The website is completely silent on whether one can disenroll from Part A. Only pursuant to the POMS is an individual not allowed to disenroll from Part A. This Court was seriously misled by the Defendants during its consideration of BRIAN HALL’S *Motion for a Temporary Restraining Order*.

through his Congresswoman to the SSA to obtain the rationale for why that POMS did not conflict with 42 U.S.C. § 426(a). Never did the SSA representative claim that the POMS had no force of law and did not prohibit him from getting out of Medicare, Part A. On the contrary, the POMS were being enforced by the SSA. *SMF*, ¶¶ 41-65, Exhs. 1, 3, 4, 6 and 8 (*Kraus*). The SSA claimed to KRAUS in writing that the POMS “reflected the intent of the law.” *SMF*, ¶ 55, Exh. 6 (*Kraus*). Of course, they do not.

With every other Plaintiff in this case, an examination by them was conducted to determine why they were being lawfully “compelled” to enroll in Medicare, Part A, when they applied for Social Security monthly benefits or when they considered doing so. None of them found 42 U.S.C. § 426(a) to mandate such enrollment as a condition of receiving Social Security monthly benefits. All of them believed the requirements in the POMS to be contrary to 42 U.S.C. § 426(a). *SMF*, ¶¶ 15-29 (*Hall*); 41-65, Exhs. 1-9 (*Kraus*); 79-81 (*Arme*); 92-97 (*Randall*) and 109-113 (*Rogers*). There is no way the Defendants – or this Court, for this matter - can truly define “shall be entitled” to mean “must be enrolled,” or the like. It clearly cannot be read to mean “shall, subject to the defeasance of all Social Security monthly benefits.” Yet the POMS define “shall be entitled” to mean just that!

It is well-established that an agency cannot escape scrutiny by simply labeling a rule as a “mere interpretation.” *Appalachian Power Company, et al. v. EPA*, 208 F.3d 1015, 1024 (D.C.Cir. 2000). “We must still look to whether the interpretation itself carries the force and effect of law,....or rather whether it spells out a duty fairly encompassed within the regulation that the interpretation purports to construe.” *Id. c.f. Paralyzed Veterans of America, et al. v. D.C. Arena, LP, etc.*, 117 F.3d 579, 588 (D.C.Cir. 1997).

None of the cases cited by the Defendants stand for the proposition that the provisions of the *SSA Program Operations Manual System* have no force of law or are not binding. All of the cases cited by the Defendants state the contrary. In *Washington Dept. of Social Services v. Keffeler*, 537 U.S. 371, 123 S.Ct. 1017, 154 L.Ed 2d 972 (2003) the Supreme Court actually referred to the POMS as “the publicly available operating instructions for processing Social Security claims.” *Id.* 537 U.S. at 385, 123 S.Ct. at 1025. The Court then stated: “While their administrative interpretations are not the products of formal rule-making, they nevertheless warrant respect in closing the door on any suggestion that the usual rules of statutory construction should get short-shrift for the sake of reading ‘other legal process’ in abstract breadth...” *Id.*, 537 U.S. at 385, 123, S.Ct. at 1026.

Likewise, the Defendants’ reliance upon *Schweiker v. Hansen*, 450 U.S. 785, 101 S.Ct. 1468, 67 L.Ed2d 685 (1981), provides them no help. There, the Court held that when an SSA field representative erroneously responded to an oral inquiry regarding eligibility and the SSA claims manual provisions, if they had been consulted, would have stated the contrary, the agency still could not be estopped to provide the benefits. The fact was the claimant failed to follow a “procedural requirement of actually filing an application for benefits was fatal to her case.” The fact that a representative of SSA failed to follow the POMS when he gave advice to the claimant did not estop the government. *Id.*, 450 U.S. at 789-790, 101 S.Ct. 1468, 1471-1472.

Neither *McNamar v. Apfel*, 172 F.3d 764 (10<sup>th</sup> Cir. 1998) nor *Bubnis v. Apfel*, 150 F.3d 177 (2<sup>nd</sup> Cir. 1998) help the Defendants either. In *McNamar*, provisions of the POMS were actually presented to the Court by the SSA as “expressions of the law that should be enforced.” They were. Two POMS provisions were referenced by the U.S. Court of Appeals for the Tenth Circuit as policies “which appear to foreclose appellant’s argument that his/her insurance

premiums should have been excluded medical expenses.” *Id.*, 172 F.2d at 766. The only inquiry left in that case, according to the court, was “whether these agency interpretations are arbitrary, capricious, or contrary to law.” *Id.* The court found those were not.

In *Bubnis*, the U.S. Court of Appeals for the Second Circuit was asked to determine whether the Commissioner of SSA’s determination of the monthly offset rate for federal disability payments for those having workers’ compensation lump-sum settlement awards were lawful. The Court determined that they were and that the provisions of the POMS which state such were entitled to “substantial deference, and will not be disturbed, **as long as they are reasonable and consistent with the statute.**” *Id.*, 150 F.3d at 181 (emphasis added).

These POMS actually “bind private parties....with the force of law.” *Cement Kiln Recycling Coalition v. EPA*, 493 F.2d 207, 254 (D.C.Cir. 2007) *c.f.*, *General Elec. Co. v. EPA*, 290 F.3d 377, 382 (D.C.Cir. 2002). “[A]n agency pronouncement is binding as a practical matter,” the U.S. Court of Appeals for the District of Columbia has concluded, “if it appears on its face to be binding, or is applied by the agency in a way that indicates it is binding.” *Cement Kiln Recycling Coalition v. EPA*, 493 F.3d at 254. The POMS are clearly being enforced by the Defendants to force the enrollment in Medicare, Part A, of those who apply for Social Security monthly benefits. The statute, 42 U.S.C. § 426(a), does not require such enrollment; it merely provides an individual “entitlement” to Medicare, Part A, if he/she is entitled to Social Security monthly benefits. The Defendants, to date, have presented no properly-promulgated regulations in the *Code of Federal Regulations* that contain any provisions even close to what is provided in the POMS. The POMS stand alone. Their very wording illustrates they are being enforced as the law; they instruct the employees of HHS and SSA to require individuals to accept Medicare, Part A, or be denied their Social Security monthly benefits. *SMF*, ¶¶ 173-176.

C. **Plaintiffs Have Presented Ample Allegations and Facts Illustrating Their Standing to Challenge the Effect of the POMS Upon Them**

The Defendants claim that Plaintiffs, BRIAN HALL, JOHN J. KRAUS and RICHARD K. ARMEY, were not “forced” into Medicare, Part A. Instead, they signed applications for Medicare, Part A, when they applied for their Social Security benefits. To the Defendants, these Plaintiffs “voluntarily” entered into those applications. *Def. Mem.*, pp. 12-13. To the Defendants, it seems, being **forced** to accept Medicare, Part A, as a condition of an individual receiving his/her Social Security monthly benefits, is a “voluntary” act. They do not state to this Court that there are any other applications for Social Security monthly benefits; there is only one, of course. An applicant must sign it, or, if he/she refuses, be denied his/her Social Security monthly benefits. That application is the Defendants’ means of enforcing the POMS; there exists nothing else upon which to base the POMS. That, to the Defendants, is a “voluntary” application for Social Security benefits. Of course, it is anything but voluntary.

Defendants then state that any injury arising from the requirement that Plaintiffs be enrolled in Medicare, Part A, in order to obtain their Social Security monthly benefits, “would plainly not [have resulted] from any conduct of the Defendants, but from the unchallenged statutory provision giving rise to the Medicare, Part A, entitlement. 42 U.S.C. § 426(a).” *Def. Mem.*, p. 13. Never do the Defendants state what language in 42 U.S.C. § 426(a) requires one to be enrolled in Medicare, Part A, as a condition of receiving his/her Social Security monthly benefits. Never do the Defendants even argue that the words “shall be entitled” actually mean one must accept Medicare, Part A, as a condition of receiving Social Security monthly benefits. The Defendants never define “entitlement” or “entitled” for this Court at all. They do not because for them to do so would highlight, magnify and underscore the absolute absurdity of their argument. “Shall be entitled” does not mean “must be enrolled.”

Plaintiffs meet all of the requirements for standing in this Court. HALL, KRAUS and ARMEY show actual injury in that they have been denied their FEHB program coverage by the enforcement of the POMS. HALL has suffered his FEHB insurance carrier “taking back” its 2009 contribution to his HSA since the denial by this Court of his Motion for a Temporary Restraining Order; both HALL and KRAUS can no longer contribute to their HSAs.<sup>10</sup> HALL, KRAUS and ARMEY have also been denied the freedom to make their own decisions regarding their health care and health care providers, as well as the privacy of their health and health records. They have been forced into a system that is nearly bankrupt and will continue to ration health care services more and more. They have real injuries and imminent injuries attributable to the Defendants that can be addressed by this Court. *Fox v. Leavitt, supra*.

RANDALL and ROGERS will suffer the loss of their freedom to make their own decisions regarding their health care and health care providers, as well as the privacy of their health and health care records, if they are required to sign the SSA application in order to obtain their Social Security monthly benefits. Their refusal to sign that application has cost them, and is costing them, thousands of dollars each year. ROGERS is losing \$27,000 a year in monthly benefits. If RANDALL and ROGERS refuse to sign the unlawful application, they will **never** get the Social Security benefits they have had set aside over their forty (40) years of professional service. They are placed in the dilemma of incurring the disadvantages of complying or risking penalties for non-compliance. *Doe v. Bolton, supra; Epperson v. Arkansas, supra.* and *Whitney v. Heckler, supra*.

Without question, the injuries being suffered by the Plaintiffs are directly attributable to the POMS. The Social Security Act, particularly 42 U.S.C. § 426(a), is a benign enactment

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<sup>10</sup> Title 26 U.S.C. § 223 (b)(7) denies all tax benefits for contributions to HSAs once an individual becomes a Medicare beneficiary. See, *IRS Publication 969* at [www.irs.gov](http://www.irs.gov).

entitling the Plaintiffs to Medicare, Part A, if they are “entitled” to Social Security monthly benefits. Only the POMS, promulgated by the Defendants – and enforced by them – make “entitlement” to Social Security monthly benefits **conditioned** upon enrolling in Medicare, Part A. The POMS do not even reference the statute they purportedly interpret. It is time for the Defendants’ absurd defense to end. “Shall be entitled” does not mean “must be enrolled.” If all of the foregoing isn’t enough, when JOHN J. KRAUS objected to signing the application for Social Security monthly benefits and asked for authority for the requirement that he also enroll in Medicare, Part A, he was actually handed *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary* by the SSA agent.

Plaintiffs’ claims here may be readily addressed by this Court. The Defendants may clearly be enjoined from enforcing the POMS pursuant to 5 U.S.C. §§ 702 to 706. The Defendants may be further mandatorily enjoined to allow Plaintiffs to receive their Social Security monthly benefits without having to enroll in, or remain enrolled in, Medicare, Part A. Defendants’ Motion to Dismiss must be denied as Plaintiffs have shown herein actual or imminent injury in fact, attributable to the POMS (which are being enforced by the Defendants), and a favorable decision here will provide Plaintiffs redress. *Fox v. Leavitt, supra*.

## **II. PLAINTIFFS HAVE NO OTHER RECOURSE THAN THE JUDICIAL REMEDY**

### **A. There Are No Statutory or Regulatory Administrative Remedies Available To The Plaintiffs**

The Defendants in this case literally argue out of both sides of their mouths on the issue of administrative remedies just as they do on the issue of standing. They argue that there is no statutory or regulatory mechanism to avoid Medicare, Part A, and retain entitlement to one’s Social Security monthly benefits, and then they argue that Plaintiffs failed to exhaust their administrative remedies. In their *Opposition Memorandum to Plaintiff, BRIAN HALL’S, Motion*

for a Temporary Restraining Order (“*Def. Opp.*”), the Defendants stated the following:

There is.... no separate statutory or current regulatory means of avoiding one’s “entitlement” to Medicare, Part A, benefits, at least so long as one retains entitlement to monthly Social Security benefits.

*Def. Opp.*, p. 5.

During the course of oral argument on January 16, 2009, counsel for the Defendants argued that no statutory or regulatory means of avoiding one’s entitlement to Medicare, Part A, existed so long as one retains entitlement to Social Security monthly benefits over and over again. This Court accepted that assertion and incorporated their written argument *verbatim* in its *Memorandum Opinion* of January 28, 2009 on page 8.

Again, in *Defendants’ Memorandum in Support of the Motion to Dismiss*, they state that same proposition, asserting:

There is no currently existing process whereby someone entitled to Medicare, Part A, can “enroll” therein (or, *a fortiori*, disenroll from) and no such process is mandated by any statute or regulation.

*Def. Mem.*, p. 1.<sup>11</sup>

Plaintiffs have no other route for relief except the judicial avenue. Just as the Defendants have argued over and over again, no mechanism exists for the Plaintiffs to protect their Social Security monthly benefits while they seek not to participate in Medicare, Part A. *SMF*, ¶ 179. Plaintiffs are 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*; all of the Plaintiffs are "entitled" to Social Security monthly benefits, and, thus, such is not the issue which they are trying to resolve. Rather, they seek to not enroll in, or to opt out of, Medicare, Part A – an issue about which Section 405g is silent.

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<sup>11</sup> See also *Def. Mem.*, p. 29, where Defendants explain “entitlement” to Medicare, Part A, benefits follows automatically for all people who are entitled to monthly Social Security benefits and that under current law there is no mechanism for individuals entitled to monthly Social Security benefits to ‘waive’ the ‘entitlement.’”

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 understand 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, all of the Plaintiffs are “entitled” to Social Security and Medicare, Part A, already, but they do not want any Medicare, Part A, benefits.

To underscore the fact that no administrative remedy exists to address the Plaintiffs’ determination to not enroll in, or to disenroll from, Medicare, Part A, and not suffer the sanction of losing their Social Security monthly benefits, neither the Secretary of HHS, nor the Commissioner of SSA provide any means by which the Plaintiffs may notify them of their determination not to enroll in, or to disenroll from, Medicare, Part A. There does exist such a mechanism to enable them to not enroll in Medicare, Part B, and one of those Plaintiffs who is now enrolled in Medicare, Part A, BRIAN HALL, has exercised that right. *SMF*, ¶¶ 23-25 (*Hall*); [http://www.coproducer.com/Med\\_Enroll\\_Card.pdf](http://www.coproducer.com/Med_Enroll_Card.pdf). That no administrative mechanism

exists to allow Plaintiffs to question the requirement that they enroll in Medicare, Part A, as a condition of receiving their Social Security monthly benefits is a direct result of the POMS. *SMF*, ¶ 179.

The Defendants' argument that Plaintiffs' amended complaint should be dismissed because they have failed to exhaust administrative remedies is a sham. There are no administrative remedies available to the Plaintiffs on the issue raised herein. The Defendants' Motion to Dismiss must be denied.

**B. Plaintiff, JOHN J. KRAUS, Sought to Pursue Administrative Remedies to Disenroll From Medicare, Part A, When He Applied for His Social Security Benefits, but the Defendants Failed and Refused to Even Respond to His Appeal**

Individuals have attempted to not enroll in, or disenroll from, Medicare, Part A, in the past. In every case, the Defendants have refused to make any "initial" or "final" determination at all. Plaintiff JOHN J. KRAUS applied for his Social Security monthly benefits in February 2005 and informed the SSA that he did not want to enroll in Medicare, Part A. A former employee in the United States Department of the Navy, KRAUS had obtained health insurance, which included an HSA, through the FEHB program. The SSA informed him when he applied for Social Security monthly benefits that he could not "waive Medicare, Part A entitlement." He tried to appeal the refusal of the SSA to allow him to waive his entitlement to Medicare, Part A, through his Congresswoman. The SSA refused to consider his objections. On February 10, 2006, he demanded a hearing before an ALJ by certified mail, return receipt requested. To date, neither the Commissioner of SSA, nor anyone in the SSA, have ever responded to his request, even though it was received by the SSA on February 13, 2006 and signed by Janice Garvey of the SSA. *SMF*, ¶¶ 41-65, Exh. 9 (*Kraus*). Although the Defendants have asserted that JOHN J. KRAUS had not sought an appeal to an ALJ - and there was no evidence that he forwarded such

a request by certified mail, return receipt requested (*Def. Mem.*, pp. 24-25) - he unequivocally **did** make such a request and **did** send it by certified mail, return receipt requested. It was the SSA that simply **ignored** it. JOHN J. KRAUS has received no response to his appeal for three (3) years! *SMF*, ¶ 64, Exh. 9 (*Kraus*).

Witness David Nelson also sought to disenroll from Medicare, Part A. He, like JOHN J. KRAUS, was informed that he could not waive Medicare, Part A, entitlement. Nelson sought an initial determination from HHS and SSA on October 4, 1999. After providing what must be the most strained, illogical explanation for why an applicant for Social Security monthly benefits must be enrolled in Medicare, Part A, Sheree R. Kanner, Associate General Counsel of HHS, wrote the following on October 4, 1999:

Because Mr. Nelson's entitlement to Medicare, Part A, is as a result of his entitlement to Title II retirement benefits, and not as a result of a successful application for Medicare, Part A, benefits, **the Secretary [of HHS] has not made, and will not make, an initial determination with respect to his Part A entitlement.**

*SMF*, ¶ 123, Exh. D (*Nelson*).

Not only does no administrative remedy exist, **the Defendants will not even provide an individual appealing the forced enrollment in Medicare, Part A, with any administrative process if they are asked to do so.** The SSA never responded to Mr. Nelson's request at all. It has been ten (10) years! The Defendants have not permitted any administrative review of the POMS. Rather, they have frustrated all such attempts.

C. **The POMS Challenged Herein Are System-wide Rules and, As Such, This Court Has Historically Held That Any Attempt to Exhaust Administrative Remedies in Challenging Them Would Be Futile and Unnecessary**

The POMS are system-wide rules which are explicit; according to them one cannot waive Medicare, Part A, entitlement without losing his/her monthly Social Security benefits. As the

POMS are system-wide rules, there are no facts for the Secretary of HHS and Commissioner of SSA to weigh even if an individual were to be provided with an administrative process. *SMF*, ¶ 171.

This Court has ruled that one need not pursue administrative remedies before proceeding to a United States District Court when challenging system-wide rules and the challenge is collateral to any claim for benefits. *Tataranowicz v. Sullivan*, 753 F.Supp. 978 (D.D.C. 1990) *rev'd on other grnds*, 959 F.2d 268 (D.C.Cir. 1992). In *Tataranowicz*, a civil action was filed in this Court against the Secretary of HHS 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 (100) 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.

The Secretary 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 Stanley 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 **“system wide...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 (emphasis added).

The U.S. Court of Appeals for the District of Columbia agreed with Judge Sporkins' determination regarding jurisdiction. Citing *Matthews v. Diaz*, 426 U.S. 67, 96 S.Ct. 1883, 48 L. Ed.2d 478 (1976), the court concluded:

Here, judicial resolution of the statutory issue (1) will not interfere with the agency's efficient functioning; (2) will not thwart any effort at self-correction; (3) will not deny the court or parties the benefit of the agency's experience or expertise; and (4) will not curtail development of a record useful for judicial review.

*Tataranowicz v. Sullivan*, 959 F.2d at 275.

Indeed, *Tataranowicz* falls within a significant line of cases decided by this Court that emanate from a prominent decision of the Supreme Court. In *Bowen v. City of New York*, 476 U.S. 467, 106 S.Ct. 2022, 90 L. Ed.2d 462 (1986), 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 vitiation of an unlawful policy, and, the claimants were likely to be irreparably harmed if the exhaustion requirement was 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 of HHS which required the SSA 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 (emphasis added).

This case is even more compelling than *Tataranowicz*, *Pratt*, *Duggan* and *Bowen v. City of New York*. **None of the Plaintiffs seek any benefits from Medicare, Part A, whatsoever.**

**This action involves no claims.** There are no facts unique to any of them that are relevant to this case. No facts adduced at any hearing would aid this Court at all. Certainly, the Secretary of HHS and Commissioner of SSA hold no “expertise” in deciding questions of pure law. *SMF*, ¶¶ 171, 177 and 178.

Practically speaking, what discretion do the Secretary of HHS or Commissioner of SSA possess to entitle one or all of the Plaintiffs to not enroll in, or disenroll from, Medicare, Part A, and retain their entitlement to Social Security benefits? May RICHARD K. ARMEY get out, but not the rest? May LEWIS RANDALL and NORMAN ROGERS avoid signing the application, but all of the other Plaintiffs must remain Medicare beneficiaries? And, if so, on what basis would the Secretary or the Commissioner so determine? The answer is simple – there is no discretion. Otherwise, all the Defendants’ arguments that there is no mechanism for the Plaintiffs not to enroll in Medicare, Part A – upon which this Court has heretofore relied – were and are complete fabrications that counsel knew were fabricated. Like so many of their arguments, the Defendants’ reliance upon exhaustion of administrative remedies is a sham; it is based upon the worst of double-speak.

All of the Plaintiffs simply do not want to enroll in, or they seek to disenroll from, Medicare, Part A, and not suffer the loss of their Social Security monthly benefits. The Defendants’ POMS at issue here prohibit them from not enrolling in, or disenrolling from, Medicare, Part A, without also surrendering their Social Security monthly benefits. Plaintiffs challenge system-wide rules. The judicial remedy is the only remedy available to the plaintiffs. The Defendants’ Motion to Dismiss should be denied.

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

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

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

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. 1367, 4 L.Ed.2d. 1435 (1960). The only route one may pursue to become “entitled” to Social Security monthly 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(1) 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(1) 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(1) 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.

42 U.S.C. § 402(a)(j) (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. An individual “entitled” to Social Security monthly benefits does not have to apply for them. “Shall be entitled” in 42 U.S.C. § 402 does not mean “must be enrolled.” There are no other conditions in 42 U.S.C. § 402, 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).

## 2. 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)*

42 U.S.C. § 426(a) (emphasis added).

An individual must attain the age of sixty-five (65) years and be entitled to Social Security monthly benefits to be “entitled” to Medicare, Part A. 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 still be accessing only that to which he was “entitled.” “Shall be entitled,” for purposes of Medicare, Part A (42 U.S.C. § 426(a)), cannot have a different meaning from “shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402).

### **3. The Medicare Preamble Statutes Protect The Individual’s Choice of Health Insurance Plans**

If the foregoing statutes are not enough to illustrate the voluntariness of Medicare, Congress actually made it clear in a “preamble” statute. 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 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.” 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 apply for coverage under Medicare, Part A, or, his/her Social Security monthly benefits, to which he/she would otherwise be entitled, would be denied.** Why would Congress guarantee the free choice of health insurer if it intended to “force” everyone into Medicare, Part A? Once in Medicare, Part A, there is no other coverage, save a secondary carrier under Part B.

### **4. 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.**

##### **5. The Fact That Medicare Is An “Entitlement” Does Not Make Enrollment In It 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.” *Black’s Law Dictionary*, Revised 4<sup>th</sup> Ed. Put another way, “entitlement” has been defined as “to give one a right to do or have something; allow; qualify.” *The American Heritage Dictionary of the English Language*, New York: American Heritage Pub. Co., 1970. “Require,” on the other hand, means “to direct, order, demand, command, compel or exact.” *Black’s Law Dictionary*, Revised 4<sup>th</sup> Ed; *The American Heritage Dictionary of the English Language*.

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 or access his/her benefits.

The U.S. Court of Appeals for the Ninth Circuit followed *Webster’s Third New International Dictionary* in interpreting the word “entitlement.” Construing entitlement under § 1127 of the Social Security Act, the Court held:

In the ordinary use of English, “entitled” means “to give right or legal title to, qualify [one] for something; furnish with proper grounds for seeking or claiming something.” *Webster’s Third New International Dictionary*, 758 (1976).

*Fagner v. Heckler*, 779 F.2d 541, 543 (9<sup>th</sup> Cir. 1985).

The United States Court of Claims held similarly in *Merrill v. United States*, 338 F.2d 372, 374 (1964) and *Hurt v. United States*, 309 F.2d 404, 406 (1993). The Supreme Court of Minnesota held the term “entitled” to be “equivalent” to “eligible.” *State v. Jansen*, 290 N.W. 557 (1940).

The Defendants turn to *Jewish Hospital, Corp. v. Secretary of Health and Human Services*, 19 F.3d 270 (6<sup>th</sup> Cir. 1994) in a last ditch attempt to somehow equate “entitlement” with what is found in the POMS. There, the Court considered a Medicare reimbursement provision allowing the Secretary of HHS to adjust Medicare Prospective Payment System (“PPS”) payments to hospitals. The Court considered the word “eligible” with respect to Medicaid patients and “entitlement” with respect to Medicare patients. There, the Court asserted that “[t]o be entitled to some benefit means that one possesses the right or title to that benefit.” That definition is exactly the same as found in *Black’s Law Dictionary*, *The American Heritage Dictionary of the English Language* and *Webster’s Third New International Dictionary*

aforementioned. The Defendants cannot sustain an argument that the POMS properly define the term “entitlement.” “Shall be entitled” means nothing more than “having a right to do or have something.” It does not mean that individual entitled **must** accept that to which he is “entitled.”

An individual “entitled” to Social Security monthly benefits under (42 U.S.C. § 402) is not mandated to apply for them; it is wholly voluntary. These very Defendants so argued in *Leverett v. United States Bureau of Health and Human Services*, 2003 WL 21770800 (D.Colo. 2003), and the court agreed, holding: “[N]othing in the Social Security system requires [an individual] to apply for and receive Social Security benefits.” *Id.* at 2. Why would “shall be entitled” mean something different when applied to Medicare, Part A, 42 U.S.C. § 426(a)? It cannot and does not. Even though an individual “shall be entitled” to Medicare, Part A, he/she does not have to accept it. “Shall be entitled,” for purposes of Medicare, Part A (42 U.S.C. § 426(a)), is no different than “shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402).

#### 6. The Challenged POMS Should Be Given No Deference Whatsoever

The Defendants claim that the POMS “are not a final agency action.” They then claim that, at the very least, they are “reasonable interpretations of the Social Security Act and SSA’s own implementing regulations.” *Def. Mem.*, p. 29. To analyze any agency interpretation of a statute such as the POMS, the Supreme Court has articulated a methodology:

When a court reviews an agency’s construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. **If the intent of Congress is clear, that is the end of the matter**; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction in the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the

question for the court is **whether the agency’s answer is based on a permissible construction of the statute.**

*Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843, 104 S.Ct. 2778, 2781-2782, 81 L.Ed 2d 94 (1984) (emphasis added).

The POMS are completely at odds with 42 U.S.C. § 426(a). Although the Defendants are accorded authority to promulgate regulations to administer the Social Security and Medicare statutes, that authority does not extend to promulgating policies that are at variance with the statutes. Wrote the Supreme Court:

We have long recognized that considerable weight should be accorded to an executive department’s construction of a statutory scheme it is entrusted to administer [citations omitted]. The fair measure of deference to an agency administering its own statutes has been understood to vary with the circumstances, and the courts have looked to the degree of the agency’s care, its consistency, formality, and relative expertness, **and to the persuasiveness of the agency’s position.**

*United States v. Mead Corp.*, 533 U.S. 218, 227-228, 121 S.Ct. 2164, 2171-2172, 150 L. Ed2d 292 (2001) (emphasis added).

As the POMS are policies that were not promulgated pursuant to the APA, the threshold for reviewing what deference, if any, is accorded them is low. *SMF*, ¶ 172. *Christensen v. Harris County*, 529 U.S. 576, 587 120 S.Ct. 1655, 1662, 146 L. Ed.2d 621 (2000) (reviewed opinion letter from U.S. Department of Labor); *Reno v. Koray*, 515 U.S. 50, 61, 115 S.Ct. 2021, 2027, 132 L. Ed2d 46 (1995) (reviewing Bureau of Prisons Program Statement, an “internal agency guideline”); *Martin v. Occupational Safety and Health Review Comm’n.*, 499 U.S. 144, 157, 111 S.Ct. 1171, 1179, 113 L. Ed2d 117 (1991) (reviewing OSHA agency enforcement guidelines). But, the Supreme Court has also noted: “[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent.” For if the intent of Congress is clear and the Secretary’s interpretation of the statute is contrary to the intent, “that is the end of the matter.” *Chevron, U.S.A., Inc. v.*

*Natural Resources Defense Council, Inc.*, 467 U.S. at 843, n.9, 104 S. Ct. at 2782, n.9.

Here, the Congressional mandate is clear with respect to 42 U.S.C. §§ 402 and 426(a). Those “entitled” to Social Security monthly benefits are “entitled” to enrollment in Medicare, Part A. They are not required to take it; they simply have a right to it. To say anything else is to deny the plain meaning of the words “shall be entitled.”

The POMS are classic examples of agency overreach; neither SSA nor HHS can come up with a reason why they have taken the words “shall be entitled” and turned them into what is found in the POMS. Deference, indeed, has its limits. Courts must invalidate agency policies that are “inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement.” *Federal Election Comm’n. v. Democratic Senatorial Campaign Comm’n.*, 454 U.S. 27, 32, 102 S. Ct. 38, 42, 70 L.Ed 2d 23 (1981). When a court determines that “there are compelling reasons that [an agency interpretation] is wrong, the court may invalidate the agency’s action. *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381, 89 S. Ct. 1794, 1802, 23 L. Ed 2d 371 (1969). Likewise, “a reviewing court should not defer to an agency position which is contrary to an intent of Congress expressed in unambiguous terms.” *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 476, 112 S. Ct. 2589, 2594, 120 L.Ed 2d 379 (1992); *International Brotherhood of Teamsters v. Daniel*, 439 U.S. 551, 566, n.20, 99 S. Ct. 790, 800, n.20, 59 L. Ed2d 808 (1979).

This Court has stated law similarly before. Judge Joyce Hens Green concluded in a challenge to Prospective Reimbursement regulations of the End-Stage Renal Disease program:

The agency’s expertise in the complex area of health care regulation entitles it to a large measure of deference from the court. However, deference is not warranted in this instance because, in promulgating these regulations, the Secretary has disregarded the statutory language and has undermined the statutory objective. **If the agency rejects the reasonable interpretation of the statute, the court must**

**honor the clear meaning of a statute, as revealed by its language, purpose and history.**

*National Ass'n. of Patients on Home Dialysis and Transplantation, Inc., et al. v. Heckler*, 588 F.Supp. 1108, 1127 (D.D.C. 1984) (emphasis added).

Title 42 U.S.C. § 426(a) is unambiguous. It only grants individuals an “entitlement” to Medicare, Part A, nothing more. It does not compel one to enroll in Medicare, Part A, nor does it compel the defeasance of Social Security monthly benefits if one does not enroll in Medicare, Part A. “Shall be entitled” for purposes of Social Security monthly benefits (42 U.S.C. § 402) means it is wholly voluntary; it cannot mean anything different for purposes of Medicare, Part A (42 U.S.C. § 426(a)). This Court should accord the POMS no deference at all. The POMS are plainly contrary to the express intent of Congress.

**7. The Challenged POMS 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)**

By the very reading of the Social Security Act and the Medicare Act, enrollment is absolutely voluntary for both. For the Secretary of HHS and Commissioner of SSA to make receipt of Social Security monthly benefits conditioned upon applying for Medicare, Part A, is absolutely contrary to 42 U.S.C. §§ 402 and 426(a) and 42 U.S.C. §§ 1395 *et seq.*, and, thus, is invalid. 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). *Federal Election Comm'n. v. Democratic Senatorial Campaign Comm., supra*; *Red Lion Broadcasting Co. v. F.C.C., supra*; *National Ass'n. of Patients on Home Dialysis and Transplantations, Inc., et al. v. Heckler, supra*.

Executive agencies cannot legislate; any quasi-legislative authority exercised by any agency “must be rooted in a grant of such power by Congress and subject to limitations which

that body imposes.” *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, 99 S.Ct. 1705, 1718, 60 L. Ed.2d 208 (1979), *c.f.*, *Batterton v. Francis*, 432 U.S. 416, 425, n. 9, 97 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. at 304, 99 S.Ct. at 1718-1719. “The pertinent inquiry,” wrote the Supreme Court in *Chrysler*, “is whether under any arguable *statutory* grants of authority the [agency’s] requirements are reasonably within the contemplation of that grant of authority.” *Id.*, 441 U.S. at 306, 99 S.Ct. at 1720.<sup>12</sup>

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. 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). It is clear this Court should invalidate POMS as they are contrary to the Social Security Act and Medicare Acts. As the Supreme Court noted:

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. The reviewing court should not attempt itself to make up for such deficiencies; one may not supply a reasoned basis for the agency’s action that the agency itself has not given.

*Motor Vehicles Mfrs. Ass’n. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 2867, 77 L. Ed.2d 443 (1983).

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<sup>12</sup> The challenged policies herein are “substantive” or “legislative” rules. See Argument V,C, hereinbelow.

The POMS are “arbitrary, capricious....and....not in accordance with law.” 5 U.S.C. §§ 706(2)(A), (B) and (C). Accordingly, this Court should grant Plaintiff’s Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement.

**B. 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 Secretary of HHS and Commissioner of SSA 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 entitlement.

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 of SSA make Social Security or Medicare, Part A, mandatory. The Commissioner does not mandate that Social Security monthly benefits will be denied to any otherwise entitled individual who does not enroll in, or disenrolls from, Medicare, Part A. **In fact, the Commissioner uses the term “eligibility” interchangeably with “entitlement.”** The Commissioner then defines “entitlement” as nothing more than when an individual “**meets all the requirements for entitlement....**” 20 C.F.R. § 406.3.<sup>13</sup> He does not define “entitlement” as being anything similar to what is found in the POMS. He does not predicate the loss of an individual's monthly Social Security benefits on him/her not enrolling in, or disenrolling from, Medicare, Part A. “Entitlement” and “eligibility” are used to define the availability of Medicare, Part A, for anyone entitled to Social Security monthly benefits.

Likewise, the properly-promulgated regulations of the Secretary of HHS do not make enrolling in, or disenrolling from, Medicare, Part A, mandatory, nor do they predicate an

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<sup>13</sup> This definition is drawn from the original Medicare Act introduced in 1965. *Hearings Before the Committee on Finance, United States Senate, 89<sup>th</sup> Congress, First Session*, on H.R. 6675, Washington, DC: U.S. Government Printing Office, 1965, p. 4.

individual losing his or her monthly Social Security benefits upon him or her not enrolling in, or disenrolling from, Medicare, Part A. Thus, 42 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).

The Defendants try to assert that 20 CFR § 404.640 somehow forms the basis for the POMS. *Def. Mem.*, p. 30. Unfortunately for the Defendants, it does nothing of the sort. All that provision does is set forth how an individual may withdraw from receiving Social Security monthly benefits! **It does not address Medicare at all.** None of the Plaintiffs want to withdraw from receiving their Social Security monthly benefits; they do not want to enroll, or remain enrolled, in Medicare, Part A.

The Defendants then try to pawn off on this Court that 42 CFR § 406.6 somehow mandates enrollment in Medicare, Part A. *Def. Mem.*, pp. 33-34. To reach that result they refer the Court to paragraph (e). Paragraph (e), though, refers only to those who “must pay a monthly

premium for hospital insurance.” That would not refer to the Plaintiffs because all of them would be “entitled” to Medicare, Part A, and would not pay any premiums for that coverage. The Defendants’ reliance upon 20 CFR § 404.640 and 42 CFR § 406.6 only illustrates that the challenged POMS cannot find support either in 42 U.S.C. § 426(a) or in any of the properly-promulgated regulations of the Secretary of HHS or the Commissioner of SSA.

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

Plaintiffs must succeed on the merits of this case because the properly-promulgated regulations of the Secretary of HHS and the Commissioner of SSA underscore the voluntariness of Medicare, Part A, and that the Defendants, statutorily, cannot deny an individual’s monthly Social Security benefits if he or she does not enroll in, or disenrolls from, Medicare, Part A. This Court should grant Plaintiff’s Motion for Summary Judgment and declare the challenged POMS invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

Because it has been established that Medicare, Part A, is voluntary, the Defendant’s policies or rules set forth in the POMS must be invalid because the Defendants have actually taken it upon themselves to “legislate” by promulgating and enforcing those policies or rules. The Supreme Court has addressed this issue multiple times. In *Chrysler Corp. v. Brown*, 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.*

*Id.*, 441 U.S. at 302-303, 995 S.Ct. at 1718 (emphasis added).

Although Congress granted to the Secretary of HHS and Commissioner of SSA the power to promulgate regulations to carry into effect the Social Security and Medicare Acts (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 of HHS or the Commissioner of SSA the power to make mandatory that which Congress determined to be voluntary. Likewise, Congress did not grant to the Secretary of HHS or the Commissioner of SSA 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 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*, 144 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., Bowles v. Willingham*, 321 U.S. 503, 64 S.Ct. 641, 88 L.Ed 892 (1944). Here, the Secretary of HHS and Commissioner of SSA have subverted the statutes in question. They have exercised “discretion to determine what the law shall be” rather than how the law shall be executed as written by Congress.

The POMS find absolutely no support in the Social Security or Medicare Acts. Both acts provide benefits to individuals who are “entitled” to them. The Defendants have even admitted that “shall be entitled” in 42 U.S.C. § 402 does not mean “must be enrolled.” Clearly, “shall be entitled” in 42 U.S.C. § 426(a) cannot mean “must be enrolled.” Congress provided explicit statutory provisions governing how and under what circumstances Social Security monthly 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, the POMS, must be declared invalid as contrary to the intent of Congress, an exercise of authority not granted by Congress to the Secretary of HHS or the Commissioner of SSA, 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 grant Plaintiffs’ Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

According to 5 U.S.C. § 558(b) of the APA, “a sanction may not be imposed....except within jurisdiction delegated to the agency and as authorized by law.” Section 558(b) requires

statutory authority for all sanctions; it does not distinguish on its face between punitive sanctions and ordinary sanctions. It speaks of “sanctions,” period! *American Bus Ass’n v. Slater*, 231 F.3d 1 (D.C. Cir. 2000).

In *American Bus Ass’n.*, the U.S. Court of Appeals for the District of Columbia 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 Social Security monthly benefits and forcing him or her to repay all the benefits previously paid, because he or she refused to enroll in, or 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.<sup>14</sup>

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<sup>14</sup> 20 CFR § 404.640 is no help as Defendants suggest. *Def. Mem.*, p. 35. Plaintiffs do not want to withdraw from Social Security. They want to claim their entitlement. They want to withdraw from, or not enroll in, Medicare, Part A. 20 CFR § 404.640 does not address that issue; rather, it addresses only withdrawing from Social Security itself.

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

This Court should grant Plaintiffs' Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

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

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

**1. The Challenged Policies Are Agency Rules Under The APA**

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.

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....” The challenged POMS 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, the POMS are “rules” for purposes of the APA, 5 U.S.C. § 551(4).

**2. The Challenged POMS, 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.

5 U.S.C. § 553.

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 the POMS were not promulgated by means of rule-making; rather, they were simply incorporated into the *SSA Program Operations Manual System* by the agency without informing the public. *SMF*, ¶¶ 171-172.

**B. The POMS Are Not Rules Relating to “Benefits” or “Interpretive” Rules**

**1. The POMS 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 SSA and the Centers For Medicare and Medicaid Services of HHS 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 (9<sup>th</sup> 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.

## 2. The POMS 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. at 301, 99 S.Ct. at 1717. What distinguishes a “substantive” rule from an “interpretive” rule has been addressed by the Supreme Court. In *Batterton v. Francis*, 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.

*Id.*, 432 U.S. at 425, n.9, 97 S.Ct. at 2405 n.9.

In *Chrysler Corp. v. Brown*, the Court reviewed all of its prior holdings on the issue. The *Chrysler* court noted that in *Morton v. Ruiz*, 415 U.S. 199, 232-235, 94 S.Ct. 1055, 1073-1074, 39 L. Ed.2d 270 (1974) 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. v. Brown*, 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 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. v. Brown*, 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* (1941), p.27.

The Supreme Court 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).<sup>15</sup> The POMS, though, are not “interpretive” rules; rather, they have the “force and effect of law,” and are meant to “implement” the Social Security and Medicare Acts. Without question, they “affect individual rights and obligations.” Because there are no similar rules in the *Code of Federal Regulations* – and 42 U.S.C. § 426(a) does not provide similar language – the POMS are the **only** rules mandating Medicare, Part A, enrollment as a condition of receiving Social Security monthly benefits. As the U.S. Court of Appeals for the District of Columbia held:

If an agency acts as if a document issued at its headquarters is controlling in the field, if it treats the document in the same manner as it treats a legislative rule...if it leads private parties...to believe they [must] comply with the terms of the document, then the agency’s document is, for all practical purposes, “binding.”

*Appalachian Power Co. v. EPA*, 208 F.3d at 1021.

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:

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<sup>15</sup> The Secretary of HHS and the Commissioner of SSA defend this case on the ground that these POMS are “interpretative” rules and they should not be given the force of law. *Def. Mem.*, pp. 34-35. Based on that defense, this Court is not required to give the POMS any effect whatsoever; it should, accordingly, determine 42 U.S.C. § 426(a) does not mandate enrollment in Medicare, Part A. Thus, the Defendants should be enjoined to permit the Plaintiffs to not enroll in, or disenroll from, Medicare, Part A, and keep their Social Security monthly benefits.

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 Secretary of HHS and the Commissioner of SSA are actually using the POMS to “force” individuals to accept Medicare, Part A, even though the Social Security Act and Medicare Act – and the properly-promulgated regulations of the Secretary and Commissioner - do not. As *In Home Health Care*, there are no references in the challenged policies or rules to any statute that is being interpreted, much less, 42 U.S.C. § 426(a). If those entitled to Social Security monthly benefits do not accept Medicare, Part A, the rules are being used to strip them of all their Social Security “savings.” These are not “interpretative” rules; they are “substantive” or “legislative” rules. As such, they are “final” agency actions. *Appalachian Power Co. v. EPA*, supra.; *Yale-New Haven Hospital, et al. v. Leavitt*, 470 F.3d 71 (2<sup>nd</sup> Cir. 2006); *In Home Health Care, Inc. v. Bowen*, supra.

C. **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. *Yale-New Haven Hospital, et al. v. Leavitt*, supra; *Appalachian Power Co. v. EPA*, supra.; *Louisiana Federal Land Bank Ass’n., FLCA v. Farm Credit Admin.*, 336 F.3d 1075 (D.C.Cir. 2003); *Spirit of the 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). In *Home Health Care, Inc. v. Bowen*, supra. Accordingly, the POMS must be declared void and invalid. These policies literally “affect individual rights and obligations,” implement two (2) major congressional enactments and are administered as though they have “the force and effect of law,” yet they were promulgated without any rule-making, thus denying the public the opportunity to participate and comment on their appropriateness and legality. This Court should grant Plaintiffs’ Motion for Summary Judgment and 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.”

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

**A. Plaintiffs Are Being Denied Their Fundamental Right of Privacy By Being Forced to Enroll in Medicare or Being Denied The Right to Get Out of Medicare Pursuant to The Challenged Policies**

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 especially as it is historically 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.

Plaintiffs BRIAN HALL, JOHN J. KRAUS and RICHARD K. ARMEY have suffered the disruption of their FEHB health care insurance programs. HALL, KRAUS and ARMEY are now not allowed to pay privately for their own health care services. They are having to choose physicians only from a pool of those who actually participate in Medicare, an ever-dwindling number. They have lost control over their own health care decision-making. HALL and KRAUS have had to cease making contributions to their HSAs. Thus, their HSAs have become moribund. HALL'S FEHB insurance carrier has actually "taken back" its 2009 contribution to his HSA after the Court denied his Motion for Temporary Restraining Order. If HALL, KRAUS or ARMEY had refused to accept Medicare, Part A, when they applied for Social Security, they would have been denied their Social Security monthly benefits. Plaintiffs LEWIS RANDALL and NORMAN ROGERS do not want to be enrolled in Medicare for all the above reasons, but they are not able to obtain their Social Security monthly benefits so long as they do not sign the Defendants' application. ROGERS has been losing \$27,000.00 in Social Security monthly benefits each year.

The present claims rest, in part, upon a violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendment privacy rights of the Plaintiffs to exercise their freedom to choose their own health care 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. The Plaintiffs are suffering – and 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 undermines Plaintiffs’ fundamental rights under the Constitution. This Court should grant Plaintiffs’ Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).

**B. Plaintiffs Are Being Denied Their Property Interest In Their Social Security By The Challenged Policies**

Whether a wage earner has a property interest in monthly Social Security benefits has been addressed by the Supreme Court. In *Flemming 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 of HHS and/or Commissioner of SSA 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 (2<sup>nd</sup> 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 POMS are clearly arbitrary, capricious and not provided by law. Only Congress can “alter, amend or repeal” any provision of the Social Security or Medicare Acts. It has never done so in order to force an individual to forego his or her Social Security monthly benefits if he or she did not want to participate in Medicare, Part A. The POMS are patently arbitrary and capricious; they have been promulgated and are being enforced completely contrary to the statutes and without authority. Accordingly, the POMS violate the Due Process Clause of the Fifth Amendment to the Constitution of the United States. This Court should grant Plaintiffs’ Motion for Summary Judgment and declare the challenged policies invalid and enjoin their enforcement pursuant to 5 U.S.C. § 706(2)(A), (B) and (C).<sup>16</sup>

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<sup>16</sup> Defendants go to great lengths to complain about what would happen if this Court enjoined them. *Def. Mem.*, p. 14, n.8. The Defendants would have to perform as Congress intended. Such would not cause any difficulty whatsoever. For one, Social Security and Medicare are two different programs administered by two different agencies. At present, individuals are paid Social Security monthly benefits at age 62 and not provided any Medicare benefits until age 65. The Defendants have experienced no problems with that. When an individual becomes entitled to Medicare at age 65, HHS “automatically”

## CONCLUSION

For all the foregoing reasons Plaintiffs pray that this Court deny Defendants' Motion to Dismiss and grant Plaintiffs' Motion For Summary Judgment, declaring the *POMS HI 00801.002, Waiver of HI Entitlement by Monthly Beneficiary, POMS HI 00801.034, Withdrawal Considerations*, and *POMS GN 00206.020, Withdrawal Considerations When Hospital Insurance is Involved* void as contrary to law and of no effect, and enjoining the Defendants, permanently and mandatorily, to permit the Plaintiffs to not enroll in, or disenroll from, Medicare, Part A, and retain their Social Security monthly benefits.

Respectfully submitted,

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enrolls him/her in both Parts A and B; it then allows him/her to opt out of Part B. <http://www.medicare.gov/basics/socialsecurity.asp>. The Defendants have experienced no problems with that either. Individuals must be able to opt out of Part A like they are able to do with Part B. That is the intent of Congress.