No. _____

In the Supreme Court of the United States

BRIAN HALL, et al.,
Petitioners,

v.

KATHLEEN SEBELIUS, et al.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

(1) Under the Social Security and Medicare Acts, does the Social Security Administration have the power to condition the ability of a person to waive Medicare Part A (dealing with hospital insurance) on his or her surrender of all past and future Social Security benefits?

(2) Does the recent decision of this Court in *National Federation of Independent Business v. Sebelius*, 567 U.S. ____, 132 S. Ct. 2566 (2012) impose constitutional limitations on the power of the Social Security Administration to condition the waiver of Medicare Part A on the surrender of all past and future Social Security benefits?

(3) Should the Social Security Administration receive limited deference under *Skidmore v. Swift & Co.,* 323 U.S. 134 (1944), when it offers no reasoned explanation for linking Social Security with Medicare Part A in short rules that on their face are motivated in part by SSA's disagreement with the philosophical and religious beliefs of those individuals seeking to separate the two entitlement programs?

PARTIES TO THE PROCEEDINGS

Petitioners, Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus and Richard K. Armey, were the appellants in the court below. Respondents, Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, and Mark J. Astrue, Commissioner of the Social Security Administration, were the appellees in the court below.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners, Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus and Richard K. Armey, respectfully petition for a Writ of Certiorari to review the Order of the United States Court of Appeals for the District of Columbia ("Court of Appeals") in this case.

OPINIONS BELOW

The decision of the Court of Appeals is reported at 667 F.3d 1293 (D.C. Cir. 2012). (App. 1a) The decision of the District Court for the District of Columbia (hereinafter "District Court") is reported at 770 Supp. 2d 61 (D. D.C. 2011). (App. 24a) The Order on the Petition for Rehearing and Rehearing *En Banc* in the Court of Appeals is reported in 2012 U.S. App. LEXIS 10889. (App. 42a and 48a)

JURISDICTION

The judgment of the United States Court of Appeals for the District of Columbia Circuit was entered on February 7, 2012. (App. 1a) A Petition for Rehearing and for Rehearing *En Banc* was timely filed, and the Court denied the Petition for Rehearing and Rehearing *En Banc* on May 30, 2012. (App. 42a and 48a) The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS INVOLVED

Article I, Section 8, Clause 1, provides in relevant part: "The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and

provide for the common defense and general welfare of the United States."

The Fifth Amendment to the United States Constitution provides in relevant part: "nor [shall any person] be deprived of life, liberty or property, without due process of law; nor shall private property be taken for public use, without just compensation."

STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 402(a)

> "Every individual who —
> (1) is a fully insured individual . . .
> (2) has attained age 62, and
> (3) has filed application for old-age insurance benefits . . .
> shall be entitled to an old-age insurance benefit for each month . . . ."

(App. 50a)

42 U.S.C. § 426(a)

> "Every individual who . . . has attained the age of 65, and is entitled to monthly [Social Security benefits] under [42 U.S.C. § 402] of this title . . . shall be entitled to hospital insurance benefits under Part A of [this chapter] . . . ."

(App. 51a)

STATEMENT OF PROCEEDINGS BELOW

The Petitioners in this case, Brian Hall, Lewis Randall, Norman Rogers, John J. Kraus, and Richard K Armey, are retirees who filed suit in the District of Columbia District Court on October 9, 2008. Their Amended and Substituted Complaint was filed on December 15, 2008. Jurisdiction for the Amended and Substituted Complaint was predicated upon 42 U.S.C. §§ 405(g) and 1395ff, 28 U.S.C. §§ 1331, 2201 and 2202 and FRCP 57, 42 U.S.C. §§ 401 *et seq.* and §§ 1395 *et seq.,* 5 U.S.C. § 558(b) and §§ 702 to 706 and Article 1, Section 1 and the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the U.S. Constitution. The Amended Complaint alleged that the rules issued and enforced by the Social Security Administration (SSA) through its Program Operations Manual System – POMS HI 00801.002, "Waiver of HI Entitlement by Monthly Beneficiary" (App. 53a); POMS HI 00801.034. "Withdrawal Considerations" (App. 55a); and POMS GN 00206.020, "Withdrawal Considerations When Hospital Insurance is Involved" (App. 57a) (collectively referred to as "POMS rules") – and enforced by the Department of Health and Human Services ("HHS") – were invalid insofar as they required the Petitioners to abandon their Social Security benefits if they did not enroll in, or withdrew from, Medicare Part A. The District Court Judge, Rosemary M. Collyer, denied the relief they sought. In a Preliminary Memorandum Opinion, the District Court held that the POMS rules were "final agency action" under the Administrative Procedure Act, 5 U.S.C. § 551(13), Mem. (Dist. Ct. Dkt. #21), 5-7, which was entitled to deference under *Skidmore v. Swift & Co.,* 323 U.S. 134 (1944). The District Court then held that the POMS rules rightly specified that all individuals "are immediately and

automatically entitled to Medicare Part A benefits upon their sixty-fifth birthdays," in contrast with Medicare Part B, dealing with physician services, which did require a distinctive application. *Hall,* 770 F. Supp. at 68. (App. 36a)

The Court of Appeals affirmed on February 7, 2012 by a two-to-one vote. In his short opinion, Kavanaugh, J. (joined by Ginsburg, J.) did not rely on *Skidmore* deference to the POMS rules, but agreed with the District Court that the Petitioners were "automatically entitled" to receive their Medicare Part A benefits, and they could disclaim them only by forfeiting all present and past Social Security benefits, or roughly $280,000.00. [1] *Hall*, 667 F.3d at 1294 (App. 2a to 8a) The dissent (Henderson, J.) denied that the POMS rules were entitled to *Skidmore* deference, and then accepted Petitioner's claim that there is no statutory linkage between Social Security and Medicare Part A. *Id.* at 1297-1302 (App. 9a to 21a)

The Court of Appeals then unanimously denied Petitioners' Petition for Rehearing and for Rehearing *En Banc* on May 30, 2012. 2012 U.S. App. LEXIS 10889 (App. 42a and 48a) Writing separately, Henderson, J., reiterated her firm opposition to the majority's ruling, which Kavanaugh, J., stoutly

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[1] A male at age 62 has about a 20 year life expectancy. The maximum current benefits are around $24,000 per year. Since the benefit escalation roughly offsets the discount factor, it is correct to sum up all future years to make the correct estimate. See, e.g., for the analogous calculation in tort damages, See Carter & Palmer, *Real Rates, Expected Rates, and Damages Awards*, 20 J. LEGAL STUD. 439, 461 (1991).

reaffirmed. (App. 44a to 47a) The mandate was entered by the Court on June 12, 2012.

This Petition for a Writ of Certiorari follows.

INTRODUCTION

This Petition for a Writ of Certiorari addresses the vital question of whether the Social Security Program is tied to Medicare Part A. Judge Kavanaugh's weakly-reasoned majority opinion sustained the POMS rules that link the two programs together. *Hall,* 667 F.3d at 1294-1297 (App. 2a-8a) Certiorari should be granted to overturn the POMS rules which distort the relationship between the two statutes. Overturning the ruling below would for the first time expand consumer choice by allowing people to opt out of Medicare Part A at age 65 without sacrificing their Social Security benefits, thereby reducing the financial losses in Medicare Part A.

Notwithstanding these key advantages, for many years the SSA has forged a nonexistent link between Social Security and Medicare Part A, under which anyone who turns down Medicare Part A must also withdraw from the Social Security Program, by returning all past Social Security payments received and abandoning any claim to future payments—a lifetime financial penalty of about $280,000. That link is found neither in 42 U.S.C. § 402(a), which allows individuals to enroll for their Social Security benefits at age 62, nor in 42 U.S.C. § 426(a), which allows them to participate in Medicare Part A at age 65.

The POMS rules come in the teeth of a statutory provision that says that all persons "shall be entitled,"

not required, to join Medicare Part A at age 65. It undercuts SSA's and HHS's widely-trumpeted declaration that individual participation in both Social Security and Medicare Part A is "voluntary," which cannot be the case if the price of staying out of Medicare Part A is repaying all past and forfeiting all future Social Security benefits.

The POMS rules also ignore a simple way to integrate the two statutes that preserves their separate entitlements: just treat the automatic enrollment feature of Medicare Part A as a *convenience* for applicants, most all of whom at present wish to enroll in both programs. The same preference is not true for Medicare Part B, which many people do not wish to enroll in, if only to keep their current physicians, and for whom automatic enrollment could lead to unnecessary confusion. The best reading of the two statutory provisions vests Medicare Part A benefits in only those persons who chose not to *waive* them. That approach is also in harmony with 42 U.S.C. § 402(n), (t), (y), (u) and (x), where Congress provided explicit instances of when Social Security benefits may be "terminated;" not enrolling in, or disenrolling from, Medicare Part A are not among them.

Petitioners' case also raises a major constitutional issue that was *not* in play before February 2012. The Petitioners contend that SSA's explicit linkage of Social Security to Medicare Part A runs afoul of the constitutional limitations on the federal spending power. This claim has now been made viable by this Court's recent decision in *National Federation of Independent Business v. Sebelius,* 567 U.S. _____, 132 S. Ct. 2566 (2012) ("*NFIB*") handed down on June 28,

2012. Before *NFIB*, the common legal wisdom held that the federal government could attach whatever conditions it chose on any and all grants of federal money. See *South Dakota v. Dole*, 483 U.S. 203 (1987). Every single lower court judge relied on *Dole* to reject spending clause challenges to the Medicaid extension in the PPACA. See, *NFIB,* 567 U.S. at ____ 132 S.Ct. at 2582 (slip op. at 10-11) and *Florida v. United States Dep't. of Health & Human Servs.,* 648 F.3d 1235, 1268 (11th Cir. 2011). The sudden change in legal environment thus makes it appropriate to mount this challenge for the first time on certiorari, if only for remand and reconsideration under *NFIB*. Of course, under *NFIB* the Court can avoid the entire constitutional issue by reading 42 U.S.C. § 426(a) as creating a waivable right in Petitioners. "And it is well established that if a statute has two possible meanings, one of which violates the Constitution, courts should adopt the meaning that does not do so." *NFIB*, 132 S.Ct. at 2594 (slip op. at 31).

NFIB made clear that, in dealing with relationships between the federal government and the States, the Congress could not condition the willingness to participate in a new program that was intended to extend Medicaid coverage to persons within 100 to 133 percent of the poverty line on the withdrawal of all Medicaid funds from all existing Medicaid programs. Linking the two programs together was like putting "a gun to the head" of the States, *Id.*, 132 S.Ct. at 2604 (slip op. at 51), just as the SSA is now putting a gun to the head of the Petitioners in this case.

NFIB arose in the context of federalism. But equal or greater coercive arrangements can be found in cases that deal with the relationship of the individual to the

federal government. Constitutionally, fully vested Social Security benefits count as property under the Due Process Clause, see *Goldberg v. Kelly*, 397 U.S. 254 (1970), *Board of Regents v. Roth*, 408 U.S. 564 (1972). The doctrine of unconstitutional conditions thus limits the types of conditions that SSA can impose on Social Security payments. In this case, SSA and HHS have given no reason whatsoever why these programs should be linked together. Nor is it possible to conceive of any such justification. The two programs are separately financed and operated. The actions in the one program have nothing to do with the success of activities under the other. The Petitioners are not seeking to game the system, but only to avoid forfeiting the benefits under Social Security while withdrawing from Medicare Part A, knowing that they must continue to pay the full Medicare tax on both their earned and investment income for a program from which they want to renounce all benefits. The government offers no reasoned explanation why what is already for them a losing financial proposition should become a catastrophic one. Indeed, the case for imposing the condition here is weaker than it was in *NFIB,* where the government at least sought the legitimate objective of expanding Medicaid coverage. The metaphor of a gun to the head applies as much, if not more, to this case than to *NFIB*.

Nor does the Petitioners' case rest solely on the metaphor of a "gun to the head" to explain why the SSA's and HHS's threat to cut all Social Security benefits counts as coercion. Equally relevant to this inquiry is the doctrine of unconstitutional conditions as raised in *Nollan v. California Coastal Commission,* 483 U.S. 825 (1987) and *Dolan v. City of Tigard,* 512 U.S. 374 (1994). Those two cases asked whether a

local government could condition a building permit on the willingness of a landowner to comply with certain conditions. In both cases, this Court held that it could do so only if the stated condition had a close "nexus" to some legitimate government interest, lest it become a form of "out-and-out-extortion," *Nollan*, 483 U.S. at 837. Unless the conditions related to the prevention of future harm from the landowner's new venture or to some return benefit that the landowner would receive from government, the government could not condition the permit on compliance with added conditions.

The analysis in both these public areas rests on solid private law foundations. The analysis of forced connection between Social Security and Medicare Part A tracks in all relevant ways the treatment of similar tie-in arrangements under the antitrust laws, which is concerned with the improper leverage by a party with dominant economic position, if that dominant party is unable to offer a suitable efficiency explanation for its conduct. The United States with its absolute taxing power has a dominant position that cannot be eroded by time, by new entrants or technological innovation. Yet it offers no explanation at all for this onerous linkage.

In sum, whether one speaks of the Spending Clause, the Takings Clause, or the antitrust laws, the analysis is the same. Whenever the federal government uses its monopoly position to leverage itself benefits for which it would otherwise have to pay, it must show some social (i.e. efficiency) justification for its use. No such justification was attempted for SSA's and HHS's crude effort to tie the turndown of benefits under Medicare Part A to the forfeiture of all past and future Social Security

benefits. The unprincipled government effort to link these programs must be rejected as unconstitutional.

REASONS FOR GRANTING THE PETITION

I.

THE SSA AND HHS HAVE MISINTERPRETED BOTH THE SOCIAL SECURITY ACT AND THE MEDICARE ACT BY INSISTING THAT ANY PERSON WHO WISHES TO OPT OUT OF MEDICARE PART A MUST SACRIFICE ALL HIS/HER SOCIAL SECURITY BENEFITS UNDER SECTION 402(a) OF THE ACT.

A. Whether the POMS Rules Are Entitled to Deference and Subject to De Novo Review.

The novel threshold question in this case asks about the level of deference that this Court should give to the administrative agency that offers *no* reasons for its judgments. Deference under *Chevron U.S.A. Inc. v. Natural Resource Defense Council, Inc.*, 467 U.S. 837 (1984) is out of the question given the absence of any notice and comment procedure. Indeed, in a break from the District Court, the majority of the Court of Appeals examined this issue of statutory construction *de novo*, without granting SSA and HHS some limited deference under *Skidmore v. Swift & Co.,* 323 U.S. 134 (1944).

The District Court treated the POMS rules as an "interpretative ruling" under 5 U.S.C. § 553(b)(A), citing such cases as *Davis v. Secretary of Health and Human Services,* 867 F.2d 336 (6th Cir. 1989) ("Although the POMS is a policy and procedure

manual that employees of the [SSA] use in evaluating Social Security claims and does not have the force and effect of law, it is nevertheless persuasive.") *Id*. at 340.

But *Davis* is worlds apart from the instant case. There, the SSA had to interpret the phrase "intentionally causing that person's death." "POMS 00304.115, Meaning of Intentional Homicide," offered a detailed and impartial examination of the key terms, before concluding that only accidental and justifiable homicides excluded a person from receiving survivor benefit. The Secretary earned *Skidmore* deference by doing the type of impartial analysis that merits judicial confidence. In contrast, SSA's and HHS's sorry performance in this case reveals not the slightest evidence of any intellectual exertion. Their curt POMS rules contain no reasons, and consider no alternative reading. The *entirety* of its discussion is put in simplistic dialogic form:

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

Thereafter the POMS offer this "Policy Answer:"

> "Individuals entitled to monthly benefits which confer eligibility for HI may not waive HI [Hospitalization Insurance under Medicare Part A] entitlement. The only way to avoid HI entitlement is through withdrawal of the monthly benefit application. Withdrawal requires repayment of all Social Security

> Retirement Benefits [SSRB] and HI benefit payments made."

POMS HI 00801.002 (App. 53a)

Rephrasing a question is a poor excuse for an answer. *See Gonzales v. Oregon*, 546 U.S. 243 (2006). Note that the supposed linkage between 42 U.S.C. § 402(a) and 42 U.S.C. § 426(a) says nothing about the forfeiture of Social Security Benefits, nor the loss of previous Medicare Part A benefits by individuals who have paid in full premiums for their coverage. Any claim of agency expertise is whittled down to nothing once courts defer to vacuous claims that rest solely on a naked assertion of power.

This claim for deference is even weaker, moreover, because the POMS answer notes that the question comes from those who have doubts about both Social Security and Medicare Part A "because of religious or philosophical reasons or because they prefer other health insurance." That government response lands with full force on any individuals who for religious, philosophical or financial reasons have the temerity to question the dominant place that entitlement programs like Social Security and Medicare Part A have in American life. These rules offer SSA and HHS the ideal place to strike back because they know that only the few stout opponents of these entitlement programs would be prepared to mount a challenge that, even if successful, will require them to make major financial sacrifices. Deny this simple claim by a narrowly-crafted ruling and the vast bulk of the American public remains indifferent to the outcome because they have no intention of opting out of Medicare Part A.

This particular POMS sally is not an isolated effort to target programmatic opponents. In a December 8, 2010 ruling, POMS announced that the papers of anyone who wished to withdraw from the Social Security program had to be "filed within 12 months of the first month of entitlement." See 20 C.F.R. § 404.640 & 75 Fed. Reg. 76256 (Dec. 8, 2010), cited in *Hall*, 770 F. Supp.2d at 65, n. 4 (App. 33a). The District Court declined to discuss this ruling after its rejection of the initial forfeiture claim. But that ruling surely illustrates how far SSA and HHS are prepared to push their power even in the total absence of any textual peg on which to hang their administrative hat. Nor is there any regulatory need to tighten this screw. The longer any person waits under the current scheme, the larger the benefits under both Social Security and Medicare Part A that must be sacrificed. But the 12-month ruling just gratuitously puts yet another nail into the coffin of those who might wish to pay a heavy price to opt out of a government program. That decision is made, knowing that the continued presence of any person inside Medicare Part A will *cost* the government money. No government expertise can account for this troublesome course of events in which political ideology infuses every government decision.

B. No Matter What Level of Deference Is Afforded, the POMS Rules Are Flatly Inconsistent with Both the Social Security and Medicare Acts.

No matter how much deference is afforded the POMS rules, they are inconsistent with the language, structure, history and purpose of the overall regime. 42 U.S.C. § 402(a), first enacted in 1935, states simply that (most) citizens who reach age 62 or over and apply

for Social Security benefits "shall be entitled" to receive Social Security benefits. This section contains no additional conditions. The text of §402(a) was not modified on passage of the Medicare Part A statute in 1965. 42 U.S. C. § 426(a), in turn, provides that "every individual who has attained the age of 65 and is entitled to monthly [Social Security] benefits, shall be entitled to hospital insurance benefits." It too contains no additional conditions on coverage.

The separation between the two programs is no accident. Social Security and Medicare Part A are separately funded and separately operated. The solvency or efficiency of the one program in no way depends upon who participates in the other. In this situation, moreover, none of the Petitioners have sought to game the system for their private advantage. Indeed, on their own theory, they *concede* that they must continue to pay Medicare taxes on all their earned and investment income even after retirement, for which they will receive in exchange nothing at all. Their opting out of Medicare Part A provides a windfall for the government and other Medicare participants, even if the Petitioners are allowed to keep all of their Social Security benefits.

The government offers only a hyper-technical defense of this one-sided deal. The government argued and the Courts below opined that the omission of an explicit "application" requirement in Section 426(a) leads necessarily to the conclusion that once persons are covered under Social Security they are "immediately and automatically" enrolled in Medicare Part A once they reach age 65, three years *later*. But neither "immediately," nor "automatically," are found anywhere in statutory language. They were added to

it by the force of the POMS rules, whose reading both the District Court and the Court of Appeals accepted without explanation.

Their collective view, moreover, is flatly inconsistent with two salient features of the statute that all three parties acknowledge. First, the POMS rules make hash of the word "entitled" in Section 426(a). The word "entitled" speaks of an option that is granted to the party who receives it. Thus, every dictionary definition stresses that "entitle" gives one a "title to" something. *Black's Law Dictionary*, Revised 4th Ed., speaks of something "capable of being chosen" or "legally qualified." *Webster's Third New International Dictionary* says "entitlement" means: "to give right or legal title to, qualify for something; furnish with the proper grounds for seeking or claiming something." Entitlements are explicit benefits, not hidden burdens. Even the majority opinion in the Court of Appeals states that "the plain meaning of the statutory term 'entitled'" requires a choice, only to miss the point entirely by insisting that this entitlement is already satisfied because under the POMS scheme "they already have a choice to accept or reject those benefits." *Hall,* 667 F.3d. at 1296 (App. 6a).

The utter confusion in the Court of Appeals majority opinion comes from its Pickwickian sense of the word "choice." A robber gives you a choice between your money and your life. But, like SSA and HHS here, he offers no explanation as to why you are not entitled to *both*. A religious believer may be given a choice between abstaining from worship or forfeiting all Social Security benefits, but he is surely denied the "free exercise" of his religion, especially after this

Court's recent unanimous decision in *Hosanna-Tabor Evangelical Lutheran Church and School* v. EEOC, 565 U.S. __, 132 S. Ct. 694 (2012). But the majority opinion in the Court of Appeals falls headlong into just this trap with its own misconceived example:

> A poor citizen might be entitled under federal law to food stamps. The citizen does not have to take the food stamps. But even so, she nonetheless remains legally entitled to them. So it is here.

Hall, 667 F.3d at 1296 (App. 6a).

Yet surely that food stamp recipient is not required to waive her Social Security benefits in the bargain! The sad and inescapable truth is that the POMS rules have turned a clear statute on its head by *requiring* any eligible person entitled to Medicare Part A to surrender about $280,000 in Social Security benefits to secure that ever-elusive option. This ad hoc condition is imposed even though 42 U.S.C. § 402(n), (t), (y), (u), (v) and (x) provide the only instances Congress determined would terminate Social Security benefits. None of them include not enrolling in, or disenrolling from, Medicare Part A.

Second, every party hereto has repeatedly acknowledged that participation in both Social Security and Medicare Part A is "voluntary" with the beneficiary. See *Hall*, 667 F.3d at 1296 (App. 6a). How is that possible if the price for turning down Medicare Part A is the loss of $280,000 in Social Security payments, past and future? No one would say that participation in Medicare Part A would count as voluntary if the applicant had to make a $280,000.00

payment to SSA and HHS. Just what is the difference between the two cases? Perhaps entering into Medicare Part A provides huge net benefits to the individuals who choose to enroll. But if it does, there is all the more reason *not* to penalize the hardy few who disagree with that SSA and HHS judgment.

There is, moreover, no reason to twist the language of the statute to achieve this dubious result. Congress could have well removed the requirement for individuals to apply separately for Medicare Part A to eliminate the paperwork burden from a program that is, in fact, willingly accepted by most eligible persons. The correct solution, however, allows any Medicare-eligible individual who wants out of the program to *waive* the benefits by filing a simple form to that effect. That simple solution thus keeps separate the two entitlement programs that are at no point linked together in the basic statutory scheme. The Social Security law contains many places where the requirement of an application is *waived* for the benefit of the applicant. Thus, persons who receive Social Security benefits such as a widow, a widower, or a surviving divorced spouse of an individual whose benefits were fully vested need not file an application to receive benefits "for the month before the month in which the insured has died." 42 U.S.C. § 416(b). Similarly, the application requirement is waived for individuals who are moving between disability and retirement benefits. 42 U.S.C. § 416(i). The basic theme is clear. Any application requirement is waived for the *convenience* of plan participants who should not be burdened with needless paperwork during difficult times of personal transition.

The Court of Appeals insists that there is "no statutory avenue," *Hall,* 667 F.3d at 1296 (App. 6a), to allow for the needed disclaimers. But then it never explains what statutory avenue allows the POMS automatic vesting rule to demand the sacrifice of all Social Security benefits. Smuggling the word "automatically" into the statute wrongfully blocks the simple waiver that preserves the operational separation of the two programs. The Court of Appeals majority acknowledges that this is an atypical law suit because the Petitioners have sued because "they *don't* want government benefits." *Id.* at 1294 (App. 2a) (italics in original). Why then kick them in the teeth when the waiver they seek harms no other person or program?

The Court of Appeals does no better with its last gasp argument when it insists that Petitioners "seek a legal declaration that Medicare Part A benefits cannot be paid on their behalf—a declaration, in other words, that they are not legally entitled to Medicare Part A benefits." Not so. The Petitioners do not want —and never have wanted—a declaration that they are "not legally entitled to Medicare Part A benefits." Rather, they want a declaration that lets them waive those benefits without having to sacrifice their Social Security benefits. If the POMS rules can contain a conditional waiver, surely SSA and HHS can draft an unconditional one for far less than the $100 million that it has insisted the change would take. This clause should do: "Any person eligible to receive Medicare, Part A, is entitled to decline that benefit without waiving any of his or her Social Security benefits."

Finally, for its last gasp, the majority opinion in the Court of Appeals also hints that the Petitioners only

want to opt out of Medicare Part A to be able to procure "better private insurance coverage." That point is a red herring. Private insurers may well insist that anyone eligible for Medicare Part A cannot get coverage unless they also take Medicare Part A. But so what? That is Petitioners' problem, which they can likely solve even if only some insurers are willing to write first dollar coverage for an additional premium. The record reveals that Petitioners' insurance will cover them if they opt out of Medicare. Give the Petitioners their relief, and they are more than capable of fending for themselves in the private insurance market without further intervention from SSA and HHS.

II.

THE CONSTITUTIONAL PROHIBITION AGAINST UNCONSTITUTIONAL CONDITIONS PROHIBITS THE TIE-IN ARRANGEMENT THAT THE POMS RULES IMPOSE ON BENEFICIARIES OF SOCIAL SECURITY AND MEDICARE PART A BENEFITS.

A. The Recent Decision in this Court in *NFIB* Raises Profound Issues That Touch Many Areas of Constitutional Law.

In *NFIB*, this Court struck down Title II of the PPACA insofar as it denied any State the right to withdraw from the Medicaid extension program unless it forfeited all benefits to which it was otherwise presently entitled under all other well-established Medicaid programs. That epic decision necessarily invokes the complex law of unconstitutional conditions. See, generally, Richard A. Epstein,

BARGAINING WITH THE STATE (1993). At one time, the received wisdom against the doctrine was syllogistic in nature: "The right to absolutely exclude all right to use, necessarily includes the authority to determine under what circumstances such use may be availed of, as the greater power contains the lesser." *Davis v. Massachusetts,* 167 U.S. 43, 48 (1897). The modern case law has moved decisively in the opposite direction. See, e.g., *Hague v. Committee for Industrial Organization (CIO)*, 307 U.S. 496, 515-516 (1939) (effectively overruling *Davis).* The question is why the shift. The answer lies in the awareness of risk of abuse of the monopoly power possessed by governments at all levels and in all activities.

Without question, ordinary competitive bargains necessarily accept this greater/lesser distinction, for the business world can only function if sellers are allowed to raise their offers and buyers to lower theirs until the two sides reach an agreement or go separate ways. Nonetheless, whenever a private or public party possesses monopoly power, this syllogism no longer holds, because the ability to impose conditions can easily lead to an abuse of monopoly power with a concomitant reduction in social welfare. That is exactly what happens when the State has ownership of a unique asset, the public commons, to which all have a right to enter, which in *Hague* led the Jersey City political machine to impose a discriminatory exclusion of the CIO from the use of the public streets. More generally, if any government agency gets the extra advantage of imposing either this condition or that, by either admitting this person or that, it may use that discretion to diminish the overall social welfare, as was done with the constriction of State choices in connection with the Medicaid expansion.

The great challenge of the law of unconstitutional conditions is to distinguish those conditions that pose a threat to a competitive order from those which do not. This inquiry arises whenever the government is in a position to award contracts or issue permits to individual citizens or groups. As such, the overall problem spans the full range of constitutional issues from federalism, to contract theory, to antitrust law, to due process and takings laws—and to the ability of SSA and HHS to tie rejection of Social Security benefits to the rejection of Medicare Part A.

B. This Court's Recent Analysis of Coercion in NFIB Calls into Sharp Question the Decision of the Court of Appeals in the Instant Case.

The initial step in Chief Justice Roberts' opinion in *NFIB* reaffirmed the explicit linkage between the Court's jurisprudence under the Spending Clause and the basic law of contract:

> We have repeatedly characterized . . . Spending Clause legislation as 'much in the nature of a *contract*.' The legitimacy of Congress's exercise of the spending power "thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system.

NFIB, 132 S.Ct. at 2602 (slip op. at 46-47) (internal citations to *Pennhurst State School and Hospital v.*

Halderman, 451 U.S. 1 (1981), omitted; italics in original).

That said, the accounts of coercion developed in the law of contracts also carry over to constitutional law. Thus elsewhere, the Chief Justice writes:

> Instead of simply refusing to grant the new funds to States that will not accept the new conditions, Congress has also threatened to withhold those States' existing Medicaid funds. The States claim that this threat serves no purpose other than to force unwilling States to sign up for the dramatic expansion in health care coverage effected by the Act.
>
> Given the nature of the threat and the programs at issue here, we must agree. We have upheld Congress's authority to condition the receipt of funds on the States complying with restrictions on the use of those funds, because that is the means by which Congress ensures that the funds are spent according to its view of the "general Welfare." Conditions that do not here govern the use of the funds, however, cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.

Id., 132 S.Ct. at 2603-2604 (slip op. at 49-50).

These passages were penned in the context of federal-state relationships, and they made certain a

finding of coercion even though the Congress has a legitimate objective to expand Medicaid coverage. But their central message applies with still greater force to the current dispute where the federal government, without any legitimate purpose at all, uses explicit "threats to terminate other significant independent grants" to ordinary individuals. If the government cannot tie withdrawal from an established Medicaid program to the refusal to participate in a new Medicaid program, it cannot tie the loss of Social Security benefits to withdrawal from Medicare Part A. In neither case may the government constitutionally ask a party to sacrifice one entitlement for the refusal to accept a second.

Two features about *NFIB* clarify the constitutional situation in the instant dispute. First, *NFIB* introduces some needed clarity into the distinction between "encouragement" and "coercion" that has proved so elusive in dealing with these questions. Under the received wisdom about *South Dakota v. Dole,* prior to *NFIB*, the distinction was treated as though cases were arrayed on some sliding scale. Under that amorphous test, no federal appellate court had ever invalidated any conditional grant. *Id.*, 132 S.Ct. at 2682 (slip op. at 10-11) and *Florida v. United States Dept. of Health & Human Services*, 648 F.3d at 1268. But in *NFIB* the Chief Justice drew one clear line in the sand: no party can be forced to sacrifice *existing* rights under an established program if they wish to turn down an offer to receive a new set of benefits. To be sure, the federal government may still insist on the States "complying with restrictions on the use of those [Medicaid] funds," just as it can limit the types of expenditures covered under Medicare Part A. What the federal government could *not* do in *NFIB*

was to leverage its control over existing Medicaid programs to gain control over new ones. *NFIB,* 132 S.Ct. at 2603-2607 (slip op. 50-56).

Second, consent by the victim does not defeat a claim of coercion. In *NFIB*, the federal government insisted that "the original Medicaid provisions" contain a clause expressly reserving "[t]he right to alter, amend, or repeal any provision" of the Medicaid statute. 42 U.S.C. § 1304. Nonetheless, the Medicaid extension was a radical departure from past practices that drastically reduced the choices of the States without any offsetting public justification. *NFIB* stands for the proposition that the Constitution imposes conditions on the way the federal government can spend tax revenues. See *Id*., 132 S.Ct. at 2606-2607 (slip op. at 54-55).

C. The Contract and the Antitrust Law Both Show the Limits on Consent in Connection with Private Market Actors.

United States v. Bethlehem Steel Corp., 315 U.S. 289 (1942), shows the tight linkage between the law of economic duress and the doctrine of unconstitutional conditions. In *Bethlehem Steel, the* question was whether, at the height of World War I, the United States government could set aside its shipbuilding contracts on grounds of duress, in light of Bethlehem's dominant position in the shipbuilding industry. The Court rejected that claim in light of the course of negotiations between the parties, but the dissent of Justice Frankfurter perceptively addresses the larger issues in words that have direct relevance here:

> Fraud and physical duress are not the only grounds upon which courts refuse to enforce contracts. The law is not so primitive that it sanctions every injustice except brute force and downright fraud. More specifically, the courts generally refuse to lend themselves to the enforcement of a "bargain" in which one party has unjustly taken advantage of the economic necessities of the other. . . . It always is for the interest of a party under duress to choose the lesser of two evils. But the fact that a choice was made according to interest does not exclude duress. It is the characteristic of duress properly so called.

Id. at 326.

This point speaks directly to the arguments from "choice" raised by the majority opinion in the Court of Appeals. See *Hall*, 667 F.3d at 1296. More generally, the analytical landscape in contract law runs as follows. In competitive markets, every person is entitled to take the most aggressive stance possible in dealing with potential trading partners, all of whom are able to go elsewhere, leading to a competitive equilibrium where price converges on marginal cost. But that approach to contracting does not apply to the renegotiation of existing contracts in *Bethlehem Steel*. Now there is only one party with whom a deal can be made, which raises the risk of a serious holdout problem that could allow for the extraction of monopoly rents.

The dangers of monopoly power, of course, are not limited to cases of contract modification. They apply with equal force to any case in which potential

purchasers of goods and services have only one place to turn. At this point, an absolute right to refuse cannot be given to the dominant party. Indeed, just this situation led Sir Matthew Hale in the late 17th Century to speak about firms that "were affected with the public interest" in his treatise *De Portis Maribus* (Concerning the Gates to the Sea), which questioned the monopoly power over entrance and exit into a country. His account was then turned into law in the great English case of *Alnutt v. Inglis*, 12 East 527, 104 Eng. Rep. 206 (K.B. 1810), which held that any party that holds either a legal or natural monopoly must deal with all comers on reasonable and nondiscriminatory, or RAND terms. Lord Ellenborough thus put the point as follows:

> There is no doubt that the general principle is favored, both in law and justice, that every man may fix what price he pleases upon his own property, or the use of it; but if for a particular purpose the public have a right to resort to his premises and make use of them, and he have a monopoly in them for that purpose, if he will take the benefit of that monopoly, he must, as an equivalent, perform the duty attached to it on reasonable terms. . . .
>
> And, according to [Lord Hale], whenever the accident of time casts upon a party the benefit of having a legal monopoly of landing goods in a public port, as where he is the owner of the only wharf authorized to receive goods which happens to be built in a port newly erected, he is confined to take reasonable compensation only for the use of the wharf.

Alnutt, 12 East at 538, 104 Eng. Rep. at 210-211.

Alnutt v. Inglis made its way firmly into the American constitutional law of rate regulation in *Munn v. Illinois*, 94 U.S. 113, 127-128 (1876), where this passage was quoted in full. See Richard A. Epstein, PRINCIPLES FOR A FREE SOCIETY: RECONCILING INDIVIDUAL LIBERTY WITH THE COMMON GOOD, ch. 10 (1998), whose implications cannot be explored here. That same concern with a dominant market position has also expressed itself in the development of the antitrust law insofar as it dealt with tie-ins, exclusive dealing and other kinds of contracts. For a general discussion, see Keith N. Hylton, ANTITRUST LAW: ECONOMIC THEORY & COMMON LAW EVOLUTION, ch. 10 (2003). In compressed form, this Court first developed a *per se* prohibition against all tie-in arrangements, that is those contracts whereby customers who wished to purchase a dominant (or "tying") product had to agree to purchase a second (or "tied" product), with it. See *International Salt v. United States*, 332 U.S. 392 (1947). At no point did customer consent to the tie-in arrangement ever count as a defense to potential antitrust liability. The *per se* rule, however, was eventually softened to take into account the possibility that particular tie-in arrangements could be supported by efficiency justifications (e.g. quality control purposes) that outweighed any adverse monopoly effects. See, e.g. *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984); Louis Kaplow, *Extension of Monopoly Power Through Leverage*, 85 COLUM. L. REV. 515 (1985), and for a recent guide, Warren S. Grimes, *Tying: Requirements Ties, Efficiency and Innovation*, TESTIMONY ON SINGLE-FIRM CONDUCT AND ANTITRUST LAW, BEFORE DEPARTMENT OF JUSTICE AND

FEDERAL TRADE COMMISSION (2006) (available at http://www.justice.gov/atr/public/hearings/single_firm/comments/219982.htm).

Even the most cursory appreciation of the antitrust law reveals that SSA and HHS POMS rules on Social Security benefits challenged herein create an illegal tie. First, SSA and HHS have, without question, a dominant position, far greater than that which could ever be obtained by any private firm. The government has the uncontested monopoly power to tax, which cannot be eroded by the passage of time, by the entry of new firms, or by technological innovations. SSA's and HHS's vise-like hold over both entitlement programs is therefore subject to the very sorts of abuse that Chief Justice Roberts identified in rejecting the tie-in arrangement required by the Medicaid extension. Second, SSA and HHS have not offered a glimmer of an efficiency justification for the tie between Social Security and Medicare Part A. Viewed through the lens of tie-in law the SSA's and HHS's power grab should be instantly rejected. Given the tight connection between the law of contract and the law of unconstitutional conditions, the same fate should await SSA's and HHS's administrative decision under constitutional law.

D. The Doctrine of Unconstitutional Conditions Has a Similar Role to Play in Takings and Due Process Law.

The same pattern of doctrinal interactions found under the Spending Clause applies with equal force in connection with the law of takings and due process, which have long had a close interaction with each other. To be sure Social Security benefits, even when

vested, do not count as common law property, such as those which are covered by the takings law. See, e.g., *Flemming v. Nestor*, 363 U.S. 603 (1960), whose strong reliance on "alter and amend" language in the Social Security Act, id. at 610-611, may itself be called into question by *NFIB*. Nonetheless, it is equally clear since this Court's decision in *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972) that government entitlements enjoy some constitutional protections: "Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as State law — rules or understandings that secure certain benefits and that support claims of entitlement to those benefits." Clearly Social Security benefits quality for protection against their arbitrary destruction.

Most critically, the issue of unconstitutional conditions came into this branch of law in *Roth's* companion case, *Perry v. Sindermann*, 408 U.S. 593 (1972), where Sindermann had taught at Odessa Junior College in the Texas State College system for ten years on a set of one-year contracts. Unlike Roth, he did not have explicit contractual protection when the Texas system decided not to renew his contract. He thus had no property interest of the sort found in *Roth*. Sindermann nonetheless alleged that is dismissal stemmed from his public disagreement with the college president. In holding that Sindermann could well have a valid First Amendment claim, the Court attacked the venerable "right-privilege" distinction, see supra at *Id.* at 601 to 603, and thus linked the doctrine of unconstitutional conditions to the First Amendment, as it applies to both federal and

State governments, even in the absence of a vested property right.

In the present case, therefore, the doctrine should apply to the attachment of any potentially unconstitutional conditions to Petitioners' Social Security benefits. An explanation of how it works is found in *Nollan v. California Coastal Commission,* 483 U.S. 825 (1987), a takings case. California authorities told Nollan that he would receive a building permit to rip down his own 521-square foot shack in order to construct a new 1,740 square foot house, with a two-car garage, but only if he first surrendered a lateral easement in front of his property to the public. The Coastal Commission was under no obligation to give the building permit. If it had flat-out denied the building permit, the case would have had no theoretical interest. But in this instance the Commission sought to condition the permit in order to gain a bargaining advantage. Without the tie-in to the permit, it would have to pay to acquire the easement. By tying it to the permit, it hoped to get something for nothing. Justice Scalia denounced the Commission's effort to leverage its police power as a form of "out-and-out-extortion," *Id*. at 837. Indeed the Commission's approach was so potent precisely because it was perfectly rational for any landowner to surrender a lateral easement that costs it, say, $100,000, in order to secure a building permit worth perhaps five times that amount. (Indeed all other landowners presented with this offer did surrender. Nollan built first and forced the Commission to chase after him. *Id*. at 828-830).

The appearance of mutual gain through bargaining led Justice Brennan, in dissent, to defend the

Commission's deal. "[A]ppellants benefit both as private landowners and as members of the public from the fact that new development permit requests are conditioned on preservation of public access," he opined. *Id.* at 856. But Justice Brennan's implicit appeal to the traditional contractual ideal of mutual gain misses the economic inefficiency created by the tie-in arrangement. See, Richard A. Epstein, *The Harms and Benefits of* Nollan *and* Dolan, 15 NORTHERN ILLINOIS UNIVERSITY LAW REV. 479 (1995).

One vital reason for the just compensation requirement in takings law is to give some assurance that the property taken is worth more in public hands than in private hands, so that government coercion under eminent domain is used solely to advantage social welfare. By tying the permit to the easement, the Coastal Commission negated that social purpose. If the lateral easement across Nollan's land were worth only $50,000 to the public by its own honest valuation, the Commission will not pay the market rate of compensation of $100,000 to condemn it. But the Commission will *always* get this lateral easement for free under a tying arrangement, so long as the easement is worth less to Nollan than the building rights from the new permit. The tie-in arrangement thus lets the State coerce a taking which has *negative* social value. Granting the permit without taking the easement in the case just given increases the social value by $400,000.00. Imposing the condition reduces that social value to $350,000.00. That is why it is necessary to police these tied exercises of the permit power (as well to prevent as any unreasonable delays in issuing permits), which allows for this abuse. Cf. *Tahoe-Sierra Preservation Council, Inc. v. Tahoe Regional Planning Agency*, 535 U.S. 302 (2002).

The persistent problem of the illicit tie-in does not invalidate as unconstitutional all conditions on the improvement of real estate, any more than it does so for conditions on Medicare or Medicaid payments. In *Dolan v. City of Tigard*, 512 U.S. 374 (1994), the landowners sought a permit to pave over a new parking lot for their business, but the City told them that they could receive the permit only if they first met two conditions. First, they had to deed over to the City a portion of the lot for use as greenway to allow the free passage of upstream water through their land, which was located in a 100-year flood plain. Second, the Dolans had to yield a 15-foot strip of land adjacent to the floodplain for use as a foot and bike path by the public at large. Both of these conditions were held improper under *Nollan*. Rehnquist, C.J., stated: "We think a term such as 'rough proportionality' best encapsulates what we hold to be the requirement of the Fifth Amendment." *Id.* at 391.

That test did not erect an impossible barrier. The appropriate nexus would have been satisfied if the greenway was needed to control any runoff once the Dolans paved over some portion of their land. Likewise, the bicycle path could have been required if its sole (or perhaps only primary) users were the Dolans and their patrons. But on the facts of *Dolan,* the harms to be prevented were all caused by others, and the new bike path likewise conferred all its benefits on others. Charging the cost of this improvement to the Dolans violates the well known fairness prescription in *Armstrong v. United States*, 364 U.S. 40, 49 (1960) ("The Fifth Amendment's guarantee that private property shall not be taken for a public use without just compensation was designed to bar government from forcing some people alone to

bear public burdens which, in all fairness and justice, should be borne by the public as a whole.") But it also creates a manifest social loss, or inefficiency, for the voting public is all too willing to increase the overall level of public expenditures beyond what is socially optimal if they can force the cost on to a small fraction of the total number. The winning faction compares only its private cost with its overall benefit. Yet the proper social comparison, which was obscured by the tying technique, requires that *all* costs and benefits be taken into account. Many deals that are great for the dominant faction are terrible for the public as a whole. At this point, the logic of *Nollan* takes over in *Dolan*. An honest valuation of both the flood easement and the bike path can be obtained only if they are severed from the development permit in this case. The illicit tie-in produces only social losses, which was why *Dolan* was correctly reasoned and decided.

E. These Strong Precedents Require a Reexamination of the Constitutional Foundations of the POMS Rules in the Instant Case.

The impressive array of cases, drawn from multiple areas, shows the imperative need to scrutinize the conditions of government permits and grants, given the inherent dangers in the state's undisputed ability to exert monopoly power against its citizens and all other persons subject to its control. That risk of the abuse of state power reaches its zenith when government officials have the combined powers of taxation and regulation at their disposal. The Petitioners have been subject to this double-barreled attack, when their sole supposed wrong has been to refuse to join in Medicare Part A on turning age 65.

By their actions, the Petitioners have not imposed harm on any other citizens; nor have they sought to gain any illicit benefit for themselves. They only wish to be left out of a Medicare system into which they must continue to pay in taxes on both their earned and investment income. SSA's or HHS's POMS rules illicitly tie the receipt of Social Security funds to the participation in Medicare Part A. They also mandate the repayment of all such funds received from both programs if a citizen withdraws from Medicare Part A. The SSA has offered no efficiency justification for this manifest diminution of consumer choice, which appears to reflect and reinforce SSA's and HHS's own political position as the dominant dispenser of health care services in the United States. In this instance, the statutory language offers no support whatsoever for linking Social Security benefits to participation in Medicare Part A. No such justification is supplied solely because SSA and HHS make light of all philosophical, religious and business objections to its program. This arrogation of state power also runs smack into the newly reinvigorated doctrine of unconstitutional conditions as it applies to Congress's Power to Tax and Spend. This case thus affords this Court the unique opportunity to deal with a range of issues on administrative power, statutory construction, and constitutional law that received only the back-of-the-hand treatment inside SSA and HHS, in the District Court and by the majority of the Court of Appeals. The time to remedy this sorry state of affairs is now.

CONCLUSION

This Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

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APPENDIX A

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 11-5076

Argued October 13, 2011
Decided February 7, 2012

[Caption as amended February 24, 2012]

BRIAN HALL, ET AL.,	)
APPELLANTS	)
	)
v.	)
	)
KATHLEEN SEBELIUS, SECRETARY OF THE	)
UNITED STATES DEPARTMENT OF HEALTH	)
AND HUMAN SERVICES, AND MICHAEL J.	)
ASTRUE, COMMISSIONER OF THE SOCIAL	)
SECURITY ADMINISTRATION,	)
APPELLEES	)
	)

Appeal from the United States District Court
for the District of Columbia
(No. 1:08-cv-01715)

Kent M. Brown argued the cause for appellants. With him on the briefs was *Frank M. Northam*.

Samantha L. Chaifetz, Attorney, U.S. Department of Justice, argued the cause for appellees. With her on the brief were *Tony West*, Assistant Attorney General, *Ronald C. Machen Jr.*, U.S. Attorney, *Beth S. Brinkmann*, Deputy Assistant Attorney General, and *Mark B. Stern*, Attorney. *R. Craig Lawrence*, Assistant U.S. Attorney, entered an appearance.

Before: GINSBURG,[1] HENDERSON, and KAVANAUGH, *Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* KAVANAUGH, with whom *Circuit Judge* GINSBURG joins.

Dissenting opinion filed by *Circuit Judge* HENDERSON.

KAVANAUGH, *Circuit Judge*: This is not your typical lawsuit against the Government. Plaintiffs here have sued because they *don't* want government benefits. They seek to disclaim their legal entitlement to Medicare Part A benefits for hospitalization costs. Plaintiffs want to disclaim their legal entitlement to Medicare Part A benefits because their private insurers limit coverage for patients who are entitled to Medicare Part A benefits. And plaintiffs would prefer to receive coverage from their private insurers rather than from the Government.

Plaintiffs' lawsuit faces an insurmountable problem: Citizens who receive Social Security benefits

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[1] As of the date the opinion was published, Judge Ginsburg had taken senior status.

and are 65 or older are automatically entitled under federal law to Medicare Part A benefits. To be sure, no one has to take the Medicare Part A benefits. But the benefits are available if you want them. There is no statutory avenue for those who are 65 or older and receiving Social Security benefits to disclaim their legal entitlement to Medicare Part A benefits. For that reason, the District Court granted summary judgment for the Government. We understand plaintiffs' frustration with their insurance situation and appreciate their desire for better private insurance coverage. But based on the law, we affirm the judgment of the District Court.

I

Most citizens who are 62 or older and file for Social Security benefits are legally entitled to receive Social Security benefits. *See* 42 U.S.C. § 402(a). Since Congress created Medicare in 1965, entitlement to Social Security benefits has led automatically to entitlement to Medicare Part A benefits for those who are 65 or older. *See* 42 U.S.C. § 426(a); *see also* Social Security Amendments of 1965, Pub. L. No. 89-97, § 101, 79 Stat. 286, 290.

Plaintiffs Armey, Hall, and Kraus all receive Social Security benefits and are 65 or older. Therefore, they are automatically entitled to Medicare Part A benefits. But they want to disclaim their legal entitlement to Medicare Part A benefits.[2] In other words, they want

[2] The two other named plaintiffs do not now receive Social Security benefits but they wish to be able to do so without becoming entitled to Medicare Part A benefits.

not only to reject the Medicare Part A benefits (which they are already free to do) but also to obtain a legal declaration that the Government *cannot* pay Medicare Part A benefits on their behalf. According to plaintiffs, if they could show their private insurers that they are not legally entitled to Medicare Part A benefits, they would receive additional benefits from their private insurers. Plaintiffs argue that the statute allows them to disclaim their legal entitlement to Medicare Part A benefits and that the agency has violated the statute by preventing them from doing so.[3]

II

We first consider plaintiffs' standing. Plaintiffs claim that their private insurers have curtailed coverage as a result of plaintiffs' entitlement to Medicare Part A benefits. Plaintiff Armey declared that his legal entitlement to Medicare Part A benefits led his Blue Cross plan to reduce coverage without a matching reduction in premium. Plaintiff Hall declared that his Mail Handlers plan stopped acting as his primary payer because of his legal entitlement to Medicare Part A benefits. They claim they would receive enhanced coverage from their private insurers if they were not entitled to Medicare Part A benefits. For purposes of the standing inquiry, we must accept those declarations as true.

We conclude that Armey and Hall have suffered injuries in fact from their reduced private insurance.

---

[3] Plaintiffs specifically target the agency's Program Operations Manual System, which does not allow a beneficiary to disclaim the legal entitlement to Medicare Part A benefits.

They have shown causation because their private insurance has been curtailed as a direct result of their legal entitlement to Medicare Part A benefits. And as to redressability, plaintiffs claim that they could obtain additional coverage from their private insurance plans if allowed to disclaim their legal entitlement to Medicare Part A benefits.

Because Armey and Hall have standing, we need not address standing for the other plaintiffs. We therefore proceed to the merits.

III

Because plaintiffs are 65 or older and are entitled to Social Security benefits, they are "entitled to hospital insurance benefits" through Medicare Part A. 42 U.S.C. § 426(a). But plaintiffs do not want to be legally entitled to Medicare Part A benefits.

To be clear, plaintiffs already "may refuse to request Medicare payment" for services they receive and instead "agree to pay for the services out of their own funds or from other insurance." MEDICARE CLAIMS PROCESSING MANUAL, ch. 1, § 50.1.5 (2011). So they can decline Medicare Part A benefits.

But plaintiffs want something more than just the ability to decline Medicare payments. They seek a legal declaration that Medicare Part A benefits *cannot* be paid on their behalf – a declaration, in other words, that they are not legally entitled to Medicare Part A benefits. But the statute simply does not provide any mechanism to achieve that objective. If you are 65 or older and sign up for Social Security, you are automatically entitled to Medicare Part A benefits.

You can decline those benefits. But you still remain entitled to them under the statute.

What plaintiffs really seem to want is for the Government and, more importantly, their private insurers to treat plaintiffs' decision not to accept Medicare Part A benefits as meaning plaintiffs are also not legally entitled to Medicare Part A benefits. But the problem is that, under the law, plaintiffs remain legally entitled to the benefits regardless of whether they accept them.

Consider an analogy. A poor citizen might be entitled under federal law to food stamps. The citizen does not have to take the food stamps. But even so, she nonetheless remains legally entitled to them. So it is here.

Plaintiffs offer four arguments for why they must be allowed to disclaim their legal entitlement to Medicare Part A benefits. None is persuasive.

First, plaintiffs say that the plain meaning of the statutory term "entitled" requires that the beneficiary be given a choice to accept or reject Medicare Part A. But plaintiffs' entitlement is to "hospital insurance *benefits*" under Medicare Part A. 42 U.S.C. § 426(a) (emphasis added). As explained above, plaintiffs may refuse Medicare Part A *benefits*. *See* MEDICARE CLAIMS PROCESSING MANUAL, ch. 1, § 50.1.5. So they already have a choice to accept or reject those benefits.

Second, plaintiffs claim that, by statute, Medicare Part A is a voluntary program. That's true in the sense that plaintiffs can always obtain private insurance and decline Medicare Part A benefits. But the fact that the

program is voluntary does not mean there must be a statutory avenue for plaintiffs to disclaim their legal entitlement to Medicare Part A benefits.

Third, plaintiffs acknowledge that they can escape their entitlement to Medicare Part A benefits by disenrolling from Social Security and forgoing Social Security benefits. From that, plaintiffs contend that entitlement to Medicare Part A benefits has thereby been made a prerequisite to receiving Social Security benefits, in contravention of the statute governing entitlement to Social Security benefits. But plaintiffs have it backwards. Signing up for Social Security is a prerequisite to Medicare Part A benefits, not the other way around.

Fourth, plaintiffs note that entitlement to Social Security benefits is optional and argue that entitlement to Medicare Part A should likewise be optional. But Social Security participation is optional because filing an application for benefits is a statutory prerequisite to entitlement. *See* 42 U.S.C. § 402(a)(3). Congress could have made entitlement to Medicare Part A benefits depend on an application. But Congress instead opted to make entitlement to Medicare Part A benefits automatic for those who receive Social Security benefits and are 65 or older.

In sum, plaintiffs' position is inconsistent with the statutory text. Because plaintiffs are entitled to Social Security benefits and are 65 or older, they are automatically entitled to Medicare Part A benefits. The statute offers no path to disclaim their legal entitlement to Medicare Part A benefits. Therefore, the agency was not required to offer plaintiffs a

mechanism for disclaiming their legal entitlement, and its refusal to do so was lawful.[4]

* * *

We affirm the judgment of the District Court.

So ordered.

[4] We have considered plaintiffs' other arguments and find them without merit.

KAREN LECRAFT HENDERSON, *Circuit Judge*, dissenting:

In *Silver Blaze*, a prized race horse disappears from its stable on the eve of a high-stakes race. By the time Inspector Gregory arrives from Scotland Yard, Sherlock Holmes is on the case.

> Gregory: "Is there any point to which you would wish to draw my attention?"
>
> Holmes: "To the curious incident of the dog in the night-time."
>
> Gregory: "The dog did nothing in the night-time."
>
> Holmes: "That was the curious incident."

SIR ARTHUR CONAN DOYLE, MEMOIRS OF SHERLOCK HOLMES 22 (A. L. Burt Co. 1922) (1894). What led Holmes to conclude that the dog knew the thief was its silence. The dog did not bark. Ditto here. The majority's silence on the sole question in this case—is the Social Security Administration (SSA) authorized to penalize an individual who seeks to decline Medicare, Part A coverage by requiring him to forfeit his Social Security benefits and repay any benefits previously received—provides the answer: no. Because I believe that SSA's Program Operations Manual System

(POMS) gives the SSA power that the Congress in no way provides, I respectfully dissent.[1]

I.

The Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, establishes a program of health insurance for the elderly and disabled. Medicare Part A, often called "Hospital Insurance" or "HI," covers services furnished by hospitals and other institutional providers. An individual is statutorily entitled to Medicare, Part A upon becoming entitled to monthly Social Security retirement benefits (SSRB).[2] Under the Medicare Act:

> Every individual who:
>
> (1) has attained age 65, and

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[1] Although the plaintiffs assert that the POMS was produced by Health and Human Services (HHS) Secretary Sebelius and SSA Commissioner Astrue jointly, *see, e.g.*, Am. and Substituted Compl. ¶18, the POMS is an internal *SSA* document used by *Social Security* employees in assessing *Social Security* claims, Appellees' Br. at 8; Program Operations Manual System Home, https://secure.ssa.gov/apps10/ (last visited January 23, 2012). Accordingly, this dissent addresses only Commissioner Astrue's authority *vel non* to devise the challenged POMS provisions.

[2] Certain individuals are not statutorily entitled to Part A benefits because they do not qualify for SSRB. Specifically, under 42 U.S.C. § 1395i-2(a), an individual who (1) "has attained the age of 65;" (2) "is enrolled in [Medicare, Part B];" (3) "is either (A) a citizen or (B) an alien lawfully admitted for permanent residence;" and (4) "is not otherwise entitled [to Medicare, Part A] . . . shall be eligible to enroll in [Medicare, Part A]." To secure Medicare, Part A benefits, he must apply and periodically pay premiums—much like private insurance.

> (2)(A) is entitled to monthly insurance benefits under [42 U.S.C. § 402(a)], . . .
>
> shall be entitled to hospital insurance benefits under part A . . . for each month for which he meets the condition specified in paragraph (2) . . . .

42 U.S.C. § 426(a). Thus, anyone who "is entitled" to SSRB "shall be entitled" to Medicare, Part A benefits immediately upon his 65th birthday. *Id.* Under the Social Security Act:

> Every individual who
>
> (1) is a fully insured individual (as defined in [42 U.S.C. § 414(a)]),
>
> (2) has attained age 62, and
>
> (3) has filed application for old-age insurance benefits . . .
>
> shall be entitled to . . . old-age insurance benefit[s] . . . .

42 U.S.C. § 402(a). To be "entitled" to SSRB, then, an individual must first apply therefor; if he fails to file an application, he is not "entitled" to the benefits regardless of his age or working history.

The POMS is a massive internal set of provisions, produced without notice and comment rulemaking and used by SSA employees to process claims for SSRB. *See Wash. Dep't. of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 US. 371, 385

(2003) (POMS provides "the publicly available operating instructions for processing Social Security claims"); *Power v. Barnhart*, 292 F.3d 781, 786 (D.C. Cir. 2002) (POMS is an "interpretive document" "lack[ing] . . . administrative formality"). The provisions of the POMS relating to HI alone include more than 100 printed pages. *See* SSA's Program Operations Manual System, https://secure.ssa.gov/apps10/poms.nsf/chapterlist!openview&restrictto category=06 (last visited Jan. 23, 2012).[3] The plaintiffs[4] limit their statutory, procedural and constitutional challenges to three provisions of the POMS, arguing that they impermissibly tether Medicare, Part A entitlement to SSRB by penalizing them if they decline Medicare, Part A coverage.

The first of the three challenged provisions, POMS HI 00801.002, reveals the ad hoc manner in which the entire POMS was assembled. The "Introduction" to the provision provides in full: "Some individuals entitled to monthly benefits have asked to waive their HI entitlement because of religious or philosophical reasons or because they prefer other health insurance." POMS HI 00801.002. Then, without so much as a word of explanation as to the statutory basis or rationale behind it, the provision announces SSA's answer, dubbing it "Policy."

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[3] The POMS fits nicely the description the United States Supreme Court once used for the Medicaid statute: " 'an aggravated assault on the English language, resistant to attempts to understand it.' " *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 n.14 (1981) (quoting *Friedman v. Berger*, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976)).

[4] I agree with my colleagues that plaintiffs Hall and Armey have the requisite standing to pursue this suit. Majority Op. at 4.

> 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 [SSRB] and HI benefit payments made.[5]

POMS HI 00801.002 (emphasis in original). The other two provisions are equally opaque as to their rationale and silent on their authority. POMS HI 00801.034 provides:

> To withdraw from the HI program, an individual must submit a written request for withdrawal and must refund any HI benefits paid on his/her behalf as explained in GN 00206.095 B.1.c.
>
> An individual who filed an application for both monthly benefits and HI may:
>
> - withdraw the claim for monthly benefits without jeopardizing HI entitlement; *or*
>
> - withdraw the claim for both monthly benefits and HI.

---

[5] On its face, POMS HI 00801.002 requires a person who does not want Medicare, Part A coverage to refund both SSRB and HI benefits. Plaintiffs Hall and Armey limit their challenge to the required forfeiture and repayment of their SSRB only.

> The individual may *not* elect to withdraw only the HI claim.[6]

(emphases in original). The third, POMS GN 00206.020, repeats the bare command that "a claimant who is entitled to monthly [SSRB] cannot withdraw HI coverage only since entitlement to HI is based on entitlement to monthly [SSRB]." In short, with no explanation (other than the above clause beginning "since") much less a statutory basis, all three challenged provisions empower SSA personnel to force an individual who does not want Medicare, Part A coverage to forfeit future SSRB and refund SSRB payments already received.

II.

"Not every agency interpretation of a statute is appropriately analyzed under *Chevron* [*U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)]." *Ala. Educ. Ass'n v. Chao*, 455 F.3d 386, 392 (D.C. Cir. 2006). Indeed, *Chevron* deference is appropriate only if the Congress has delegated authority to an agency to make rules having the "force of law" and the agency rule at issue was "promulgated in the exercise of that authority." *United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001). Although SSA Commissioner Astrue is authorized to issue rules with the "force of law," *see* 42 U.S.C. § 405(a), the POMS was not produced in the exercise of that

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[6] Interestingly, this provision—contrary to the position of Commissioner Astrue who asserts that anyone entitled to SSRB "need not apply for" Medicare, Part A coverage, Appellees' Br. at 17—declares that an individual can "file[] an application for both [SSRB] and HI," POMS HI 00801.034.

authority. As we made plain in *Power v. Barnhart*, "[the POMS] lack the administrative formality or other attributes that would justify substantial judicial deference under *Chevron* . . . and hence . . . they would *at best* qualify for the more limited form of deference under *Skidmore v. Swift & Co.*, 323 U.S. 134, [139-140] (1944)." 292 F.3d at 786 (emphasis added). But neither *Skidmore*, *Chevron* nor *Mead* requires any deference to an *ultra vires* "interpretive document." *See, e.g.*, *Ry. Labor Execs. Ass'n v. Nat'l Mediation Bd.*, 29 F.3d 655, 671 (D.C. Cir. 1994) ("[D]eference is warranted only when Congress has . . . 'delegat[ed] . . . authority to the agency.' " (quoting *Chevron*, 467 at 843-44)); *Natural Res. Def. Council v. Reilly*, 983 F.2d 259, 266 (D.C. Cir. 1993) ("[I]t is only legislative intent to delegate . . . authority that entitles an agency to advance its own statutory construction" (internal quotation marks and citations omitted; brackets in original)); *see also D.C. Hosp. Ass'n. v. District of Columbia*, 224 F.3d 776, 780 (D.C. Cir. 2000) ("Because the provision at issue here is unambiguous, we owe no deference to a contrary construction even if formally adopted by the Secretary of [HHS].").

Here, the scope of the relevant provisions of the Medicare and Social Security Acts is as plain as the definition of "entitled." Under 42 U.S.C. § 426(a), a person who is "entitled" to SSRB and has reached age 65 "shall be entitled" to Medicare, Part A benefits. "Entitled" is synonymous with "eligible," which means "*capable* of being *chosen*" or "legally qualified." BLACK'S LAW DICTIONARY 521 (6th ed. 2002) (emphases added). To "entitle" means "to give a 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 (1993). As explained by the Supreme Court,

> Both in legal and general usage, the normal meaning of entitlement is a right or benefit for which a person qualifies . . . . It means only that the person satisfies the prerequisites attached to the right.

Ingalls Shipbuilding v. Dir., 519 U.S. 248, 256 (1997) (internal quotation marks and citation omitted). This definition has been applied by our Circuit and others in interpreting the terms "entitlement" and "entitled" as they are used in other parts of the Social Security and Medicare Acts. *See Krishnan v. Barnhart*, 328 F.3d 685, 688 (D.C. Cir. 2003) (to be "entitled" means that an individual "qualifies" or has met the requisite requirements to obtain the benefits); *Jewish Hospital, Inc. v. Sec'y of HHS*, 19 F.3d 270, 275 (6th Cir. 1994) (as used in the Medicare Act, "[t]o be entitled . . . means [to] possess[] the right or title to that benefit" (emphasis removed)); *Fagner v. Heckler*, 779 F.2d 541, 543 (9th Cir. 1985) (as used in Social Security Act, "entitled means to give right or legal title to, qualify (one) for something; furnish with proper grounds for seeking or claiming something" (internal quotation marks and citation omitted)).

Although the district court noted that the "plain-English reading of the word 'entitled' has its attraction[]," the court nonetheless held that "in context [of] Medicare 'entitled' does not actually mean 'capable of being rejected.' " *Hall v. Sebelius*, 770 F. Supp. 2d 61, 67 (D.D.C. 2011). If the Congress had wanted to make enrollment in Part A optional, the court stated, it would have said so expressly. *Id.* at

67-68. In 42 U.S.C. § 1395i-2, for example, the Congress provided that every individual who (1) "has attained the age of 65;" (2) "is enrolled in [Medicare, Part B];"[7] (3) "is either (A) a citizen or (B) an alien lawfully admitted for permanent residence"; and (4) "is not otherwise entitled [to Medicare, Part A] . . . *shall be eligible to enroll in* [Medicare, Part A]." 42 U.S.C. § 1395i-2(a) (emphasis added). In the court's view, if the Congress had wanted Medicare, Part A coverage to be optional under 42 U.S.C. § 426(a), the statute would have provided that any person entitled to receive SSRB who reaches the age of 65 "shall be eligible to enroll in [Medicare, Part A]." *Hall*, 770 F. Supp. at 68.[8]

My colleagues reach a similar conclusion. Citing a single provision of Secretary Sebelius's Medicare Claims Processing Manual, they conclude:

> Congress could have made entitlement to Medicare Part A benefits depend on an application. But Congress instead opted to make entitlement to Medicare Part A benefits

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[7] Medicare, Part B provides coverage for the costs of physicians' services and other medical services. Unlike Medicare, Part A, which is financed by a mandatory payroll tax, Medicare, Part B is financed in large part by enrollees' premiums.

[8] Comparing 42 U.S.C. § 426(a) and 42 U.S.C. § 1395i-2, as the district court did, is not that persuasive. Under the first provision, an individual's eligibility for Medicare, Part A coverage occurs by operation of law if he is at least 65 years old and receives SSRB. The second provision, however, requires him to apply for the coverage. The two provisions address different circumstances (in one, the benefit is by operation of law and in the other, by application) and so are not *in pari materia*.

> automatic for those who receive Social Security Benefits and are 65 or older.

Majority Op. 6-7.[9] According to the majority, because the statute offers "no path to disclaim their legal entitlement to Medicare Part A benefits," the "agency was not *required* to offer plaintiffs a mechanism for disclaiming their legal entitlement." Majority Op. 7 (emphasis added). But that is not to say that, having *chosen* to allow disclaimer via the POMS, the POMS can take away a *statutory* entitlement (i.e., SSRB) as a condition of the disclaimer.

Plaintiffs Hall and Armey do not dispute that entitlement to Medicare, Part A occurs by operation of law. *See* Reply Br. at 2 ("Plaintiffs-Appellants never suggested that they sought to renounce their entitlement to Medicare, Part A, and they did not contend that the Defendant-Appellees must allow them to . . . somehow declare that Plaintiffs-Appellants are not entitled to Medicare, Part A."). Instead, they argue something much more fundamental, i.e., that there is no statutory authority for the POMS's edict that an individual who declines Medicare, Part A

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[9] The majority opinion cites an equally ad hoc manual put together not by SSA Commissioner Astrue but by codefendant Sebelius, which states that a Medicare beneficiary "may refuse to request Medicare payment" for services he receives and instead "agree to pay for the services out of [his] own funds or from other insurance." Majority Op. at 5 (citing Medicare Claims Processing Manual, ch. 1, § 50.1.5 (2011)). But even a cursory examination of the Medicare, Part A maze reveals this option to be illusory. Under 42 U.S.C. § 1395cc(a)(1)(A)(i), a hospital cannot charge or accept private payment "for items or services for which [an] individual is entitled to have payment made under [Medicare, Part A]."

coverage is required to forego/refund SSRB. I agree. The relevant language of both statutes, 42 U.S.C. §§ 402(a) and 426(a), reads identically in that they both provide that an individual "shall be entitled" to benefits if he meets certain qualifying conditions. Neither statute requires an "entitled" individual to accept the benefits. Nor do they even hint at permitting the SSA to withdraw SSRB and demand repayment thereof if an individual does not want to participate in Medicare, Part A. The POMS alone does that. It gives SSA Commissioner Astrue a power not provided him by the Congress—the power to penalize a person who is "entitled" to Medicare, Part A by operation of law but who does not want Part A coverage by stripping that person of future SSRB and forcing repayment of SSRB already received.[10]

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[10] For this reason, my colleagues' analogy to a "poor citizen" who is "entitled to" but "does not have to take food stamps" is inapposite. *See* Majority Op. at 5. Indeed, much like the rest of its analysis, the majority opinion's analogy misses the issue in this case: whether an agency, without statutory authority, can require a person to forego/refund a *statutory* entitlement simply because he does not want another federal benefit that also accrues by operation of law. If the food stamp beneficiary could decline that benefit only by also giving up Medicaid and repaying all Medicaid benefits received, I wonder if my colleagues would endorse *that* agency overreach. Here's another analogy. A person born in the United States is, by operation of law, entitled to the benefits of citizenship upon his birth. U.S. Const., Amend. XIV, § 1 ("All persons born . . . in the United States . . . are citizens of the United States and the State wherein they reside."); *see, e.g.*, 22 U.S.C. § 212 (a "person[] . . . owing allegiance . . . to the United States"—i.e., a citizen or national—is entitled to a U.S. passport). If he were to eventually renounce his citizenship, *see* 8 U.S.C. § 1481(a)(5), could the United States Department of Education, through an "interpretive document," force him to repay the federal portion of his primary/secondary public education? Of course not.

In *American Bar Association v. FTC*, we made plain that an agency cannot exercise regulatory power without congressional grant. 430 F.3d 457, 468 (D.C. Cir 2005). As we explained, "if we were 'to *presume* a delegation of power' from the absence of 'an express *withholding* of such power [in the statute], agencies would enjoy virtually limitless hegemony.' " *Id.* (quoting *Ry. Labor Execs. Ass'n*, 29 F.3d at 671) (emphasis in original); *see also Ry. Labor Execs. Ass'n*, 29 F.3d at 671 (to suggest "deference is implicated any time a statute does not expressly *negate* the existence of a claimed administrative power (i.e., when the statute is not written in "thou shalt not" terms), is both flatly unfaithful to the principles of administrative law . . . and refuted by precedent"). As the Supreme Court has aptly observed, the "[Congress] does not . . . hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). If the Congress had intended to impose the "death penalty" on SSRB for anyone declining Medicare, Part A coverage, it would not have hidden the imposition in the non-germane phrase "shall be entitled." By using the word "entitled," the Congress made plain that the "legal right or title" to Medicare, Part A coverage, while *available* by operation of law, is not unwaivable, much less waivable *only* by sacrificing benefits for which an individual has paid.[11]

Because there is no statutory basis for the challenged provisions of the POMS, they are *ultra vires*. "The legislative power of the United States is vested in the Congress, and the exercise of

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[11] In response to this well-settled authority, my colleagues—again—do not bark.

quasi-legislative authority by governmental departments and agencies must be rooted in a grant of such power by the Congress and subject to limitations which that body imposes." *See Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979). The authority to administer the law is not the power to make the law. *Orion Reserves Ltd. P'ship v. Salazar*, 553 F.3d 697, 703 (D.C. Cir. 2009). Accordingly, "a regulation contrary to a statute is void." *Id.* Commissioner Astrue is clothed with exceptional authority but even he cannot make law.[12]

For the foregoing reasons, I respectfully dissent.

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[12] Because I believe the POMS are plainly *ultra vires*, I do not address the plaintiffs' procedural and constitutional challenges.

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 11-5076

September Term, 2011

[Filed February 7, 2012]
[Caption as amended February 24, 2012]

BRIAN HALL, ET AL.,	)
APPELLANTS	)
	)
v.	)
	)
KATHLEEN SEBELIUS, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND MICHAEL J. ASTRUE, COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION,	)
APPELLEES	)
	)

Appeal from the United States District Court
for the District of Columbia
(No. 1:08-cv-01715)

Before: GINSBURG,* HENDERSON, and KAVANAUGH, *Circuit Judges*

J U D G M E N T

* As of the date the opinion was published, Judge Ginsburg had taken senior status.

This cause came on to be heard on the record on appeal from the United States District Court for the District of Columbia and was argued by counsel. On consideration thereof, it is

ORDERED and **ADJUDGED** that the judgment of the District Court appealed from in this cause is hereby affirmed, in accordance with the opinion of the court filed herein this date.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY:
/s/
Jennifer M. Clark
Deputy Clerk

Date: February 7, 2012

Opinion for the court filed by Circuit Judge Kavanaugh.
Dissenting opinion filed by Circuit Judge Henderson.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 08-1715 (RMC)

[Filed March 16, 2011]

BRIAN HALL, *et al*.	)
	)
Plaintiffs,	)
	)
v.	)
	)
KATHLEEN SEBELIUS, Secretary, Department of Health and Human Services, *et al*.,	)
	)
Defendants.	)
	)

MEMORANDUM OPINION

Plaintiffs are retired Federal employees who have reached age 65 and have applied for, and are receiving, Social Security Retirement benefits. As a result, they are "entitled" to Medicare Part A, coverage. They do not, however, want Medicare coverage. And the only avenue provided to Plaintiffs to un-entitle themselves is to cease receiving Social Security Retirement benefits – and to repay all such benefits already received. Plaintiffs declaim that such a requirement is

contrary to the Social Security Act, of which Medicare is a part. The Court concludes that Plaintiffs' claims are without merit.

Medicare costs are skyrocketing and may bankrupt us all; nonetheless, participation in Medicare Part A (for hospital insurance) is statutorily mandated for retirees who are 65 years old or older and are receiving Social Security Retirement (so-called 'old age') benefits. Whether Congress intended this result in 1965 or whether it is good fiscal and public policy in 2011 cannot gainsay the language of the statute and the regulations. Accordingly, summary judgment will be entered for Defendants.

I. FACTS

Plaintiffs Brian Hall, John Kraus, and Richard Armey share the following characteristics:

- They are retired from Federal employment and have attained the age of 65.
- They applied for, and are receiving, Social Security Retirement benefits.
- They are entitled to benefits under Medicare Part A.
- They had previously been enrolled in health plans under the Federal Employees Health Benefit (FEHB) program and wish to continue that coverage in full.

- They do not want to be covered by Medicare Part A and want to disenroll from Medicare Part A.

- They want to continue receiving their monthly Social Security Retirement benefits.

These facts are all undisputed and, for purposes of resolving this dispute, are the only facts that pertain.

II. LEGAL STANDARDS

A. Summary Judgment

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment must be granted when "the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Diamond v. Atwood*, 43 F.3d 1538, 1540 (D.C. Cir. 1995). Moreover, summary judgment is properly granted against a party that "after adequate time for discovery and upon motion . . . fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322. To determine which facts are "material," a court must look to the substantive law on which each claim rests. *Anderson*, 477 U.S. at 248 (1986). A "genuine issue" is one whose resolution could establish an element of a claim or defense and, therefore, affect the outcome of the action. *Id.*; *Celotex*, 477 U.S. at 322.

In ruling on a motion for summary judgment, the court must draw all justifiable inferences in the nonmoving party's favor and accept the nonmoving party's evidence as true. *Anderson*, 477 U.S. at 255. A nonmoving party, however, must establish more than "the mere existence of a scintilla of evidence" in support of its position. *Id.* at 252. To prevail on a motion for summary judgment, the moving party must show that the nonmoving party "fail[ed] to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex*, 477 U.S. at 322. By pointing to the absence of evidence proffered by the nonmoving party, a moving party may succeed on summary judgment. *Id.* In addition, the nonmoving party may not rely solely on allegations or conclusory statements. *Greene v. Dalton*, 164 F.3d 671, 675 (D.C. Cir. 1999). Rather, the nonmoving party must present specific facts that would enable a reasonable jury to find in its favor. *Greene*, 164 F.3d at 675. If the evidence "is merely colorable, or is not significantly probative, summary judgment may be granted." *Anderson*, 477 U.S. at 249-50 (citations omitted).

B. Standing

If a plaintiff cannot meet the constitutional requirement of standing, courts lack jurisdiction to reach the merits of the case. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 101 (1998); *Grand Council of the Crees v. FERC*, 198 F.3d 950, 954 (D.C. Cir. 2000). To have Article III standing, a plaintiff must establish: "(1) [he] has suffered an 'injury in fact' that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the

injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs.*, 528 U.S. 167, 180-81 (2000) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992)).

III. ANALYSIS

While the Court finds that Plaintiffs have standing with which to bring this lawsuit, they cannot survive summary judgment because the statutory scheme dictates that Medicare Part A is mandatory for those individuals who are 65 years old and are receiving Social Security Retirement benefits.

A. Standing Exists

Messrs. Kraus, Armey, and Hall have applied for and are receiving monthly Social Security Retirement benefits and wish to continue to do so; however, they wish to opt-out of Medicare Part A for various personal, financial, and other reasons. Defendants argue Plaintiffs have no standing to sue. As the Court found in *Iyengar v. Barnhart*,

> [I]n order [] for plaintiffs to establish their standing to sue, they need not eliminate all doubt as to whether the challenged action . . . caused [their injury]. . . . Rather, plaintiffs must show only (1) a substantial probability that [their injury] was or is being caused by the [defendant's] policy, and (2) a reasonable likelihood that eliminating that policy will [redress that injury].

233 F. Supp. 2d 5, 10 (D.D.C. 2002). Plaintiffs' alleged injury is being forced to either (1) have inferior insurance foisted upon them, thereby precluding their ability to be covered by superior insurance; or (2) receive their superior non-Medicare Part A insurance at the cost of relinquishing their Social Security Retirement benefits, and re-paying past benefits received. Plaintiffs ask the Court to remedy this injury by invalidating the internal regulations that dictate this untenable choice – internal regulations which Plaintiffs claim are in contravention of the Social Security Act and the Medicare Act. Assuming this to be the case, the Court would have the power to invalidate those contravening regulations, thereby providing Plaintiffs with the redress they request.

The Secretary extolls the benefits of Medicare Part A and suggests that Plaintiffs would agree they are not truly injured if they were to learn more about Medicare, perhaps through discovery. *See, e.g.*, Defs.' Statement of Genuine Issues of Material Fact with Respect to Pls.' Mot. for Summ. J. [Dkt. #41] ¶ 35. Plaintiffs politely decline. The parties use a lot of ink disputing whether Plaintiffs' desire to avoid Medicare Part A is sensible. This is not an issue the Court needs to address. Plaintiffs have standing because they cannot avoid Medicare without forgoing Social Security Retirement benefits; they argue that there is no statutory tie between the two. This dispute constitutes a case or controversy without regard to why Plaintiffs prefer other insurance coverage. As such, Plaintiffs have standing to bring this lawsuit.

B. The Social Security and Medicare Statutory Scheme

The Medicare Act, which is enacted at Title XVIII of the Social Security Act and codified at 42 U.S.C. § 1395 *et seq.*, establishes a program of health insurance for the elderly and disabled. Medicare Part A, often called "Hospital Insurance" or "HI," covers services furnished by hospitals and other institutional providers. 42 U.S.C. § § 1395c–1395i-5. Entitlement to Medicare Part A benefits occurs automatically for individuals who turn 65 and are "entitled" to monthly Social Security Retirement benefits under 42 U.S.C. § 402. *See* 42 U.S.C. § 426(a)("Every individual who . . . has attained the age of 65, and is entitled to monthly [Social Security benefits] under [42 U.S.C. § 402] of this title . . . shall be entitled to hospital insurance benefits under Part A of [this chapter] . . . .").[1] By contrast, Medicare Part B, which provides supplemental medical insurance benefits for certain medical and health care services not otherwise covered under Medicare Part A, including physician services, is an optional program to which individuals are not automatically entitled. Individuals entitled to Part A must pay for Medicare Part B and may choose to opt out of Part B. *See* 42 U.S.C. §§ 1395j-1395w-5. This distinction–between the mandatory nature of Part A and the optional nature of Part B–has been specifically recognized by the Supreme Court: "This optional

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[1] Certain disabled persons and qualified railroad retirement beneficiaries are also entitled to Medicare Part A coverage. Since Plaintiffs are entitled to Medicare Part A because they are receiving Social Security Retirement benefits, however, this decision focuses only on that category of Medicare Part A beneficiaries.

coverage [under Medicare Part B] . . . supplements the *mandatory* institutional health benefits (such as coverage for hospital expenses) provided by Part A." *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 674-75 (1986) (emphasis added).

"Entitled" is the statutory word that applies to both Social Security Retirement benefits and Medicare Part A but one becomes "entitled" through different routes. Under the Social Security Act:

> Every individual who –
>
> (1) is a fully insured individual (as defined in section 414(a) of this title),[2]
> (2) has attained age 62, and
> (3) has filed application for old-age insurance benefits . . .
>
> shall be entitled to an old-age insurance benefit for each month . . . .

42 U.S.C. § 402. Thus, one must *apply* for Social Security Retirement benefits; if you fail to apply, you will not be "entitled" to the benefit, without regard to age or working history. Medicare Part A works differently. As relevant to Plaintiffs, the Medicare statute provides:

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[2] 42 U.S.C. § 414(a) defines a "fully insured individual" predominately as one who has at least 40 quarters of coverage, *i.e.*, contributions to Social Security over at least 40 quarters of a work life.

> Every individual who –
>
> (1) has attained age 65, and
> (2)(A) is entitled to monthly insurance benefits under section [42 U.S.C. § 402] of this title . . .
>
> shall be entitled to hospital insurance benefits under part A of title XVIII [of this chapter] for each month for which he meets the condition specified in paragraph (2) . . . .

42 U.S.C. § 426(a). What this means is that an individual who has applied for Social Security Retirement benefits and qualifies to receive such bebenfits, so that he is "entitled" to Social Security Retirement benefits, automatically becomes "entitled" to Medicare Part A upon his 65th birthday. The only way to avoid entitlement to Medicare Part A at age 65 is to forego the source of that entitlement, *i.e.* Social Security Retirement benefits. There are but two ways to forego Social Security Retirement benefits: (1) fail to apply even though qualified, *see* 42 U.S.C. § 402(a) (requiring the filing of an application); or (2) withdraw one's application and repay all retirement benefits already received, *see* 20 C.F.R. § 404.640.

Social Security regulations provide a means of avoiding entitlement to monthly Social Security Retirement benefits and thereby also provide a means of avoiding entitlement to Medicare Part A benefits. An individual may withdraw an application for Social Security Retirement benefits after it has been filed by submitting a written request and either repaying "[a]ll benefits already paid" or upon the SSA being "satisfied

that they will be repaid." *See* 20 C.F.R. § 404.640.[3] These regulations are of no assistance to Plaintiffs, however, since they want to avoid Medicare Part A and retain their Social Security Retirement benefits.[4]

The interrelationship between Social Security Retirement benefits and Medicare Part A is explained in SSA's Program Operations Manual System ("POMS"), an SSA handbook designed for internal use by SSA employees in processing claims. Plaintiffs focus their challenge on three provisions of the POMS, which they assert force them to enroll in Medicare Part A and provide that they will lose their monthly Social Security Retirement benefits if they choose not to enroll. POMS HI 00801.002, titled "Waiver of HI Entitlement by Monthly Beneficiary," states that a person who is entitled to monthly Social Security Retirement benefits may not "waive" Medicare Part A "entitlement," but may avoid such "entitlement" by withdrawing an individual's application for monthly Social Security Retirement benefits, which would

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[3] The Secretary explains that this repayment regulation was adopted years ago to terminate the practice of applying for benefits, receiving them for a while, and then withdrawing the application, which resulted in an interest-free loan from the government. *See* 75 Fed. Reg. 76256 (Dec. 8, 2010).

[4] The Court notes that 20 C.F.R. § 404.640 was recently amended on December 8, 2010, to include a requirement, *inter alia*, that a withdrawal from Social Security Retirement benefits be "filed within 12 months of the first month of entitlement." *See* 20 C.F.R. § 404.640; *see also* 75 Fed. Reg. 76256 (Dec. 8, 2010). In light of the disposition of this case, this decision does not need to address, nor does it address, whether that one-year limitation would apply to Plaintiffs.

"require[] repayment" of all benefits received. *See* POMS HI 00801.002.

The other two challenged POMS provisions repeat the same premise (specifically referring back to POMS HI 00801.002) while providing additional information about different kinds of permitted withdrawals. POMS HI 00801.034, titled "Withdrawal Considerations," states:

> 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. . . . An individual who filed an application for both monthly (Social Security Retirement] benefits and HI may:
>
> - withdraw the claim for monthly [Social Security Retirement] benefits without jeopardizing HI entitlement; **or**
> - withdraw the claim for **both** monthly [Social Security Retirement] benefits and HI.
>
> The individual may **not** elect to withdraw only the HI claim.

POMS HI 00801.34. Finally, POMS GN 00206.020, titled "Withdrawal (WD) Considerations When Hospital Insurance (HI) is Involved," is to the same effect. It concludes: "However, a claimant who is entitled to monthly [Social Security Retirement] benefits cannot withdraw [from Medicare Part A] coverage only, since entitlement to [Medicare Part A] is based on entitlement to monthly [Social Security

Retirement] benefits (see HI 00801.002)." POMS GN 00206.020.

Plaintiffs filed this lawsuit pursuant to the Medicare Act, 42 U.S.C. § 1395 *et seq.*, the Social Security Act, 42 U.S.C. § 401 *et seq.*, and the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 *et seq.*, alleging that the Social Security Administration's ("SSA") regulations regarding Medicare Part A, as set forth in the SSA's POMS, are invalid and operate either to deprive Plaintiffs of their right to Social Security benefits or to force them to "enroll in" Medicare Part A against their will. *See generally* Am. Compl. ¶¶ 37–60. Plaintiffs seek an order enjoining Defendants from "enforcing" the three challenged POMS provisions, and "allowing Plaintiffs not to enroll in, or to disenroll from, Medicare, Part A, without the loss of their Social Security [Retirement] monthly benefits." Am. Compl. (Prayer for Relief) ¶ 5. The Court will not grant such relief because the POMS are a proper implementation of the Social Security and Medicare Acts.

C. The POMS Result from Proper Implementation of the Social Security and Medicare Acts and Regulations Thereunder

Just as Plaintiffs complain, they have no choice but to participate in Medicare Part A, unless they forego all Social Security Retirement benefits in the future and repay those benefits already received. This result occurs by operation of law, not the POMS, which only reflect the legal realities. It was not by mistake or inadvertence that SSA published the internal POMS; the Medicare Act specifies that all persons who have reached age 65 and who are receiving Social Security

Retirement benefits are "entitled" to Medicare Part A. *See* 42 U.S.C. § 426. The statute does not require any "enrollment" procedure for this entitlement to attach. Successive Secretaries since 1965 have not engaged in rulemaking to establish any enrollment procedure for Medicare Part A. There is a "dis-enrollment" possibility, albeit very unattractive, that allows a 65 year-old beneficiary to make himself un-entitled for Medicare Part A by foregoing one of the essential requirements to become entitled to Medicare Part A – receipt of Social Security Retirement benefits.

Plaintiffs argue that nothing in the Social Security Act deprives them of their Social Security Retirement benefits just because they want to avoid Medicare Part A. Inasmuch as the Medicare Act is part of the Social Security Act, this argument is not entirely accurate. But the point that the Social Security Act, without reference to Medicare Part A, does not specifically state that it requires foregoing Social Security Retirement benefits in order to avoid Medicare Part A is a legitimate one. The point is sufficient to require the Court's attention and consider the matter at length to ensure the Secretary is correct.

The issue for Plaintiffs is the consequence of being "entitled" to Medicare Part A, more than the entitlement itself. If they could be entitled but decline, they would be happy, just as one can decline Social Security Retirement benefits by not applying for them. Unfortunately for Plaintiffs, the Medicare Act is very clear that persons entitled to Social Security Retirement benefits, *i.e.*, of an age and work history and application therefore, are immediately and automatically entitled to Medicare Part A benefits upon their sixty-fifth birthdays.

That Medicare entitlement has very specific consequences for a retired Federal employee: If a Federal retiree who has attained age 65 is "not covered" by Medicare Part A, perhaps because he withdrew his application for Social Security Retirement benefits, his FEHB "plan, other than a prepayment plan described in" 5 U.S.C. § 8903(4), "may not provide benefits . . . to pay a charge imposed by any health care provider, for inpatient hospital services which are covered for purposes of benefit payments" by Medicare Part A, "to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes." 5 U.S.C. § 8904(b)(1)(A). Thus, even if Plaintiffs were to forego and repay all Social Security Retirement benefits, their FEHB-paid benefits would be no more, and no less, than what Medicare Part A would provide.[5]

Plaintiffs argue that "entitled" to Social Security Retirement benefits does not mean "required to accept" so that "entitled" to Medicare Part A benefits does not mean "required to accept." While the Plaintiffs' plain-English reading of the word "entitled" has its attractions, in context the Medicare "entitled" does not actually mean "capable of being rejected." An individual is "entitled" to Social Security Retirement benefits only *after* he has worked the requisite quarters, attained age 62 (or more), and *filed an application*. *See* 42 U.S.C. § 402. There being no affirmative filing of an application necessary for a Medicare Part A entitlement, it is a different type of

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[5] Defendants recognize that Plaintiff Kraus is exempted from 5 U.S.C. § 8904(b)(1)(A) because he was enrolled in a prepayment plan described in 5 U.S.C. § 8903(4). Defs.' Supplemental Brief [Dkt. # 48] at 2.

entitlement because of its automatic nature. The Medicare Part A entitlement is tied exclusively to the fulfilment of two requirements: (1) receiving Social Security Retirement benefits; and (2) being age 65 – the removal of either having the effect of disestablishing that entitlement.

Plaintiffs would read "entitled" to require either an application to enroll in Medicare Part A or at least an opportunity to dis-enroll because they define "entitled" to mean: "to give legal right or legal title to, qualify [one] for something; furnish with proper grounds for seeking or claiming something." Pls.' Mem. in Support of its Mot. for Summ. J. [Dkt. #39-1] at 13 (citing *Fagner v. Heckler*, 779 F. 2d 541, 543 (9th Cir. 1985) (citing *Webster's Third New International Dictionary* 758 (1976))). Congress knows how to write such a provision and, in fact, did so for persons who are not entitled to Medicare Part A but have (1) enrolled in Medicare Part B and (2) are citizens or have resided for five years' continuous residence in the United States as aliens lawfully admitted for permanent residence. *See* 42 U.S.C. § 1395*i*-2. Such persons must "enroll" and pay premiums for Medicare Part A coverage. In contrast, as Plaintiffs acknowledge, they are "entitled" to Medicare Part A without enrollment because they are 65 and are receiving Social Security Retirement benefits. Requiring a mechanism for Plaintiffs and others in their situation to "disenroll" would be contrary to congressional intent, which was to provide "*mandatory*" benefits under Medicare Part A for those receiving Social Security Retirement benefits. *See Bowen*, 476 U.S. at 674-75.

V. CONCLUSION

Plaintiffs are trapped in a government program intended for their benefit. They disagree and wish to escape. The Court can find no loophole or requirement that the Secretary provide such a pathway. Defendants' Motion for Summary Judgment [Dkt. # 42], which was previously denied without prejudice, is reconsidered and will be granted and Plaintiffs' Motion for Summary Judgment [Dkt. # 51] will be denied. A memorializing Order accompanies this Memorandum Opinion.

Date: March 16, 2011

/s/
ROSEMARY M. COLLYER
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 08-1715 (RMC)

[Filed Mach 16, 2011]

BRIAN HALL, *et al*.	)
	)
Plaintiffs,	)
	)
v.	)
	)
KATHLEEN SEBELIUS, Secretary, Department of Health and Human Services, *et al*.,	)
	)
Defendants.	)

ORDER

For the reasons stated in the Memorandum Opinion filed simultaneously with this Order, it is hereby

ORDERED that Defendant's Motion for Summary Judgment [Dkt. # 42], which was previously denied without prejudice is reconsidered, and is **GRANTED**; and it is further

ORDERED that Plaintiffs' Motion for Summary Judgment [Dkt. # 51] is **DENIED**; and it is further

ORDERED that this case is **DISMISSED**; accordingly, this case is closed. This is a final appealable order. *See* Fed. R. App. P. 4(a).

SO ORDERED.

Date: March 16, 2011

/s/
ROSEMARY M. COLLYER
United States District Judge

APPENDIX C

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 11-5076

September Term 2011
1:08-cv-01715-RMC

[Filed May 30, 2012]

Brian Hall, et al.,	)
	)
Appellants	)
	)
v.	)
	)
Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, and Michael J. Astrue, Commissioner of the Social Security Administration,	)
	)
Appellees	)

BEFORE: Henderson[*] and Kavanaugh,[**] Circuit Judges; Ginsburg,[**] Senior Circuit Judge

O R D E R

Upon consideration of appellants' petition for panel rehearing filed on March 22, 2012, and the response thereto, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Jennifer M. Clark
Deputy Clerk

[*] A statement by Circuit Judge Henderson, specially concurring, is attached.

[**] A statement by Circuit Judge Kavanaugh, with whom Senior Circuit Judge Ginsburg joins, concurring in the denial of rehearing, is attached.

HENDERSON, *Circuit Judge*, specially concurring:

My colleague concurring in the denial of panel rehearing is apparently surprised that the "[p]laintiffs' petition for rehearing appears to reflect some misunderstanding about our holding in this case." Concurrence at 3 (Kavanaugh, J.). I, in contrast, am in no way surprised by the substance of the plaintiffs' petition, especially its assertion that the majority's holding "is over an issue that was not even before the Court." Pl.'s Pet. 1. Any disconnect between the panel majority opinion and the plaintiffs' petition is the consequence of the opinion's own avoidance of the sole issue in this case: Whether the Social Security Administration is authorized to penalize an individual who declines Medicare, Part A coverage by requiring him to forfeit his Social Security retirement benefits and repay any benefits previously received. The plaintiffs pushed the issue in their opening brief, *see, e.g.*, Appellant's Br. 22 ("The POMS require, subject to severe penalty for non-compliance, what Congress made to be purely voluntary."), and again in their reply brief, *see, e.g.*, Appellant's Reply Br. 4 ("The only issue is whether 'entitlement' under § 426(a) means that a person so entitled must accept Medicare, Part A, benefits as a condition of receiving Social Security retirement benefits."). Like a parent who yells "get in the game" to his child picking daisies in the outfield, the plaintiffs ask the court to "get in the game" and finally address the issue it ignored. *See* Pl.'s Pet. at 4-5 ("[T]he actual question placed before this Court is whether the Social Security Administration can lawfully promulgate a quasi–regulatory provision that penalizes individuals who seek to decline coverage under Medicare, Part A, by requiring them to forfeit their Social Security retirement benefits."). While I

consider the plaintiffs' rehearing petition to be an exercise in futility and therefore do not dissent from the denial thereof, I feel compelled to point out my concurring colleague's insistence on miscalling the game.

KAVANAUGH, *Circuit Judge*, with whom *Senior Circuit Judge* GINSBURG joins, concurring in the denial of panel rehearing:

Plaintiffs' petition for rehearing appears to reflect some misunderstanding about our holding in this case.

To be crystal clear, no one is forced to accept Medicare Part A benefits for hospitalization costs. Someone who is 65 or older and has signed up for Social Security is automatically entitled to Medicare Part A benefits. But that person is not forced to accept those Medicare benefits.

What really seems to be going on in this case is that plaintiffs' private insurers are curtailing coverage because plaintiffs have another source of coverage – namely, Medicare Part A. Plaintiffs are not happy that their private insurers are in effect penalizing them based on their entitlement to Medicare Part A benefits. Plaintiffs therefore want to "disenroll" from Medicare Part A. They claim a statutory right to "disenroll" and argue that the Department of Health and Human Services and the Social Security Administration have improperly denied them that right.

No matter how plaintiffs label it, however, their grievance about the private insurance consequences of their entitlement to Medicare Part A benefits would be answered only if (i) the private insurers did not penalize plaintiffs based on their entitlement to Medicare Part A benefits or (ii) plaintiffs could somehow disclaim their entitlement to Medicare Part A benefits in a manner that would satisfy the private

insurers that plaintiffs are not entitled to another source of coverage.

We obviously cannot do anything here about the coverage practices of private insurers. And the statute simply provides no mechanism for a person who is 65 or older and has signed up for Social Security to disclaim his or her entitlement to Medicare Part A benefits (or to "disenroll," as plaintiffs put it). To reiterate, no one is forced to take Medicare Part A benefits. But the key problem for plaintiffs is that their private insurers apparently will not ignore the fact that plaintiffs are able to obtain Medicare Part A benefits.

One of the consequences of the expanded social safety net fashioned by the Federal Government is that private entities or charities sometimes adjust benefits based on whether a recipient is otherwise entitled to government-provided benefits. We recognize that plaintiffs are frustrated with this particular manifestation of that broader phenomenon. But absent a constitutional or statutory violation, it is not our role to police that allocation of government and private resources.

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 11-5076

September Term 2011
1:08-cv-01715-RMC

[Filed May 30, 2012]

Brian Hall, et al.,	)
	)
Appellants	)
	)
v.	)
	)
Kathleen Sebelius, Secretary of the United States Department of Health and Human Services and Michael James Astrue, Commissioner of the Social Security Administration,	)
	)
Appellees	)

BEFORE: Sentelle, Chief Judge; Henderson, Rogers, Tatel, Garland, Brown, Griffith, and Kavanaugh, Circuit Judges; Ginsburg, Senior Circuit Judge

O R D E R

Upon consideration of appellants' petition for rehearing en banc, the response thereto, and the

absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Jennifer M. Clark
Deputy Clerk

APPENDIX D

OLD-AGE AND SURVIVORS INSURANCE BENEFIT PAYMENTS

Old-Age Insurance Benefits

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

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

(2) has attained age 62, and

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

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

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

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

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

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

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

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 202, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits uner part A of title XVIII,

(B) is a qualified railroad retirement beneficiary, or

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

conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

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

APPENDIX E

POMS Section: HI 00801.002

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

HI 00801.002 Waiver of HI Entitlement by Monthly Beneficiary

A. INTRODUCTION

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

B. POLICY

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

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

HI 00801.002 - Waiver of HI Entitlement by Monthly Beneficiary - 6/29/2010

Batch run: 06/29/2010
Rev:06/29/2010

POMS Section: HI 00801.034

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

HI 00801.034 Withdrawal Considerations

A. POLICY

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

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

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

- withdraw the claim for **both** monthly benefits and HI.

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

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

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

B. REFERENCE

See GN 00206.020 for a complete discussion of withdrawal considerations.

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

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

POMS Section: GN 00206.020

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

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

A. Background

1. Before 1/1/81

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

2. Effective 1/1/81

P.L. 96-473 modified the law to provide that an individual 65 or over who filed an application for monthly RSI benefits and HI, is deemed to have filed separate applications for cash benefits and HI coverage. In addition, the individual is deemed entitled to HI based on the date of an original application for monthly benefits which was subsequently withdrawn.

P.L. 96-473 applies only to those claimants who are age 65 or over. It does not apply to:

- Disability (i.e., DIB or disability freeze) applicants; or

- Childhood disability beneficiaries (CDBs), disabled widow(er)s (DWBs) or disabled surviving divorced spouses.

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

B. Policy

The claimant can withdraw an application for:

- RSI cash benefits only;

- RSI cash benefits and HI coverage (see HI 00801.022 and GN 00204.021 for an explanation of these benefits); or

- Medicare Only (See HI 00801.008, HI 00801.145, HI 00801.197).

However, a claimant who is entitled to monthly RSI benefits cannot withdraw HI coverage only since entitlement to HI is based on entitlement to monthly RSI benefits (see HI 00801.002). If a numberholder (NH) filed before age 65 so that his/her spouse would be entitled to HI, and later withdraws the application, the spouse will retain HI entitlement regardless of whether the initial entitlement was before or after 1/1/81.

EXAMPLE 1

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

entitlement which began in 6/99 at age 65, and his wife maintained her HI entitlement which began in 6/96.

EXAMPLE 2

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

C. Procedure

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

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

Make sure that the WD request clearly states whether the person wants to include HI coverage in the scope

of the WD (see GN 00204.020 for scope of the application). If the claimant wishes to withdraw both RSI and HI coverage, specify the person's reasons for withdrawing HI coverage.

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

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

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