[NOT YET SCHEDULED FOR ORAL ARGUMENT]

No. 13-5003

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, et al.,

Plaintiffs-Appellants,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services, in her official capacity, et al.,

Defendants-Appellees.

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

BRIEF FOR THE APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici.

The plaintiffs-appellants are the Association of American Physicians and Surgeons and Alliance for Natural Health, USA. The defendants-appellees are Kathleen Sebelius, Secretary of Health and Human Services; Jacob J. Lew, Secretary of the Treasury; Carolyn W. Colvin, Acting Commissioner of the Social Security Administration; and the United States of America. No one participated as amicus curiae in this Court or in the district court.

B. Rulings Under Review.

The ruling under review is the Memorandum Opinion (per Hon. Amy Berman Jackson) dated October 31, 2012 and published at 901 F. Supp. 2d 19 (2012).

C. Related Cases.

This case has not previously been before this Court or any other court of appeals, and we are not aware of any related cases within the meaning of D.C. Circuit Rule 28(a)(1)(C).

/s/Dana Kaersvang
DANA KAERSVANG

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GLOSSARY

JA	Joint Appendix
HHS	United States Department of Health and Human Services
POMS	Social Security Program Operations Manual System

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331, 49 Stat. 1921, D.C. Code § 11-501, and the district court's general equity jurisdiction. As discussed at Parts C and D of the Argument, the district court lacked jurisdiction over several of plaintiffs' claims. The district court entered final judgment for the government on October 31, 2012. JA_ (Dkt. No. 58). Plaintiffs filed a timely notice of appeal on December 28, 2012. Dkt. No. 60. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUE

Plaintiffs challenge the minimum coverage provision of the Affordable Care Act, 26 U.S.C. § 5000A ("Section 5000A"), asserting that it is an unconstitutional taking. Plaintiffs also challenge various provisions of an interim rule regarding Medicare reimbursements and of a Social Security handbook regarding Medicare Part A entitlement. Finally, plaintiffs assert that the Secretary of Health and Human Services and the Commissioner of the Social Security Administration violated fiduciary duties to the American people and request an "accounting" of Social Security and Medicare. The question presented is whether the district court correctly dismissed plaintiffs' complaint in its entirety, because plaintiffs' challenge to Section 5000A is foreclosed by the Supreme Court's recent decision in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012)

("*NFIB*"), plaintiffs' challenge to the interim final rule regarding Medicare reimbursements is now moot, and plaintiffs lack standing to pursue their remaining claims.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes are reproduced in the addendum to plaintiffs' brief.

STATEMENT OF THE CASE

Plaintiffs, two organizations of health care providers, challenge the constitutionality of the minimum coverage provision of the Affordable Care Act; an interim final rule relating to payment for Medicare referrals; and Social Security handbook provisions that lay out the process by which individuals can withdraw applications for Social Security benefits and thereby cease to be entitled to benefits under Medicare Part A. Plaintiffs also request an "accounting" of the Medicare and Social Security programs. The district court dismissed their challenge to the statute and portions of their challenge to the interim regulation on the merits, and dismissed plaintiffs' other claims for lack of standing.[1]

STATEMENT OF FACTS

Plaintiffs are two organizations of health care providers. Their complaint challenged a variety of statutory and regulatory provisions. See JA_ (Second

[1] Plaintiffs also asserted in a supplemental brief filed more than two years into this lawsuit that the Affordable Care Act was enacted in violation of the Origination Clause. The district court held that this argument was waived. See JA_ (Op. 20-21).

Amended and Supplemental Complaint ("Compl.")). As we discuss in our Argument, plaintiffs lack standing to pursue some of these claims, some of their contentions are moot and others are foreclosed by decisions of the Supreme Court and this Court that issued while this litigation was pending. We describe briefly each of the claims at issue on appeal and the challenged provisions.

1. Section 5000A of the Internal Revenue Code, added by the Affordable Care Act

Section 5000A of the Internal Revenue Code, which was added by the Affordable Care Act (challenged in Count 3 of the complaint) will, when it takes effect in 2014, require non-exempted individuals to make specified payments to the IRS if they fail to maintain minimum health coverage for themselves or their dependents. *See NFIB*, 132 S. Ct. at 2580. Plaintiffs alleged in district court that Section 5000A exceeds Congress's authority under the Commerce Clause, violates both the Due Process Clause and the Fifth Amendment's prohibition on takings without just compensation, and "[i]f a tax," is "either an un-apportioned capitation or direct tax or a non-uniform excise tax." JA_ (Compl. 19).

While this case was pending in district court, the Supreme Court upheld Section 5000A as a valid exercise of Congress's taxing power. *See NFIB*, 132 S. Ct. 2566. Following the Supreme Court's decision, the district court ordered the parties to file simultaneous supplemental briefs. Plaintiffs renewed their takings

clause challenge and also argued for the first time that the Affordable Care Act was enacted in violation of the Origination Clause.

The district court rejected these arguments, holding that plaintiffs failed to state a claim. The district court held that plaintiffs' takings clause argument "lacks any vitality in light of the Supreme Court's decision upholding" Section 5000A under the taxing power. JA_ (Op. 22). The district court reasoned that Section 5000A is "neither arbitrary, nor a confiscation of property," and that the taxation power "would be useless" if "the government were prohibited from using tax money for the benefit of the American people." JA_ (Op. 22). The district court declined to address the Origination Clause argument, explaining that "plaintiffs waived it by failing to assert it in their complaint or opposition to the motion to dismiss, even though defendants argued in their motion to dismiss that the provisions are justified under Congress's taxation power." JA_ (Op. 20-21).

2. Interim Rule Governing Medicare Reimbursements

Plaintiffs also challenge an interim final rule and associated changes to a Medicare internal claims processing manual (known as "change requests") regarding reimbursements for Medicare referrals (Count 4 of the complaint). The Medicare statute has long required physicians who treat Medicare patients to either enroll in or opt out of Medicare, and required suppliers of items and services under Medicare Part B to identify the referring physician by name and provider number

in order to receive reimbursement. *See* 42 U.S.C. § 1395*l*(q)(1), (2); *United Seniors Ass'n, Inc. v. Shalala*, 182 F.3d 965, 967 (D.C. Cir. 1999). Through the challenged interim final rule, HHS proposed to track compliance with these requirements by denying payment for claims that did not properly identify a referring physician. *See* JA_ (Change Requests 6417, 6421 at Add. 13-25).

Plaintiffs asserted that the interim final rule and associated change requests were procedurally invalid because, in their view, HHS was required to issue them through notice-and-comment rulemaking. While this case was pending in district court, HHS issued a final rule, following notice and comment, addressing these issues. *See* 77 Fed. Reg. 25,284 (Apr. 27, 2012). As we explain in Part B of our Argument, plaintiffs' procedural challenge to the interim final rule is moot because that rule has now been superseded by the final rule issued through notice and comment.

The district court addressed the claim before it without reference to the final rule. The district court rejected plaintiffs' procedural challenge to the rule, reasoning that existing law already required physicians that refer under Medicare Part B to either enroll in or opt out of Medicare. JA_ (Op. 30). The court observed that the changes "simply dictate the verification processes that HHS will use to ensure that claims for referred items or services were validly referred by a qualified physician." JA_ (Op. 33). The district court held that the interim final rule could

be issued without notice and comment because it represents the "reassertion of a preexisting requirement." JA_ (Op. 34).

3. Social Security Handbook Provisions

Plaintiffs also challenge certain Social Security handbook provisions regarding Medicare Part A entitlement for citizens age 65 or older who receive Social Security benefits (Count 1 of the complaint).

The Medicare amendments, since their enactment, have established automatic entitlement to Part A benefits for all individuals who have "attained age 65" and are "entitled to monthly [old-age] insurance benefits" under 42 U.S.C. § 402. 42 U.S.C. § 426(a). Eligible individuals need not use their Medicare Part A benefits, but they remain legally entitled to those benefits if they are 65 or older and receiving Social Security benefits.[2] *Hall v. Sebelius*, 667 F.3d 1293, 1297 (D.C. Cir. 2012), *cert. denied*, 133 S. Ct. 840 (2013).

Social Security regulations set out the procedures for filing or withdrawing Social Security benefits applications. *See* 20 C.F.R. § 404.640. Since 1940, regulations have permitted the voluntary withdrawal of an application before a determination on the application has been made. 5 Fed. Reg. 1849, 1866 (May 23,

[2] This automatic entitlement relates only to Part A, which provides "protection against the costs of hospital and related care[.]" H.R. Rep. No. 89-213, at 4 (1965). Medicare Part B, which provides protection against the costs of physicians' services and other medical and health services, is a voluntary supplemental plan that is not at issue in this count.

1940) (20 C.F.R. § 403.704 (1941)). Since 1963, the regulations have also permitted the withdrawal of an application after it has been adjudicated, provided that, among other things, the individual repays any benefits received. 28 Fed. Reg. 4494, 4495 (May 4, 1963) (adding subsection (b) to 20 C.F.R. § 404.615). This process for withdrawing a Social Security application after it is adjudicated has the effect of providing a process by which individuals may cease to be entitled to Medicare Part A, although there is "no statutory avenue" for doing so, *Hall*, 667 F.3d at 1294.

These statutory and regulatory provisions are reflected in the Social Security Program Operations Manual System (called "POMS"), a Social Security Administration handbook designed for internal use by SSA employees processing claims. JA_ (Op. 7). Plaintiffs challenged the Social Security handbook, arguing that its provisions were beyond the agency's authority and, at a minimum, had to be enacted through notice-and-comment rulemaking.

While this suit was pending in district court, this Court decided *Hall v. Sebelius*, 667 F.3d 1293 (D.C. Cir. 2012), *cert. denied*, 133 S. Ct. 840 (2013), in which it rejected a challenge to the same Social Security handbook provisions. This Court held that the statute "simply does not provide any mechanism" to disclaim Medicare Part A entitlement while receiving Social Security benefits. *Hall*, 667 F.3d at 1294.

After supplemental briefing, the district court here held that plaintiffs lack standing to challenge to the Social Security handbook provisions. The district court reasoned that "the internal handbook does not create or eliminate any legal entitlements; it simply states what they are under existing law." JA_ (Op. 10). The district court also reasoned that, unlike the plaintiffs in *Hall*, plaintiffs here "do not show that their members suffer any injury by becoming entitled to Medicare Part A." JA_ (Op. 11). Instead, plaintiffs' allegations of harm relate to "'compelled participation'" in Medicare Part A. JA_ (Op. 10). The district court explained that, as this Court held in *Hall*, the provisions challenged "do not actually compel participation" and "any individual who is entitled to Medicare Part A may decline all of the benefits the program provides." JA_ (Op. 10, 12). The district court also rejected plaintiffs' competitive disadvantage argument, holding that, since Medicare Part A covers institutional health care providers, not physicians' services, plaintiff physicians had not sufficiently alleged that their practices would be affected. JA_ (Op. 12).

In the alternative, the district court held that it would dismiss this count on the merits in light of *Hall*. The district court reasoned that "the only claim asserted here that was not directly rejected in *Hall*" is the argument that notice-and-comment rulemaking was required to promulgate the handbook provision. JA_ (Op. 14 n.3). The district court reasoned that, since this Court "found that the

automatic entitlement is required by the Medicare statute itself," the handbook provisions would be valid interpretive rules. *Ibid*.

4. Accounting of Social Security and Medicare

Plaintiffs also argued that the Secretary of HHS and the Commissioner of Social Security had "violate[d their] fiduciary and equitable duties" "to the American people" and that Medicare and Social Security "face[] insolvency because of federal mismanagement." JA_ (Counts 5 and 6 of the complaint, pp. 27-28). Plaintiffs requested that the district court order an "accounting" for Social Security and Medicare. *Ibid.*

The district court held that plaintiffs lack standing to assert this claim. It reasoned that "this challenge rests on a generalized grievance about the unforeseeable future of Medicare and Social Security." JA_ (Op. 35). The district court rejected the argument that plaintiffs' members had a particular interest in Medicare, reasoning that "the financial interest of their members is no stronger than the financial interest of all Americans who will reach the age of Social Security and Medicare eligibility." JA_ (Op. 35). The district court further held that "the problem here is not just that the alleged harm at issue is widely shared, but that it is too abstract and indefinite in nature to satisfy the concrete and particularized requirement." JA_ (Op. 35).

SUMMARY OF ARGUMENT

In *NFIB*, the Supreme Court rejected a constitutional challenge to 26 U.S.C. § 5000A, which provides that, beginning in 2014, a non-exempted individual who fails to maintain minimum essential health coverage must make a specified payment to the Internal Revenue Service. The Supreme Court held that Section 5000A is a valid exercise of Congress's taxing power. *See NFIB*, 132 S. Ct. at 2593-2600. The district court correctly held that, in light of *NFIB*, plaintiffs' takings challenge to Section 5000A is meritless.

Plaintiffs also assert that the Affordable Care Act was enacted in violation of the Origination Clause. The district court correctly held that plaintiffs waived this argument by failing to raise it in district court until the supplemental briefing stage.

Plaintiffs bring a procedural challenge to a final interim rule regarding Medicare asserting that it should have been promulgated through notice and comment. This challenge is moot. The interim rule has been superseded by a final rule promulgated by HHS after notice and comment. 77 Fed. Reg. at 25,284.

Plaintiffs also challenge certain Social Security handbook provisions relating to entitlement to Medicare Part A, arguing that notice-and-comment rulemaking was required to promulgate these provisions. As the district court held, plaintiffs lack standing to challenge these provisions. This Court also lacks jurisdiction over these claims because they were not channeled through the administrative process

as required by 42 U.S.C. § 405(h). On the merits, as the district court held, plaintiffs' argument is foreclosed by this Court's recent decision in *Hall v. Sebelius*. In *Hall*, this Court concluded that the statute itself requires the result set out in the handbook, indicating that the handbook provisions are valid interpretive guidance.

The district court also correctly concluded that plaintiffs lack standing to assert their claim requesting an "accounting" of the Medicare and Social Security programs. As the district court reasoned, plaintiffs' asserted injuries are both generalized and highly speculative.

STANDARD OF REVIEW

This Court reviews de novo the district court's grant of a motion to dismiss. *Kim v. United States*, 632 F.3d 713, 715 (D.C. Cir. 2011).

ARGUMENT

THE DISTRICT COURT CORRECTLY HELD THAT SEVERAL OF PLAINTIFFS' CLAIMS WERE MERITLESS AND THAT IT LACKED JURISDICTION OVER THE REMAINING CLAIMS.

A. The District Court Correctly Dismissed Plaintiffs' Challenge to the Constitutionality of the Affordable Care Act

1. In *NFIB*, the Supreme Court rejected a constitutional challenge to 26 U.S.C. § 5000A, which provides that, beginning in 2014, a non-exempted individual who fails to maintain minimum essential health coverage must make a specified payment to the Internal Revenue Service. The Supreme Court held that

individuals have the "lawful choice" to make payment to the IRS under Section 5000A "in lieu of buying health insurance," *NFIB*, 132 S. Ct. at 2597, 2600, and the Court upheld Section 5000A as a valid exercise of Congress's taxing power. *See id*. at 2593-2600.

Plaintiffs challenge Section 5000A, the same provision that the Supreme Court upheld in *NFIB*,[3] arguing that it is an unconstitutional taking because it asks "healthy private individuals to support unhealthy private individuals." Pl. Br. 32. As the district court explained, plaintiffs' claim is foreclosed by *NFIB*. JA_ (Op. 20). Plaintiffs' argument is that Congress could not constitutionally use the taxing power to encourage people to purchase health insurance. The Supreme Court, however, held that the fact that "§ 5000A seeks to shape decisions about whether to buy health insurance does not mean that it cannot be a valid exercise of the taxing power." *NFIB*, 132 S. Ct. at 2596. On the contrary, "[e]xercises of the taxing power are one obvious example" of laws that affect recognized economic values without running afoul of the takings clause. *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1978). Thus, "[i]t is beyond dispute that '[t]axes and user fees . . . are not 'takings.'" *Koontz v. St. Johns River Water Management*

[3] Plaintiffs seek to distinguish *NFIB* by arguing that they raise an as-applied challenge, but the district court correctly held that plaintiffs waived their as-applied challenge by failing to raise it in either their complaint or their opposition to the motion to dismiss. Op. 21 n.6. In any event, this argument is meritless whether construed as a facial or an as-applied challenge.

Dist., 133 S. Ct. 2586, 2600 (2013) (quoting *Brown v. Legal Foundation of Wash.*, 538 U.S. 216, 235 (2003)).

In district court, plaintiffs also raised an equal protection challenge to Section 5000A and challenged provisions of the Affordable Care Act relating to employers. They did not, however, assert these claims in their opening brief on appeal.[4] Since filing their opening brief, plaintiffs have filed two 28(j) letters that make reference to the employer-related provisions of the Act and one that makes reference to the equal protection challenge. Because plaintiffs did not challenge the district court's holdings dismissing these claims in their opening brief, however, these challenges are waived.[5] *See Duncan's Point Lot Owners Ass'n Inc. v. F.E.R.C.*, 522 F.3d 371, 377 (D.C. Cir. 2008) ("the opening brief must contain 'appellant's contentions and the reasons for them, with citations to the authorities'" (quoting Fed. R. App. P. 28(a)(9)(A))).

[4] Although plaintiffs rely on equal protection in an attempt to establish standing, Pl. Br. 17-19, they do not assert an equal protection claim in their opening brief. *See United States v. Baugham*, 449 F.3d 167, 178 n.3 (D.C. Cir. 2006) ("a 'legal argument' must be 'appropriately identified as such – appearing in a section of the brief devoted to that argument'").

[5] Plaintiffs' 28(j) letters appear to raise new issues related to the government's authority under 26 U.S.C. § 4980H. These issues are not part of this case and are not related to the arguments plaintiffs made in district court. If these arguments were before the Court, they would not be viable for many reasons. But plaintiffs acknowledged in a 28(j) letter filed July 11, 2013 that this "has no lawful impact on this litigation." 28(j) Letter Re: Mazur, "Continuing to Implement the ACA in a Careful, Thoughtful Manner," at 2.

2. Plaintiffs also assert that the Affordable Care Act was passed in violation of the Origination Clause. Plaintiffs failed to raise this claim in their complaint; they did not seek leave to add this claim in an amended complaint; and they made no reference to this claim in opposing the government's motion to dismiss. JA_ (Op. 20-21 & n.6). Instead, they raised this contention for the first time in supplemental briefing more than two years after the suit was filed. The district court correctly concluded that the argument was waived.[6] *Ibid.*; *see also Liberty University, Inc. v. Lew*, __ F.3d __, 2013 WL 3470532, *4 n.3 (4th Cir. July 11, 2012) (holding that plaintiffs waived the Origination Clause argument where they failed to raise it until after the Supreme Court decided *NFIB*).

Plaintiffs mistakenly suggested in their motion for an injunction pending appeal that they were unable to raise an Origination Clause challenge until the Supreme Court held that Section 5000A was a constitutional exercise of the taxing power. On the contrary, plaintiffs argued from the inception of the litigation that the minimum coverage provision was an unconstitutional tax. *See, e.g.*, JA_ (Compl. 29) (claiming that the minimum coverage provision was an an

[6] Plaintiffs asserted in a recent 28(j) letter that the government did not argue in district court that the Origination Clause argument was waived after plaintiffs raised it in their supplemental briefs. Per the district court's order of July 13, 2012, however, the government and plaintiffs filed their supplemental briefs simultaneously.

unconstitutional direct tax). They were fully capable of including an Origination Clause challenge in a complaint or an amended complaint, but they did not do so.[7]

B. Plaintiffs' Challenge to the Interim Rule Regarding Medicare Referral Requirements Is Moot

Plaintiffs challenge an interim final rule regarding Medicare referrals, arguing that it should have been enacted through notice and comment.

Long before the challenged interim final rule was promulgated, the Medicare statute required physicians who treat Medicare patients either to enroll in Medicare and comply with its requirements and fee limitations, or to formally opt out of Medicare. *See United Seniors Ass'n, Inc. v. Shalala*, 182 F.3d 965, 966-967 (D.C. Cir. 1999). The Medicare statute has also long required suppliers of Part B items and services to identify the referring physician by name and provider number in order to receive reimbursement.[8] 42 U.S.C. § 1395*l*(q)(1), (2). Through the challenged interim final rule and associated change requests, HHS proposed to

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[7] The question of whether Section 5000A was enacted in violation of the Origination Clause is before this Court in another case, in which plaintiff amended his complaint to raise the issue in district court. *Sissel v. United States Department of Health and Human Servs.*, __ F.Supp.2d__, 2013 WL 3244826, *7 (D.D.C. 2013) (holding that the Origination Clause argument "cannot withstand even a cursory review of previous interpretations of the Origination Clause"), *appeal pending*, No. 13-5202 (D.C. Cir.).

[8] The Affordable Care Act provided additional express authority for the Secretary to require that physicians who refer beneficiaries for Part B items and services be enrolled in Medicare and use a standard provider number. *See* Affordable Care Act, Pub. L. No. 111-148 § 6405, 124 Stat. 119, 768-69 (2010) (codified at 42 U.S.C. §§ 1395m(a)(11)(B), 1395f(a)(2), 1395n(a)(2), 1395f note).

track compliance with these requirements. *See* 75 Fed. Reg. 24,437 (May 5, 2010); JA_ (Change Requests 6417, 6421 at Add. 13-25). The rule required that Medicare claims for certain services contain the name and provider number of a referring physician, if applicable, who is either enrolled in Medicare in approved status or has validly opted out of the Medicare program.[9] 42 C.F.R §§ 424.507(a)(1)(iii)(C), 424.507(b)(1)(iii).

Plaintiffs argued that the interim final rule was not a valid interpretive rule and could be promulgated only through notice-and-comment rulemaking. However, the interim final rule has now been superseded by a final rule promulgated after notice and comment. *See* 77 Fed. Reg. 25,284. The final rule differs from the interim rule in significant ways. *See, e.g.*, 77 Fed. Reg. at 25,291-92 (explaining changes made in response to comments). Plaintiffs' challenge to the superseded interim final rule is thus "quite obviously moot." *Am. Fed. of Gov't Employees, AFL–CIO v. Office of Pers. Mgmt*, 821 F.2d 761, 766 n.4 (D.C. Cir. 1987).

[9] The revised system is being implemented in two phases. In phase 1, which began in 2009, individuals submitting claims without valid referring physician information are notified that necessary information is missing. Otherwise valid claims are nevertheless still paid. JA_ (Change Requests 6417, 6421 at Add. 14, 21). Under phase 2, which has not yet gone into effect, claims will not be paid until the required information is provided. JA_ (Change Requests 6417, 6421 at Add. 15, 22). HHS set out the phase 2 procedures in an interim rule in 2010, as well as in the change requests.

Plaintiffs assert that their claim is not moot because "once the 2012 rule is invalidated, the Administration will need to retreat to the procedurally defective actions challenged here." Pl. Br. 49. But the validity of the final rule is not at issue in this case. If that final rule were invalidated in some other lawsuit, HHS would then be required to take appropriate action in light of that hypothetical ruling.

Plaintiffs also assert that both the interim and final rule share "substantive defects." Pl. Br. 48 (italics omitted). The only "substantive defect[]" identified in plaintiffs' brief, however, is the contention that the changes effected by the rule "[w]ould [b]e *ultra vires* without [the Affordable Care Act]." Pl. Br. 51. That contention is incorrect, but regardless, plaintiffs acknowledge that HHS has authority to promulgate the rule under the Affordable Care Act, *see* Pl. Br. 51 (discussing Affordable Care Act § 6405(c) (codified at 42 U.S.C. §§ 1395m(a)(11)(B), 1395f(a)(2), 1395n(a)(2), 1395f note)), and they have provided no basis for this Court to strike down any part of the Act, let alone the Act in its entirety.

C. This Court Lacks Jurisdiction over the Challenge to the Social Security Handbook, and the Challenge is Foreclosed by *Hall*

Plaintiffs also challenge certain Social Security handbook provisions. Under the Social Security Act, "[c]itizens who receive Social Security benefits and are 65 or older are automatically entitled under federal law to Medicare Part A benefits."

Hall, 667 F.3d at 1294. Plaintiffs challenge the process by which an individual who does not wish to be entitled to Medicare Part A can withdraw his or her application for Social Security benefits.

1. As an initial matter, plaintiffs lack standing to pursue this claim. Plaintiffs have made no specific allegations of injury as a result of Medicare Part A entitlement. They assert generally that they have members—whom they do not identify—who would like to "cease participation" in Medicare Part A while still receiving Social Security retirement benefits, JA_ (Compl. 7), and that "Part A eligibility seriously erodes the freedom of choice available to the Medicare-eligible patient." Pl. Br. 55. But, as the district court observed, plaintiffs discuss *participation* in Medicare and do not assert that their members will be harmed by Medicare *entitlement.* Although citizens over 65 who collect Social Security remain entitled to Part A, "they can decline Medicare Part A benefits." *Hall*, 667 F.3d at 1295. Thus, plaintiffs cannot rely on harms that they allege result from participation in Medicare Part A to create standing.

By contrast, two plaintiffs in *Hall* asserted specific allegations of harm resulting from entitlement to Medicare benefits. They claimed that their "private insurers have curtailed coverage a result of plaintiffs' entitlement to Medicare Part A benefits" and "they would receive enhanced coverage from their private insurers if they were not entitled to Medicare Part A benefits." *Hall*, 667 F.3d at 1295.

Plaintiffs also assert generally that their member physicians who do not accept Medicare suffer economic and competitive injury from increased Medicare enrollment. Pl. Br. 14-17. The district court correctly rejected this argument, explaining that the challenged handbook provisions relate only to Medicare Part A, which covers hospital services. Physicians' services are covered separately under Medicare Part B. JA_ (Op. 12) (citing *United Seniors Ass'n, Inc. v. Shalala*, 182 F.3d 965, 967 (D.C. Cir. 1999)). Plaintiffs assert that the American Association of Physicians and Surgeons' membership includes "facilities," but the declaration they cite discusses ambulatory surgery centers, which are also covered under Medicare Part B. *See* Pl. Br. 52 (citing Smith Decl. at ¶¶ 3-8).

Plaintiffs also confuse Medicare Parts A and B when they refer generally to their discussion of the harms that they allege result from the interim final rule discussed in Part B of the Argument section of this Brief. *See* Pl. Br. 55. HHS has previously explained that "[t]he private contracting rules do not apply to individuals who have only Medicare Part A." *See* 63 Fed. Reg. 58,814, 58,850 (Nov. 2, 1998).

Finally, plaintiffs assert various third-party standing arguments, stating that physicians can bring suit on behalf of their patients. Pl. Br. 19-20. But plaintiffs acknowledge that they must still satisfy the case-or-controversy requirement. Pl. Br. 20. As explained above, they have not done so.

2. This Court lacks jurisdiction over plaintiffs' challenge to the Social Security handbook for a second reason. All claims arising under the Social Security statute must be presented to the agency and plaintiffs must exhaust administrative remedies prior to seeking judicial review. 42 U.S.C. § 405(h); 42 U.S.C. § 1395ii (making provisions of section 405 applicable to Medicare). Judicial review is then available only through review of the Agency's determination, as provided in § 405(g). The statute specifies that "No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. § 405(h). The presentment and exhaustion requirements apply to all challenges arising under the Social Security Act, including constitutional challenges to statutes. *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975). Plaintiffs cannot avoid these requirements by invoking the Court's equitable jurisdiction. *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13-14 (2000) (type of relief sought is irrelevant).[10] The presentment requirement is an absolute requirement for judicial review. *See National Kidney*

[10] This Court has recognized an exception for petitions for mandamus under appropriate circumstances, but the criteria for mandamus are not met here and plaintiff does not argue otherwise. *Action Alliance of Senior Citizens v. Leavitt*, 483 F.3d 852, 858 (D.C. Cir. 2007).

Patients Ass'n v. Sullivan, 958 F.2d 1127, 1129-30 (D.C. Cir. 1992); *Action Alliance of Senior Citizens*, 483 F.3d at 857.

This case does not fall within the narrow exception to § 405(h) that applies when application of the channeling requirement would amount to a "*complete* preclusion of judicial review." *Illinois Council*, 529 U.S. at 23. "[T]he *Illinois Council* exception is primarily concerned with whether a particular *claim* can be heard through Medicare Act channels." *Council for Urological Interests v. Sebelius*, 668 F.3d 704, 712 (D.C. Cir. 2011). It "is not intended to allow section 1331 federal question jurisdiction in every case where section 405(h) would prevent a particular individual or entity from seeking judicial review." *Id*. at 711 (discussing *Am. Chiropractic Ass'n, Inc. v. Leavitt*, 431 F.3d 812 (D.C. Cir. 2005)). This Court has held that, if the type of entity bringing suit lacks access to the administrative process, courts will determine whether application of § 405(h) would amount to "the 'practical equivalent of a total denial of judicial review'" by considering whether others might be willing and able to pursue the claim. *Council for Urological Interests*, 668 F.3d at 712 (quoting *Ill. Council*, 529 U.S. at 21-22). In this case, individual beneficiaries recently challenged these very handbook provisions. *See Hall*, 667 F.3d 1293. There is thus no basis for plaintiffs' assertion (Pl. Br. 53) that there will be "no review at all" of this issue if their claim does not go forward.

3. In any event, as the district court held in the alternative, JA_ (Op. 14 n.3), plaintiffs' challenge to the handbook provisions is foreclosed by *Hall*, which explained that the statute creates an automatic entitlement to Medicare Part A benefits for citizens over 65 who receive social security benefits. *Hall*, 667 F.3d at 1294. Medicare Part A covers hospital services.[11] Covered individuals do not need to use Medicare Part A benefits to pay for Medicare Part A services. They "can decline those benefits" and "pay for services out of their own funds or from other insurance." *Hall*, 667 F.3d at 1295-96 (internal quotation marks omitted). 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." *Id.* at 1294. This Court explained that plaintiffs who argued that Social Security benefits could not be conditioned on entitlement to Medicare "have it backwards." *Id.* at 1296.

Plaintiffs also raise a procedural challenge to Social Security's issuance of the handbook provision without notice-and-comment rulemaking. But the handbook provisions are valid interpretive guidance. As the district court held, this is apparent from *Hall's* holding that the "automatic entitlement is required by the Medicare statute itself" when an individual is over age 65 and collecting social

[11] Physician services, as well as many other types of services, are covered under Medicare Part B, in which individuals must separately enroll and pay premiums.

security. JA_ (Op. 14 n.3). To the extent that plaintiffs also complain about the process created by the agency to allow individuals to avoid Medicare entitlement by withdrawing from Social Security, this process merely reflects the long-standing regulatory requirements for withdrawing from Social Security. *See* 20 C.F.R. § 404.640. These regulatory requirements have been in place since 1963, and plaintiffs do not challenge them here. *See* 20 C.F.R. § 404.640; 28 Fed. Reg. 4494, 4495 (May 4, 1963); *see also Air Transport Ass'n of America, Inc. v. F.A.A.*, 291 F.3d 49, 55 (D.C. Cir. 2002) (holding that an interpretation is a valid interpretative rule exempt from notice-and-comment rulemaking if it is "'fairly encompassed' within the regulation it purports to construe").

D. Plaintiffs' other claims are meritless

As the district court correctly concluded, plaintiffs lack standing to pursue their claim that Secretary Sebelius and Acting Commissioner Colvin "violate[d] [their] fiduciary and equitable duties" to the "American people" and should be ordered to do "accounting[s]" for Medicare and Social Security, respectively. JA_ (Compl. 27-28). As the district court explained, plaintiffs' "challenge rests on a generalized grievance about the unforeseeable future of Medicare and Social Security." JA_ (Op. 35). Plaintiffs' alleged harms are not only "widely shared," but also "too abstract and indefinite" to satisfy the requirements of Article III. *Ibid.*

Plaintiffs also err in arguing that this case should be remanded to Judge Collyer, who handled *Hall*. No remand is necessary. In any event, the related case rule does not give litigants a substantive right to have their case heard by a particular judge.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH
FEDERAL RULE OF APPELLATE PROCEDURE 32(A)

I hereby certify that the certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font.

I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 5,567 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

/s/Dana Kaersvang
DANA KAERSVANG

CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2013, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/Dana Kaersvang
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