Essay

Medicare Part D: Rights Without Remedies, Bars to Relief, and Miles of Red Tape

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> *[I]t is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by suit or action at law, whenever that right is invaded. . . . The government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no* remedy *for the violation of a vested legal* right.[1]

Medicare Part D, enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[2] ("MMA"), was designed to revolutionize the public health system by using the private insurance market to make prescription drug coverage for the elderly available and affordable.[3] But in an ominous beginning to the pro-

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1 Marbury v. Madison, 5 U.S. (1 Cranch) 137, 163 (1803) (Marshall, J.) (quotation and citation omitted).

2 Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 26 and 42 U.S.C.).

3 *See* Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4194 (Jan. 28, 2005) ("The addition of a prescription drug benefit to Medicare represents a landmark change to the Medicare program that will significantly improve the health care coverage available to millions of Medicare beneficiaries."); *see also* N.Y. Statewide Senior Action Council v. Leavitt, 409 F. Supp.

gram, problems in transmitting information between the Social Security Administration ("SSA") and the Centers for Medicare and Medicaid Services ("CMS")—the division of the Department of Health and Human Services ("HHS")[4] responsible for administering the Medicare program—resulted in one of the biggest public health fiascos in history.[5]

One major problem stemmed from an option given to Part D beneficiaries which was designed to simplify operation of the program: HHS would transmit enrollees' requests and their prescription drug plan information to the SSA, and the SSA would deduct premiums from their Social Security benefits and pay the premiums directly to private insurers.[6] But Congress underestimated the importance of technology and the logistical challenges of large-scale bureaucratic coordination.[7] Because HHS and the SSA operate on two distinct, unconnected computer systems, there were massive transmission problems.[8] Those with already meager resources were left destitute as premiums were erroneously deducted from many beneficiaries' Social Security benefits, and others were forced to make their own out-of-pocket payments to avoid losing their prescription drug coverage when premiums were not withheld.[9]

Even more unfortunate is that despite including an inordinate number of regulations to implement Part D,[10] numerous provisions for

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2d 325, 326 (S.D.N.Y. 2005) (noting that Medicare Part D has addressed "a major gap in Medicare coverage" for approximately forty-two million Medicare beneficiaries and that the Department of Health and Human Services "has characterized [Medicare Part D] as the most significant change to the Medicare Program since its inception in 1965" (quotations and citations omitted)).

4 For convenience, this Essay will refer to actions and decisions made by CMS as those made by HHS or the Secretary of HHS. Additionally, the Essay will refer to CMS, HHS, and the Social Security Administration collectively as "the agencies."

5 *See* SARA ROSENBAUM & DAVID FRANKLIN, LAW AND THE AMERICAN HEALTH CARE SYSTEM (2d ed., forthcoming fall 2009) (manuscript at 326, on file with author); *see also* Robert Pear, *Medicare Refund Mixup Part of Larger Tangle*, N.Y. TIMES, Sept. 25, 2006, at A14 ("[H]undreds of thousands of beneficiaries have reported problems in getting the government to carry out their instructions to start or stop the withholding of premiums. Drug plans have repeatedly complained to Medicare officials that premiums have not been properly withheld and that beneficiaries have been upset.").

6 *See* Pear, *supra* note 5; *see also* Action Alliance of Senior Citizens v. Leavitt, 483 F.3d 852, 854 (D.C. Cir. 2007) (noting that as of April 2007, about 20% of enrollees had elected to have premiums withdrawn from their Social Security benefits and transmitted to prescription drug plan sponsors on their behalf).

7 *See* Pear, *supra* note 5.

8 *See id.*

9 *See id.*

10 *See* 42 C.F.R. §§ 423.1–.910 (2007).

plan sponsors to appeal adverse agency decisions,[11] selectively incorporated jurisdiction-stripping provisions,[12] and even an amendment to provide an expedited judicial review procedure for benefits disputes arising under Medicare Parts A (covering inpatient hospital services) and B (covering outpatient physician services and medical supplies),[13] lawmakers failed to include any remedial provisions for *enrollees* to appeal agency action pertaining to Part D.[14] Instead, the only appeals rights affirmatively granted to beneficiaries allow them to file grievances against and appeal decisions made by plan sponsors, not HHS or the SSA.[15] In other words, participants in Parts A and B as well as plan sponsors can obtain judicial review of agency action, and Part D enrollees can obtain judicial review of action by *plan sponsors*; however, Part D enrollees are largely prevented from obtaining judicial review of *agency action*.

Thus, Medicare Part D presents a paradox of sorts: on the one hand, the program is designed to provide medical care for the neediest individuals; on the other hand, the failure of Congress to include remedial provisions leaves many on the brink of poverty with no avenue to seek redress when avoidable errors by HHS and the SSA push them over the edge. This Essay will examine the inability of Medicare Part D enrollees to seek relief when agencies err or fail to comply with statutory provisions, and will suggest that, despite the benefits of Part D,[16] the MMA's creation of rights without remedies must be changed.

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11 *See, e.g.*, 42 C.F.R. § 423.890 (appeals involving payments to sponsors of retiree prescription drug plans).

12 *See infra* Part II.A.3.

13 *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 932, 117 Stat. 2066, 2399 (codified as amended at 42 U.S.C. § 1395ff(b)(1)–(2) (2006)).

14 This Essay will use the term "agency action" to refer both to affirmative decisions by agencies as well as to the failure to act. Administrative Procedure Act, 5 U.S.C. § 551(13) (2006) (defining "agency action" to include the "failure to act").

15 *See* 42 C.F.R. § 423.562(b) (granting enrollees the right "to have grievances between the enrollee and the Part D plan sponsor heard and resolved by the plan sponsor," "to a timely coverage determination by the Part D plan sponsor," "to request from the Part D plan sponsor an expedited coverage determination," and, if dissatisfied by a coverage determination, the right to several sequential levels of appeal including a redetermination by the plan sponsor and review by an independent review entity contracted by HHS, an administrative law judge, the Medicare Appeals Council, and ultimately a federal judge). Further, the regulations detailing timelines and other procedures for enrollees to assert their rights are framed in terms of appealing decisions and filing grievances against *plan sponsors*, not the agencies. *See* 42 C.F.R. §§ 423.564–.630.

16 This Essay will focus on the problems associated with Medicare Part D, but that is not to say that there have not been many significant benefits as well. *See, e.g.*, ROSENBAUM & FRANKLIN, *supra* note 5 (manuscript at 319) (explaining that legislation has, in fact, "made af-

Part I will provide a brief overview of Medicare. Part II will illustrate the inability of enrollees to seek redress when harmed by agency action or noncompliance with statutory provisions. Part III will conclude that Congress should fix these problems by relaxing the requirements imposed on beneficiaries seeking to remedy agency error, particularly when the agencies fail to resolve such errors in a timely fashion.

I. An Introduction to the Structure of Medicare

The Medicare program is divided into four main sections. Part A, financed through a mandatory payroll tax, provides automatic hospital insurance for people over sixty-five and to people who become disabled or have other statutorily-defined ailments.[17] Part B, a voluntary program financed though general revenues and individual premium payments, provides "supplementary medical insurance" to cover physician and outpatient services (including emergency room visits) as well as other medical care and supplies.[18] The statutes creating Parts A and B specifically define benefits and eligibility, and include provisions interpreting those definitions.[19] Both Parts are "administered by private federal entities known as Medicare administrative contractors" and "provide for a detailed process of administrative review of agency action."[20]

Unlike Parts A and B, however, Parts C and D are market-based programs that provide private insurance options to Medicare enrollees.[21] Part C, known as "Medicare Advantage" allows those eligible for Medicare Parts A and B to use their coverage to enroll in private health maintenance organizations that have contracted with the government to provide services.[22] Similarly, Part D allows those entitled to Part A benefits to purchase prescription drug plans from "private

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fordable prescription drugs far more available to the elderly, as indicated by a significant increase before and after passage of the law in the proportion of elderly Americans with some form of prescription drug coverage"). *But see id.* (stating that despite the benefits of the program in general, "the performance of the legislation in the case of low income Medicare beneficiaries has been, frankly, dismal").

17 *Id.* (manuscript at 297–98).

18 *Id*. (manuscript at 298).

19 *Id*. (manuscript at 303–04).

20 *Id*. (manuscript at 305).

21 *Id*. (manuscript at 307).

22 *Id*.

risk-bearing entities"[23] and provides subsidies to the poor to help pay for those plans.[24]

Those participating in the prescription drug program have the option of receiving their outpatient prescription drugs in two ways: (1) as part of a standalone Prescription Drug Plan ("PDP") or (2) through an already-existing Part C Medicare Advantage Drug Plan ("MA-PD").[25] Each of the PDP and MA-PD plans must offer a "'basic benefit' that consists of a formulary (i.e., a specified list of covered items) meeting certain standards . . . . Once this required level of coverage is offered, MA-PDs and PDPs may also offer supplemental benefits, called 'enhanced alternative coverage,' for an additional premium."[26] Part D plans have some flexibility to design the plan in terms of specific drug coverage and cost-sharing structures,[27] but all plans must still "establish and maintain procedures for grievances, coverage determinations, and appeals."[28]

At the same time, however, the MMA did not establish any provisions allowing beneficiaries to assert claims against the agencies rather than plan sponsors. To the contrary, the MMA incorporated provisions already present in the Social Security Act that attempt to explicitly strip courts of federal question jurisdiction under 28 U.S.C. § 1331.[29] Thus, even though the MMA imposes several affirmative obligations on HHS,[30] the same statute fails to create a right of action to enforce those obligations.

II. The Inability of Courts to Compel Agency Action or Provide Relief Under the MMA

It seems that Congress did almost everything possible to make administrative blunders a nightmare to fix. Although not a problem unique to Medicare, beneficiaries who are harmed by administrative errors are either completely barred from seeking redress in federal

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23 *Id*. (manuscript at 321).

24 *Id*.; *see also* 42 C.F.R. § 423.315(b), (d) (2007) (requiring HHS to make general subsidies as well as to make payments "for premium and cost sharing subsidies, including additional coverage above the initial coverage limit, on behalf of certain subsidy-eligible individuals").

25 *See* David H. Nayebaziz, *The Alphabet Soup That Is Medicare: The Case for Medicare Part D*, HEALTH LAW., Jan. 2007, at 11, 13.

26 ROSENBAUM & FRANKLIN, *supra* note 5 (manuscript at 322) (quoting Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4197 (Jan. 28, 2005)); *see also* 42 C.F.R. § 423.104.

27 *Id.* (citing Medicare Prescription Drug Benefit, 70 Fed. Reg. at 4197); *see also* 42 C.F.R. § 423.104(e)–(f).

28 *Id.* (citing 42 C.F.R. § 423.562(a)(1)).

29 28 U.S.C. § 1331 (2006); *see also infra* Part II.A.3.

30 *See infra* Part II.

courts or must first traverse miles of red tape before judicial review is even a possibility. Indeed, the MMA at least attempts to strip courts of jurisdiction under 28 U.S.C. § 1331, though courts have found ways to disregard the MMA in extraordinary cases.[31] Unlike Medicare Parts A and B and other programs such as Medicaid, Part D neither contains any explicit remedial provisions for agency noncompliance with the statute, nor have courts been willing to imply a cause of action.[32] Even constitutional due process claims have proven unavailing because of the high threshold to recovery in cases of agency action.[33] Overall, there are three significant impediments preventing Part D beneficiaries from obtaining relief when their rights are violated: (1) initial barriers to judicial review such as general administrative prerequisites to jurisdiction, the MMA's jurisdiction-stripping provisions, and standing; (2) the lack of an explicit or implicit cause of action in the statute; and (3) a very high threshold to prove a due process violation. This Part of the Essay addresses these three issues.

A. Threshold Bars to Relief: Standing and Jurisdiction

A significant obstacle to relief faced by individuals harmed by agency action is convincing a court it has jurisdiction to hear the case. One aspect of jurisdiction requires plaintiffs to establish they have standing by proving the agency (whether HHS or the SSA) caused an injury which is redressable by the court.[34] Even if plaintiffs have standing, however, they must still "present" any complaints to the agency and "exhaust" available administrative procedures for relief before courts will have jurisdiction to hear the case.[35] Further, Congress may elect, as it did in enacting the MMA, to explicitly strip courts of jurisdiction to review agency action, creating yet another barrier to relief.

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31 *See* 42 U.S.C. § 1395ii (2006); *see also infra* Part II.A.3.

32 *See infra* Part II.B.

33 *See, e.g.*, Machado v. Leavitt, 542 F. Supp. 2d 185, 195 (D. Mass. 2008) ("Courts have been careful to grant agencies substantial leeway in accomplishing the often complex and demanding tasks assigned to them, setting a high threshold for finding unconstitutional governmental delay.").

34 *See* Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992) (discussing the elements of standing); *see also* Fla. Audubon Soc'y v. Bentsen, 94 F.3d 658, 663–66 (D.C. Cir. 1996) (en banc) (explaining that a court only has jurisdiction to hear a claim if the plaintiffs establish standing).

35 *See infra* note 43 and accompanying text.

1. Standing

Many courts have been reluctant to find that plaintiffs suing to remedy errors caused by agency action have standing and have accordingly refused to grant relief. In *Long Term Care Pharmacy Alliance v. Leavitt*,[36] for example, the plaintiffs alleged that by failing to provide accurate and timely information regarding eligibility for Part D as required by the MMA, HHS caused many PDPs to improperly withhold co-payment reimbursements for drugs dispensed to indigent beneficiaries.[37] The court first noted that "nothing in the MMA establishes any benchmarks for data accuracy or mandates any time tables by which [HHS] must provide eligibility data."[38] In light of the Supreme Court's admonition that courts are not "empowered to enter general orders compelling compliance with broad statutory mandates,"[39] the court concluded that ordering HHS to be "*more* timely or *more* accurate" would exceed the court's authority.[40] Accordingly, the alleged injuries were not redressable by court action and the plaintiffs therefore lacked standing.[41] Although the case focused on injuries only indirectly caused by agency action—ultimately it was the PDPs that had harmed the plaintiffs by withholding reimbursements[42]—the case nevertheless illustrates one of the many jurisdictional bars to relief faced by plaintiffs harmed by agency error.

2. General Administrative Prerequisites to Jurisdiction: Presentment and Exhaustion

Part D beneficiaries seeking to recover from injuries caused by government action face several other administrative prerequisites to judicial review of agency action: "presenting" claims to the agency for

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36 Long Term Care Pharmacy Alliance v. Leavitt, 530 F. Supp. 2d 173 (D.D.C. 2008).

37 *Id.* at 175.

38 *Id.* at 184.

39 Norton v. S. Utah Wilderness Alliance, 542 U.S. 55, 66 (2004); *see also Lujan*, 504 U.S. at 568 (plurality opinion) ("[S]uits challenging, not specifically identifiable Government violations of law, but the particular programs agencies establish to carry out their legal obligations . . . [are], even when premised on allegations of several instances of violations of law, . . . rarely if ever appropriate for federal-court adjudication." (quoting Allen v. Wright, 468 U.S. 737, 759–60 (1984)) (alterations in original)).

40 *Long Term Care Pharmacy Alliance*, 530 F. Supp. 2d at 184–85.

41 *Id.* at 185.

42 Indeed, the court held that the plaintiffs independently lacked standing because they failed to satisfy causation. *See id.* at 180–83. The court's rationale is inapplicable, however, in cases where agency action *directly* affects Part D beneficiaries such as when the government improperly deducts insurance premiums from Social Security benefits. *See* Machado v. Leavitt, 542 F. Supp. 2d 185, 194 (D. Mass. 2008); *see also infra* Part II.B.

resolution—which is nonwaivable—and "exhausting" available administrative procedures—which is waivable at the option of the agency or the court.[43] Allegations that pursuing the administrative appeals process would be "futile" are almost always insufficient to overcome either of these requirements, even if constitutional claims such as due process violations are raised.[44] Although these requirements are designed to avoid undue judicial influence in agency affairs which courts often lack expertise to address,[45] they effectively serve as a bar because many beneficiaries have insufficient resources or knowledge of complicated administrative procedures to satisfy statutory requirements.

This problem was illustrated in *Action Alliance of Senior Citizens v. Leavitt*,[46] where the D.C. Circuit examined the scope of the presentment and exhaustion requirements. In a "monumental gaffe," the SSA erroneously refunded over $47 million in premiums to 230,000 Part D beneficiaries who had elected to have the SSA deduct their Part D premiums from their Social Security benefit checks.[47] When the Commissioner of the SSA attempted to recover the mistaken payments, the plaintiffs filed suit, asserting that they were entitled to written notice of their right to seek a hardship waiver from repayment of the erroneous refund and an oral hearing.[48]

In support of their claim, the plaintiffs first cited § 404(b) of the Social Security Act, prohibiting the government from recovering overpayments when the recipient is without fault and such action would

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43 *See* Indep. Living Ctr. of S. Cal., Inc. v. Leavitt, No. 2:06-cv-0435-MCE-KJM, 2006 U.S. Dist. LEXIS 44312, at *10 (E.D. Cal. June 29, 2006) ("The case law firmly establishes that 'virtually all legal attacks' implicating the Medicare statutory scheme must be routed, at least initially, through the Medicare administrative appeals process." (quoting Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 13 (2000))); *see also id.* at *10–11 (citing Heckler v. Ringer, 466 U.S. 602, 617 (1984)) (describing the presentment and exhaustion requirements).

44 *See* Mathews v. Eldridge, 424 U.S. 319, 328–29 (1976) (noting that initial claim presentment is "an essential and distinct precondition" for jurisdiction and is "purely jurisdictional in the sense that it cannot be waived by the Secretary in a particular case" (quotations omitted)); Weinberger v. Salfi, 422 U.S. 749, 766 (1975) ("[E]xhaustion . . . may not be dispensed with merely by a judicial conclusion of futility . . . .").

45 *See Indep. Living Ctr.*, 2006 U.S. Dist. LEXIS 44312, at *10 ("Exhaustion of administrative remedies is generally required in order to prevent 'premature interference with agency processes, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review.'" (quoting *Weinberger*, 422 U.S. at 765)).

46 Action Alliance of Senior Citizens v. Leavitt, 483 F.3d 852 (D.C. Cir. 2007).

47 *Id.* at 854.

48 *Id*. at 855.

either "defeat the purpose of [Social Security] or would be against equity and good conscience."[49] Before reaching the merits, however, the court first considered its jurisdiction in light of 42 U.S.C. § 405(h)[50], which provides that "[n]o action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 . . . to recover on any claim arising under [the Social Security Act]."[51]

This provision works in tandem with 42 U.S.C. § 405(g)[52], which allows for judicial review of agency action after the claimant has presented the case to the agency and the Secretary of HHS (or Commissioner of the SSA) has rendered a final decision—the final step in exhausting administrative remedies.[53] Acknowledging one plaintiff had contacted "Medicare and Social Security" after receiving the erroneous check and another had notified the Administrator of CMS that information provided to beneficiaries did not mention the right to seek a waiver, the court held that these attempts failed to satisfy the presentment requirement because neither specifically mentioned § 404(b).[54] Similarly, although "§ 405(h)'s jurisdiction-stripping provision (which explicitly mentions only §§ 1331 and 1346) does not in theory bar a court from exercising mandamus jurisdiction [under 42 U.S.C. § 1361] with respect to a Social Security claim," the court held that the existence of an alternative remedy—presenting the claim under § 404(b)—precluded mandamus.[55]

This first part of the court's analysis ignores the essential question: what rights do Part D enrollees harmed by agency error truly have if they are unable to seek relief when injured? One commentator has described the *Action Alliance* decision as "distressing" and argues that it demonstrates an "extremely narrow view of what constitutes presentment [that] deviates from Supreme Court authority and could establish a difficult procedural hurdle for plaintiffs to overcome in challenging the Secretary [of HHS]'s policies."[56] Indeed, in

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49 *Id.*; *see also* 42 U.S.C. § 404(b) (2006).

50 42 U.S.C. § 405(h).

51 *Action Alliance*, 483 F.3d at 856 (quoting 42 U.S.C. § 405(h)). The court noted that the reference to "any" officer of the United States includes the Secretary of HHS in addition to the Commissioner of the SSA. *Id.*

52 42 U.S.C. § 405(g).

53 *Action Alliance*, 483 F.3d at 856–57 (citing Mathews v. Eldridge, 424 U.S. 319, 328 (1976)).

54 *Id.* at 857.

55 *Id.* at 858 (citing Heckler v. Ringer, 466 U.S. 602, 620–21 (1984)).

56 SALLY HART & GILL DEFORD, CTR. FOR MEDICARE ADVOCACY, INC., MEDICARE LITI-

several other cases, courts have held that the presentment requirement should be interpreted liberally.[57] It is anomalous, therefore, that the court would find the plaintiffs' presentment attempts insufficient merely because the enrollees, who likely have little if any knowledge of Social Security's complex statutory framework, failed to mention the specific provision that allows for waivers of repayment. Further, it is counterintuitive that the court would require plaintiffs to cite the waiver provision in order to satisfy presentment when the very reason the plaintiffs were suing was because they did not receive notice of their right to seek that waiver. Although this particular claim arose due to improper action by the SSA rather than HHS, it still was the result of the MMA's integration of the SSA and HHS as part of Medicare Part D. Regardless of which agency was at fault, the court's decision illustrates the consistent pattern of denying (or at least unnecessarily delaying) Part D enrollees the ability to vindicate their rights by applying for a hardship waiver.

3. The MMA's Jurisdiction-Stripping Provisions

After holding that the plaintiffs had failed to satisfy presentment with respect to the *Social Security* waiver provision (and thus did not reach the merits of the claim), the *Action Alliance* court concluded on the merits that the *Medicare* waiver provision[58] did not provide a source of recovery for the plaintiffs.[59] The court again began with an examination of its jurisdiction, noting that § 405(h)'s bar to § 1331 federal question jurisdiction is expressly integrated into Medicare.[60] "Thus, general federal question jurisdiction is generally unavailable

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GATION: EXPERIENCES WITH COURTS PAST AND PRESENT 7 (2007), http://www.justicepartnership.org/ForgottenAmericansConference/Documents/LitigationPaper.ltrhd.pdf.

57 *See, e.g.*, Cares, Inc. v. Leavitt, No. S-05-2553 FCD GGH, 2007 U.S. Dist. LEXIS 50198, at *7 (E.D. Cal. July 11, 2007) (explaining that "[t]he presentment requirement should be construed liberally," and although mere reliance on an "initial application for benefits" is insufficient, filing a request for a hearing with the Social Security Department, even if ignored, satisfies presentment); Situ v. Leavitt, No. C06-2841 TEH, 2007 U.S. Dist. LEXIS 5903, at *6–7 (N.D. Cal. Jan. 12, 2007) (presentment requirement should be construed liberally and is satisfied by making a complaint through a phone call or other contact with the agency).

58 *See* 42 U.S.C. § 1395gg(c) (2006) ("There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made . . . with respect to an individual who is without fault . . . if such adjustment (or recovery) would defeat the purposes of title II [welfare] or title XVIII [Medicare] or would be against equity and good conscience.").

59 *See Action Alliance*, 483 F.3d at 860–61.

60 *Id.* at 858; *see also* 42 U.S.C. § 1395ii ("The provisions of . . . subsections (a), (d), (e), (h), (i), (j), (k), and (l) of [42 U.S.C. § 405], shall also apply with respect to [Medicare] to the same extent as they are applicable with respect to [Social Security] . . . .").

for 'any claim arising under' the Medicare Act—i.e., any claim that has its 'standing and . . . substantive basis' in that Act."[61] Despite this, however, the court explained "the Supreme Court has recognized an exception to this rule where application of § 1395ii 'would not lead to a channeling of review through the agency, but would mean no review at all.'"[62]

Turning to the question of whether any such review channels existed in the Medicare statute, the court concluded that because the MMA lacked any "affirmative grant of (channeled) jurisdiction over Medicare Part D claims of the type pressed by the Alliance,"[63] the exception announced by the Supreme Court required the court to retain jurisdiction under § 1331.[64] Indeed, the court noted that § 405(g)'s judicial review provision—which provided such a channel for review of the § 404(b) Social Security waiver claim discussed in the first portion of the opinion—was "conspicuously absent from the list of [Social Security] provisions incorporated into Medicare by § 1395ii."[65] Further, other provisions for judicial review in Medicare do not apply to claims arising under Part D,[66] and Part D's own limited judicial review provision only provides for review of claims against plan sponsors rather than the agency itself.[67] Despite finding an exception to retain jurisdiction, however, the court still dismissed the plaintiffs' claim on the merits: "by its plain terms, [the Medicare waiver provision] applies to overpayments to a provider of services for items or services furnished an individual[ ] [and] has nothing to do with erroneous refunds of Medicare premiums."[68]

Again, the court's decision appears to foreclose relief for Part D beneficiaries harmed through no fault of their own. This result undermines the very policy underlying the Social Security and Medicare

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61 *Action Alliance*, 483 F.3d at 858–59 (quoting Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 11 (2000)).

62 *Id.* at 859 (quoting Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 17 (2006)); *see also* Am. Chiropractic Ass'n v. Leavitt, 431 F.3d 812, 816 (D.C. Cir. 2005) (citing Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 22–23 (2006)) ("The exception applies not only when administrative regulations foreclose judicial review, but also when roadblocks practically cut off any avenue to federal court.").

63 *Action Alliance*, 483 F.3d at 859.

64 *See id.* at 858–59.

65 *Id.* at 859.

66 *Id*. at 859–60 (explaining that 42 U.S.C. § 1395ff(b)(1)(A) (2006) only covers claims arising under Medicare Parts A and B and that 42 U.S.C. § 1395w-22(g), which is incorporated into the Medicare Part D judicial review provision, only incorporates provisions pertaining to "coverage determinations by a Part C *private insurer*" (emphasis added)).

67 *Id.* (citing 42 U.S.C. § 1395w-104(h)(1) (2006)).

68 *Id.* at 860–61 (quotations omitted).

waiver provisions: that when the government mistakenly gives extra money to elderly individuals in dire need of assistance, especially when they have already spent the money and repayment would pose a substantial hardship, those people should at least have the ability to seek a reimbursement waiver.[69] But the statutory framework of the Social Security Act and the MMA, aided by a strict interpretation of the presentment requirement by the *Action Alliance* court, leaves enrollees harmed by agency mistakes with practically no remedy.

Thus, to return to the initial question posed: what rights do Part D participants truly have when the agencies charged with providing essential public health benefits err? Under the MMA, there are none (even if the court is able to find a reason to overcome the jurisdiction-stripping provision and apply § 1331), and the repayment waiver provision is substantively inapplicable. Under the Social Security Act, participants have the right to expend what may prove to be an inordinate amount of time and effort presenting a case and cutting through miles of bureaucratic red tape exhausting administrative remedies (even assuming one could figure out how to appeal) just to keep, on average, $215.[70]

B. The Absence of a Statutory Basis to Compel Agency Action

Just as the *Action Alliance* court held that the Medicare repayment waiver provision did not provide a statutory basis for redress when premiums were incorrectly refunded, the MMA similarly lacks express or implied remedial provisions which address other types of agency error. An egregious example of the MMA imposing affirmative obligations on HHS and the SSA without providing for a remedy for noncompliance concerns enrollees who elect to pay for prescription drug plans through deductions in Social Security benefits. Despite provisions in the MMA mandating that HHS provide accurate and timely information concerning the premiums and plan information to the SSA,[71] courts have read the statute as being essentially toothless.

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69 The court itself recognized the unjust result. *See id.* at 855 (noting that one plaintiff had, in fact, already spent the money and claimed she would be unable to repay it).

70 *See id.* at 854.

71 *See* 42 U.S.C. § 1395w-24(d)(3) (2006) (requiring that HHS provide the SSA with accurate information about the monthly premiums for enrollees electing to pay premiums through withholding money from Social Security benefits "by the beginning of each year" and that HHS properly update that information "periodically throughout the year"); *see also* 42 U.S.C. § 1395w-113(c)(1) (applying the same provision to PDP plans).

In *Machado v. Leavitt*,[72] the plaintiffs were all enrollees in Medicare Part D who

> ha[d] undisputedly endured months of futile, and no doubt maddening, attempts to remedy improper withholdings—contacting the SSA, CMS, and their plan providers on numerous occasions only to be met with disclaimers of responsibility or false reassurances that the problem would soon be corrected. For most of them, Social Security benefits are their only source of income and the amounts erroneously withheld from those funds represent a significant deprivation and cause substantial hardship.[73]

In analyzing whether there was any basis to grant the plaintiffs' request for an injunction directing HHS and the SSA to correct the premium withholding mistakes, the court looked first to the regulatory scheme set out in the MMA.[74] The court observed that the only explicit requirement imposed on HHS in the MMA is to provide information about the enrollees to the SSA at the beginning of the year and to periodically update that information.[75] It further noted that the MMA sets no deadlines for HHS to correct premium withholding errors or refund erroneously withheld benefits.[76] These minimal requirements, the court concluded, implied that "[t]he communication and updating obligations . . . seem designed, not to protect beneficiaries, but merely to facilitate the basic operation of this vast program[ ] [and that] [i]t is hard to see how these implementing provisions can be construed to constitute a vehicle for redress of inevitable errors and delay."[77]

In other words, although the statute imposes an affirmative requirement on HHS to transmit information to the SSA, the *de minimis* nature of the regulations, in the court's opinion, suggests that a failure to comply with the provisions does not establish a valid cause of action. Relying on Supreme Court precedent instructing courts to avoid entering "'general orders compelling compliance with broad statutory mandates,'"[78] the court reasoned that any court order re-

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72 Machado v. Leavitt, 542 F. Supp. 2d 185 (D. Mass. 2008).

73 *Id.* at 189. Two plaintiffs also had premiums only intermittently withheld from their Social Security benefits, resulting in bills from their insurers which forced them to make direct payments. *Id.* at 191.

74 *Id.* at 192.

75 *Id.*

76 *Id.*

77 *Id.*

78 *Id.* at 193 (quoting Norton v. S. Utah Wilderness Alliance, 542 U.S. 55, 66 (2004)).

quiring HHS to reduce error and correct mistakes more promptly would unduly interfere with agency discretion and resource allocation.[79] Thus, despite imposing affirmative obligations on HHS and the SSA, the MMA leaves Part D enrollees harmed by agency noncompliance with no avenue to seek a remedy.

Turning to the plaintiffs' assertion that the premium withholding errors violated 42 U.S.C. § 407(a)'s prohibition on transferring or assigning Social Security benefits, the court again emphasized that Congress must have known that there would be errors in implementing Medicare Part D and noted the absence of any explicit remedial provisions for noncompliance with the statutory provisions.[80] This absence, the court concluded, clearly indicated that Congress at no point intended to allow enrollees harmed by agency error to be able to seek relief under 42 U.S.C. § 407(a), even if the error was "gross and accompanied by inexcusable delay in its correction."[81] Again, Congress had apparently created a right without providing for a remedy.

Interestingly, the court failed to mention, much less recognize a right of action in, 42 U.S.C. § 404(a)(1)(B)'s requirement that the Commissioner of Social Security make payment of any amounts improperly withheld.[82] Regardless of the reason for this omission, this again illustrates how the MMA imposes obligations on government agencies to provide benefits to enrollees without allowing those harmed by noncompliance to seek redress.

Thus, enrollees are prevented from seeking relief when harmed by agency action not only on the basis of preliminary jurisdictional hurdles such as standing, presentment, and exhaustion, but also because the MMA did not create express (and courts have not implied) remedial provisions. Those receiving premium overpayments from the government have no right under Part D to seek a repayment waiver and may seek a waiver under the Social Security Act only if they are familiar enough with the statutory framework to cite the specific waiver provision.[83] Further, those who do not receive the support to which they are entitled because of delays in transmitting informa-

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79 *See id.*

80 *See id.* at 194 ("Congress had to have known that the mechanism for implementing Medicaid Part D premium withholding would, like all things human, sometimes fail to operate flawlessly. Errors would be inevitable, and if Congress had meant them to subject the defendant agencies to statutory liability it would have recognized this possibility explicitly.").

81 *Id.*

82 *See* 42 U.S.C. § 404(a)(1)(B) (2006).

83 *See* Action Alliance of Senior Citizens v. Leavitt, 483 F.3d 852, 857–61 (D.C. Cir. 2007).

tion are unable to enforce the very provisions that are designed to avoid such problems.[84]

C. The (Unlikely) Possibility of Due Process as a Basis to Compel Agency Action

Despite rejecting any statutory basis to compel HHS and the SSA to prevent premium withholding errors through more accurate and timely transmission of information, the *Machado* court did not leave the enrollees totally helpless. Instead, the court recognized that the substantial hardship endured by the enrollees might be so extreme as to constitute a deprivation of due process under the Constitution.[85] Although this left open the possibility that a court could hear claims, the court cautioned that because "[c]ourts have been careful to grant agencies substantial leeway in accomplishing the often complex and demanding tasks assigned to them [and have thus set] a high threshold for finding unconstitutional governmental delay,"[86] the plaintiffs might have substantial difficulty in alleging sufficient facts to demonstrate a deprivation of due process.[87] And, even if the plaintiffs could establish a due process violation, "the crafting of an appropriate judicial remedy for unconstitutional delay would require careful consideration."[88] The court also noted that a judicial reluctance to find due process violations is especially appropriate when, as is true with Medicare, "an agency's delay seems to have been result of the demands of implementing a national administrative scheme."[89] Although the court suggested that the agency might easily be able to correct the premium withholding errors, thereby militating in favor of finding a due process violation, it ultimately concluded that this was a question of fact that could not be resolved on the pleadings alone and denied the defendant's motion to dismiss on that issue.[90]

Despite arguably encouraging language in *Machado*, however, plaintiffs seeking to prevail on a due process claim face a difficult uphill battle. First, "[i]t has long been held that the due process clauses of both the Fifth and Fourteenth Amendments are intended to prevent governmental abuse of power, and 'generally confer no affirma-

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84 *See Machado*, 542 F. Supp. 2d at 192–94.

85 *See id.* at 194.

86 *Id.* at 195.

87 *See id.* at 196.

88 *Id.* at 195 n.4.

89 *Id.* at 196.

90 *Id.* at 196–97.

tive right to governmental aid.'"[91] Thus, it is unlikely that, standing alone, a relatively short-term reduction in Social Security benefits due to agency error would provide an adequate basis for a due process challenge even if the error caused a substantial hardship for the beneficiary.

Second, as noted above,[92] the exhaustion requirement "applies with full force to . . . beneficiaries seeking to raise constitutional claims."[93] Although there is no specific administrative appeals process available in Medicare Part D for beneficiaries to "exhaust," this principle would apply to all suits brought under the Social Security Act, which does have such procedures.[94] Indeed, in *Weinberger v. Salfi*,[95] the Court held that a challenge to the denial of benefits, though having roots in the Constitution, was still a claim "arising out of" the Social Security Act and thus subject to the jurisdiction-stripping provisions in § 405(h).[96] The Court reasoned that any claim, such as the one at issue, in which "both the standing and the substantive basis" for the claim is found in the Social Security Act comes within the purview of § 405(h) and is thus subject to presentment and exhaustion requirements.[97] Because the Supreme Court has extended this principle to Medicare as well,[98] it is hard to imagine a claim against an agency for noncompliance with the *Medicare statute* that would not find "both its standing and the substantive basis" *in that statute*.

Finally, even if a plaintiff could overcome the jurisdictional hurdles, satisfy the high threshold to establish a due process claim, and convince the court that it possessed the *power* to provide a remedy, it is still unlikely that a court would be able to fashion an appropriate remedy as the Supreme Court has repeatedly warned courts to avoid making "general orders compelling compliance with broad statutory mandates."[99] Thus, due process claims provide an unlikely avenue through which injured enrollees may seek relief, once again leaving beneficiaries unable to seek relief when harmed by agency action.

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91 Indep. Living Ctr. of S. Cal., Inc. v. Leavitt, No. 2:06-cv-0435-MCE-KJM, 2006 U.S. Dist. LEXIS 44312, at *23 (E.D. Cal. June 29, 2006) (quoting DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 196 (1989)).

92 *See supra* note 44 and accompanying text.

93 *Indep. Living Ctr. of S. Cal.*, 2006 U.S. Dist. LEXIS 44312, at *10 (citing Weinberger v. Salfi, 422 U.S. 749, 763–64 (1975)).

94 *See* 42 U.S.C. § 405(b), (g) (2006).

95 Weinberger v. Salfi, 422 U.S. 749 (1975).

96 *Id.* at 760–61.

97 *Id.*

98 *See* Heckler v. Ringer, 466 U.S. 602, 615–16 (1984).

99 *See, e.g.*, Norton v. S. Utah Wilderness Alliance, 542 U.S. 55, 66 (2004).

III. Proposal

The significant problems highlighted by these cases demonstrate the need to create a fast-track procedure to grant beneficiaries harmed by agency action the opportunity to seek prompt relief. This Part of the Essay proposes that Congress amend the MMA by relaxing jurisdictional requirements (i.e., presentment and exhaustion) and creating an express cause of action for minor, easily-fixable claims arising under Part D or, in the case of premium issues, the Social Security Act. This legislation could be as simple as a two-part provision that (a) mandates relaxed presentment standards to conform with most cases (thereby formally rejecting the *Action Alliance* court's analysis), and (b) automatically waives exhaustion requirements if the agency at issue does not fix simple errors such as those in *Action Alliance* and *Machado* promptly (e.g., within 30 days) to allow prompt judicial review if necessary.

Indeed, Congress already included fast-track procedures in the MMA for remedying agency errors in other contexts. For example, Congress amended existing review procedures with respect to benefits claims under Medicare Parts A and B to create an expedited judicial review procedure.[100] That provision instructs the Secretary of HHS to establish procedures which allow service providers or individuals entitled to benefits to obtain expedited review when the designated review entity does not have authority to decide a question of law and there are no material facts in dispute.[101] The review entity is required to make a determination within sixty days or the injured party may file a civil suit in court.[102]

A provision allowing for faster resolution of *factual* agency errors (such as erroneous premium refunds or deductions) are arguably easier to address and would be even less of a burden on the courts. Whereas agencies might have an incentive to expend resources litigating ambiguous or complex legal provisions to clarify the state of the law, there is no reason for agencies to litigate their own factual errors when they can be easily fixed by altering an incorrect data entry. This legislation would create a quick and definite timeframe for agencies to correct minor, easily-fixable errors resulting from erroneous transmis-

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100 *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 932, 117 Stat. 2066, 2399 (codified as amended at 42 U.S.C. § 1395ff(b)(1)–(2) (2006)).

101 42 U.S.C. § 1395ff(b)(2) (2006).

102 *Id.* § 1395ff(b)(2), (c).

sions of information.[103] Further, it would still accomplish Congress's goal of channeling review through the agencies before the courts and would give courts the benefit of agency expertise when needed.[104] And, most importantly, those with meager resources would not be forced to wait upwards of a year to receive a relatively modest amount of money on which to live.[105]

Ostensibly, the reason for precluding review of Part D claims such as those discussed in *Machado*, *Action Alliance*, and *Long Term Care Pharmacy Alliance* is that granting review could overly burden courts and prevent them from realizing the benefits of agency expertise.[106] But a court would ultimately have jurisdiction to decide cases anyway if a beneficiary presented and exhausted claims with the agency or if review was otherwise unavailable.[107] In other words, because there are no specific procedures in place to review premium refund and withholding errors, and because these errors will at some point amount to a due process violation, courts theoretically already have jurisdiction to hear these cases.[108] Thus, creating an expedited review procedure will not unduly burden the courts or agencies, just shorten the amount of time the agencies have to remedy minor errors.

Conclusion

As the foregoing analysis suggests, the MMA has utterly failed to provide relief for Part D enrollees harmed by agency action. Al-

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103 Indeed, the *Machado* court suggested that correcting the premium-withholding errors would be a simple task. *See* 542 F. Supp. 2d at 196.

104 *See* Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 13 (2000) ("[C]hanneling . . . legal attacks through [agencies] . . . assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts . . . ." (quotations omitted)).

105 *See Machado*, 542 F. Supp. 2d at 189–90 (explaining that the premium amounts at issue were less than $60 per month per individual).

106 *Cf. Ill. Council on Long Term Care*, 529 U.S. at 13 (noting that "[i]n the context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations, any of which may become the subject of a legal challenge in any of several different courts, paying" the price of limited case-by-case judicial review "may seem justified").

107 *See id.* at 19 (holding that § 405(h), incorporated into Medicare by § 1395ii, cannot serve to completely bar jurisdiction when there is no available review procedure); *see also supra* notes 43–44 and accompanying text (discussing presentment and exhaustion requirements); *supra* note 62 and accompanying text (discussing the exception to provisions that bar jurisdiction in federal courts).

108 *See, e.g.*, Action Alliance of Senior Citizens v. Leavitt, 483 F.3d 852, 858–60 (D.C. Cir. 2007) (claims for waiver of repayment when government improperly refunded premiums); *Machado*, 542 F. Supp. 2d at 194 (claims that erroneous premium withholdings constitute a constitutional due process violation).

though there are detailed appeals processes for claims by enrollees directed at *plan sponsors* and for claims by plan sponsors against agencies, Part D neither incorporates the Social Security Act's general judicial review provisions nor does it establish its own provisions to allow enrollees to challenge *agency* action. Many of the nation's neediest individuals have been denied their Social Security benefits due to easily fixable computer glitches and incompatible information transmission protocols. Others, who were—through no fault of their own—erroneously refunded prescription drug plan premiums are unable to seek a hardship waiver at all under the MMA and may only seek relief using Social Security provisions after completing several levels of administrative review. Problems in implementing the MMA, exacerbated by many jurisdictional, statutory, and constitutional obstacles to relief, have essentially created a system of rights without remedies in violation of bedrock principles of our legal structure.[109] The most efficient and practical solution is to amend the MMA to grant a specific cause of action for enrollees harmed by agency action and relax the jurisdictional requirements for judicial review if agencies fail to correct easily-fixable mistakes. Without such a mechanism, many more of this nation's poor and elderly will remain at risk.

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109 *See* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 163 (1803) (Marshall, J.).