E-FILED

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	CV 13-8728-GHK (CWx)	Date	August 5, 2014
Title	*Stanley H. Epstein v. Sylvia M. Burwell*		

Presiding: The Honorable	**GEORGE H. KING, CHIEF U. S. DISTRICT JUDGE**	
Beatrice Herrera	N/A	N/A
Deputy Clerk	Court Reporter / Recorder	Tape No.

Attorneys Present for Plaintiffs:	Attorneys Present for Defendants:
None	None

Proceedings: **(In Chambers) Order re:** Defendant's Motion to Dismiss for Lack of Subject Matter Jurisdiction [Dkt. Nos. 31, 32]

This matter is before us on Defendant's Motion to Dismiss for Lack of Subject Matter Jurisdiction ("Motion"). We have considered the papers filed in support of and in opposition to the Motion and deem this matter appropriate for resolution without oral argument. L.R. 7-15. As the Parties are familiar with the facts, we will repeat them only as necessary. Accordingly, we rule as follows:

I. Background

On November 26, 2013, Plaintiff Stanley Epstein ("Epstein") filed a Class Action Complaint against the Secretary of Health and Human Services ("the Secretary")[1] challenging her administration of Medicare Part D claims that straddle two different coverage stages. The Secretary now moves to dismiss Epstein's Complaint on three grounds: (i) Epstein lacks Article III standing; (ii) his claim does not meet the Medicare statute's amount in controversy requirement; and (iii) there is no mandamus jurisdiction.

A. Statutory Background

In 2003, Congress established the most recent addition to Medicare: Part D. 42 U.S.C. § 1395w-101, *et seq.* Part D allows Medicare beneficiaries to obtain federally-subsidized drug benefits through private insurers ("Sponsors"). In addition to monthly premiums and a deductible, each time a Part D enrollee purchases a drug, he is responsible for paying either a fixed-dollar amount ("copayment") or a percentage of the cost ("coinsurance").[2] The amount of an enrollee's payment depends on which of

[1] Pursuant to Fed. R. Civ. P. 25(d), Sylvia M. Burwell, the current Secretary of Health and Human Services, is automatically substituted as named defendant for Kathleen Sebelius.

[2] Under his plan, Epstein pays a fixed-dollar copayment, rather than coinsurance, with the amount of his copayment varying depending on the drug purchased.

three coverage stages he is in. When the enrollee's total prescription costs for the year are below the "initial coverage limit," he is in the Initial Coverage Stage. During this stage, the enrollee and the Sponsor share the cost of prescription drugs, with the enrollee typically paying 25% of his prescription costs.[3] *See* 42 U.S.C. § 1395w-102(b)(2). The enrollee enters the Catastrophic Coverage Stage when his total prescription costs exceed the "annual out-of-pocket threshold." During this final stage, the enrollee pays very little of his prescription costs. *See* 42 U.S.C. § 1395w-102(b)(4). Between these two stages is a gap in insurance coverage colloquially known as the Part D "donut hole."[4] When the enrollee is in the Coverage Gap Stage, he must pay 100% of his prescription costs (in addition to his monthly premiums).[5] This case involves the methodology used to administer "straddle claims"—i.e. prescription drug purchases that straddle two different coverage stages.

B. Factual Background

In 2010, Epstein was enrolled in a Part D plan administered by Humana. (Compl. ¶ 31). On December 17, 2010, he purchased a covered prescription drug called Actonel. (*Id.* ¶ 32). At the time of this purchase, he had incurred $2,746.67 in prescription drug costs in 2010, meaning he was $83.33 below the initial coverage limit. (*Id.* ¶ 34). Because the Actonel cost $334.92, his December 17 purchase pushed him into the donut hole.

During the Initial Coverage Stage, Epstein's copay for the Actonel was $187.50. (*Id.*). Accordingly, if his entire Actonel purchase had been made during the Initial Coverage Stage, Humana's share of the costs would have been $147.42 (i.e. $334.92 – $187.50 = $147.42). (*Id.*). Epstein contends

---

[3] Copayments during this stage must be "actuarially equivalent . . . to an average expected payment of 25 percent." 42 U.S.C. § 1395w-102(b)(2)(A)(ii). "Many Medicare drug plans place drugs into different 'tiers' on their formularies," and "[d]rugs in each tier have a different cost." Medicare.gov, What Drug Plans Cover, http://www.medicare.gov/part-d/coverage/part-d-coverage.html. "A drug in a lower tier will generally cost [enrollees] less than a drug in a higher tier." *Id.*; *see also* Compl. Ex. A at 42-44.

[4] In 2010, when Epstein incurred his costs, the initial coverage limit was $2,830, the out-of-pocket threshold was $4,550, and the Coverage Gap Stage existed between $2,830 and $4,550. *See* Centers for Medicare & Medicaid Services (CMS), *CMS Announces 2010 Payment Information for Part C Medicare Advantage Plans and Part D Prescription Drug Plans* (Apr. 6, 2009), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2009-Fact-Sheets-Items/2009-04-06.html.

[5] The Affordable Care Act, enacted in 2010, altered this scheme so that current enrollees in the donut hole will pay less than 100% of their costs. It also closes the coverage gap altogether as of 2020 so that enrollees will pay 25% of their costs (or the actuarial equivalent of an average expected payment of 25%) until they enter the Catastrophic Coverage Stage. *See* 42 U.S.C. §§ 1395w-102(b)(2)(C)(ii)(III), (b)(2)(D)(ii)(VI).

that Humana should have paid this $147.42-share for his straddle claim because he was still in the Initial Coverage Stage when he made the purchase (the "Initial Stage Approach"). (*Id.* ¶ 35). Alternatively, Epstein contends that the Medicare statute requires that Humana at least pay its pro rata share of all costs beneath the initial coverage limit (the "Pro Rata Approach"). (*Id.* ¶ 34). Under the Pro Rata Approach, Humana would have paid its 44% share[6] of the $83.33 he paid for the Actonel, $36.66, before he reached the $2,830 initial coverage limit. (*Id.*).

When Epstein submitted his insurance claim for the Actonel to Humana, it denied the claim entirely. Because Epstein's $187.50 copay for the Actonel had pushed him into the donut hole, Humana concluded that Epstein was not entitled to any benefits. (*Id.* ¶ 32). In other words, Humana had counted Epstein's copay towards the initial coverage limit before determining its share of the cost. This is the "Copay-First Approach" to straddle claims.

Upon Humana's denial of his claim, Epstein exhausted his administrative remedies. First, Epstein sought a redetermination from Humana, which was denied. (*Id.* ¶ 36). Then, Maximus, an independent review entity ("IRE") upheld Humana's decision. (*Id.*). On December 21, 2011, Epstein requested a hearing before an ALJ. (*Id.*) Because Epstein sought only $36 under his Pro Rata Approach, the ALJ dismissed Epstein's claim as beneath the $130 amount in controversy requirement for an ALJ hearing. (*Id.* ¶ 36). The Medicare Appeals Council ("MAC") reversed this decision because Epstein could meet the $130 threshold under the Initial Stage Approach. (*Id.* ¶ 39). On remand, the ALJ adopted the Initial Stage Approach and ordered Humana to pay Epstein $147.42. (*Id.*). Humana sent Epstein a check for this amount on July 27, 2013. (Rausch Decl. ¶ 9).

The MAC then reviewed the ALJ's decision. (Compl. Ex. D at 1). It ultimately decided that the Copay-First Approach is the correct method for resolving Epstein's straddle claim and that Humana therefore rightly rejected his claim. (*Id.* at 9). Notwithstanding this decision, Humana has not attempted to recoup the $147.42 it sent to Epstein. (Rausch Decl ¶ 11). Nor does it intend to do so in the future. (*Id.*).

Epstein filed a class action complaint on November 26, 2013 challenging the Secretary's policy of resolving straddle claims by adding the enrollee's copay for a prescription drug to the enrollee's cumulative drug costs before determining whether the enrollee is in the Initial Coverage Stage or the donut hole. Epstein contends that this policy contravenes the Medicare statute's requirement that Sponsors pay a share of enrollees' prescription costs until enrollees reach the initial coverage limit. He argues that the Secretary's Copay-First Approach to straddle claims improperly deprives enrollees of Part D benefits because it allows Sponsors to "evade their obligation to pay their proper share of covered prescription drug costs" during the Initial Coverage Stage and "artificially lower[s] the Coverage Gap threshold." (Compl. ¶¶ 7-8).

[6] Humana's $147.42-share for the Actonel is 44% of its $334.92 cost.

II. Legal Standard

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(1) challenges the jurisdiction of the court over the subject matter of the action. As a court of limited jurisdiction, federal courts possess only those powers authorized by statute or the Constitution. *See Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994). Although Congress has granted federal courts jurisdiction to hear most cases arising under federal law, *see* 28 U.S.C. § 1331, it has strictly limited our jurisdiction over actions arising under the Medicare statute. *See* 42 U.S.C. § 1395ii (incorporating 42 U.S.C. § 405(h) into the Medicare statute); *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 12-13 (2000). "[U]nder section 405(h) . . . the exercise of federal jurisdiction is circumscribed by, and limited to, whatever jurisdiction exists under the specific Medicare provisions." *Athens Community Hosp., Inc. v. Schweiker*, 686 F.2d 989, 992-93 (D.C. Cir. 1982). The plaintiff, as the proponent of federal jurisdiction, bears the burden of establishing compliance with the Medicare statute's jurisdictional requirements (or establishing some other basis for subject matter jurisdiction). *See Kokkonen*, 511 U.S. at 377.

III. Discussion

A. Standing

As an initial matter, the Secretary asserts that Epstein lacks Article III standing because Humana sent him a check for the $147 he sought for his 2010 straddle claim. "Standing is a threshold matter central to our subject matter jurisdiction. We must assure ourselves that the constitutional standing requirements are satisfied before proceeding to the merits." *Bates v. United Parcel Serv., Inc.*, 511 F.3d 974, 985 (9th Cir. 2007). Standing requires three elements: injury in fact, causation, and redressability. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). To satisfy the injury-in-fact element, the plaintiff must have suffered an injury that is both (i) concrete and particularized, and (ii) actual or imminent, not conjectural or hypothetical. *Id.*

"[A] plaintiff is presumed to have constitutional standing to seek injunctive relief when [the plaintiff] is the direct object of [government] action challenged as unlawful." *L.A. Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 655 (9th Cir. 2011). Here, Epstein clearly was the object of the governmental action at issue—the Secretary affirming the denial of his 2010 straddle claim. The Secretary's allegedly unlawful Copay-First Approach to straddle claims directly affects Epstein, who has straddle claims on an annual basis. (*See* Epstein Decl. ¶¶ 3-4).

That Humana has not sought to recover the $147 to which it was legally entitled after the MAC reversed the ALJ does not alter this analysis.[7] Although Epstein may no longer have an economic or

[7] If, on the other hand, the MAC had determined that Epstein was legally entitled to the $147 and that Humana's denial of his straddle claim was unlawful, Epstein would no longer have any standing to seek judicial review. *See Haro v. Sebelius*, 747 F.3d 1099, 1106, 1110 (9th Cir. 2013).

pecuniary injury stemming from his 2010 straddle claim, "[i]t is well established that less tangible forms of injury, such as the deprivation of an individual right conferred by statute, may be sufficiently particularized and concrete to demonstrate injury-in-fact." *L.A. Haven Hospice*, 638 F.3d at 656. The Medicare statute confers a right to benefits. Epstein alleges that the Secretary's approach to straddle claims impermissibly constricts this statutorily guaranteed right. It is sufficient for Article III standing purposes that Epstein alleges that the Secretary used a method to resolve his straddle claim that contravenes the Medicare statute.[8] *See id.* The legal right asserted by Epstein is the right to have the coverage stages applied in a manner consistent with the Medicare statute, "not the right to the return of a certain amount of money." *See id.* (quoting *Lion Health Servs., Inc. v. Sebelius*, 689 F. Supp. 2d 849, 855 (N.D. Tex. 2010)); *see also Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 53 (D.D.C. 2010) (explaining that "apart from any economic harm caused by the application of the challenged regulation," the application of an unlawful regulation itself constitutes an injury-in-fact). Because the MAC's final decision endorsing the Copay-First Approach impacts Epstein's ongoing personal rights under the Medicare statute, Epstein has a sufficient personal stake to appeal the MAC decision and pursue declaratory and injunctive relief. *See L.A. Haven Hospice*, 638 F.3d at 655. Accordingly, Epstein has Article III standing to challenge the Secretary's method for resolving straddle claims. *See, e.g.*, *Am. Petroleum Inst. v. Johnson*, 541 F. Supp. 2d 165, 176 (D.D.C. 2008) ("[S]tanding is . . . self-evident when the plaintiff is a regulated party."). We therefore now turn to whether we have subject matter jurisdiction under the Medicare statute.

B. Amount in Controversy

After satisfying the administrative exhaustion prerequisites, an enrollee who has a dispute with his Part D plan can seek judicial review under 42 U.S.C. § 405(g), "the sole avenue for judicial review for all claims arising under the Medicare Act." *Heckler v. Ringer*, 466 U.S. 602, 615 (1984) (internal quotation marks and alterations omitted). To be eligible for such judicial review, the enrollee's claim must first satisfy Medicare Part D's amount in controversy threshold. *See* 42 U.S.C. § 1395w-104(h) (incorporating 42 U.S.C. § 1395w-22(g)(4)-(5)); *Mitchell v. Occidental Ins., Medicare*, 619 F.2d 28, 30 (9th Cir. 1980). In 2013, when Epstein filed his Complaint, the amount in controversy threshold was $1400. *See* 77 Fed. Reg. 59618, 59619 (Sept. 28, 2012). "When a Medicare plaintiff is unable to meet the statutorily-prescribed jurisdictional amount, jurisdiction is lacking and dismissal is appropriate." *Froehlich v. Leavitt*, 2008 WL 2397473, at *7 (E.D. Cal. June 11, 2008) (quoting *Schwartz v. Medicare*, 832 F. Supp. 782, 790 (D.N.J. 1993)); *see also, e.g.*, *Acquisto v. Secure Horizons ex rel. United Healthcare Ins. Co.*, 504 F. App'x 855, 856 (11th Cir. 2013).

Here, Epstein does not dispute that the claim he pursued through the administrative appeals process is valued, at most, at $147. He contends that he nevertheless satisfies the $1,400 amount in

[8] Because Epstein continues to challenge the Secretary's final decision, *Haro*, upon which the Secretary relies, is readily distinguishable. (Jt. Br. 44). In stark contrast to Epstein, who vigorously contests the Secretary's straddle-claim methodology and continues to feel its effects, the *Haro* plaintiff "did not challenge Medicare's final reimbursement calculation" and had no continuing interest in the Secretary's collection practices, as they did not threaten to cause her future injury. *Id.* at 1109, 1110.

controversy requirement because: (i) the Medicare statutory and regulatory scheme permits him to aggregate his claim with those of absent class members; and (ii) his individual claim for declaratory and injunctive relief is worth more than $1,400, as he will have a straddle claim worth approximately $116 every year for the rest of his life.

1. Aggregation of Class Claims

Epstein first argues that 42 U.S.C. § 1395ff(b)(1)(E)(ii) and 42 C.F.R. § 405.1006 allow him to aggregate his claim with the claims of absent class members to satisfy the amount in controversy. The Secretary maintains that Epstein's reliance on these provisions is misplaced because they apply only to Medicare Part A and Part B claims, not to Part D claims. And even if these provisions were applicable to Epstein's Part D claim, the Secretary asserts that they would be of little help to Epstein because, like the Part D aggregation provision, they only permit claims to be aggregated for judicial review if they have first been aggregated at the ALJ stage of administrative review.

Although the Parties spend substantial space in their briefs debating the first issue—the extent to which the Part A and Part B aggregation provisions apply to Part D claims—we need not resolve it here. Even if we assume that the Part A and Part B aggregation provisions upon which Epstein relies could apply to his Part D claim, these provisions would not permit him to aggregate putative class members' claims for the first time at this stage of the proceedings.[9] In order for multiple claims to be aggregated pursuant to these provisions, appellants must expressly request aggregation before the ALJ, and the ALJ must determine that other aggregation criteria have been satisfied. *See* 42 C.F.R. § 405.1006(e)-(f).[10]

Epstein insists that the Part A and Part B regulations permit aggregation for the first time in district court. (Jt. Br. 23-24). As support for this proposition, Epstein highlights language in § 405.1006(a) providing that claims may be aggregated to "meet the amount in controversy requirement

[9] The anti-aggregation doctrine disallows aggregation for purposes of satisfying a statute's amount in controversy requirement unless the aggregation is expressly authorized by a statute or interpretive regulation. *Urbino v. Orkin Servs. of Cal.*, 726 F.3d 1118, 1122 (9th Cir. 2013). While CAFA provides such authorization, Epstein does not (and cannot) assert CAFA jurisdiction in this case because the United States cannot be sued under § 1332. *United States v. Park Place Associates, Ltd.*, 563 F.3d 907, 919 n.7 (9th Cir. 2009). Nor can federal agencies or officials. *See, e.g.*, *Am. National Bank & Trust Co. v. Sec. of Housing & Urban Development*, 946 F.2d 1286, 1291 (7th Cir. 1991).

[10] Part D's aggregation provision, 42 C.F.R. § 423.1970(c), likewise makes plain that aggregation must occur at the ALJ stage. Part D claims may only be aggregated before an ALJ if the claims: (i) have already been considered by an IRE, (ii) meet the applicable filing requirements, and (iii) involve the same prescription drug. 42 C.F.R. § 423.1970(c)(2). Finally, the request for ALJ hearing must "list[] all of the appeals to be aggregated." *Id.*

for an ALJ hearing or judicial review."[11] Epstein overstates the significance of this provision. It says nothing whatsoever about whether claims that were not aggregated before the ALJ can be aggregated in the first instance before the district court. Instead, it merely provides that properly aggregated claims may remain aggregated to meet the amount in controversy requirement for judicial review. Moreover, interpreting this provision as authorizing aggregation for the first time in court makes little sense when considered in the full context of § 405.1006. Epstein's interpretation would render the aggregation criteria set forth in § 405.1006(e)-(f) a practical nullity. Under Epstein's reading, unless a claimant could not satisfy the mere $130 amount in controversy requirement for an ALJ hearing, he would undoubtedly opt to wait to aggregate at the judicial review stage, when, according to Epstein, there would be no aggregation prerequisites whatsoever. Epstein offers no explanation as to why § 405.1006 would allow appellants to disregard its explicit aggregation prerequisites simply because they waited to aggregate claims at the last possible moment. Because Epstein has offered no reasonable alternative interpretation, we adopt the Secretary's view that the Medicare regulations require that claims be aggregated during the administrative process.[12]

This interpretation of the aggregation provisions is also consistent with § 405(g)'s broad jurisdictional bar against claims that have not been presented for administrative review. *See Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) ("[The Medicare Act] demands the 'channeling' of virtually all legal attacks through the agency . . . ."); *see also Haro*, 747 F.3d at 1112-13 (holding that before plaintiffs can assert a claim arising under the Medicare Act in federal court, the plaintiffs must have presented precisely the same claim to the agency). The Supreme Court has explained that while this channeling requirement may make it more difficult for individuals to obtain judicial review, it "assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by individual courts applying 'ripeness' or 'exhaustion' exceptions case by case." *Ill. Council*, 529 U.S. at 13.

---

[11] Epstein also cites language in § 405.1006(c) that a party "must meet the amount in controversy requirements of this subpart at the time [he] requests judicial review." It is unclear why he thinks this subsection supports his argument, as it does not address aggregation procedures at all. If anything, this language seems to support the Secretary's argument that aggregation must occur during the administrative process. If claims have not been aggregated pursuant to the procedures outlined in § 405.1006(e)-(f), then the amount in controversy requirements of § 405.1006(c) cannot fairly be construed as having been satisfied "at the time [the party] requests judicial review."

[12] Moreover, we defer to an agency's interpretation of its own regulations, even when it is advanced in a legal brief, unless there is a reason to "suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Auer v. Robbins*, 519 U.S. 452, 462 (1997). This is not a case where the agency's interpretation is so lacking in the "hallmarks of thorough consideration" that we should decline to grant it *Auer* deference. *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2169 (2012). Epstein has made no showing that the Secretary's interpretation conflicts with the agency's prior interpretations. *Id.* at 2166. Nor does he offer any other evidence to suggest her interpretation is merely a "convenient litigating position." *Id.*; *see also Sw. Pharmacy Solutions v. CMS*, 718 F.3d 436, 442-43 (5th Cir. 2013).

In a footnote, Epstein off-handedly suggests that he in fact did aggregate his claims with class members' claims during the administrative process. He purports to have accomplished this aggregation by simply "assert[ing] claims on behalf of . . . all putative class members" during the administrative review process. (Jt. Br. 23). But, as explained above, in order to aggregate claims to meet the amount in controversy, Medicare's aggregation provisions require more than merely asserting claims on behalf of others. Appellants must also satisfy the aggregation criteria set forth in the applicable regulations. *See* 42 C.F.R. §§ 405.1006(e)-(f), 423.1970(c)(2). Notwithstanding Epstein's vague argument to the contrary, Epstein unequivocally did not aggregate during the administrative process because he did not satisfy these aggregation criteria. The MAC expressly determined that the "record lack[ed] any indication that multiple appellants ha[d] requested aggregation" and therefore concluded that "only [Epstein] is a party to this matter." (Compl., Ex. D at 6). Accordingly, because Epstein did not comply with the requisite aggregation procedures during the administrative review process, putative class members' claims may not be used to push this case over the amount in controversy threshold.

2. Value of Epstein's Individual Injunctive Relief Claim

Alternatively, Epstein contends that, even if he cannot aggregate his claim with those of putative class members, his individual injunctive relief claim itself satisfies the $1,400 amount in controversy. Given that he intends to remain enrolled in Medicare Part D and likely will continue taking prescription drugs, Epstein asserts it is "virtually certain" that he will continue to have straddle claims on a yearly basis. (Epstein Decl. ¶ 4). Based on the value of the straddle claims that were denied in 2011, 2012, and 2013, Epstein projects that these future straddle claims will be worth an average of $116. (*Id.* ¶¶ 3-4). Taken together with the fact that he is "80 years old and in excellent health," Epstein argues that the $116 value of these yearly straddle claims means his injunctive relief claim should be valued at more than $1,400. (*Id.* ¶ 4).

"In actions seeking declaratory or injunctive relief, it is well established that the amount in controversy is measured by the value of the object of the litigation." *Hunt v. Wash. State Apple Adver. Comm'n*, 432 U.S. 333, 347 (1977). In applying this test, we consider only that which flows "directly and with a fair degree of probability from the litigation." *See Kheel v. Port of N. Authority*, 457 F.2d 46, 49 (2d Cir. 1972). Accordingly, an injunctive or declaratory relief claim typically cannot satisfy the amount in controversy requirement and establish jurisdiction, "where the monetary value of injunctive or declaratory relief is too speculative." *PeriCor Therapeutics, Inc. v. Am. Arb. Ass'n*, 2013 WL 654123, at *2 (C.D. Cal. Feb. 20, 2013) (internal quotation marks omitted); *accord Mann v. Unum Life Ins. Co. of Am.*, 505 Fed. App'x 854, 856 (11th Cir. 2013) ("When the value of injunctive relief is too speculative and immeasurable, it will not be included in the amount in controversy.") (internal quotation marks omitted); *Jackson v. Am. Bar Ass'n*, 538 F.2d 829, 831 (9th Cir. 1976) (holding that speculative future funds were insufficient to satisfy amount in controversy requirement).

Here, Epstein's attempt to use the projected value of future straddle claims to satisfy the amount in controversy fails for the simple reason that the math does not add up. After 2019, for all practical purposes, the donut hole will no longer exist. As of 2020, enrollees will only be responsible for the amount of their copayment or coinsurance until they reach the annual out-of-pocket threshold and the

catastrophic coverage kicks in. *See* 42 U.S.C. §§ 1395w-102(b)(2)(C)-(D), 1395w-102(4)(A). In other words, by 2020 enrollees' costs will be the same whether they are in the Initial Coverage Stage or the donut hole. After 2019, then, Epstein will no longer have any claims denied because they straddle the Initial Coverage Stage and the donut hole.[13] He therefore could realistically only have straddle claims denied in 2014-2019. Even if we assume that $116 is a fair, non-speculative valuation of these future straddle claims, over six years these claims would only add up to $696, less than half the amount in controversy required. Accordingly, Epstein's claims do not meet the statutorily-prescribed jurisdictional amount, and we lack subject matter jurisdiction under the Medicare Act.

C. Mandamus Jurisdiction

As an alternative basis for subject matter jurisdiction, Epstein asserts jurisdiction under the Mandamus Act, 28 U.S.C. § 1361. While 42 U.S.C. § 405(h) explicitly withdraws federal question jurisdiction over cases that arise under the Medicare Act, this provision is silent as to whether

[13] Epstein attempts to argue that this is not the case, but his argument is unclear and unsupported by any authority. Although he recognizes that the recent Part D amendments have reduced the amount enrollees will have to contribute towards their prescription costs when they are in the donut hole, he nevertheless insists that he will continue to have straddle claims worth $116 after 2019. He makes this argument based on his erroneous understanding of the way in which the ACA amendments will affect enrollees who have copayment plans (as opposed to standard coinsurance plans). Epstein suggests that when enrollees with copayment plans make a purchase that straddles the coverage stages, they will have to pay their copay *plus* 25% of the cost of the drug that is in the donut hole. There is no reason to suspect that this double counting will occur. Once enrollees reach the donut hole, they will either pay the amount of their copay (if they have a copay plan) *or* 25% (if they have a coinsurance plan). Nothing in the statute suggests that an enrollee would have to contribute a copay and coinsurance for a purchase that straddles the coverage stages, or that a copay plan would somehow become a coinsurance plan in the donut hole. Because the amendments provide that an enrollee will only be responsible for the amount of the copay regardless of whether he is in the Initial Coverage Stage or the donut hole, Epstein will no longer have any straddle claims after 2019. *Compare* 42 U.S.C. § 1395w-102(b)(2)(A)(ii) (enrollee must pay the actuarial equivalent of an average expected payment of 25 percent during Initial Coverage Stage) *with* 42 U.S.C. §§ 1395w-102(b)(2)(C)(i)(II), (D)(i)(II) (in 2020 and each subsequent year, enrollee must pay the actuarial equivalent of an average expected payment of 25 percent in donut hole). In any event, even if the donut hole remained in its current state and Epstein continued to incur straddle claims worth $116 on an annual basis, to reach the requisite amount in controversy he would need to have such claims for 12 years. Given that an 80-year-old male has an average life expectancy of 8.5 additional years, the straddle claims that Epstein may have after these 8.5 years are too speculative to be included in the amount in controversy. *See* www.socialsecurity.gov/cgi-bin/longevity.cgi; http://www.ssa.gov/oact/STATS/table4c6.html.

mandamus jurisdiction remains available. *See, e.g.*, *John Muir Mem. Hosp., Inc. v. Califano*, 457 F. Supp. 848, 857 (N.D. Cal. 1978). The Ninth Circuit, however, has held that mandamus will lie against the Secretary pursuant to § 1361. *See, e.g.*, *Johnson v. Shalala*, 2 F.3d 918, 924 (9th Cir. 1993).

Section 1361 grants this Court "original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." However, "mandamus is an extraordinary remedy and is available to compel a federal official to perform a duty only if: (1) the individual's claim is clear and certain; (2) the official's duty is nondiscretionary, ministerial, and so plainly prescribed as to be free from doubt; and (3) no other adequate remedy is available." *Kildare v. Saenz*, 325 F.3d 1078, 1084 (9th Cir. 2003) (quoting *Patel v. Reno*, 134 F.3d 929, 931 (9th Cir. 1998)).

Here, there is no basis for this Court to invoke mandamus jurisdiction because Epstein does not establish that the Secretary owes him any duty that is nondiscretionary and so plainly prescribed as to be free from doubt. Epstein alleges that the Secretary has breached her duties in two respects. First, he contends that the Secretary has failed to honor the initial coverage stage limit mandated by Congress. Were the Secretary to honor this limit, Epstein argues, Sponsors would share costs on a pro rata basis up to the initial coverage limit. Second, Epstein argues that the Secretary has failed to comply with her ministerial duty to implement policies pursuant to 42 U.S.C. § 1395hh(a) and the APA. According to Epstein, the Secretary's Copay-First Approach changes substantive legal standards governing the scope of benefits granted by Medicare. Accordingly, Epstein argues, the Secretary must formally promulgate regulations governing straddle claims.

First, regarding the initial coverage limit, the Secretary maintains that she applies the same limit as Epstein would have her apply—the congressionally-mandated limit. Only, she applies it in a way with which Epstein disagrees. The Secretary frames Epstein's argument as an "order-of-operations challenge." (Jt. Br. 46). Epstein, she maintains, cannot contend that she applied the wrong limit; instead, he simply "disagrees with the decision to count his co-pay towards [the] limit first, before Humana determined its share of the cost." (*Id.*). The Secretary also emphasizes that § 1395w-102(b)(3)(A), the provision that sets the initial coverage stage limit, is silent as to how to process claims against the limit. While the Secretary's framing of the issue is perhaps somewhat unfair,[14] this last point is dispositive. There can be no mandamus jurisdiction here because the statute is completely silent as to how straddle claims should be administered. Section 1395w-102(b)(3) requires plans to have "an initial coverage limit on the maximum costs that may be recognized for payment purposes." That is substantively the extent of the provision. It does not prescribe how the costs of a drug that straddles two coverage stages should be allocated. Nor does the statute mandate that the Secretary process straddle claims according to any particular method. Because all the statute does is set a cap on the costs that *may* be recognized for cost-sharing, we cannot agree with Epstein that the Secretary has failed to comply

[14] Epstein's claims do not hinge on whether his copayment was processed before or after a determination of Humana's costs. Either way, he argues, he should not have to pay the full cost of his Actonel prescription. Epstein does not challenge the order of operations so much as he contests the determination that Humana need not share all costs below the initial coverage limit amount.

with a duty that is so plainly prescribed as to be free from doubt. Under the plain language of the statute, the Secretary has abided by the maximum coverage limit, and that is the extent of her duty.

Likewise, Epstein has failed to establish that the Secretary owes any clear duty to formally promulgate regulations governing straddle claims. Section 1395hh(a) of the Medicare Act, upon which Epstein relies, reads as follows:

> No rule, requirement, or other statement of policy . . . that establishes, or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation . . . .

42 U.S.C. § 1395hh(a)(2). Similarly, under the APA, the Secretary has a duty to: (1) publish notice of proposed regulations, and (2) give interested parties an opportunity to voice objections and concerns about the proposed regulation. *See* 5 U.S.C. § 553. Because § 1395hh(a)(2) does not impose greater standards than the APA, the two can be discussed together. *See Via Christi Regional Med. Ctr., Inc. v. Leavitt*, 509 F.3d 1259, 1271 n.11 (10th Cir. 2007); *see also Erringer v. Thompson*, 371 F.3d 625, 633 (9th Cir. 2004) (assuming without deciding that the standards are the same).

Epstein alleges that the Secretary denies millions of dollars in benefits each year to Part D enrollees who have a right to those benefits. Therefore, he contends, the Secretary's method for processing straddle claims changes substantive legal standards governing the scope of benefits and should be subject to the requirements of the APA and/or § 1395hh(a)(2). Epstein cites no authority for this proposition. Nor does he explain how the denial of an alleged *right* constitutes a change to legal *standards* governing the scope of benefits. Rather, he asks this Court to conclude that, because the Secretary's straddle claims policy does not necessarily require cost-sharing up to the maximum extent possible under the Medicare statute, the Secretary has altered substantive legal standards. Epstein ignores the fact that there simply are no legal standards which govern claims in this area.

In the absence of such standards, the Secretary may decline to pass regulations and instead rely on adjudication or adopt interpretive rules. Because the determination to allow individual adjudication is discretionary, mandamus will not lie to compel the Secretary to pass regulations. *See Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 96-97 (1995) ("[T]here [is no] basis for suggesting that the Secretary has a statutory duty to promulgate regulations that, either by default rule or by specification, address every conceivable question . . . ."); *Heckler v. Ringer*, 466 U.S. at 617 ("[T]he means by which [the Secretary] implements her decision, whether by promulgating a generally applicable rule or by allowing individual adjudication, are clearly discretionary decisions."). The Secretary maintains that her decision regarding the processing of Epstein's straddle claim is the "quintessential example of an interpretive rule." (Jt. Br. 48). Neither the Secretary nor Epstein attempt to weigh this "rule" against the

Ninth Circuit's three-part test for distinguishing interpretive rules from legislative ones,[15] but we are satisfied that the Secretary's approach to straddle claims is in fact an interpretive rule, as it merely involves "the agency's construction of the statutes and rules which it administers." *See Miller v. Cal. Speedway Corp.*, 536 F.3d 1020, 1033 (9th Cir. 2008). As such, it need not be subjected to formal comment and rulemaking procedures. *See Erringer*, 371 F.3d at 630 ("The notice and comment requirement . . . does not apply to 'interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice.'") (quoting 5 U.S.C. § 553(b)(3)(A)).

Accordingly, there is no basis for exercising mandamus jurisdiction in this case. The Secretary does not owe Epstein a "clear nondiscretionary duty" to process straddle claims according to any particular approach. *Heckler*, 466 U.S. at 615. Nor is she required to promulgate a regulation to govern such claims.

IV. Conclusion

Based on the foregoing, Defendant's Motion is **GRANTED**. This action is **DISMISSED** for lack of subject matter jurisdiction.

IT IS SO ORDERED.

-- : --

Initials of Deputy Clerk Bea

[15] *See Erringer*, 371 F.3d at 630 (discussing the three-part test for distinguishing between rules that have the "force of law," which are deemed legislative, and those that are interpretive only). A rule has the "force of law": "(1) when, in the absence of the rule, there would not be an adequate legislative basis for enforcement action; (2) when the agency has explicitly invoked its general legislative authority; or (3) when the rule effectively amends a prior legislative rule." *Id.* (quoting *Hemp. Indus. Ass'n v. DEA*, 333 F.3d 1082, 1088 (9th Cir. 2003)).