1 **UNITED STATES COURT OF APPEALS**
2 **FOR THE SECOND CIRCUIT**
3
4 August Term, 2019
5
6 (Argued: October 7, 2019 Decided: September 23, 2020)
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8 Docket No. 18-2390-cv
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12 JONATHAN A. BLOOM,
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14 *Plaintiff-Appellant*,
15
16 v.
17
18 ALEX AZAR, SECRETARY, UNITED STATES DEPARTMENT OF
19 HEALTH AND HUMAN SERVICES,
20
21 *Defendant-Appellee*.*
22 ---
23
24 Before:
25
26 LIVINGSTON, *Chief Judge*, LEVAL and LOHIER, *Circuit Judges*.
27
28 Jonathan A. Bloom requested Medicare coverage to offset the costs
29 associated with a device that he uses to treat his diabetes. The Medicare
30 Appeals Council rejected three of Bloom's requests. When Bloom sought
31 judicial review of the Appeals Council's adverse decisions, the United States
32 District Court for the District of Vermont (Crawford, C.J.) dismissed Bloom's
33 suit in part on the ground that the amounts involved in the challenged
34 decisions fell below the amount-in-controversy requirement upon which the
35 Medicare Act conditions judicial review, and that Bloom could not
36 "aggregate[]" those amounts to cure that jurisdictional deficiency. 42 U.S.C.

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* The Clerk of Court is directed to amend the caption as set forth above.

1 § 1395ff(b)(1)(E)(ii). We **VACATE** the District Court's judgment and
2 **REMAND** for proceedings consistent with this opinion.
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4 JAMES PISTORINO (Debra M. Parrish, *on the brief*),
5 Parrish Law Offices, Pittsburgh, PA, (Craig S. Nolan,
6 Alexandrea L. Nelson, *on the brief*), Sheehey Furlong
7 & Behm P.C., Burlington, VT, *for Plaintiff-Appellant*
8 Jonathan A. Bloom.
9
10 MELISSA A.D. RANALDO, Assistant United States
11 Attorney (Gregory L. Waples, Assistant United
12 States Attorney, *on the brief*), *for* Christina E. Nolan,
13 United States Attorney for the District of Vermont,
14 Burlington, VT, *for Defendant-Appellee* Alex Azar,
15 Secretary, United States Department of Health and
16 Human Services.
17
18 LOHIER, *Circuit Judge*:

19 Jonathan A. Bloom is a Medicare beneficiary who uses a Continuous
20 Glucose Monitoring device (CGM) to manage his Type I diabetes. Since 2011
21 Bloom has regularly sought Medicare coverage to offset the costs associated
22 with his CGM. Three times between 2015 and 2017, the Medicare Appeals
23 Council rejected Bloom's requests for coverage. Bloom challenged the
24 Appeals Council's adverse decisions in federal court, but the United States
25 District Court for the District of Vermont (Crawford, C.J.) dismissed Bloom's
26 suit in part. It concluded that two of the three challenged decisions failed to
27 meet the $1,500 amount-in-controversy threshold for federal court jurisdiction
28 under the Medicare Act. It also held that the Medicare Act did not permit

Bloom to cure the jurisdictional deficiency by “aggregat[ing]” the three separate amounts at issue in each decision. 42 U.S.C. § 1395ff(b)(1)(E)(ii). The question before us is whether the District Court erred in refusing to let Bloom aggregate his claims to satisfy the Act’s amount-in-controversy requirement. For the reasons below, we **VACATE** the District Court’s judgment and **REMAND** for proceedings consistent with this opinion.

BACKGROUND

I

Jonathan Bloom has been suffering from Type I diabetes for several decades. Bloom’s diabetes is currently “brittle”—that is, particularly acute—which means that his blood-glucose levels fluctuate “rapidly” every day, sometimes even “unpredictably.” Appellant’s App’x 179. And unlike the many diabetics who can tell when their blood sugar is too low, Bloom suffers from “hypoglycemic unawareness,” a condition that makes it is “impossible” for him “to detect when he is experiencing [] unexpected[ly] low” blood sugar. Id. As a result, Bloom has fallen unconscious into a diabetic coma on three separate occasions, two of which were “life threatening.” Special App’x 4.

1 Since 2006 Bloom has attempted to better manage his diabetes by using
2 a CGM—essentially a tiny sensor that he inserts just under his skin to actively
3 monitor his blood-glucose levels. The CGM evaluates Bloom's blood sugar
4 every five minutes, and "warn[s] him of drops in glucose that would lead to
5 [further bouts of] unconsciousness." Supp. App'x 87. The device "has
6 markedly improved [Bloom's] . . . quality of life and overall safety." Special
7 App'x 4.

8 Bloom sought Medicare coverage for his CGM at least thirteen separate
9 times. On three occasions, the Appeals Council denied Bloom's requests for
10 coverage. First, in a decision dated November 13, 2015 (the M-15-1505
11 decision), the Appeals Council denied Bloom coverage for a thirty-day supply
12 of disposable CGM sensors valued at $473. Second, in a decision dated
13 February 24, 2016 (the M-15-4332 decision), the Appeals Council denied
14 Bloom's claim for coverage of a CGM transmitter and two sets of disposable
15 CGM sensors, which cost a total of $1,976. Finally, in a decision dated
16 January 27, 2017 (the M-16-10554 decision), the Appeals Council denied
17 Bloom coverage for a ninety-day supply of disposable CGM sensors, totaling
18 $1,419. With respect to each denial, the Appeals Council concluded that

1 Bloom's CGM was "precautionary" in nature and thus failed to serve a
2 "primary medical purpose." Appellant's App'x 73 (M-15-4332 decision), 185
3 (M-15-1505 decision), 270 (M-16-10554 decision).

4 II

5 In 2016 Bloom filed this lawsuit against the agency responsible for
6 overseeing the Appeals Council, the Department of Health and Human
7 Services (HHS), to challenge the three decisions denying coverage. See
8 generally 42 U.S.C. §§ 1395ff(b)(1)(A), 1395ii, 405(g), 405(h). Bloom and HHS
9 each eventually moved for judgment based on the pleadings and the
10 administrative records. As relevant here, the District Court granted HHS's
11 motion in part, concluding that it lacked jurisdiction to review the M-15-1505
12 and M-16-10554 decisions because the dollar amounts at issue in each of those
13 decisions fell below the amount-in-controversy requirement upon which the
14 Medicare Act conditions judicial review. The District Court also concluded
15 that Bloom could not "aggregate[]" the amounts at issue in each decision to
16 satisfy the amount-in-controversy threshold and cure the jurisdictional
17 deficiency. Id. § 1395ff(b)(1)(E)(ii).
18 This appeal followed.

DISCUSSION

I

At issue in this appeal are the Appeals Council's M-15-1505 and M-16-10554 decisions denying Bloom's claims. There is no dispute that these decisions present common questions of law and fact. Bloom argues that the District Court had jurisdiction under 42 U.S.C. § 1395ff(b)(1)(E)(i) to review his challenges to those decisions because the aggregated amount of those claims indisputably exceeded $1,500. On de novo review, we agree. See United States v. Williams, 733 F.3d 448, 452 (2d Cir. 2013).

A

We begin with the language of the Medicare Act, which contains two provisions that are directly relevant to our resolution of this appeal.

The first provision states that "[a] hearing . . . shall not be available to an individual . . . if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000." 42 U.S.C. § 1395ff(b)(1)(E)(i). The $1,000 amount in controversy is annually adjusted for inflation and was at set at $1,500 in 2016, the year in which Bloom sought judicial review. See Medicare Program;

1 Medicare Appeals; Adjustment to the Amount in Controversy Threshold
2 Amounts for Calendar Year 2016, 80 Fed. Reg. 57,827, 57,828 (Sept. 25, 2015);
3 see also 42 U.S.C. § 1395ff(b)(1)(E)(iii).

4 The second provision at issue in this appeal directs that "[i]n
5 determining the amount in controversy, the Secretary [of HHS], under
6 regulations, shall allow two or more appeals to be aggregated if the appeals
7 involve" "the delivery of similar or related services to the same individual by
8 one or more providers of services or suppliers." 42 U.S.C. § 1395ff(b)(1)(E)(ii).
9 Medicare beneficiaries may thus aggregate their claims for benefits, but only
10 upon satisfying the following conditions: the claimant's unaggregated claims
11 must (1) involve "related services" (here, the CGM sensors and transmitters)
12 that (2) are rendered "to the same individual" (Bloom) (3) by "one or more
13 providers." Id.

14 So long as each Medicare claim before the district court satisfies these
15 conditions, the text of § 1395ff(b)(1)(E) permits plaintiffs to aggregate the
16 amount of their claims against HHS to meet the amount-in-controversy
17 requirement for judicial review. The statutory text directs the Secretary to
18 make regulations that allow two or more appeals to be aggregated (under

stated conditions) in determining the amount in controversy without suggesting that those regulations should apply only to agency review and not to judicial review. The statute thus expresses congressional intent that, as to both agency and judicial review, aggregation is permitted when the claims conform to the conditions specified. This reading of the text reflects a basic reality: federal courts have long permitted the aggregation of a single plaintiff's claims against a single defendant to satisfy the jurisdictional amount in controversy in other contexts. Take, for example, "[t]he traditional judicial interpretation" of the diversity jurisdiction statute's amount-in-controversy requirement, which "has been from the beginning that . . . [a]ggregation has been permitted . . . in cases in which a single plaintiff seeks to aggregate two or more of his own claims against a single defendant." Snyder v. Harris, 394 U.S. 332, 335 (1969). The same was true for the federal question statute, which until 1980 carried its own amount-in-controversy requirement. See Hunter v. United Van Lines, 746 F.2d 635, 650 (9th Cir. 1984) (collecting authorities); Hales v. Winn-Dixie Stores, Inc., 500 F.2d 836, 846 n.11 (4th Cir. 1974) ("The general rule is that in an action involving a single plaintiff and a single defendant, when the basis of jurisdiction is

diversity of citizenship or when each of the claims sought to be joined involves a federal question, a party may aggregate all the claims he has against an opposing party in order to satisfy the requisite jurisdictional amount."); see also 14AA Charles A. Wright & Arthur R. Miller, Federal Practice and Procedure § 3704 (4th ed. 2020). There is no textual basis to conclude that the Medicare Act, which by its terms mandates regulations that allow aggregation of claims by a single plaintiff against a single defendant involving "related services," prevents the aggregation of all claims against HHS in the district court over which the court would independently have jurisdiction but for the jurisdictional amount requirement.

The District Court, relying on the fact that § 1395ff(b)(1)(E)(ii) is directed to "the Secretary [of HHS]," interpreted that provision as applying only to appeals before the agency. The court concluded that § 1395ff(b)(1)(E) "is silent about aggregation of claims at the district court level." The lack of any mention of aggregation at the judicial review stage, the court reasoned, suggested that Congress intended to exclude aggregation of claims by a court. Special App'x 11.

1 We disagree with the District Court's interpretation of §
2 1395ff(b)(1)(E)(ii). That provision, which mandates that aggregation be
3 permitted in certain circumstances, does not specify that its command is
4 limited to agency review. While its true that the provision is directed to "the
5 Secretary," it instructs the Secretary to promulgate regulations providing for
6 aggregation in the enumerated circumstances. That in no way implies that
7 the provision addresses only aggregation before the agency. We see no basis
8 for the District Court's conclusion that § 1395ff(b)(1)(E)(ii) speaks only of
9 aggregation at the agency level. The more natural reading is that the
10 regulations to be promulgated by the Secretary must allow aggregation
11 regardless of whether in agency review or judicial review.
12 Even if we agreed with the District Court that § 1395ff(b)(1)(E)(ii) is
13 limited to agency review, and thus is silent as to judicial aggregation, we
14 would not agree that this silence indicates, by negative inference, an intention
15 to bar judicial aggregation. That argument brings to mind the "interpretive
16 canon, expressio unius est exclusio alterius, expressing one item of [an]
17 associated group or series excludes another left unmentioned." NLRB v. Sw.
18 Gen., Inc., 137 S. Ct. 929, 940 (2017) (quotation marks omitted). We do not

1 think that the canon would apply here to preclude aggregation of Bloom's

2 claims before the District Court.

3 First, the Government notably does not rely on expressio unius to press

4 its argument on appeal. And second, the canon in any event has its limits.

5 The Supreme Court has explained that the "force of any negative implication"

6 derived from expressio unius "depends on context." Id. (quotation marks

7 omitted). Expressio unius thus applies only when "it is fair to suppose that

8 Congress considered the unnamed possibility and meant to say no to it,"

9 Barnhart v. Peabody Coal Co., 537 U.S. 149, 168 (2003), that is, "when

10 circumstances support[] a sensible inference that the term left out must have

11 been meant to be excluded," NLRB, 137 S. Ct. at 940 (quotation marks

12 omitted); see Antonin Scalia & Bryan A. Garner, Reading Law: The

13 Interpretation of Legal Texts 107 (2012) ("Virtually all the authorities who

14 discuss [expressio unius] emphasize that it must be applied with great

15 caution, since its application depends so much on context.").[1] We thus turn to

[1] The Supreme Court has often declined to rely on the expressio unius canon when it is insufficiently sensitive to context. See, e.g., NLRB, 137 S. Ct. at 940; Marx v. Gen. Revenue Corp., 568 U.S. 371, 381–384 (2013); Barnhart, 537 U.S. at 168; Chevron U.S.A. Inc. v. Echazabal, 536 U.S. 73, 80–83 (2002); United States v. Vonn, 535 U.S. 55,

1 the context in which the relevant statutory language was forged. See FDA v.

2 Brown & Williamson Tobacco Corp., 529 U.S. 120, 144 (2000).

3 B

4 In 1986 Congress codified in the Medicare Act an early version of the

5 agency aggregation provision at issue in this case. See Omnibus Budget

6 Reconciliation Act of 1986, Pub. L. No. 99-509, sec. 9341, 100 Stat. 1874, 2037–

7 38. HHS proposed a set of rules to implement that provision. One of these

8 rules provided:

9 (a) The determination as to whether the amount in
10 controversy is—
11
12 (1) $100 or more is made by the presiding officer;
13
14 (2) $1,000 or more is made by the reviewing court.
15
16 (b) In determining the amount in controversy, the presiding
17 officer and the reviewing court, as appropriate, also make
18 the determination as to what constitutes similar or related
19 services and common issues of law and fact.
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65 (2002); United Dominion Indus., Inc. v. United States, 532 U.S. 822, 836 (2001); Pauley v. BethEnergy Mines, Inc., 501 U.S. 680, 703 (1991); Burns v. United States, 501 U.S. 129, 136 (1991); cf. Abbott Labs. v. Gardner, 387 U.S. 136, 141 (1967) ("The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to review is too important to be excluded on such slender and indeterminate evidence of legislative intent." (quotation marks omitted)).

1 Medicare Program; Aggregation of Medicare Claims and Administrative

2 Appeals and Judicial Review, 56 Fed. Reg. 28,353, 28,359 (June 20, 1991)

3 [hereinafter "1991 Proposed Rule"] (quotation marks omitted). As early as

4 1991, therefore, HHS recognized that "reviewing court[s]" could aggregate

5 similar Medicare claims to determine the amount in controversy in Medicare

6 cases. Id. Three years later, when the notice-and-comment period for the

7 proposed rules concluded, HHS again acknowledged that the Medicare Act

8 permitted district courts to aggregate similar Medicare claims:

> 9 [T]he statute does not require the courts to follow the
> 10 administrative aggregation rules established by [HHS] for
> 11 determining the amount in controversy. However, the
> 12 courts may wish to use the administrative rules as a
> 13 reference point for determining the amount in controversy
> 14 at the judicial level.

15

16 Medicare Program; Aggregation of Medicare Claims for Administrative

17 Appeals, 59 Fed. Reg. 12,172, 12,174 (Mar. 16, 1994) [hereinafter "1994

18 Statement and Rule"]. Consistent with this interpretation, HHS promulgated

19 the following rule in 1994: "[W]hen a civil action is filed, [HHS] may assert

20 that [its regulatory] aggregation principles . . . may be applied to determine

21 the amount in controversy for judicial review." Id. at 12,182. That new rule

1 would have been entirely unnecessary had HHS believed that courts could
2 not aggregate Medicare claims under § 1395ff.

3 At various times, then, HHS has either openly supported the
4 aggregation of claims to trigger judicial review, see 1991 Proposed Rule, 56
5 Fed. Reg. at 28,359 (lodging power in "the reviewing court"), or attempted to
6 confine the statutory authority of federal courts to do so, see 1994 Statement
7 and Rule, 59 Fed. Reg. at 12,182 (providing that agency aggregation
8 provisions may govern in court). Whatever its objective, HHS has thus
9 repeatedly acknowledged that the Act vests district courts with the authority
10 to aggregate qualifying Medicare claims to satisfy the amount-in-controversy
11 requirement in Medicare cases. See Brown & Williamson Tobacco Corp., 529
12 U.S. at 144.

13 We presume that Congress was aware of HHS's position on this central
14 issue of judicial authority to aggregate Medicare claims when, in 2000, it last
15 amended the aggregation and amount-in-controversy language of § 1395ff.
16 See Consolidated Appropriations—FY 2001, Pub. L. No. 106-554, § 1869, 114
17 Stat. 2763, 2763A-536 (2000). We see no evidence at all that this amendment
18 was intended to upend HHS's longstanding acceptance of judicial

aggregation of Medicare claims, or to limit aggregation to administrative proceedings. The only relevant congressional report in the legislative history of the amendment tells us that Congress intended to permit aggregation to satisfy the amount-in-controversy threshold for district court proceedings. Specifically, the House Conference Report for the 2000 amendment explains:

> [if] contested amounts are greater than $100, an individual would be able to appeal an adverse reconsideration decision by requesting a hearing by the Secretary . . . . If the dispute is not satisfactorily resolved through this administrative process, and if contested amounts are greater than $1,000, the individual would be able to request judicial review . . . . Aggregation of claims to meet these thresholds would be permitted.

H.R. Rep. No. 106-1033, at 895 (2000) (Conf. Rep.) (emphasis added).

The Report (and the emphasized language in particular) thus strongly suggests that the amendment's drafters sought to permit aggregation in both the administrative and the judicial contexts. The Report's use of the plural "these thresholds" when referencing aggregation can only refer to the separate amount in controversy "thresholds" for administrative and judicial review mentioned in the prior sentences. Id.

In considering the foregoing history, we must presume that Congress acted against the prevailing regulatory backdrop relating to judicial

1 aggregation. See Brown & Williamson Tobacco Corp., 529 U.S. at 144; New
2 York v. U.S. Dep't of Homeland Sec., 969 F.3d 42, 70–74 (2d Cir. 2020). We
3 have already described HHS's repeated acknowledgments that judicial
4 aggregation of Medicare claims is permissible. Congress would have been
5 aware of HHS's position prior to 2000 as it considered whether claims could
6 be aggregated for judicial review. See Lorillard v. Pons, 434 U.S. 575, 580–81
7 (1978).

8 HHS's view persisted after the congressional amendments. In 2005
9 HHS promulgated a rule that "[t]o be entitled to judicial review, a party must
10 meet the amount in controversy requirements of this subpart at the time it
11 requests judicial review." Medicare Program: Changes to the Medicare
12 Claims Appeal Procedures, 70 Fed. Reg. 11,420, 11,486 (Mar. 8, 2005)
13 [hereinafter "2005 Rule"]. This rule, which HHS argues limits beneficiaries
14 from "aggregat[ing] claims . . . after the ALJ stage of review," Appellee's Br.
15 26, clearly presumes that plaintiffs may aggregate their Medicare claims in
16 court to meet § 1395ff's jurisdictional amount. It specifically provides
17 definitions for "purposes of aggregating claims to meet the amount in

controversy requirement for an ALJ hearing or judicial review." 2005 Rule, 70 Fed. Reg. at 11,486 (emphasis added).

In sum, HHS has long had the view that district courts enjoy an independent ability to aggregate claims under the Medicare Act, while Congress, which we presume was aware of HHS's position, has said nothing that would disturb that view. This backdrop of legislative and regulatory history confirms what the Medicare Act's text itself makes clear enough: "[a]ggregation of claims to meet" the Act's amount-in-controversy requirement for judicial review is "permitted." H.R. Rep. No. 106-1033, at 895.

III

In urging a contrary conclusion, HHS claims that permitting judicial aggregation would render aggregation before the agency superfluous. But a quick example shows why this is wrong. Suppose a Medicare beneficiary had two claims, each for $51. Without aggregating both claims at the agency level, the beneficiary would not be entitled to a hearing before an ALJ on either claim. See 42 U.S.C. § 1395ff(b)(1)(E) ($100 amount in controversy for ALJ hearing). As a result, the beneficiary would also not be entitled to judicial

review of either claim because the Medicare Act requires that claims first be exhausted through the administrative process. See 42 U.S.C. § 1395ff(b)(1)(A); id. § 405(g). Agency aggregation thus permits Medicare beneficiaries to seek review of smaller coverage requests that the agency otherwise could not review. And agency aggregation will continue to serve that important function whether or not judicial aggregation is permitted.

HHS also submits that its interpretation of the Medicare Act "represents a permissible construction of the statute entitled to deference under" either Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), or Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 414 (1945). Again, we disagree.

Starting with Chevron deference, the agency claims that the regulatory provisions that govern the aggregation of claims before an ALJ, see 42 C.F.R. § 405.1006(e)–(f), "do not provide a means for a beneficiary to aggregate claims in the first instance after the ALJ stage of review," Appellee's Br. 26. But whether or not these regulatory provisions now create a means to aggregate claims is irrelevant to the principal question of statutory interpretation before us, which is whether aggregation is permissible under

1 the Medicare Act. HHS's regulations do not answer whether claims _must_ be
2 aggregated before the agency as a precondition to aggregation before a
3 district court, or whether claims _may_ be aggregated before the district court at
4 all. So even if we were inclined to defer to HHS's regulations under _Chevron_,
5 deference would make no difference to our resolution of this appeal.[2] In any
6 event, deference to HHS's aggregation regulations would be inappropriate
7 even if they answered the question presented since we hold that Congress
8 already "has directly spoken," _Chevron_, 467 U.S. at 842, in requiring the
9 agency to provide for judicial aggregation.

10 For similar reasons, HHS's interpretation of its own regulation is not
11 entitled to deference under _Seminole Rock_. Since the statute provides for
12 aggregation before the district court, we do not owe deference to an HHS
13 interpretation adopting a contrary rule.

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[2] HHS also argues that 42 C.F.R. § 405.1006(c) specifically forecloses Bloom's suit. That provision states: "To be entitled to judicial review, a party must meet the amount in controversy requirements of this subpart at the time it requests judicial review." _Id._ But as neither party disputes, the combined value of Bloom's claims at the time he filed suit exceeded the Medicare Act's amount-in-controversy requirement for judicial review. The principal question for us is whether Bloom was entitled to combine the value of his claims in order to satisfy that requirement.

IV

This brings us to a few important points about the limitations of our holding. The first point relates to the exhaustion requirement involving Medicare claims. Beneficiaries may not obtain judicial review of claims, whether individual or aggregated, that were not previously adjudicated before and finally decided by the agency (for example, claims of less than $100 that were not aggregated before the agency). See 42 U.S.C. § 1395ff(b)(1)(A); id. § 405(g). The second point is that the various timing requirements in HHS's regulations together work to restrict the number of claims that can be aggregated in a single civil action. See 42 C.F.R. § 405.1006(e)(ii). The last limit is HHS's latitude in formulating rules to govern the administrative appeals process, including rules that specifically curtail the aggregation of administrative appeals. See 42 U.S.C. § 1395ff(b)(1)(E)(ii).

With these limits in mind, we hold that the Medicare Act does not prohibit Bloom from aggregating his claims for the first time in district court. Our conclusion rests on the text of the Medicare Act, as reinforced by its regulatory and legislative history. Because we conclude that the Medicare

1 Act permits Bloom to aggregate his claims before the District Court, we do

2 not address Bloom's alternative argument that the District Court should have

3 exercised supplemental jurisdiction over the M-15-1505 and M-16-10554

4 decisions. See 28 U.S.C. § 1367.

5 **CONCLUSION**

6 For the foregoing reasons, we **VACATE** the District Court's judgment

7 and **REMAND** for proceedings consistent with this opinion.