No. _____

In the Supreme Court of the United States

JENNIFER PERKINS,

Petitioner,

v.

US AIRWAYS, INC..; U.S. AIRWAYS GROUP; AMERICAN AIRLINES GROUP, successor by merger to U.S. AIRWAYS, INC.; and US AIRWAYS HEALTH BENEFIT PLAN,

Respondents.

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

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Petitioner has been continuously employed as a flight attendant with Respondent US Airways, Inc. (US Air), a member of the flight attendants' union, and a participant in the US Airways Health Benefit Plan (the Plan) since 1992. Lightning struck Petitioner on a jetway while she was working for US Air. Petitioner continued working for US Air without taking a leave of absence after she was struck. Petitioner's condition worsened considerably, and she has been on approved medical leave of absence since October 2001. Petitioner began receiving long-term disability benefits from US Air in February 2002, and she began receiving Medicare disability benefits in September 2003. As a result of her current employment status with US Air and her membership in the union, Petitioner is entitled to continue receiving benefits, including retirement benefits, health benefits, and seniority through US Air. While on approved medical leave, Petitioner has experienced several issues with Respondents improperly determining its payer status as secondary to Medicare. During all relevant times, Petitioner has timely paid the full amount of her health insurance premium in order to maintain the high-quality coverage offered by the Plan. Petitioner successfully appealed those determinations through 2010; however, in 2011, Respondents refused to correct its erroneous payer status determination and denied Petitioners' claims for health benefits. In connection with Respondents' denials in 2010 and 2011, Petitioner requested copies of certain Plan documents in order to assist her in appealing the denials. Respondents repeatedly failed to timely provide

Petitioner with copies of the Plan documents she requested.

The questions presented are:

1) Did the Court of Appeals err in affirming the District Court's dismissal of Petitioner's claims based on alleged violations of subsection (b) of the Medicare as Secondary Payer Act when the dismissal was not based on the unambiguous statutory definition of "current employment status" provided by Congress in that subsection and instead was based upon a regulatory definition for that same term, *see Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984); when Petitioner's Complaint established Petitioner's status as a current employee and union member; and when Petitioner's Complaint alleged Medicare had already determined its payer status was secondary to Petitioner's employer-sponsored health benefits claims?

2) Did the Court of Appeals err in affirming the dismissal of Petitioner's claim alleging a violation of the Employee Retirement Income Security Act of 1974 for unreasonable denial of benefits when the terms of Petitioner's employer-sponsored health benefit plan forming the basis for Respondents' denial of Petitioner's employer-sponsored health benefit claims pertaining to Medicare payment priority alter the express and unambiguous definition of "current employment status" set forth by Congress in the Medicare as Secondary Payer Act; when precedent from the Courts of Appeals for the D.C. and the Sixth Circuits indicates that plan provisions violating federal statutes, including the Medicare as Secondary

Payer Act, are void for violating federal law and denial of benefits claims; when Medicare previously determined its payer status was secondary to Petitioner's employer-sponsored health benefits; and when an independent third-party reviewer selected and paid by Respondents determined Respondents' payment priority was primary to Medicare?

3) Did the Court of Appeals err in affirming the District Court's grant of summary judgment against Petitioner on her claim for failure to timely provide plan documents, as required by ERISA, when Respondent US Airways, Inc. did not timely provide Petitioner with the documents she requested on multiple occasions, as required by ERISA; when the District Court's grant of summary judgment was based on clear errors of law; and when the evidence in the record before the District Court supported the assessment of a monetary penalty against US Airways, Inc.?

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This case is an ideal vehicle for resolving the deference federal courts give to administrative definitions of terms for which Congress has provided a statutory definition. *Chevron* deference in many respects can provide a helpful and relevant mechanism for courts to ascertain legislative intent; however, where agency interpretations or regulations limit the scope of unambiguous statutory provisions, particularly statutory definitions crafted by Congress, such deference is improper and impermissibly infringes upon Congress's lawmaking power.

OPINIONS BELOW

The unreported opinion of the Court of Appeals is produced at App. 2a to 3a. 709 Fed. Appx. 188 (4th Cir.2018). The Court of Appeals' unreported order denying Petitioner's Petition for Rehearing is produced at App. 1a.

The unreported order of the District Court granting summary judgment against Petitioner is produced at App. 4a to 32a. 2017 WL 1196805 (Mar. 31, 2017). The unreported order of the District Court denying Petitioner's Motion to Alter or Amend as to the District Court's order dismissing certain of Petitioner's causes of action is produced at App. 33a to 42a. 2016 WL 420899 (Aug. 10, 2016). The unreported order of the District Court denying Petitioner's Motion to Alter or Amend as to the District Court's order dismissing certain of Petitioner's causes of action is produced at App. 43a to 74a. 2015 WL 5783561 (Sept. 30, 2015).

JURISDICTION

The judgment of the District Court was entered on March 31, 2017. A notice of appeal to the Fourth Circuit Court of Appeals was filed on April 28, 2017, and the case was docketed in the court of appeals on May 2, 2017 (4th Cir., No. 17-1565). The Fourth Circuit Court of Appeals issued its decision on January 19, 2018. The Fourth Circuit Court of Appeals denied a petition for rehearing on February 26, 2018. The jurisdiction of this Court is thereby invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The text of the relevant sections of the Employment Retirement Security Act of 1974 and the Medicare as Secondary Payer Act is reproduced in the Appendix, along with the relevant regulations. *See* 28 U.S.C. §§ 1291, 1331; 29 U.S.C. §§ 1001, 1024, 1132, 1133, 1395y(b); 103 Stat. 2229, 2230 (Dec. 19, 1989); 107 Stat. 593, 595 (Aug. 10, 1993); 29 C.F.R. § 2575.502c-1; 42 C.F.R. § 411.104; 60 Fed. Reg. 45344-01, 45346 (Aug. 31, 1995).

STATEMENT OF THE CASE

This case involves a dispute regarding US Airways, Inc.'s ("US Air") wrongful denial of Petitioner Jennifer Perkins' 2011 health benefits claims, in violation of the Medicare Secondary Payer Act (MSP statute), 42 U.S.C. § 1395y(b), and the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1113(a)(1)(B) and (g). This case also involves a dispute regarding US Air's repeated

failures to timely provide requested plan documents, in violation of ERISA. 29 U.S.C. § 1132(c)(1).

A. Factual Background

Petitioner has continuously been an employee of US Air, a member of the Association of Flight Attendants, AFL-CIO ("the Union"), and a participant in the US Airways Health Benefit Plan ("the Plan") since 1992.

After being struck by lightning on the jetway while working for US Air, Petitioner has suffered from a variety of serious health problems. In 2001 her condition worsened to the point that she became physically unable to perform her duties—she has been on an approved medical leave of absence since October 2001, and in February 2002, Petitioner began receiving long-term disability (LTD) benefits from US Air. Petitioner began receiving Medicare benefits in September 2003. Notwithstanding the fact that Petitioner receives Medicare benefits while on approved medical leave, Petitioner is entitled to continue receiving benefits, including retirement benefits, health benefits, and seniority through US Air as a result of her current employment status and her status as a member of the union.

In 2010, Petitioner experienced an issue when US Air improperly determined its payer status was secondary to Medicare. In connection with Petitioner's attempts to get US Air to reverse its 2010 determination, Petitioner wrote US Air requesting certain summary plan descriptions (SPD) on October 18, 2010. On October 27, 2010, US Air provided

Petitioner with some, but not all, of the SPDs she requested. After receiving the documents provided by US Air in October 2010, Petitioner opened the envelope, wrote down the name of four different documents provided by US Air, put them back in the envelope, and gave them to her former attorney when she retained him in January 2011.

On November 4, 2010, Petitioner wrote US Air, noting she still had not received all of the SPDs she requested and identifying the SPDs she still needed. Petitioner's letter specifically noted US Air had provided copies of the SPDs for the 1993 Health Benefit Plan, 2001 LTD Benefit Plan, 2003 Health Benefit Plan, and the 2004 LTD Benefit Plan. That letter again requested Health Benefit Plan SPDs for 2000, 2001, and 2010, and LTD Benefit Plan SPDs for 2000, 2003, and 2010. US Air responded to Petitioner's letter on November 8, 2010, stating it had provided Petitioner with the only SPDs that there were.

On January 25, 2011, Petitioner's former attorney wrote US Air regarding its erroneous 2010 payer status determination and to obtain copies of the plan documents Petitioner requested from US Air on October 18 and November 4, 2010. On February 11, 2011, US Air responded to Petitioner's former attorney, citing the Plan and certain amendments thereto, and the Plan's 1993, 2003, and 2008 SPDs. US Air's letter to Petitioner's former attorney specifically cited to pages 120-122 of the 1993 SPD. The letter purported to provide copies of certain documents; however, copies of those documents were not provided to Petitioner. Further, the letter claimed

US Air had sent Petitioner the Plan's SPDs for 1993, 2003, and 2008, as well as the LTD Plan's plan document and its current SPD on October 25, 2010.

Petitioner's former attorney ceased representing her in May 2011, after successfully resolving Petitioner's issue with US Air's erroneous 2010 payer status determination. In April 2011, Petitioner requested all of the documentation pertaining to her file from her former counsel's paralegal. Petitioner reviewed the documents provided, "and the only thing [she] was given was the 1993 [SPD]," and it was only during this review that Petitioner discovered the 1993 SPD was missing pages 121 through 125—which were the key pages addressing the primary versus secondary payer issue. When Petitioner met with her former attorney in May 2011, she requested all of her documents and inquired about the pages missing from the 1993 SPD; however, after a diligent search, neither her former attorney nor his paralegal were able to locate the missing pages nor could they confirm they had ever received those pages.

In July 2011, Petitioner began appealing US Air's denial of her 2011 health benefit claims after US Air, once again, erroneously determined its payer status was secondary to Medicare, resulting in Petitioner's 2011 health benefit claims, which total $10,848.00, being unpaid. Petitioner timely appealed US Air's denials. However, despite an external reviewer—a benefit specialist and health plan manager who was selected and paid by US Air—determining US Air was required to cover Petitioner's claims as primary payer under the Plan, and despite

Medicare denying being primary for Petitioner's 2011 claims, US Air continued to deny Petitioner's claims for benefits. In 2011 alone, Petitioner paid 100% of her monthly insurance premiums, totaling $7,757.52, for the privilege of participating in the Plan so that she would have high-quality insurance coverage.

It was during the time that Petitioner was pursuing her appeal of US Air's denial of her 2011 health benefit claims that, on September 30, 2011, Petitioner sent US Air a written request for "all the documents required under ERISA, including all records and supporting information that was in your possession at the time you made the decision to unilaterally name yourself the secondary pay[e]r of my medical benefits for 2011."[1] Petitioner's September 30, 2011 request specifically requested copies of "the relevant Summary Plan D[e]scriptions, all relevant amendments to Summary Plan D[e]scriptions, . . . and other documents relied upon by BCBSNC, U.S. Airways, Inc., and any other claims fiduciaries." Petitioner closed her September 30, 2011 letter to US Air with this simple request, "If you could please expedite my request it would be greatly appreciated . . . ."

It was not until December 2, 2011, that US Air responded to Petitioner's September 30, 2011 letter, acknowledging Petitioner's September 30, 2011 document request and her question regarding the issues with the payer status for her 2011 medical benefits. Nevertheless, US Air's letter stated "we

[1] Petitioner's September 30, 2011 letter to US Air was delivered to US Air on October 4, 2011.

have already provided all relevant plan documents, summary plan descriptions and collective bargaining agreements that govern the terms of your medical coverage," referring her to its February 2011 letter. (emphasis added). US Air's letter did not specify which of the "relevant" documents "govern[ing] the terms of [her] medical coverage" it had previously provided nor did it enclose any of the materials Petitioner requested with its December 2, 2011 letter.

On December 13, 2011, Petitioner sent US Air a letter to follow up on her unfulfilled September 30, 2011 request for plan documents. Petitioner acknowledged US Air's explanation that it had previously sent certain documents to her former attorney; however, Petitioner reiterated her request for plan documents, noting it was her right under ERISA to request those documents. Additionally, Petitioner's letter specifically requested "[a]ll Summary Plan D[e]scriptions in FULL (my copy and Attorney Adams' copy of the 1993 Health Benefit Plan were missing pages 121 thru 125), all relevant amendments to the Summary Plan D[e]scriptions, and all collective bargaining agreements." Petitioner wanted the plan documents to provide her new attorney with "anything pertaining to ERISA, anything that an attorney would need to go over my case." This was because Petitioner "did not know exactly what all was needed"—so she requested "the entire administrative record," including the plan documents referenced in her September and December 2011 letters to US Air. Petitioner's letter reminded US Air that ERISA required it to provide her with the requested materials within 30 days after

such request. US Air never responded to Petitioner's December 13, 2011 letter.

After Petitioner's efforts to resolve the issues regarding US Air's 2011 payer status determination and obtain copies of the plan documents relevant to US Air's 2011 determination proved unfruitful, Petitioner engaged a new attorney to assist her with resolving those issues. On January 25, 2012, Petitioner's new counsel wrote to US Air, highlighting US Air's failure to provide Petitioner with the plan documents requested on September 30 and December 13, 2011. Petitioner's new counsel reiterated Petitioner's request for plan documents, asking US Air to provide them, including the document that was missing pages 121 through 125 that Petitioner wrote about in her December 13, 2011 letter, "without further delay."

On February 14, 2012, Petitioner's new counsel received US Air's letter dated January 31, 2012, acknowledging receipt of the January 25, 2012 letter and enclosing copies of the 1993 and 2008 SPDs for the Plan. US Air's letter did not enclose any of the other documents Petitioner requested from US Air in her September 30 and December 13, 2011 letters.

B. Procedural History

On June 24, 2014, Petitioner brought an action against US Air and the Plan in the District Court alleging four causes of action: unreasonable denial of health insurance benefits, improper claims procedure, failure to timely provide plan documents, and violation of the MSP statute. The District Court

denied Defendants–Respondents' motion to dismiss Petitioner's ERISA claim for failure to timely provide plan documents, but granted the motions to dismiss Petitioner's remaining claims for failure to state a claim. (App.43a-74a.) As to Petitioner's claim for unreasonable denial of health benefits, the District Court found the terms of the Plan provided that Medicare was the primary payer on Petitioner's claims. (App.43a-74a.) As to Petitioner's second cause of action for improper claims procedure, the District Court found the Complaint's factual allegations were not sufficiently specific to show how US Air violated the procedural requirements of 29 U.S.C. § 1133. (App.43a-74a.) Finally, the District Court found Petitioner did not state a claim for violation of the MSP statute because under the terms of the Plan, Medicare, and not the Plan, was the primary payer for Petitioner's claims. (App.43a-74a.)

Petitioner moved for the District Court to reconsider its order dismissing her claims, asserting the District Court's decision in dismissing her claims was based on clear errors of law and amendment was necessary to prevent manifest injustice. The District Court denied Petitioner's motion. (App.33a-42a.)

Later, the District Court granted summary judgment in favor of US Air on Petitioner's only remaining claim against US Air for failure to timely provide plan documents. (App.4a-32a.) In granting summary judgment against Petitioner on her claim pursuant to 29 U.S.C. §1132(c)(1), the District Court found there was no genuine issue of material fact regarding the completeness of the 1993 SPD that Petitioner received in October 2010 because Petitioner

did not sufficiently rebut US Air's contention that the 1993 SPD mailed to Petitioner in October 2010 was not missing pages 121 through 125 when she first received the document. (App.4a-32a.) As to the 2008 SPD, the District Court found that there was no genuine issue of material fact regarding when US Air provided the document to Petitioner as US Air provided evidence showing it timely provided the document to Petitioner because, regardless of whether it was provided to Petitioner in October 2010, US Air provided a copy of the 2008 SPD to Petitioner's former attorney in February 2011. (App.4a-32a.) As to Petitioner's separate requests for plan documents from September 30 and December 13, 2011, the District Court found there was no genuine issue of material fact because, regardless of whether US Air was required to provide Plaintiff with historical copies of plan documents (i.e. the 1993 SPD), ERISA did not require US Air to provide Petitioner with copies of plan documents it had already provided in response to Petitioner's October 2010 request for plan documents. (App.4a-32a.) Finally, the District Court found that even if US Air violated ERISA by failing to timely provide Petitioner with plan documents, no penalty against US Air was warranted because Petitioner was not prejudice prejudiced by such violations. (App.4a-32a.)

Petitioner appealed the District Court's ruling to the Fourth Circuit Court of Appeals on April 28, 2017. The court of appeals dispensed with oral argument and affirmed the district court's ruling "for the reasons stated by the district court." (App.2a-3a.) Thereafter, Petitioner sought rehearing from the

Court of Appeals, which the Court of Appeals denied. (App. 1a.)

As soon as the Fourth Circuit denied Petitioner's appeal, US Air began attempting to terminate Petitioner's health insurance even though she is still US Air's employee, still a member of the Union, and still pays the full amount of her premium each month with no subsidy from US Air.

Petitioner now seeks a writ of certiorari from this Court on the three important questions presented in this case.

REASONS FOR GRANTING CERTIORARI

I. The lower court erred by affirming the dismissal of Petitioner's claims for violation of the MSP statute and for unreasonable denial of health insurance benefits in violation of ERISA pursuant to rule 12(b)(6), Fed.R.Civ.P.

The MSP statute, which Congress has amended various times,[2] prohibits a large group health plan (LGHP) from considering a disabled individual's entitlement to Medicare benefits based on disability when the LGHP covers that individual because of

[2] Prior versions of the MSP statute's prohibition only applied to "disabled active individuals." (103 Stat. 2229, 2230 (Dec. 19, 1989, P.L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6202 (b)(1))); however, in 1993, Congress eliminated the concept of "active individual" from the MSP statute. 107 Stat. 593, 595 (Aug. 10, 1993, P.L. 103-66, Title XII, Ch. 2, Subch A, Part III, §§ 13561(e)(1)(E)–(F)); *see also* 60 Fed. Reg. 45344-01, 45346 (Aug. 31, 1995).

their "current employment status with an employer." 42 U.S.C. § 1395y(b)(1)(B)(i). The MSP statute provides its own definition for the term "current employment status," which Congress instructed is to be used for purposes subsection (b) of the MSP statute.[3] As used in subsection (b), "[a]n individual has 'current employment status' with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship." 42 U.S.C. §1395y(b)(1)(E)(ii). "Congress intended that the term 'current employment status' be given the broadest application possible." *Santana v. Deluxe Corp*, 12 F. Supp. 2d 162, 172 (D. Mass. 1998) (finding the MSP statute did not apply to *former* employees because *former* employees do not have *current* employment status).

To state a claim for violation of the MSP statute, a plaintiff must plead sufficient factual matter, accepted as true, to show a primary plan failed to provide for primary payment in accordance with 42 U.S.C. §1395y(b)(3)(A). A large group health plan (LGHP) that insists Medicare pay for claims as primary payer when an individual has coverage under the LGHP because of their "current employment

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[3] In creating the concept of "current employment status" for subsection (b) of the MSP statute, Congress sought to prevent private plans from shifting costs to the public fisc and to ameliorate the problems of escalating healthcare costs and private plans providing inferior benefits or coverage for medical treatment that is also covered by Medicare. *Bio-Med. Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, (hereinafter, "*Bio-Med*"), 656 F.3d 277, 282 (6th Cir.2011) (citing *Fanning v. United States*, 346 F.3d 386, 388 (3d Cir.2003)); *New York Life Ins. Co. v. United States*, 190 F.3d 1372, 1373 (Fed. Cir.1999).

status" violates the MSP statute in the most self-serving manner. 42 U.S.C. § 1395y(b)(1)(B)(i). Under the express language of the MSP statute, an individual has "current employment status" if the individual is "an employee… or is associated with the employer in a business relationship." 42 U.S.C. § 1395y(b)(1)(E)(ii).

When an LGHP's provisions alter the payment priority scheme set forth in the MSP statute, those provisions are "void for violating federal law" because they violate the MSP statute. *Bio-Med.*, 656 F.3d at 283–84. In such a case, "[t]he effect of [the MSP statute] is to nullify any plan provision that would 'carve out' expenses covered by Medicare and thus, in effect, make the plan's coverage secondary to Medicare." *Health Ins. Ass'n of Am., Inc. v. Shalala,* 23 F.3d 412, 418 (D.C. Cir. 1994). Under ERISA, the denial of benefits based on void plan provisions is unreasonable, an abuse of discretion, and in violation of ERISA because adherence to those provisions results in a violation of federal law (i.e. the MSP statute). *Id.*

a. The District Court improperly disregarded the MSP statute's definition of "current employment status" in finding the Complaint did not state a claim under the MSP statute.

In dismissing Petitioner's claim under the MSP statute, which also serves as the foundation for her claim for unreasonable denial of benefits under ERISA, the District Court did not reference or even cite to the MSP statute's definition of "current employment status." (App.43a-74a.) Instead, in

dismissing Petitioner's claims and denying Petitioner's motion to reconsider, the District Court's relied on a narrower, more restrictive definition of the term set forth in regulations in finding Petitioner failed to state a claim under the MSP statute. (App.43a-74a.) 42 C.F.R. § 411.104. Because the MSP statute includes an explicit definition for "current employment status," which Congress expressly provided for purposes of subsection (b) of the MSP statute, the District Court committed a clear error of law in disregarding that definition and concluding the Complaint did not state a claim under the MSP statute.

In construing the terms of a statute, courts should read statutory terms, *including any statutorily provided definitions for such terms*, according to their plain meaning. *See Bailey v. United States,* 516 U.S. 137, 144–45 (1995); *United States v. Missouri Pac. R.R. Co.,* 278 U.S. 269, 278 (1929). When those terms are clear and unambiguous, the court assigns them their "ordinary and natural" meaning. *Bailey,* 516 U.S. at 145. So long as the statutory language is reasonably definite, that language must be regarded as conclusive—at least in the absence of an unmistakable Congressional intent to the contrary. *Dickerson v. New Banner Institute, Inc.,* 460 U.S. 103, 110 (1983); *United States v. Turkette,* 452 U.S., 576, 580 (1981); *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.,* 447 U.S. 102, 108 (1980). "When a statute includes an explicit definition, [courts] must follow that definition." *Stenberg v. Carhart,* 530 U.S. 914, 942 (2000). "Statutory definitions control the meaning of statutory words." *Lawson v. Suwannee Fruit & S.S.*

Co., 69 S.Ct. 503, 504 (1949). Courts need not to delve into a complicated analysis when Congress "has directly spoken to the precise question." *Jacobs v. N.C. Admin. Office of the Courts*, 780 F.3d 562, 573 (4th Cir. 2015) (citing *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984)).

Under section (b) of the MSP statute, "[a]n individual has 'current employment status' with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship." 42 U.S.C. §1395y(b)(1)(E)(ii) (emphasis added). If any of these three statutory criteria are satisfied, an individual has "current employment status" under subsection (b) of the MSP statute and an LGHP is prohibited from considering a disabled individual's entitlement to Medicare benefits. 42 U.S.C. §1395y(b)(1)(B)(i).

It is undisputed that Petitioner is and has been an employee of US Air since 1992 and that all relevant times, Petitioner has been a member of the Union. However, under a narrower, more restrictive regulatory definition of "current employment status" adopted after Congress amended the MSP statute—the application of which would certainly run afoul of Congress's intent[4] in amending subsection (b) of the MSP statute to provide its own statutory definition of "current employment status"— Petitioner would technically not have current employment status as an employee, even though she is a long-time employee of US Air, because she has been receiving LTD benefits through her employer for longer than 6 months. 42

[4] *See* note 3 supra. (addressing congressional intent.)

C.F.R. § 411.104. However, Medicare has consistently denied being primary payer for Petitioner's claims. Accordingly, an application of the MSP statute's definition of "current employment status" to the allegations in the Complaint yields but one conclusion—the Complaint states a claim for violation of subsection (b) of the MSP statute because it alleges that Petitioner is an employee of US Air and a member of the Union that has been covered under the Plan by virtue of her current employment status and US Air made its 2011 payment priority determination based on Petitioner's entitlement to Medicare benefits. Thus, the District Court erred in finding the Complaint did not state a claim under subsection (b) of the MSP statute.

b. The District Court erred in finding the relevant provisions of the Plan do not violate the MSP statute.

The District Court's determination that the Complaint did not state a claim for unreasonable denial of benefits relied on the language of the Plan's "Disability" provision in concluding the Plan was not the primary payer for Petitioner's 2011 health care claims.[5] However, the "Disability" provision of the Plan relied on by the District Court violates subsection (b) of the MSP statute because it illegally restricts the payment priority set forth in the MSP

[5] Petitioner's Complaint referenced the Plan's 2011 Summary of Material Modifications, but did not reference the "Disability" provision of the Plan. However, as addressed herein, because the terms of the "Disability" provision violate subsection (b) of the MSP statute, they are void for violating federal law. Under the remaining terms of the Plan, Medicare is secondary payer.

statute by distinguishing between classes of employees when Congress's definition provides for no such distinction and because the Plan's provisions improperly dictate when the Plan will pay as primary. The Plan also does not take into account an individual's status as a Union member.

Section 4.5 of the 1992 iteration of the Plan addresses the Plan's coordination with Medicare regarding payment priority. Section 4.5 explains that, except were an employee is still "active . . . [w]hen a Participant is eligible for Medicare . . . this Plan will pay benefits only after Medicare has paid its benefits; provided, however, that the Plan will only pay benefits before or after Medicare has paid benefits, as applicable, if the Participant has enrolled for Medicare Parts A and B." Section 3.1 of the Plan states, "An 'inactive' Employee is an Employee who is on leave from employment with his Employer." The Plan's 2003 Amendment to Section 4.5 also provides the same payment priority, with immaterial alterations.

The Plan's 2011 Summary of Material Modifications (2011 SMM), portions of which Petitioner cited in her Complaint, provides:

> **Coordination With Medicare for Disabled Individuals (SPD, Page 36)**
> * * * *
> If you . . . are enrolled in Medicare while you are actively employed, participation in this Plan will continue as long as you are an active employee and remain enrolled. This Plan will be the primary

carrier and Medicare will be the secondary carrier.

If you are on a leave of absence or you are receiving disability benefits, please note the following important rules regarding coverage under Medicare:

Leave of Absence: If you take a leave of absence and retain coverage under the Plan, the Plan will continue to pay primary for as long as you retain your right to return to active employment, i.e., your employment is not terminated by the company. If your employment is terminated by the company, Medicare will become primary.

Disability: If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from the company, the Plan will continue to pay primary for the first 6 months of your disability coverage, i.e., while disability benefits are subject to FICA tax. After this 6 month period, Medicare will become primary for you and/or any covered dependents.

When Medicare becomes primary, the Plan assumes you are enrolled in both Medicare Part A and B, so review your options when you become eligible for Medicare (either due to age or disability).

Although inapplicable to Petitioner's 2011 benefit claims, the 2013 iteration of the Plan incorporates the "Disability" provision from the 2011 SMM in all relevant respects.

In its 1993 amendments to subsection (b) of the MSP statute, Congress eliminated the concept of an "active individual."[6] 103 Stat. 2230. Since 1993, subsection (b) of the MSP statute has prohibited LGHPs from considering an individual's entitlement to Medicare benefits based on "current employment status," which subsection (b) of the MSP statute has expressly defined since 1993. 42 U.S.C. §1395y(b)(1)(E)(ii). Notwithstanding these important amendments to the MSP statute, US Air violated the MSP statute by basing its 2011 payment priority determination on Plan provisions incorporating restrictive concepts that Congress expressly removed from the MSP statute over twenty years ago. Those antiquated and illegally restrictive plan provisions are "void for violating federal law" because they violate the MSP statute. *Bio-Med.*, 656 F.3d at 283–84; *Shalala,* 23 F.3d at 414. Moreover, US Air's 2011 payment priority decision denying Petitioner's health benefits claims based on the void "disability" provision

[6] The prior version of the MSP statute did not include the concept of "current employment status," and instead used the now-eliminated concept of "active individual," which the prior version of the MSP statute defined, in relevant part, as "an employee (as may be defined in regulations) . . . ." 103 Stat. 2230. The MSP statute no longer references definitions set forth in the regulations, and instead, it contains its own definitions or it specifically references definitions set forth elsewhere in the U.S. Code.

is unreasonable and an abuse of discretion because adherence to that provision results in a violation of federal law—subsection (b) of the MSP statute. *Id.*

Construed in a light most favorable to Petitioner, the Complaint alleges sufficient factual matter to plausibly state a claim for relief under ERISA, 29 U.S.C. § 1132(a)(1)(B), for unreasonable denial of benefits.

The Complaint alleges that US Air unreasonably denied Petitioner benefits under the Plan in violation of ERISA, 29 U.S.C. § 1132(a)(1(B). More particularly, the Complaint alleges that Petitioner, a long-time employee of US Air Union member, has been a continuously enrolled participant in the Plan at all times relevant to her claim for health benefits. It further alleges Petitioner began receiving Medicare benefits in 2003, but asserts that the Plan should be primary and Medicare should be secondary. Further factual basis for Petitioner's claim is grounded upon: the terms of the Plan (which violate subsection (b) of the MSP statute); her allegation that US Air unilaterally ceased paying as primary in 2011, insisting that Medicare was primary, even despite the determination by the external reviewer that US Air was required to pay as primary; the fact that Medicare denied being primary in 2011; and her allegation that before 2011, US Air had tried to deny responsibility as primary payer, which Petitioner contends has been US Air's pattern and practice in dealing with her claims for benefits under the Plan.

Accordingly, the District Court erred in dismissing Petitioner's claim for unreasonable denial

of benefits in violation of 29 U.S.C. § 1132(a)(1)(B) because the Complaint's factual allegations, taken in the light most favorable to Petitioner, set forth a plausible claim for relief.

II. The District Court erred by granting summary judgment against Petitioner on her claim for failure to timely provide plan documents because, taken in the light most favorable to Petitioner, a reasonable jury could conclude US Air did not timely provide Plaintiff with the plan documents she requested on September 30 and December 13, 2011.

This Court should hold that the District Court erred in granting summary judgment against Petitioner on her claim for failure to timely provide plan documents because ERISA required US Air, as plan administrator, to provide Petitioner with the documents she requested in writing on September 30 and December 13, 2011, within thirty days of her requests, which US Air undisputedly did not do.

A district court "shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(a). "A dispute is genuine if 'a reasonable jury could return a verdict for the nonmoving party.'" *Libertarian Party of Va. v. Judd,* 718 F.3d 308, 313 (4th Cir.2013) (quoting *Dulaney v. Packaging Corp. of Am.,* 673 F.3d 323, 330 (4th Cir.2012)). "A fact is material if it 'might affect the outcome of the suit under the governing law.'" *Id.* (quoting *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248 (1986)).

In considering a motion for summary judgment, the district court must "view the evidence 'in the light most favorable to the'" nonmoving party. *Tolan v. Cotton,* 134 S.Ct. 1861, 1866 (2014) (quoting *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 157 (1970)). "Summary judgment cannot be granted merely because the court believes that the movant will prevail if the action is tried on the merits." 10A Charles Alan Wright & Arthur R. Miller et al., *Federal Practice & Procedure* § 2728 (3d ed.1998). The court therefore cannot weigh the evidence or make credibility determinations. *Tolan,* 134 S. Ct. at 1866-67; *Mercantile Peninsula Bank v. French (In re French),* 499 F.3d 345, 352 (4th Cir.2007) (citing *Anderson,* 477 U.S. at 255); *see also* Fed.R.Civ.P. 56 Advisory Committee's Note (1963) ("Where an issue as to a material fact cannot be resolved without observation of the demeanor of witnesses in order to evaluate their credibility, summary judgment is not appropriate.").

29 U.S.C. § 1132(c)(1) provides, in relevant part:

> Any administrator . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . . by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such

> participant or beneficiary in the amount of up to [$110] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, . . . each violation described in subparagraph B with respect to any single participant or beneficiary, shall be treated as a separate violation.

29 U.S.C. § 1132(c)(1).[7]

ERISA contains stringent disclosure requirements, which help to ensure an individual participant "knows exactly where [s]he stands with respect to the plan," *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 118 (1989), "which includes having the information necessary to determine her eligibility and understand her rights under the plan and to ascertain the procedures she must follow to obtain benefits." *Hartman v. Dana Holding Corp.*, 978 F.Supp.2d 957, 968-69 (N.D. Ind. 2013) (citing *Mondry v. Am. Family Mut. Ins.*, 557 F.3d 781, 793 (7th Cir. 2009)); *see also Izzo v. ING Life Ins. and Annuity Co.*, 235 F.R.D. 177, 187 (E.D.N.Y. 2005) (quoting *Firestone*, 489 U.S. at 118). These disclosure provisions, require a plan administrator to, "upon written request of any participant or beneficiary, furnish a copy of the latest updated summary[] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under

[7] 29 C.F.R. § 2575.502c-1 (increasing the per diem penalty from $100 to $110).

which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Courts have interpreted this section as requiring the plan administrator to "furnish copies of the actual plan documents (including amendments) under which the plan is operated." *Izzo*, 235 F.R.D. at 178 (quoting *McFaul v. Lowes Corp.*, 1993 WL 541778, at *2 (S.D.N.Y. Dec. 30, 1993)).

a. US Air was required to timely provide Petitioner with a copy of the 1993 SPD, the 2008 SPD, and all "other instruments under which the [P]lan [was] established or operated" in response to Petitioner's September 30 and December 13, 2011 written requests, which it did not do.

In addition to ERISA's requirement that plan administrators "furnish a copy of the latest updated summary[] plan description" within 30 days of a participant's written request, 29 U.S.C. §§ 1024(b)(4), 1132(c)(1), the plan administrator must also furnish "the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated," 29 U.S.C. § 1024(b)(4), and the plan administrator must provide historical documents to plan participants if they contain information that will allow the participant to understand and assert her rights under the plan. *Hartman v. Dana Holding Corp.*, 978 F.Supp.2d 957, 968 (N.D. Ind. 2013) (citing *Hakim v. Accenture U.S. Pension Plan*, 656 F.Supp.2d 801, 824 (N.D. Ill. 2009) and *Mondry v. Am. Family Mut. Ins.*, 557 F.3d 781, 800 (7th Cir.2009)). When historical plan documents control a participant's claim for benefits, those historical documents are

undoubtedly an instrument under which the plan was established or operated and are therefore subject to § 1024(b)(4)'s disclosure obligation. *Hartman v. Dana Holding Corp.*, 978 F.Supp.2d 957, 968 (N.D. Ind. 2013) (citing *Huss v. IBM Med. & Dental Plan*, 418 Fed.Appx. 498, 509 (7th Cir. 2011) and *Bilello v. JPMorgan Chase Ret. Plan*, 649 F.Supp.2d 142, 170 (S.D.N.Y. 2009)).

On September 30, 2011, Petitioner submitted a written request for copies of various plan documents. This written request specifically asked US Air for copies of "the relevant [SPDs]" and other plan documents required to be provided pursuant to ERISA, such as "all relevant amendments." Almost sixty days later, US Air sent Petitioner a letter stating it had "already provided all relevant plan documents, summary plan descriptions and collective bargaining agreements that govern the terms of your medical coverage," referencing its February 2011 letter to Petitioner's former counsel.[8] In a separate written request dated December 13, 2011, Petitioner reiterated her unfulfilled September 30, 2011 request and again requested that US Air provide her with "all relevant plan documents" that US Air had at the time it decided to name itself as secondary payer of her 2011 medical benefits. Petitioner's December 13, 2011 request also noted that her copy of the 1993 SPD that US Air had previously provided was missing pages 121 thru 125. US Air ignored that separate request.

[8] The February 2011 letter to Petitioner's former counsel specifically referenced the SPDs for 1993 and 2008, certain amendments to the Plan, and the collective bargaining agreement in addressing its basis for US Air's 2010 payer status determination.

The evidence in the record shows that the 1993 SPD was a "relevant," moreover, key document because it contained information that would have helped Petitioner to understand her rights under the Plan. *See Hartman*, 978 F.Supp.2d at 968. In fact, US Air's February 2011 letter to Petitioner specifically referenced the 1993 SPD in providing US Air's basis for its 2010 payer status determination, which is highly indicative of the relevance of that document in evaluating Petitioner's issues with US Air's 2011 payer status determination. Accordingly, US Air was required to timely provide Petitioner with a copy of the 1993 SPD upon receiving Petitioner's written requests for plan documents, which the evidence in the record shows US Air did not do until February 2012, when it provided copies of the 1993 and 2008 SPDs, but none of the other documents Petitioner had requested in September and December 2011, in response to Petitioner's new attorney's January 25, 2012 written request. Thus, the evidence in the record shows that US Air violated § 1132(c)(1) when it failed and refused to comply with Petitioner's requests for plan documents within 30 days of her such written requests.

b. ERISA does not relieve a plan administrator of its duty to provide plan documents within 30 days of receiving a written request for plan documents if the plan administrator previously provided said documents.

The District Court's conclusion that ERISA does not require plan administrators to provide participants with copies of plan documents if the

administrator has previously provided a copy of such documents is based on a flawed construction of 29 U.S.C. § 1132(c)(1). Simply put, § 1132(c)(1) does not provide for such a one-and-done approach. Dogs eat homework, catastrophes strike, and sometimes documents get misplaced—the statute accommodates for these contingencies and does not prohibit participants or beneficiaries from submitting multiple requests for plan documents. 29 U.S.C. §§ 1024(b)(4), 1132(c)(1). Moreover, the statute specifically takes into account the costs of providing plan documents, so it allows plan administrators to make a reasonable charge to cover the cost of furnishing such documents. 29 U.S.C. § 1024(b)(4). In fact, section 1132(c)(1) specifically indicates that "each violation . . . with respect to any single participant or beneficiary[] shall be treated as a separate violation." Thus, where multiple requests for plan documents go unfulfilled, as in this case, the statute treats each of those requests as separate violations, each of which is subject to the daily penalties provided for by section 1132(c)(1). Accordingly, because the evidence in the record shows that US Air failed and refused to timely provide Petitioner's written requests for plan documents, the District Court erred in granting summary judgment against Petitioner on this claim.

c. The District Court erred in declining to assess a monetary penalty against US Air for failure to timely provide Petitioner with the plan documents she requested from US Air on numerous occasions.

The District Court abused its discretion when it found that, even if there was a genuine issue of

material fact as to whether US Air violated 29 U.S.C. § 1132(c)(1), no monetary penalty should be assessed against US Air. (App.4a-22a.) The District Court's finding is based on an error of law—that prejudice or bad faith are *required* before a penalty is warranted for violations of § 1132(c)(1). This finding is also based on the Court's erroneous interpretation of the facts pertaining to Petitioner's request for plan documents.

A plan administrator "may in the court's discretion be personally liable to [a] participant . . . in the amount of up to [$110] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. . . . [E]ach violation . . . with respect to any single participant . . . shall be treated as a separate violation." 29 U.S.C. § 1132(c)(1). When there is some doubt about whether a someone is entitled to plan documents under §1132(c)(1), "the Supreme Court has suggested that an administrator should err on the side of caution: 'Faced with the possibility of . . . [monetary] penalties. . . , a rational plan administrator . . . would likely opt to provide . . . the information requested, . . especially when the reasonable costs of producing the information can be recovered.'" *Davis v. Featherstone*, 97 F.3d 734, 738 (4th Cir.1998) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 118 (1989)).

In determining whether to assess a penalty against a plan administrator that violates § 1132(c)(1), "two factors *generally* guide a district court's discretion: prejudice to the plaintiff and the nature of the administrator's conduct in responding to the participant's request for plan documents. Although prejudice is a pertinent factor for the district

court to consider, *it is not a prerequisite to imposing a penalty*."[9] *Davis*, 97 F.3d at 738 (emphasis added) (citations to cases from the 11th and 7th Circuit Courts of Appeals omitted); *see also, Carroll v. Continental Auto., Inc.*, 685 Fed.Appx. 272, 276-77 (4th Cir. 2017) ("Although findings of prejudice maybe relevant to a penalty determination, courts analyzing ERISA do not condition the imposition of penalties on the existence of such findings."). "[F]rustration, trouble, and expense are relevant factors for a district court to consider in deciding whether to impose a penalty." *Id.* at 738. It is proper for the district court to consider whether a participant has had to go to the trouble and expense of engaging an attorney to obtain plan documents she has requested but not received. *Id.* at 738-39. "The purpose of the penalty provision is to provide plan administrators with an incentive to meet requests for information in a timely fashion." *Id.* at 738.

The Fourth Circuit evaluates a district court's decision regarding imposition of monetary penalties pursuant to 29 U.S.C. § 1132(c)(1) under the abuse-of-discretion standard of review. *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 659 (4th Cir.1996);

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[9] Other circuit courts have used five factors in determining whether to assess penalties under § 1132(c)(1): "(1) bad faith or intentional conduct of the plan administrator, (2) length of delay, (3) number of requests made, (4) documents withheld, and (5) prejudice to the participant." *Romero v. Smith Kline Beecham*, 309 F.3d 113, 120 (3d Cir.2002); *see also McDonald v. Pension Plan of the Nysa-Ila Pension Trust Fund*, 320 F.3d 151, 163 (2d Cir.2003*); Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 847 (11th Cir. 1990) (citing five factors, but noting they are not prerequisites for imposing penalties against a plan administrator).

Highmark, Inc. v. Allcare Health Management Systems, Inc, 134 S. Ct. 1744, 1748 (2014) ("Traditionally, . . . decisions on 'matters of discretion' are 'reviewable for abuse of discretion.'" (quoting *Pierce v. Underwood,* 487 U.S. 552, 558 (1988))). "The abuse-of-discretion standard does not preclude an appellate court's correction of a district court's legal or factual error: 'A district court would necessarily abuse its discretion if it based its ruling on an erroneous view of the law or on a clearly erroneous assessment of the evidence'." *Highmark*, 134 S. Ct. at 1748 n.2 (quoting *Cooter & Gell v. Hartmarx Corp.,* 496 U.S. 384, 405 (1990)). In decisions reviewable under the abuse of discretion standard, a district court "has wide discretion when, but only when, it calls the game by the right rules." *Fox v. Vice*, 563 U.S. 826, 839 (2011). "'A district court by definition abuses its discretion when it makes an error of law.'" *Davis* 97 F.3d at 738 (quoting *Koon v. United States*, 518 U.S. 81, 100 (1996)).

The evidence in the record shows that Petitioner sent US Air multiple, unfulfilled written requests for plan documents in 2011. Petitioner's September 30, 2011 request for plan documents specifically asked US Air to expedite the request. Although US Air acknowledged Petitioner's September 30, 2011 request—almost 60 days after she sent it—it did not provide Petitioner with any plan documents. Instead, US Air stated it had already provided Petitioner with "all relevant plan documents, summary plan descriptions and collective bargaining agreements that govern the terms of your medical coverage," without specifying which of the "relevant plan documents" specifically governed the terms of

her medical coverage, particularly her pending issue with US Air's 2011 payer status determination.

Moreover, the evidence in the record shows US Air ignored Petitioner's December 13, 2011 request, as US Air never responded to Petitioner's December 13, 2011 letter. Regardless of whether US Air was required to provide Petitioner with a copy of the 1993 SPD in October 2010 and regardless of when US Air first asserts it provided Petitioner with a copy of the 2008 SPD, US Air did not provide Petitioner with any SPDs in response to her September and December 2011 requests for plan documents. Further, after Petitioner was forced to get an attorney to help her get copies of the plan documents she had already tried to obtain on her own and after US Air finally responded to Petitioner's new counsel's January 25, 2012 letter reiterating Petitioner's requests for plan documents, US Air only sent the 1993 and 2008 SPDs. Notably, US Air's response to the January 25, 2012 letter did not provide any of the previously requested "relevant group insurance policies", "relevant amendments" to the plans, nor did it provide copies of the collective bargaining agreements despite US Air's clear obligation to provide such documents, as provided by 29 U.S.C. § 1024(b)(4). In fact, US Air did not submit any evidence suggesting when, if ever, it provided Petitioner with those documents following Petitioner's written requests for the plan documents on September 30, 2011, December 13, 2011, and January 25, 2012.

Furthermore, US Air did not provide Petitioner with the complete 1993 SPD within 30 days of Petitioner's December 13, 2011 letter alerting them to the fact that her copy of said document was missing

pages. That alone is sufficient for the imposition of penalties against US Air. *Faircloth*, 91 F.3d at 659. Moreover, US Air did not so much as acknowledge Petitioner's September 30, 2011 request for plan documents until almost 60 days after receiving said request, and Petitioner was unable to obtain copies of any of the plan documents she requested, beginning on September 30, 2011, until she hired her new attorney to help her get copies of the requested plan documents and enforce her rights as provided by ERISA.

Notwithstanding the foregoing, the District Court found Petitioner did not establish she was prejudiced by US Air's failure to timely provide her with plan documents, in part because certain of these documents had apparently been provided in 2010. (App.4a-22a.) Although the specific statutory "Prejudice to the party requesting the documents is not a prerequisite to the imposition of penalties." *Faircloth*, 91 F.3d at 659 (emphasis added). Instead, it is merely one of several factors that the court may consider in determining whether and to what extent it should impose penalties for the violation of section 1132(c)(1). *Id.*

Moreover, although the District Court found Petitioner failed to establish prejudice, the evidence in the record indicates otherwise. In fact, US Air did not provide Petitioner with the copies of the documents she requested in advance of her administrative appeals—it took Petitioner's hiring of her new attorney, after she had already initiated the administrative appeals, for Petitioner to get copies of the 1993 and 2008 SPDs, and even then, US Air still

did not provide Petitioner with all of the documents she requested in September and December 2011. [10] This is more than sufficient to show Petitioner was, in fact, prejudiced by US Air's failure to comply with §1132(c)(1) and that US Air's conduct in responding to Petitioner's requests for plan documents was not reasonable.

III. This case presents a recurring question of exceptional importance warranting the Court's immediate resolution.

This case raises a question of vital importance to disabled employees in regard to their right to continue receiving highlights health benefits and to taxpayers, who should not bear the financial burden of insurance plans being held as secondary when an employee is receiving Medicare.

The consequences of the Fourth Circuit's decision are significant for Petitioner and for others in a similar position. If precedent is allowed to stand which allows a company to craft its own definition of when Medicare is to be held secondary, in violation of the MSP statute, the MSP statute will be rendered toothless. In disregarding this consequence, the Fourth Circuit has opened a door to allow private companies to circumvent important statutory protections for employees who would otherwise

[10] Petitioner's 2010 and 2011 requests for plan documents asked for <u>different</u> documents. Although US Air maintained it had already provided Petitioner with the requested documents in 2010, the evidence in the record simply does <u>not</u> support that assertion because US Air only provided copies of the 1993 and 2008 SPDs to Petitioner in February 2012.

receive the full benefit of private insurance coverage that they have earned through their "current employment status."

CONCLUSION

The petition for writ of certiorari should be granted.

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