No. 24- 356

IN THE

Supreme Court of the United States

7/1/2024

SONYA MUNROE,

Petitioner,

v.

AETNA MEDICARE AND KAREN LYNCH,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
TO THE UNITED STATES COURT OF APPEALS SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS FOR REVIEW

(1) When should courts have jurisdiction over Medicare cases where claimants have not shown that they pursued or exhausted the administrative remedies required by insurers like Aetna?

(2) Should courts require insurers like Aetna to publish lists of protocols they use for deciding which Medicare claims are urgent, especially claims for surgical procedures?

U.S. TRIAL COURT & APPELLATE PROCEEDINGS

(1) Order of Dismissal, U.S. District Court, Southern District of New York. Dated August 9, 2023. Case #23-CV-6868 (CS), *Sonya Munroe v. Aetna Medicare.*

(2) Summary Order, U.S. Court of Appeals, Second Circuit. Dated March 26, 2024. Case #23-1313-cv, *Sonya Munroe v. Aetna Medicare, Karen Lynch, Aetna President.* Judgment of the district court affirmed.

(3) Order, U.S. Court of Appeals, Second Circuit. Dated June 6, 2024. Docket No. 23-1313, *Sonya Munroe v. Aetna Medicare, Karen Lynch, Aetna President.* Request for rehearing denied.

There are no other legal proceedings related to this case.

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OPINIONS & ORDERS

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(1) The Southern District Court of New York, in *Munroe v. Aetna Medicare*, Case #23-CV-6868, dismissed the case on August 9, 2023.

(2) The U.S. Court of Appeals, Second Circuit, in *Sonya Munroe v. Aetna Medicare, Karen Lynch, Aetna President*, Case #23-1313-cv, affirmed the District Court's dismissal order on March 26, 2024.

(3) The U.S. Court of Appeals, Second Circuit, in *Sonya Munroe v. Aetna Medicare, Karen Lynch, Aetna President*, Case #23-1313-cv, denied Appellant's request for a rehearing on June 6, 2024.

BASIS FOR JURISDICTION

The Medicare Act of 1965 gives U.S. courts the authority.

CONSTITUTIONAL & STATUTORY PROVISIONS

(1) Amendment I: "Congress shall make no law . . . abridging the right of the people . . . to petition the Government for a redress of grievances."

The Constitution

(2) The Medicare Act of 1965, 42 U.S.C. §1395.

STATEMENT OF THE FACTS OF THE CASE

Copied verbatim from Petitioner's Appellant Brief

(1) March 22nd, 2023, the pain in her left leg began.

(2) March 30th, Dr. Abraham Mittelman recommended an MRI.

(3) April 22nd, the MRI showed a synovial cyst between two vertebrae. It was compressing the sciatic nerve to her left leg, causing debilitating pain.

(4) May 1st, spine surgeon Dr. Alain de Lotbinière showed her the MRI. He scheduled surgery to remove the cyst on May 31st.

(5) May 16th, Aetna denied approving coverage for May 31st surgery. They told her surgeon they required presurgical physical therapy instead.

(6) May 23rd, her surgeon appealed to Aetna. By phone, a retired spine surgeon at Aetna told him he agreed that presurgical therapy was unnecessary, but he said it was Aetna protocol and he was bound by it.

(7) May 24th, Aetna denied her surgeon's appeal. He rescheduled the surgery for July 18th.

(8) May 26th, at the therapist's prompt, Appellant began a journal recording her daily pain. On a 1-to-10 scale, least-to-worst, it varied from 6 to 9.

(9) June 19th, her last presurgical therapy session.

(10) June 24th, Aetna approved coverage for July 18th surgery.

(11) June 26th, an Aetna complaint analyst phoned Appellant that Aetna approved coverage for outpatient admission on July 18th but not for inpatient admission. Her surgeon had recommended inpatient admission.

(12) During the seven-week delay of her surgery, she kept taking the ibuprofen a doctor recommended to alleviate the pain. A dangerous side effect was diagnosed as chronic kidney insufficiency.

(13) July 18th, about noon, the surgeon removed a peanut-size cyst from her vertebrae and her sciatic pain stopped. At 5 PM the wound was still bleeding, leaking outside the dressing. Nursing staff replaced it, and she was released about 6 PM.

(14) July 19th, about 3 AM, the dressing was blood soaked again and was falling off. She managed to replace it and phoned later that morning for medical advice.

(15) Even if her surgeon had further appealed Aetna's May 24th denial of his May 23rd appeal, and if Aetna had instead approved coverage for July 18th surgery, he still could not have rescheduled it for any time before July 18th.

REASONS FOR GRANTING THE WRIT

The First Amendment grants Petitioner the right to petition the Government for a redress of grievances. Government includes courts, and nowhere does the Constitution allow Aetna to abridge Petitioner's right to petition the courts. Yet her trial and appeals courts let Aetna impose administrative remedy requirements on her and an undetermined number of other Medicare patients, requirements that deny them access to the courts. Aetna hurts them in the process, and now the Supreme Court is their only hope for a remedy.

If the Appeals Court order is let stand, Aetna will keep handicapping our eldercare health program. Through its more careful analysis of the law and a more humane interpretation of it, the Supreme Court can remove that handicap.

Her trial and appellate courts rely heavily on four cases they cite to support their decisions. (See her discussion below of the *Abbey, Heckler, Nichole*, and *Retina* cases.) But read in their entirety, all four actually contradict her courts' decisions: (1) They recognize Petitioner's case as an exception to the remedy exhaustion rule, and (2) they support her claim of immediate access to surgery.

Petitioner's success would relieve the suffering of an unknown number of other Medicare patients like her. Granting this writ would restore and strengthen their rights. Denying it would defer to the financial interests of a corporation. And it would immunize Aetna's president from public accountability for her disregard of another human being old enough to be her mother.

SUPPORTING ARGUMENTS

The following paragraphs are from Petitioner's Appellant Brief where it rebuts the appellate court's arguments. After that, there are further explanations of seven ways that the court's own case and statute citations contradict its decision.

REBUTTAL OF THE APPEALS COURT'S ARGUMENTS

Below are verbatim excerpts from Petitioner's Appellant Brief. Sections numbered 7 to 11 each start with a quote from the District Court's dismissal order.

. . . Oddly, Appellant's Court *does* cite three cases on the *Abbey* criteria – cases where superior courts hold that certain claimants need *not* meet the exhaustion requirement before suing. Appellant is clearly one of these claimants:

1st: *Bowen v. City of New York*, 476 U.S. 467 (1985), 1065 U.S. 2022: "We should be especially sensitive to this kind of harm where the Government seeks to require claimants to exhaust administrative remedies merely to enable them to receive the procedure they should have been afforded in the first place." Remedy exhaustion could not have provided Appellant any relief from the pain she suffered after Aetna decided to deny coverage for May 31st surgery. So the requirement itself – that she first present her plea to Aetna – was futile.

To paraphrase *Bowen*, 'We should be especially sensitive to the harm Appellant would suffer if the

exhaustion requirement were applied merely to enable her to receive the surgery Aetna should have afforded her in the first place.'

2nd: *Crisci v. Shalala*, 169 F.R.D. 563 (S.D.N.Y. 1996): "The possible harm plaintiffs would suffer if required to exhaust their administrative remedies further support [*sic*] waiver in this case." As in *Bowen* above, the *Crisci* court would likely say, 'Because Appellant would suffer possible harm, we support an exception to the exhaustion requirement.' In her case, it was the real harm she suffered between the May 31st cancellation and the July 18th surgery.

On May 16th, Aetna refused to approve coverage for the May 31st surgery already scheduled. Their callousness prolonged her pain until they got around to changing their mind and finally agreed to cover the surgery, never bothering to explain their reversal to her or her surgeon.

3rd: *Kendrick*, 784 F. Supp at 100 (quoting *Sullivan*, 906 FF. 2d at 98): "While each of these factors [the *Abbey* waiver criteria] is relevant to the court's determination, a 'general approach, *balancing the competing considerations to arrive at a just result, is in order*'", [emphasis supplied]. Applying *Kendrick* and *Sullivan's* law to Appellant's case: 'Because a just result is in order, we consider that Plaintiff 's need to avoid irreparable harm outweighs the remedy requirement.' In Appellant's case, the cases her Court itself cites reject exhaustion in favor of her avoiding ill health and physical debilitation – not just irreparable harm.

Another authority, one the Court does not cite, supports the futility exception in Appellant's case. In

McCarthy v. Madigan, 503 U.S. 140, 144 (1992), the court balances two interests: the individual's, in prompt access to a federal justice forum; and the agency's, requiring the individual to complete the agency's appeals process. To weigh the two interests fairly, the court looks at Congress's legislative intent. The authors of the Medicare Act of 1965 intended to provide us access to adequate medical care where it had been unavailable to so many. But when a government agency shows evidence of bad faith or past patterns that harm us, or when it takes arbitrary and unfounded positions on the merits of an individual case, courts recognize a plaintiff 's claim that remedy exhaustion would be futile. Where the injury a plaintiff would suffer is irreparable – that is, unusual and incapable of correction through later review – courts allow judicial review of an agency's decision. They allow it because the individual's interest in avoiding suffering and death outweighs the agency's interest in administering a process to provide or deny insurance coverage for medical procedures. The facts in Appellant's case obviously shift the balance her way. (She thanks *The West Virginia Law Review* [Vol. 103: 361] for their article on the subject.)

(7) *"Plaintiffs [sic] claim that she was wrongfully denied benefits is not collateral; it is the substantive claim at issue." Abbey v. Sullivan*, 978 F.2d 37: Judicial waiver of the exhaustion requirement applies where the claim is collateral to a demand for benefits. And Appellant seeks what the Court accurately says she seeks – a declaratory judgment and an injunction, but no monetary benefit. Belatedly, Aetna did approve coverage for the cyst-removal surgery, but this complaint is that Aetna *delayed* that benefit, and *that their delay caused Appellant seven weeks of pain.* As for any other benefit her claim might be

collateral to, she has withdrawn her request for the $360 she copaid for presurgical physical therapy. So there is no other benefit she seeks that her other claims could be collateral to.

(8) *"There is no indication that exhaustion would be futile. . . ."* Refutation (6), above, discusses *Crisci*, *Kendrick* quoting *Sullivan*, and *Bowen.* These courts explain why remedy exhaustion would harm her, that it would prolong the pain she was suffering because Aetna denied, then delayed, covering her surgery. They imply that in Appellant's case, exhaustion would be futile.

Saying exhaustion is futile is the same as saying that "the policies underlying the exhaustion requirement do not apply in a given case," *Abbey v. Sullivan*, 978 F.2d, (p. 47). Whatever policies might underlie the exhaustion requirement that the Court requires of Appellant, there is no hint of any Aetna policy that explains why they refused to approve Appellant's surgery for May 31st; and no hint of why they changed their mind and on June 24th agreed to cover it for July 18th.

(9) *"[T]here is no pending irreparable harm." Abbey* on its page 37 recites the three waiver criteria, one of them where the requirement would cause plaintiff *irreparable* harm. But on page 46, the court then says, "If the delay attending exhaustion would subject claimants to *deteriorating health* [emphasis supplied], then waiver may be appropriate." These claimants obviously include Appellant.

Furthermore, in dismissing Appellant's case, the Court itself cites *Crisci v. Shalala*, 169 F.R.D. 563

[S.D.N.Y. 1996]. But that court writes, "The *possible harm* [emphasis supplied] plaintiffs would suffer if required to exhaust their administrative remedies further support [*sic*] waiver in this case." So the superior courts that the Court itself cites do not regard *irreparable harm* as the necessary criterion that the Court seems to regard it. *Deteriorating health* and *possible harm* prevail when the law weighs the two interests: society's, to hold insurance companies responsible for abusing patients; versus how severe a patient's injury or poor health has to be before the judiciary will hear their petition for a redress of grievances.

The Court implies that a fatal weakness in Appellant's claim is her failure to demonstrate *pending irreparable harm*. However, fact #12, above, cites her diagnosis of chronic kidney insufficiency, a side effect of her pain medication. The Court cannot predict that Appellant's kidney condition is merely *reparable* harm. Nor can it say why Appellant, 76, must show that she suffers *irreparable* harm, or else her case does not deserve judicial scrutiny.

As standards for exhaustion waivers, superior courts recognize that *deteriorating health* and *possible harm* outweigh the absolute rigidity of *pending irreparable harm*.

(10) "*[T]he purposes of the exhaustion requirement are furthered by applying it here, as Plaintiff could obtain some or all of the relief she seeks.*" Saying she could have gotten relief through exhaustion implies that she should have, and that because she did not, her case may be dismissed. The Court, however, does not identify what relief she could have gotten that way. The Court accurately

names money damages as relief Appellant sought (but which she rescinded), a declaratory judgment, and an injunction. It then says that by exhausting the remedies, she "could obtain some or all of the relief she seeks." It does not say, however, that she 'could obtain some or all of the relief she seeks *or none at all.*' This omission cynically pits Appellant's chances for some, all, or *no relief at all*, against "the purposes of the exhaustion requirement" – which the Court never identifies. So statement 10 is no justification for dismissing the case.

(11) *"[T]he Court lacks subject matter jurisdiction...."* It does not.

The *Abbey* court writes, "We distilled from *Erika* and *Michigan Academy* the principle 'that federal jurisdiction exists where there is a challenge to the validity of an agency rule or regulation, but jurisdiction is lacking where the claim is merely that the insurance carrier misapplied or misinterpreted valid rules and regulations'" (*Abbey v. Sullivan*, 978 F.2d at 42, citing *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. at 208, 102 S.Ct. at 1654). Exactly as in *Abbey*, Appellant challenges the validity of whatever rule or protocol Aetna might have for delaying surgery coverage. She next challenges why Aetna required presurgical physical therapy instead and why they failed to explain why they decided to cover her surgery at all.

FURTHER EXPLANATION: SEVEN WAYS THAT THE APPEALS COURT'S OWN CITATIONS CONTRADICT ITS DECISION

(1) 42 U.S.C. §405(g)-(h) The court erred when it concluded, "Munroe has failed to demonstrate that her

claims would fall within an exception to the exhaustion requirement under Section 405," (Summary Order, 3/26/24, p. 4). It cites 42 U.S.C. §405(g)-(h), describing decisions by the Commissioner of Social Security "irrespective of the amount in controversy," (§405[g]). *Amount in controversy* means money a complainant failed to get after exhausting administrative remedies. Petitioner is exhausting her efforts to clarify that she doesn't want Aetna's money. Meanwhile, the court's citation of §405 is mistaken and irrelevant.

The court erred again: "Failure to exhaust deprives the federal courts of jurisdiction over such claims," (Summary Order, pp 2-3). Its category *"such claims"* does not include Petitioner's. Analysis of the cases below shows that the court errs by comparing Petitioner's to cases it hales as rebutting her argument.

(2) In Summary Order, p. 3, the court cites *Heckler v. Ringer*, 466 U.S. 602, 622 (1984), where the Supreme Court concluded it was "of no importance that [plaintiffs] . . . sought only declaratory and injunctive relief and not an actual award of benefits as well." Different facts matter, however, and here Petitioner's court lumped her into a category with the *Heckler* plaintiff. Unlike her, he was *not* seeking declaratory and injunctive relief for the patients Aetna abuses by delaying coverage for their *urgently* needed surgery. All he wanted was assurance of future coverage for surgery he might not even decide to have.

The *Heckler* court says this about the BCBR surgery (bilateral carotid body resection) that the plaintiff was considering: "Although it is true that Ringer is not seeking the immediate payment of benefits, he is clearly seeking to

establish a right to future payments should he ultimately decide to proceed with BCRB surgery," at 466 U.S. 621. Clearly there is no *urgency* in claiming "a right to future payments," a difference that Petitioner's court should have recognized.

(3) The Medicare Act precludes reimbursement for any "items or services . . . which are not reasonable and necessary for the diagnosis and treatment of illness or injury," (42 U.S.C. 1395y[a][1]). However, the Act does *not* need to say 'services that are reasonable but necessary when a medical procedure is *urgently* needed.' Urgency is implied. So Aetna wrongly delayed coverage for surgery Petitioner *urgently* needed to remove the vertebral cyst compressing her sciatic nerve, causing her nearly four months of debilitating pain, from March 22, 2023, to July 18.

These citations by her court show that it failed to acknowledge the clear difference between Ringer's BCBR and Petitioner's vertebral surgery. She asks the Supreme Court to note that difference and correct the lower court's error.

(4) By statute, the Social Security commissioner hears appeals whose claimants believe that administrative exhaustion failed to redress their grievances. Note that 42 U.S.C. §405(g) describes the commissioner's decisions as "irrespective of the amount in controversy" – meaning *an amount of money*, not an amount of pain Petitioner suffers because Aetna's administration disregarded her. Please also note that *Aetna administration* includes their president Karen Lynch, who apparently had more pressing concerns than addressing Petitioner's personal appeals to her in certified letters.

(5) The *Heckler* court says at p. 604, "Because Ringer has not given the Secretary an opportunity to rule on a concrete claim for reimbursement, he has not satisfied the nonwaivable exhaustion requirement of §405(g). Pp. 466 U.S. 620-626." Citing this in its decision, Petitioner's trial court concluded, "The District Court, therefore, had no jurisdiction as to respondent Ringer," (Order of Dismissal, p. 5). Again, fact differences matter. The *Heckler* court underlines the importance of the Secretary's "opportunity to rule on a concrete *claim for reimbursement* [emphasis supplied]." That, again, means *money* – not the Secretary ruling on how much pain Petitioner must suffer before the Secretary decides she may bypass administrative remedies and ask the court to hear her claim for urgently needed surgery.

In the above, Petitioner's lower courts both failed to recognize the difference between money and her claim for relief from the pain. The Supreme Court can now tell them.

(6) *Retina Grp. of New Eng., P.C. v. Dynasty Healthcare, LLC*, 72 F.4th 488, 492-93 (2d Cir. 2023). As above, in citing *Heckler*, the court fails to distinguish Petitioner's claim from another plaintiff's – one who claims they were underpaid for medical supplies because a government agency mishandled their application to Medicare. Again, it's not about *payment*. It's about *stopping pain.*

The court also seems unaware of the Act's description of the Social Security commissioner's role: not in deciding disputes about whether surgery is urgently needed, but in deciding *whether Aetna should pay money or withhold*

it from claimants who are NOT suffering or at risk of debilitating illness.

Petitioner's court cites the *Retina* case, §405(g): that it "[provides for judicial review of the agency's final decision] . . . [and] is the sole avenue for judicial review for all claims arising under the Medicare Act," (Summary Order, p. 3). The Act's authors, however, did *not* intend it to warehouse claimants like Petitioner, who must suffer as Aetna administrators file their folders in cabinet drawers.

Petitioner's court also quotes §405(g)-(h), that Petitioner's is like "any claims that are inextricably intertwined with what is in essence a claim for benefits," (Summary Order, p. 2). But it is rights and responsibilities that inexorably intertwine. For seven weeks Petitioner suffered the difference between her *right* to claim the surgery benefit – *not to claim the money it cost* – and Aetna's *failed responsibility* to authorize it as her only remedy. The Supreme Court can now apprise the lower courts of that difference.

(7) The court quotes Petitioner's appellant brief: "'The substance of this complaint is that Aetna *delayed* [the court's emphasis] that benefit, and *that their delay caused Appellant seven weeks of pain she would not have suffered if they had approved coverage of the surgery in the first place* [court's emphasis],'" (Summary Order, p. 3). But the court continues: "We find this argument unpersuasive because resolution of her claims alleging improper delay would still require the district court to determine whether Aetna Medicare breached its duty under the Medicare Act," (Summary Order, p. 3). The court fails to recognize that Petitioner would then have to suffer while the lower

court took however much (or little) time (maybe just *one* week?) to consider whether Aetna failed their duty under the Act. The court implies that taking the time to resolve that issue supersedes the danger Petitioner faces by further pain and debilitation while the trial court ruminates. Again, *this is NOT a claim for money under the Medicare Act. It is a claim for Petitioner's statutory right to immediate relief.*

(8) Citing *Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340 (3d Cr. 2012), the court again misperceives Petitioner, likening her to an equipment supplier who wanted money back that they claimed they overpaid a government agency. *Again, she doesn't want Aetna's money. She wants justice for however many Medicare patients Aetna is making suffer like her.* The Supreme Court can make that clear to the lower courts.

(9) Her trial court says, "[N]othing in the amended complaint suggests that Munroe could not bring her claims before the agency and then appeal any potential denial of relief to the district court," (Summary Order, p. 4). But her complaint does suggest *why courts must not let Aetna's appeals procedure subject claimants to debilitating harm.* So far, Petitioner's courts have granted Aetna an exemption from their statutory obligation to her. Worse, they have subverted her right to timely surgery, as explained in these two contexts:

(*1st*) Aetna's president is the agency's top administrator, yet neither court has held her to account for ignoring Petitioner's certified letters (6/4/23 and 8/9/23), begging her to intervene, to approve surgery coverage and resolve

the problem without a lawsuit. Letting Aetna off the hook flouts the meaning of "exhausting administrative remedies." It also subverts the Medicare Act's intent to ensure a claimant's right to urgent care by having Aetna process their claim fairly and efficiently.

(2nd) The court suggests that she first "bring her claims before the agency." But *without a court order*, how likely is Aetna to publicly admit they wronged a claimant, to publicly apologize, and then submit a remedial protocol to the court? Has any court yet upheld a claimant's right to urgent surgery, while at the same time, by force of an injunction, holding the agency to account for violating that right? The Medicare Act does *not* elevate an agency's administrative and pecuniary interests above a claimant's right to urgently needed surgery. The Act clearly implies Petitioner's right to avoid debilitating pain and the threat of long-term illness, but that's what the courts are allowing Aetna to saddle her with.

(10) The Court doesn't acknowledge *McCarthy v. Madigan*, 503 U.S. 140, 144 (1992). *The West Virginia Law Review* [Vol. 103: 361] directed Petitioner to the case. Its court said that the exhaustion doctrine "acknowledges the commonsense notion of dispute resolution that an agency ought to have an opportunity to correct its own mistake with respect to the programs it administers before it is haled into federal court," (p. 149). Fact #6 in Statement of the Facts of the Case, above, describes Aetna's obvious mistake: that their own spine surgeon told hers that he agreed that presurgical physical therapy was unnecessary, but that it was agency protocol and he was bound by it. That, plus the Aetna president's failure to

intervene, shows exactly what the *McCarthy* court warned of: that "an administrative remedy may be inadequate when the administrative body is shown to be biased or has otherwise predetermined the issue before it," (p. 149).

The *McCarthy* court was even-handed: "[A]dministrative relief need not be pursued if the litigant's interests in immediate judicial review outweigh the government's interest in the efficiency or administrative autonomy that the exhaustion doctrine is designed to further," (p. 146). Petitioner's interests clearly outweigh the government's. *She begged the courts for relief from debilitating pain, while all the McCarthy plaintiff wanted was money.* The Supreme Court can now alert the lower court to the *McCarthy* decision and apprise it of *the difference between a money claim and Petitioner's non-monetary claim for relief from suffering.*

CONCLUSION

This case challenges the Court to throw out a cost/benefit scale that, arguably, kills people. To understand that, Petitioner didn't need to read about others less fortunate who died. Experience is teaching her about "arguably": Who wins the argument that what your surgery costs the insurer has nothing to do with its benefit to you? Can conscience teach judges that the law has no use for such an equivalence? Arguably. And Petitioner hopes her argument moves the Court to grant this writ.

With respect for Justices who take on such a challenge,

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