No. 97-2000

In the Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

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

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BRIEF FOR PETITIONERS

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QUESTIONS PRESENTED

Under Pennsylvania's Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5) and (6), workers' compensation insurers are permitted to withhold payments to health care providers during a utilization review to determine whether a particular medical treatment was reasonable and necessary. The questions presented are:

1. Whether private companies providing workers' compensation insurance to private employers become "state actors" for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure.

2. Whether the Due Process Clause requires workers' compensation insurers to pay disputed medical bills prior to a determination that the medical treatment was reasonable and necessary.

RULE 24.1(b) AND 29.6 STATEMENT

Pursuant to Rule 24.1(b), petitioners state that in addition to American Manufacturers Mutual Insurance Company, petitioners here (also defendants in the court below) include Commercial Union Insurance Company, Continental Casualty Company, Donegal Mutual Insurance Company, Hartford Fire Insurance Company (misidentified in the Third Circuit caption as "Hartford Mutual Insurance Company"), Insurance Company of North America (misidentified in the Third Circuit caption as "CIGNA Corporation"), United States Fidelity and Guaranty Company (misidentified in the Third Circuit caption as "USF&G Insurance Company"), and Zurich Insurance Company (misidentified in the Third Circuit caption as "Zurich American Insurance Company").*

Defendants below who are respondents here are the School District of Philadelphia, the Pennsylvania Secretary of Labor and Industry, the Director of the Pennsylvania Bureau of Workers' Compensation, the Pennsylvania Insurance Commissioner, the Pennsylvania Treasurer, and the Director of the State Workers' Insurance Fund.

In addition to Delores Scott Sullivan, the individual plaintiffs in this putative class action include William Battle, Louis Baumgartner, Anthony Cancila, Christopher Costello, William C. Dillon, by his guardian and next friend Pauline Dillon, Terrence Ervine, Lisa Lex, Charles Matthews, and Susan Hansen. The organizational plaintiffs are the Philadelphia Area Project on Occupational Safety and Health and the Philadelphia Federation of Teachers. All of the plaintiffs below are respondents here.

Pursuant to Rule 29.6, a list of all parent companies and nonwholly owned subsidiaries of each of the corporate petitioners is contained in the Petition for a Writ of Certiorari at ii-iii. United States Fidelity and Guaranty Company has two additional nonwholly owned subsidiaries: JNO Industrial, Inc. and Octagon Services, L.L.C.

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* The parties stipulated below to a substitution of Insurance Company of North America for CIGNA Corporation.

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The opinion of the court of appeals (Pet. App. 1a-40a) is reported at 139 F.3d 158. The opinion of the district court dismissing the claims against the private insurers for lack of state action (Pet. App. 41a-61a) is reported at 913 F. Supp. 895. The district court's subsequent opinion dismissing the complaint and holding that the Pennsylvania statute does not violate procedural due process (Pet. App. 62a-82a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 13, 1998. The petition for a writ of certiorari was timely filed on June 11, 1998, and granted on September 29, 1998. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution provides in relevant part that "[n]o State shall * * * deprive any person of life, liberty, or property, without due process of law." The pertinent provisions of the Pennsylvania Workers' Compensation Act (77 Pa. Stat. Ann. § 1 *et seq.*) and relevant regulations are set forth at Pet. App. 83a-103a.

STATEMENT

This case involves a constitutional challenge to actions of private insurance companies taken pursuant to Pennsylvania's workers' compensation law. Pennsylvania authorizes a workers' compensation insurer who believes that medical care provided to an injured worker may be unreasonable or unnecessary to obtain "utilization review" — an evaluation of the treatment by an independent medical professional — and to withhold payment to health care providers for the disputed care until review is completed. The Third Circuit held that when an insurance company initiates this procedure and withholds payment, it "become[s] an arm of the State," subject to the restrictions imposed by the Fourteenth Amendment. Pet. App. 15a. It also held that the

private insurers violate the Due Process Clause by withholding payment pending the outcome of utilization review.

A. Pennsylvania's Workers' Compensation Statute And Its 1993 Cost-Containment Initiatives

Workers' compensation is a system under which employers are obligated to pay for medical care (and partial wage replacement) for employees who sustain work-related injuries or contract occupational diseases. Pet. App. 13a-14a; U.S. CHAMBER OF COMMERCE, 1997 ANALYSIS OF WORKERS' COMPENSATION LAWS, at vi. It is a no-fault substitute for the prior system of compensation under the common law of tort. See *Blake* v. *Wilson*, 112 A. 126, 128 (Pa. 1920).

The Pennsylvania workers' compensation system, involved here, is typical. Like most States, Pennsylvania makes workers' compensation coverage both mandatory and "exclusive * * * of any and all other liability." 77 Pa. Stat. Ann. § 481(a). The law dispenses with the prior cumbersome and expensive court remedy in tort and replaces it with an administrative procedure aimed at facilitating the prompt resolution of disputes between employers (or their insurers) and employees. The vast majority of claims are resolved through voluntary agreement. See D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA, at xix (1991). Disputes are adjudicated by workers' compensation judges, with a right of appeal to the Workers' Compensation Appeal Board ("Board") and then to the Pennsylvania courts. The Bureau of Workers' Compensation ("Bureau"), a part of the Department of Labor and Industry, administers the system and enforces compliance with workers' compensation laws.

To ensure that employers can meet their financial obligations, Pennsylvania requires them to "obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund," a state-conducted insurer — "or to self-insure." Pet. App. 3a. If the employer contracts with an insurer for coverage, the insurer "assume[s] the employer's liability" to pay workers' compensation benefits. 77 Pa. Stat. Ann. § 501(a)(1). Private insurers are not required to sell workers' compensation insurance and are free to

decide which employers to underwrite. All features of workers' compensation insurance coverage that are not dictated by law are determined by contract. Moreover, "no aspect of the workers' compensation system is financed with public tax dollars." D. BALLANTYNE & C. TELLES, *supra*, at 15.[1]

This case involves the procedures for resolving disputes over reimbursement of providers for medical care rendered to injured employees. The law requires insurers or self-insured employers[2] to pay only for "reasonable" and "necessary" medical care and services. 77 Pa. Stat. Ann. § 531(1), (5). Prior to 1993, however, insurers had no effective means to limit payments to such care. The "spiraling costs of medical treatment for work-related injuries" (Pet. App. 3a) became a "significant problem[] in the Pennsylvania system." D. BALLANTYNE & C. TELLES, *supra*, at 30. Between 1983 and 1991, workers' compensation medical costs increased by 240%. See D. BALLANTYNE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA, at 67 (1997). By 1993, the State Workmen's Insurance Fund was on the verge of bankruptcy. PA. LEGIS. J. — SENATE 1044 (June 16, 1993) (statement of Sen. Fisher). Employers had just been subjected to a 24% rate increase in insurance premiums. *Id.* at 1048 (statement of Sen. Mellow). In an effort to control these costs, the Pennsylvania legislature passed Act 44, creating "a utilization review process under which the reasonableness and/or necessity of an employee's [current, prospective, or past] medical treatment could be reviewed." Pet. App. 3a.

Act 44 authorizes an insurer who receives a bill for medical care that it believes is unreasonable or unnecessary to obtain utilization review. 77 Pa. Stat. Ann. § 531(5). Insurers are permitted — though

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[1] If a workers' compensation insurer in Pennsylvania becomes insolvent, its obligations are assumed by the Workers' Compensation Security Fund, 77 Pa. Stat. Ann. § 1053, but that fund is funded by taxes on the insurers themselves, *id.* § 1055. See also Pet. App. 14a n.18.

[2] Identical obligations are placed upon insurers and self-insured employers under this system. For simplicity's sake, we will usually refer in this brief simply to "insurers."

not required — to withhold payment for disputed medical bills during utilization review. *Ibid*. This is important because the law bars insurers from recouping payments made to health care providers, even if the treatment is later determined to be unreasonable or unnecessary. Pet. App. 27a; see *Moats* v. *Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). Insurers and self-insured employers are entitled to reimbursement for excessive payments from a special fund, but the fund is financed entirely from assessments levied on the insurers and self-insured employers themselves. 77 Pa. Stat. Ann. § 999.

Under the Act, employees are permitted to go to the providers of their choice after the first 90 days of treatment for a job-related injury. 77 Pa. Stat. Ann. § 531(1)(i). Providers submit bills for treatment of the injured employee directly to the insurer. *Id.* § 531(5). An insurer has thirty days either to pay the bill or to file for utilization review, which tolls the payment deadline for disputed treatment. *Ibid.*; 34 Pa. Code §§ 127.208(e)-(f), 127.403. Utiliza-tion review is initiated by submitting to the Bureau an original and eight copies of a one-page form. 34 Pa. Code § 127.452(a); J.A. 5. The decision to obtain utilization review is made independently of the Bureau, which neither encourages nor discourages utilization review but "simply provides the forms" for initiating the process. C.A. App. B199-B200; see also Pet. App. 3a.

The Bureau conducts no substantive review of the form to determine whether utilization review is appropriate; requests are reviewed solely for facial adequacy. Pet. App. 5a. If the request is incomplete or facially defective, the Bureau rejects it and sends the requester a form letter identifying the basis for rejection. *Ibid.*; C.A. App. C23. If the request is complete and appears on its face to satisfy the formal criteria for utilization review, it is forwarded to a utilization review organization ("URO") selected randomly from a list of approved UROs. Pet. App. 6a; 34 Pa. Code § 127.453.

Next, the Bureau notifies the employee, the insurer, and the health care provider that a request for utilization review has been received and forwarded to the URO. Pet. App. 6a; 34 Pa. Code § 127.453. The current notice informs the employee that a determination that treatment is not reasonable or necessary "may result in

these treatments not being paid." J.A. 50. The employee is also informed that he or she may "submit a written personal statement" to the URO "regarding your view of the reasonableness and/or necessity of the disputed medical treatment." *Ibid*. Finally, the employee is informed of his or her right to seek administrative review of an adverse utilization review determination. *Ibid.*[3]

The URO is an independent, private entity that must be capable of performing "impartial reviews" of the medical reasonableness and necessity of disputed treatment. 34 Pa. Code § 127.663(b); Pet. App. 6a n.3. The URO's review must be con-ducted by a medical professional who is "licensed in the same profession and ha[s] the same or similar specialty as that of the provider of the treatment under review." 77 Pa. Stat. Ann. § 531(6)(i). The reviewer is required to give the provider an opportunity to discuss treatment decisions, and must initiate discussion with the provider if it will assist in determining whether disputed care was reasonable and necessary. 34 Pa. Code § 127.469. Utilization review applies "generally accepted treatment protocols" and a presumption that disputed treatment is reasonable and necessary. *Id*. §§ 127.467, 127.471(b). The reviewer must find treatment to be reasonable and necessary if the "provider's records document that [it] is relieving pain or allowing the patient to continue with the activities of daily living." C.A. App. B12.

Under the statute, the URO must issue a written decision within thirty days of a request, 77 Pa. Stat. Ann. § 531(6)(ii), though in practice this typically takes about seventy days. The URO's decision may be challenged by filing a petition with a workers' compensation judge, who conducts a *de novo* hearing at which the employee may submit testimony. Pet. App. 9a; 34 Pa. Code § 127.556. If the URO determines that a disputed medical service was reasonable and necessary, the insurer must pay the bill immediately with 10% annual interest, even if it petitions for review of the decision. 34 Pa. Code § 127.208(e), (g); 77 Pa. Stat. Ann. § 717.1(a). If the URO decides that the service was unreasonable or unnecessary, then the insurer need not pay the bill unless that decision is overturned by a workers'

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[3] This form was revised to satisfy portions of the decision below that are not challenged by petitioners. See Pet. 22 n.12.

compensation judge, the Board, or the courts. The provider may not bill the employee for treatment determined to be unreasonable or unnecessary. 34 Pa. Code § 127.211(b).

The statute includes within the definition of "medical services" not only "services rendered by physicians" but also the services of "any * * * physical therapist, psychologist, [or] chiropractor." 77 Pa. Stat. Ann. §§ 29 (defining "health care provider"), 531(1)(i), 531(3)(iii). Treatment by non-physician providers generates a disproportionate number of the disputes over the reasonableness and necessity of care.[4] Of the ten individual plaintiffs in this case, for example, one worker was receiving twice-weekly chiropractic sessions more than six years after his injury (J.A. 28); one was undergoing "aquatic therapy" (*id*. at 30); one was still receiving chiropractic services and physical therapy more than fifteen years after his injury, and nearly twelve years after he had returned to work (and who was running his own business) (*id*. at 35-36); and one was receiving psychological and biofeedback therapy (*id*. at 42). The Third Circuit stated that procedural safeguards are "particularly" pertinent to recipients "of unorthodox, naturopathic, or non-traditional" treatments "such as * * * acupuncture or chiropractic manipulation." Pet. App. 31a.

B. Proceedings In The District Court

Plaintiffs in this putative class action (respondents here) are ten individuals who were or are employed in Pennsylvania and two organizations that represent Pennsylvania employees. Pet. App. 9a & nn.7-8.[5] The private defendants (petitioners here) are American

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[4] For example, approximately 37% of requests for utilization review involve care provided by chiropractors, while only 17% involve care provided by family doctors or general practitioners. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>.

[5] The proposed plaintiff class "consists of more than 40,000 workers' compensation recipients" who "have been, or will be in the future, receiving

Manufacturers Mutual Insurance Company and seven other private insurance companies that write workers' compensation policies in Pennsylvania. Plaintiffs also named as defendants the School District of Philadelphia and various state officials, who are also respondents here.[6] Plaintiffs' amended complaint requested that the court certify a defendant class of all insurance companies and self-insuring employers that have invoked the Pennsylvania utilization review procedure and withheld reimbursement for medical care during the pendency of that review. J.A. 16.

Plaintiffs alleged that Act 44's utilization review procedures violate due process and 42 U.S.C. § 1983 because they permit the deprivation of "medical benefits" without "advance notice and prior opportunity to be seen and heard * * *." J.A. 43. They sought declaratory and injunctive relief, restoration of benefits, and compensatory as well as punitive damages.

The insurers moved to dismiss on the ground that, as private companies, they are not state actors and thus cannot be sued for violations of the Due Process Clause or for action under color of state law (42 U.S.C. § 1983). After limited discovery, the district court granted their motion. Pet. App. 41a-61a. It explained that the government's involvement in the private insurers' decision to invoke utilization review and withhold payment was minimal. *Id.* at 59a. The State did not promote, support, or encourage the decision of an insurer to obtain utilization review of disputed treatment in a particular case, and the State took no action to influence a utilization reviewer's determination whether disputed treatment was medically reasonable and necessary. *Ibid*. Rather, the State merely provided private actors with a remedy for unwarranted medical claims. *Ibid*.

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medical benefits pursuant to the Pennsylvania Worker's Compensation [Act]" and whose benefits have been or will be suspended during utilization review. J.A. 12-13, 16.

[6] For a complete list of parties, see page ii, *supra*. On October 5, 1998, this Court denied petitions for certiorari filed by the School District of Philadelphia (No. 97-2030) and various officials of the Commonwealth of Pennsylvania (No. 98-161).

The state officials who remained as defendants subsequently moved to dismiss on the ground that the Pennsylvania statute does not violate procedural due process. The district court granted that motion, Pet. App. 62a-81a, after evaluating the process provided by the statute under the balancing test set forth in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). The court concluded that while an injured employee's interest in continued receipt of medical benefits was "significant" (Pet. App. 70a), it was less substantial than the interest at stake in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), because eligibility is "not based on financial need," and because the employee "may have access to additional income sources such as wage replacement." Pet. App. 70a. In addition, the court noted, the availability of full retroactive relief — as well as 10% interest to the provider and litigation costs to the worker — "lessens the potential harm to the individual employees." *Ibid*. The court observed that "nothing in the statute even requires that the medical provider stop giving the challenged treatment." *Id*. at 70a n.4. It also took note of the government interest in controlling the "high costs of medical treatment, and the corresponding high cost of insurance" in Pennsylvania. *Id.* at 75a. Balancing all of these considerations, the district court concluded that the Pennsylvania law does not violate due process.

C. Proceedings In The Court Of Appeals

A panel of the Third Circuit reversed the district court's rulings on both state action and due process issues. Pet. App. 1a-40a. In holding that the private insurers are state actors, the court of appeals emphasized that the workers' compensation system is mandatory in nature, abolishes the common law rights of employers and employees, and provides "the *exclusive* remedy available to an injured worker" in Pennsylvania. *Id*. at 13a-14a. The court also stressed that, "[i]n creating and executing this system of entitlements, the Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies." *Id*. at 14a. Pennsylvania

> extensively regulates and controls the Workers' Compensation system. Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State

> entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system.

Id. at 14-15a. The Pennsylvania law thus creates a "relationship" between the State and the insurer that "more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." *Id*. at 19a.

Turning to the due process issue, the Third Circuit held that the notice provided to employees that payments might be withheld from medical providers was constitutionally deficient and that due process requires that individual patients be given an opportunity to submit their written views on the reasonableness and necessity of challenged care to the utilization reviewer. Pet. App. 21a-33a. Petitioners have not challenged those holdings in this Court. See Pet. 22 n.12. The Third Circuit also evaluated whether payments for disputed medical services could be withheld pending utilization review, a question it characterized as whether employees were entitled to "a pre-deprivation opportunity to respond to the proposed termination of their medical benefits" under the *Mathews* balancing test. Pet. App. 25a.

The Third Circuit acknowledged that Pennsylvania has a legitimate interest in "containing the rising costs of medical care and insurance payments," and observed that "cost containment is the purpose" behind the State's enactment of the law authorizing insurers to withhold payments to medical providers during utilization review. Pet. App. 29a-30a. It rejected the district court's conclusion, however, that the risk of erroneous deprivation was slight because utilization review involved the narrow question of medical reasonableness or necessity, decided solely on the basis of "unbiased, objective, and trustworthy" medical records. *Id*. at 28a. It also rejected the contention that in applying the *Mathews* test it was required to "consider the conflicting private interest of the insurance companies." *Id*. at 27a. "On balance," the court explained, "we are not convinced that any governmental interest outweighs the [employees'] private interest" in uninterrupted payment of providers. *Id*. at 30a. The employee's interest could be adequately protected, the court held, only if insurers were required to pay the disputed bills until workers are given "an opportunity and time to submit a personal statement in

writing" to the utilization review organization "regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." *Id.* at 33a.

Accordingly, the Third Circuit declared unconstitutional the statutory provision permitting suspension of payment, which provides:

> All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)* * * *.

77 Pa. Stat. Ann. § 531(5) (emphasis added). Pet. App. 24a. The court reasoned that the italicized language — the provision it deemed offensive — was severable, and struck it from the statute. *Id.* at 25a. Under the Third Circuit's holding, therefore, the statute requires an insurer to pay provider bills within thirty days of receipt even if it seeks utilization review of the treatment.

INTRODUCTION AND SUMMARY OF ARGUMENT

The question in this case is whether the Due Process Clause is violated when private workers' compensation insurers, acting solely on their own business judgment, delay payment of disputed claims during the approximately two-month period it takes to determine whether the claims are valid. Such decisions take place in the thousands every month, in the context of almost every kind of insurance. Indeed, analogous decisions — to delay payment of a disputed contractual obligation until the dispute has been settled — are commonplace in *every* kind of business.

Under the decision below, these routine business judgments have been declared to "satisfy the constitutional requisites" for "state action." Pet. App. 19a. The practical consequence of this holding is to allow a federal court to cast aside Pennsylvania's carefully considered legislative reforms of workers' compensation law and to substitute its own notions of how to balance the risks between insurers and health care providers. Equally remarkably, the court of appeals held that delaying the payment of a doctor's bill deprives the patient of due process of law. The practical consequence of that holding is

to require insurers to pay medical claims before they can be examined for possible fraud and abuse. That is a recipe for disaster in the health care financing system.

We will demonstrate below that both aspects of the Third Circuit's decision are in error. In Part I, we will show that the unilateral business decisions of private insurance companies do not constitute "state action" under any coherent theory, and that the contrary holding below is a product of a loose and undisciplined approach that is squarely at odds with at least three of this Court's decisions. In Part II, we will show that the individual plaintiffs have not suffered any "deprivation" sufficient to support the due process holding, and that even if they had, the procedures here are fully adequate to satisfy due process.

ARGUMENT

I. PRIVATE INSURANCE COMPANIES DO NOT BECOME STATE ACTORS BY INITIATING UTILIZATION REVIEW OR WITHHOLDING PAYMENTS TO HEALTH CARE PROVIDERS

The very language of the Fourteenth Amendment — "[n]o State shall * * * deprive any person of life, liberty, or property without due process of law" — bespeaks its applicability to governmental bodies and not to private persons. Consistent with this language, this Court has always maintained, ever since the issue first arose in the *Civil Rights Cases*, 109 U.S. 3 (1883), that "'the action inhibited by the first section of the Fourteenth Amendment is only such action as may fairly be said to be that of the States.'" *Blum* v. *Yaretsky*, 457 U.S. 991, 1002 (1982) (quoting *Shelley* v. *Kramer*, 334 U.S. 1, 13 (1948)). In short, the Fourteenth Amendment "erects no shield against merely private conduct." *Shelley*, 334 U.S. at 13.

In all state action cases, the question posed is whether constitutional norms designed to limit governmental power are applicable to an arguably nongovernmental party. This distinction between public and private lies at the very heart of liberal theory. See generally J. LOCKE, SECOND TREATISE OF GOVERNMENT 44-73 [1690] (T. Reardon, ed. 1952). More specifically, the state action doctrine serves three important functions. First, in some contexts, the state

action doctrine protects the federal structure of government by limiting the scope of federal authority to its proper role in enforcing constitutional provisions directed at the States. See *Civil Rights Cases*, 109 U.S. 3 (1883).

Second, in some contexts, the state action doctrine is a recognition of the fact that many constitutional norms are liberty-enhancing when applied to the government yet liberty-infringing when applied to private parties. Compare *Hurley* v. *Irish-American Gay, Lesbian and Bisexual Group*, 515 U.S. 557, 572-73 (1995) (because parade organizers were private parties, the obligation of speech neutrality that would otherwise have attached to a public parade had to yield to free speech rights of organizers), with *Rust* v. *Sullivan*, 500 U.S. 173, 193-94 (1991) (free speech claim rejected because the speakers were, in effect, communicating the government's own message and not their own). See also *Corporation of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints* v. *Amos*, 483 U.S. 327, 339 (1987) (application of religious nondiscrimination requirement to a religious body would interfere with religious freedom); *Eu* v. *San Francisco County Democratic Cent. Comm.*, 489 U.S. 214, 224-25 (1989) (application of political neutrality requirements to political party would interfere with political advocacy). Procedural due process norms — those at issue here — make sense as applied to the government but would be highly disruptive if applied to a family or a business.

Third — and most directly pertinent here — the state action doctrine polices the boundary between judicial and legislative authority. See *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 936-37 (1982). Because constitutional norms (applicable to the government) are directly enforceable by the judiciary, a finding of "state action" has the effect of transferring regulatory authority from the legislature to the courts. Where the constitutional principle is procedural due process and the supposed "state actors" are insurance companies, a finding of state action renders any aspect of their business that can be characterized as "procedural" in nature (which is much, since processing claims is at the heart of the business) subject to judicial review — and the regulatory framework established by statute becomes vulnerable to judicial second-guessing.

In this case, for example, the effect of the "state action" holding was to empower a panel of federal appellate judges to second-guess the details of Pennsylvania's statutory scheme for regulation of the workers' compensation insurance business, and to overturn the balance the legislature struck between workers, health care providers, employers, and insurers. For reasons made manifest in the experience of this Court with economic substantive due process (see *Lochner* v. *New York,* 198 U.S. 45 (1905)), such transfers of authority from legislatures to courts are inconsistent with the democratic spirit of our institutions, and frequently result in bad policy as well. Not only are federal judges ill-equipped to make informed judgments about the insurance business (and others), but stare decisis makes constitutional litigation an inflexible and dangerous tool for routine regulatory decisionmaking. Constitutional rulings must be relatively fixed, and are not easily changed or corrected in response to experience. Decisions such as who should bear the risk of error when a provider is suspected of giving unnecessary or unreasonable care require an exercise of policy judgment on the basis of empirical experience, and should not be set in constitutional concrete. For this reason, it is vitally important that the limits of state action doctrine be observed, lest broad areas of economic and social activity be placed under the superintendence of constitutional courts rather than accountable legislatures. See Marshall, *Diluting Constitutional Rights: Rethinking "Rethinking State Action,"* 80 NW. U. L. REV. 558 (1985); Schwarzchild, *Value Pluralism and the Constitution: In Defense of the State Action Doctrine,* 1988 SUP. CT. REV. 129.

Unfortunately, the line between state and private action is not always easy to draw. This Court's decisions mandate careful and rigorous attention to the factual and legal context. The Third Circuit itself complained that courts faced with state action issues "have employed various tests and standards that have been anything but a model of clarity." Pet App. 13a. Having recognized the problem, however, the Third Circuit essentially threw up its hands, resorting to a undisciplined mode of analysis that opens the door to a dangerous expansion of state action doctrine.

A. A Private Insurer's Decision To Initiate Utilization Review Or To Withhold Payments To Health Care Providers Does Not Transform The Insurer Into An Arm Of The State

The analytical framework for deciding when the conduct of a private entity "allegedly causing the deprivation of a federal right [is] fairly attributable to the State" is set out in *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982):

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible. * * * Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

The first factor under *Lugar* serves to exclude cases where the private entity acts in violation of state law. *Id*. at 940. The second *Lugar* factor measures the "something more" — beyond mere state authorization — that is required in order for the conduct of private entities to be transformed into state action. *Id*. at 937, 939. This "something more," which the Court has "articulated [in] a number of different factors or tests in different contexts," is critically important because it ensures that "private parties" do not "face constitutional litigation whenever they seek to rely on some state rule governing their interactions with the community surrounding them." *Ibid*. These "factors or tests" are thus the heart of the state action analysis.

In marked contrast to the rigorous analysis this Court has used in its state action decisions, the Third Circuit offered a vague set of truths, half-truths, and irrelevancies in support of its conclusion that private companies making decisions pursuant to private contracts of insurance with private employers are "state actors." The appellate court stated that Pennsylvania's workers' compensation system is "a complex and interwoven regulatory web" (Pet. App. 14a), and a "'system which the government alone administers'" (*id*. at 15a (quoting *Edmonson* v. *Leesville Concrete Co*, 500 U.S. 614, 622 (1991))); that the system is "mandatory" and "exclusive," thus assertedly making workers' compensation payments a "public benefit[]" (*id*. at 14a-15a); and that the "right to invoke the superse-

deas, or to stop payments, is a power that traditionally was held in the hands of the State" (*id*. at 15a).

Under no coherent theory of state action could these miscellaneous factors lead to the conclusion that an insurer who temporarily withholds payments from health care providers or initiates the process of utilization review "may fairly be said to be a state actor." *Lugar*, 457 U.S. at 937. Unfortunately, the Third Circuit did not think it necessary to offer a coherent theory. Having cited these various factors, the court simply concluded that this "relationship more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." Pet. App. 19a. It then emphasized that its holding is "expressly limit[ed]" to the "unique context" of this case, *ibid.*, as if that could substitute for a clear explanation of why the facts of this case fit within established principles of state action doctrine.

Contrary to the Third Circuit's suggestion, this Court's cases delineating what is required (beyond state authorization of private conduct) for the conduct of private entities to be regarded as state action in fact fall into defined doctrinal categories with distinct and different definitions. See *Flagg Brothers, Inc*. v. *Brooks*, 436 U.S. 149, 158, 159 (1978) (examining in turn various discrete "line[s] of cases" and noting that the scope of the Court's "exclusive public function" cases involving elections is "carefully defined"). The definitions of state action under each category are not mere ingredients to be thrown together in a doctrinal stew, with a pinch of salt substituting for a lack of garlic or coriander. The Third Circuit's decision dramatically relaxes the requirements needed to find state action by authorizing federal judges to "mix and match" factors from various doctrinal categories that would not suffice, individually, to show state action under any of those categories. This Court should reject the Third Circuit's eclectic approach and reaffirm the distinctive and separate nature of its "public function," "state compulsion," and "joint action" cases. Cf. *Lugar*, 457 U.S. at 939 (declining to resolve

whether these tests are "actually different in operation or simply different ways of characterizing" the state action inquiry).[7]

As we explain below, the conduct of private insurance companies that is challenged in this lawsuit — withholding payments to health care providers and initiating utilization review — does not qualify as

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[7] Between the 1940s and late 1960s, this Court significantly expanded the state action doctrine in a series of cases, many of which involved claims of racial discrimination. See, *e.g.*, *Shelley* v. *Kramer*, 334 U.S. 1 (1948) (state action exists when state court enforces racially restrictive covenants); *Marsh* v. *Alabama*, 326 U.S. 501 (1946) (arrest by policeman in company-owned town constitutes state action); *Burton* v. *Wilmington Parking Auth.*, 365 U.S. 715, 725 (1961) (restaurant's refusal to serve black customer constituted state action where the state had "so far insinuated itself into a position of interdependence with" the restaurant that they "must be recognized as joint participant[s] in the challenged activity"). As one commentator has observed, the "need to expand the state action doctrine" during 1940-1970 was the result, in part, of the "absence of means other than the fourteenth amendment to attack racial injustice." Schneider, *State Action — Making Sense Out of Chaos — An Historical Approach*, 37 U. FLA. L. REV. 737, 741 (1985). In the 1960s, however, Congress passed a variety of civil rights statutes prohibiting racial discrimination in employment, education, public accommodations, housing, and other areas, making an expansive state action doctrine unnecessary. See, *e.g.*, Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964); Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 81 (1968).

Beginning in the early 1970s, this Court returned to a more restrictive approach to state action, which has continued to this day. For example, the Court overruled a decision that had extended the rule of *Marsh* v. *Alabama*, 326 U.S. 501 (1946), to a privately owned shopping center. See *Flagg Brothers*, 436 U.S. at 159-60. Compare *Hudgens* v. *NLRB*, 424 U.S. 507, 514-21 (1976), with *Amalgamated Food Employees Union Local 590* v. *Logan Valley Plaza*, 391 U.S. 308, 316-20 (1968). And in *Jackson* v. *Metropolitan Edison Co.*, the Court made clear that its "public function" theory of state action was limited to those situations where a private entity exercises powers that are "traditionally *exclusively* reserved to the State." 419 U.S. 345, 352 (1974) (emphasis added); see also *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 842 (1982). The decision below is in a sense a throwback to an earlier era, but without the pressing justification that underlay this Court's decisions during that time.

"state action" under any of this Court's established categories of state action. The decision to initiate utilization review and to withhold reimbursement is hardly a "public function" that traditionally has been reserved exclusively to the State; it is in no way compelled by Pennsylvania; and the State's "participation" does not amount to the provision of "such significant encouragement, either overt or covert, that the [insurer's] choice must in law be deemed to be that of the State." *Blum* v. *Yaretsky*, 457 U.S. 991, 1004 (1982). Nor has the State delegated to insurers any constitutional duty to perform. Not sur-prisingly, every federal court of appeals to consider the issue, other than the court below, has concluded that workers' compensation insurers making decisions of this sort are not state actors. *Stanescu* v. *Aetna Life & Cas. Ins. Co.*, 1996 WL 466648 (2d Cir. Aug. 16, 1996), cert. denied, 117 S. Ct. 1697 (1997); *Fleming* v. *Workers' Compensation Comm'n*, 1996 WL 93843 (4th Cir. Mar. 5, 1996) (per curiam), aff'g 878 F. Supp. 852 (E.D. Va. 1995); *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992); *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988); see also *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 278-80 (Pa. Commw. Ct. 1982). The Third Circuit was thus wrong to conclude that there was state action in this case.

1. The Private Insurers Are Not Performing An Exclusive Public Function

In analyzing the state action issue, the Third Circuit declared, without citation to state law or other authority, that "[t]he right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State." Pet. App. 15a.[8] The court

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[8] The Third Circuit repeatedly but erroneously used the term "supersedeas" to denote the company's decision to delay payment of a disputed claim (Pet. App. 15a; see also *id*. at 2a, 13a). This term is not used in the relevant statutory provision, 77 Pa. Stat. Ann. § 531(5). Under Pennsylvania law, the term "supersedeas" is used to refer to an order by a workers' compensation judge suspending the obligation to pay an award. See, *e.g.*, 77 Pa. Stat. Ann. §§ 774, 971(b); 34 Pa. Code §§ 131.41, 131.43. But

of appeals also characterized the provision of workers' compensation benefits as a "uniquely governmental obligation." *Ibid.* To the extent that it was suggesting that the private insurance companies qualify as state actors because they perform an exclusive public function, the Third Circuit seriously misapprehended the scope of the "public function" doctrine.

In *Jackson* v. *Metropolitan Edison Co.*, this Court made clear that the "public function" doctrine applies *only* when a private entity exercises powers that have been "traditionally *exclusively reserved* to the State." 419 U.S. 345, 352 (1974) (emphasis added); accord *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 842 (1982); *Flagg Brothers*, 436 U.S. at 157-58. Examples include the conduct of elections, see *Smith* v. *Allwright*, 321 U.S. 649 (1944), the selection of juries, see *Leesville Concrete*, 500 U.S. 614, the management of municipal parks, see *Evans* v. *Newton*, 382 U.S. 296 (1966), and the power of eminent domain, see *Jackson*, 419 U.S. at 353.

Neither the provision of workers' compensation benefits in general nor the decision to delay payment of questionable bills in a particular case is typically a governmental function at all — let alone an "exclusive" governmental function. As explained above (at 2), workers' compensation systems are simply a substitute for the tort system — different procedures and rules for determining the employer's liability to its workers for workplace injuries. To be sure, the underlying workers' compensation liability of the employer, which is the subject of the insurance, is imposed by the State. That fact, however, does not render the State responsible for the payment, or the insurer an arm of the State. Tort liability is also imposed by state law, but that does not make tort liability insurers state actors. Valid tort claims would have an equal claim to be described as "protected entitlements," yet no one would say that insurance payments to a tort victim are "public benefits."[9]

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no such order is needed when an insurer initiates utilization review under Section 531(5), nor is any judge involved at this stage. Instead, Section 531(5) merely sets a 30-day deadline in which the insurer must pay for medical expenses, but then tolls the deadline if the insurer elects to initiate utilization review. There is no "supersedeas."

[9] The Third Circuit also stated, somewhat ambiguously, that workers' compensation benefits are a "constitutionally protected entitlement." Pet.

It is no answer to say, as did the Third Circuit, that private insurance companies are carrying out an exclusive public function because workers' compensation benefits are a "uniquely governmental obligation." Pet. App. 15a. The premise of that argument is erroneous: Pennsylvania does not have any obligation to provide workers' compensation benefits itself; rather, it imposes that obligation on private parties. No taxes or legislative appropriations are involved; the entire system is financed through premiums paid by private employers. See *Dillard* v. *Industrial Comm'n*, 416 U.S. 783, 798 (1974) (workers' compensation funds "are private, not public"). Contrary to the Third Circuit's suggestion, the workers' compensation system is more accurately viewed as a mandatory term of the private employment contract between employer and employee, not unlike the minimum wage. An employer's unilateral decision to reduce a worker's wages to $1 per hour might be a violation of the minimum wage law, or of the labor contract, but it would not be a violation of constitutional due process. In any event, this Court rejected a virtually identical argument in *Jackson*. There, the utility customer argued that the electric company was providing an "essential public service required to be supplied" and thus was performing a public function. 419 U.S. at 352. This Court responded that "while the Pennsylvania statute imposes an obligation to furnish service *on regulated utilities*, it imposes no such obligation *on the State*." *Id*. at 353 (emphasis added).

Nor is the withholding of payments to a health care provider for medical care an exclusive public function. It is a routine aspect of claims processing for insurance carriers of all kinds. Indeed, it is a remarkable notion, to say the least, that a private insurance company's

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App. 14a. The right to receive workers' compensation benefits is *not* conferred by the federal or Pennsylvania constitution, but rather by Pennsylvania statute. If the Third Circuit meant merely to say that workers' compensation benefits represent a "property interest" subject to some due process protection, that statement puts the cart before the horse (appearing, as it does, in the Third Circuit's threshold discussion of state action). Whether the Constitution confers *any* protection on workers vis-a-vis the actions of private insurers hinges on whether those insurers qualify as state actors; the Third Circuit's reliance on this factor was thus entirely circular.

withholding of payments to a private party (the health care provider) under a contract with another private entity (the employer) pending resolution of a dispute over the entitlement of a private, third-party beneficiary under the contract (the employee) amounts to a traditional public function. Petitioners, after all, are private companies that have voluntarily entered into private contracts of insurance with private employers. As one court has explained:

> What is here involved is a contractual (although sanctioned by statute) claim to benefits which the other party to the contract disputes. As such, this interest is indistinguishable from the interest of the recipient of funds in any commercial situation in which periodic payments are terminated pending resolution of the underlying dispute.

Silas v. *Smith*, 361 F. Supp. 1187, 1192 (E.D. Pa. 1973) (three-judge court).

2. The Private Insurers Are Not Acting Under State Compulsion

In a separate line of cases, this Court has made clear that "a State is responsible for the discriminatory act of a private party when the State, by its law, has compelled the act." *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 170 (1970); see also *Peterson* v. *City of Greenville*, 373 U.S. 244, 248 (1963) ("When the State has commanded a particular result, it has saved to itself the power to determine that result and thereby 'to a significant extent' has 'become involved' in it."). This "state compulsion" test (*Lugar*, 457 U.S. at 939) cannot possibly be satisfied here.

As the district court explicitly found, the decision to withhold payment of disputed medical bills is made entirely by the insurers, with no hint of coercion by the State. Pet. App. 59a. Even the court of appeals acknowledged that "[t]he Act does not require — but permits — suspension of medical benefits." *Id.* at 5a. Similarly, the State in no way compels petitioners to initiate the utilization review process. See *id.* at 3a ("The decision to invoke utilization review is made independently by the employer or insurer."). Indeed, the Commonwealth does not even *encourage* insurers to withhold payment or initiate utilization review in any particular case. See *id.* at 59a (the

State "takes no substantive step to promote, support or encourage the decision of the insurer" to withhold payments). On the contrary, Pennsylvania law requires the insurer to pay for the cost of utilization review regardless of its outcome. *Id.* at 8a; 77 Pa. Stat. Ann. § 531(6)(iii). In addition, if the URO determines that the disputed medical care was reasonable and necessary, the insurer must not only pay the bill immediately but must also pay 10% annual interest on the amount withheld. 34 Pa. Code. § 127.208(e), (g); 77 Pa. Stat. Ann. § 717.1(a). In light of these disincentives, the statute cannot be said to "encourage" insurers to invoke utilization review — any more than the availability of *any* state-created remedy "encourages" resort to the remedy to gain relief.

Even if the State's workers' compensation scheme did encourage insurers to withhold payments to health care providers and to initiate utilization review, moreover, that would not suffice to convert the insurers' choices into the choices of the State. In *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), this Court refused to find state action in the choice of a private entity pursuant to a statutory authorization that encouraged the authorized actions. See *Rendell-Baker*, 457 U.S. at 841 (noting that "[b]oth [the] state and federal regulations" in *Blum* "encouraged the nursing homes to transfer patients to less expensive facilities when appropriate"). Because the private insurers' choices are entirely free from state compulsion, there is no state action under this line of authority.[10]

Thus, there is neither compulsion nor encouragement in this case. There is instead only State *authorization* — enough, in other words, to satisfy the first *Lugar* factor, but not the second. As this Court has repeatedly held, the "[p]rivate use of state-sanctioned remedies or

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[10] The Third Circuit appeared to attach significance to the fact that workers and employers are required to participate in the workers' compensation system in Pennsylvania. See Pet. App. 14a, 16a, 18a. But even if the State compels participation, that does not mean that the specific actions of the insurers at issue in this case are compelled. Students are compelled to go to school, but that doesn't make their conduct at school state action. In any event, it is only the employers and employees, not the insurers, who are compelled to participate in the system.

procedures does not rise to the level of state action." *Tulsa Professional Collection Servs., Inc.* v. *Pope*, 485 U.S. 478, 485 (1988); see also *Flagg Brothers*, 436 U.S. at 161 n.11, 164. That principle is controlling here.

3. Pennsylvania's Ministerial Role In The Utilization Review Process Does Not Place The State's "Imprimatur" On The Private Insurers' Conduct Nor Does It Make The State A Joint Participant With The Insurers

In finding state action, the Third Circuit also relied on the fact that an insurer seeking utilization review must first file a one-page form with the Bureau of Workers' Compensation, which will be disapproved if it fails to include all of the required information. According to the court of appeals, this means that "[t]he insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth" (Pet. App. 15a) and that "the Commonwealth is intimately involved in any decision by an insurer to * * * suspend medical payments." *Ibid*. This argument rests on a mischaracterization of the Bureau's role as well as a mistaken view of what is required to convert private conduct into state action under this Court's "joint action" cases.

Contrary to the Third Circuit's apparent view, the requirement of filing a form is an inconsequential detail in the regulatory scheme. The Bureau's role in processing the form (including forwarding the form, if properly completed, to a randomly selected URO) is purely ministerial.[11] As the Third Circuit itself stated, the Bureau reviews the

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[11] When the Bureau receives a request for utilization review, Bureau staff check it to ensure that the form contains all of the information requested: the name and address of the employee, employer, provider, and insurance carrier; the employee's social security number; the date of the employee's injury; the provider's specialty or area of practice; the treatment procedure to be reviewed; the date or dates of treatment to be reviewed; and an explanation why utilization review is being requested. 34 Pa. Code § 127.452(a); C.A. App. B34. Bureau staff also confirm that the date of treatment is on or after the effective date of the statute, 34 Pa. Code § 127.402; C.A. App. C33; that another party or workers' compensation judge has not already requested utilization review of the same treatment, C.A. App.

form only "to ensure that it is properly completed — *i.e.*, that all information required by the form is provided," and not in any way to "address the legitimacy or lack thereof of the request for utilization review." Pet. App. 5a; accord *id*. at 50a, 59a. The district court correctly found that the State has no involvement whatsoever in the substance of the decision either to seek utilization review or to withhold payments during that process (*id.* at 59a):

> The state takes no substantive step to promote, support, or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not significantly assist private actors when it merely provides a remedy, albeit complete with authorized forms and regulations. The state's acceptance and routing of forms completed in accordance with its instructions, in essence, * * * involves acquiescence and not compulsion on the part of the state.

The Third Circuit's statement that the State is "intimately involved in any decision by an insurer" to withhold payments (*id.* at 15a) is thus a gross exaggeration, at best.[12]

Pennsylvania's wholly ministerial role in accepting and routing the one-page form required to initiate utilization review falls well short of the "overt, significant assistance" of state officials that is required for a finding of state action under this Court's "joint action" cases. *Tulsa Professional*, 485 U.S. at 486. For example, in *Shelley* v. *Kramer*, this Court found state action in the state court's *enforcement* of

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C32; that the procedure for which review is requested matches the provider named, *id.* at C16; that the form, on its face, requests review of the reasonableness or necessity of medical treatment, *id.* at B98-B99; and that the insurer has accepted liability for a job-related injury, *id.* at C25-C27.

[12] We hasten to add, however, that even if the Commonwealth engaged in a substantive evaluation of the merits of the request for utilization review, that would not transform the insurer's invocation of utilization review into state action. When the government limits, restricts, or regulates private action, it does not become responsible for that action.

racially restrictive covenants entered into by private parties, but only because such enforcement was pursuant to state policy and placed the imprimatur of the State on the private, discriminatory conduct. 334 U.S. at 18-19.[13] There is nothing approaching such an imprimatur here. Most decisively, in *Blum* v. *Yaretsky*, this Court expressly rejected the argument that there was state action because New York required nursing home physicians to "complete patient care assessment forms and file them with state Medicaid officials." 457 U.S. at 1006-07, 1010. "We cannot say," the Court explained, "that the State, by requiring completion of a form, is responsible for the physician's decision." *Id*. at 1006-07.

Nor is the Third Circuit correct in stating (Pet. App. 15a) that there is "little difference between the approval required here and that necessary for utilizing a peremptory challenge * * * or for employing a nonclaim statute with the assistance of the probate court" as in *Leesville Concrete*, 500 U.S. 614, or *Tulsa Professional*, 485 U.S. 478. In those cases, a private party would be powerless to obtain the desired result without the intervention of the State. Private citizens do not empanel juries, and private citizens cannot cut off the claims of their creditors. Delay in paying disputed claims, by contrast, is a common insurer practice, permitted under private insurance contracts.[14] It is a self-help remedy, and can be accomplished without any involvement of the State at all. The requirement of filing a form is a (modest) *limitation* on the insurer's natural freedom of action; it

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[13] *Shelley* arguably should be understood as resting on the fact that restrictions on alienation were generally disfavored under the common law of Missouri, and could be enforced only when the state court concluded that enforcement would be reasonable and consistent with public policy. For that reason, the State's decision to enforce the restrictive agreements amounted to a declaration that public policy was served by segregation. See L. TRIBE, CONSTITUTIONAL CHOICES 260 (1985).

[14] See, *e.g.*, 1 A. WINDT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS, § 2.22, at 75 (3d ed. 1995) (insurers may "withhold payment" of disputed portions of claims pending resolution of "dispute[s] as to the existence of coverage for a portion of the insured's claim").

is not a form of encouragement, assistance, or joint participation by the State.

4. The Private Insurers Are Not Fulfilling Constitutional Obligations Of The State

Finally, the Third Circuit purported to draw support for its state action holding from this Court's decision in *West* v. *Atkins*, 487 U.S. 42 (1987). Pet. App. 16a-17a. That reliance, however, was entirely misplaced. In *West*, this Court held that a physician under contract with the State to provide medical care to inmates at a state prison hospital was acting under color of state law even though he was not officially an "employee" of the State. The principle of the case is that the State may not evade a constitutional responsibility by contracting it out to a private party. The Third Circuit, however, interpreted *West* as permitting the court to engage in a loose examination of the "relationship" between the State and private parties and the "function" of the private party in deciding the state action question. *Id.* at 16a-17a, 19a.

That analysis overlooks the fact that *West* obviously turned on a factor not present here: the State had delegated one of its constitutional duties — provision of adequate medical care to inmates (see *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976); *West*, 487 U.S. at 54-57) — to a private party. Put differently, the physician's "function" and "relationship" the Court was referring to in *West* was his role as the State's delegate in discharging its constitutional obligations. Both this Court and the Courts of Appeals have recognized that *West* turned on this point and have rejected arguments to apply it outside that context. See *Georgia* v. *McCollum*, 505 U.S. 42, 52-53 (1992); *George* v. *Pacific-CSC Work Furlough*, 91 F.3d 1227, 1232 (9th Cir. 1996), cert. denied, 117 S. Ct. 746 (1997); *Andrews* v. *Federal Home Loan Bank*, 998 F.2d 214, 218 (4th Cir. 1993).

B. The Third Circuit's Holding Is At Odds With This Court's Recent Decisions Involving Heavily Regulated Businesses

Finally, the Third Circuit's decision should be reversed because it squarely conflicts with key precedents of this Court, including *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), *Rendell-*

Baker v. *Kohn*, 457 U.S. 830 (1982), and *Blum* v. *Yaretsky*, 457 U.S. 991 (1982). In *Jackson*, this Court held that the termination of electric service by a privately owned and operated utility corporation did not constitute state action, even though the utility was heavily regulated by the State, enjoyed "at least a partial monopoly in the providing of electrical service within its territory," and acted in terminating services pursuant to authority granted under a state-approved tariff. 419 U.S. at 354, 358. A private utility's "exercise of the choice allowed by state law" does not constitute state action, the Court explained, "where the initiative comes from it and not from the State." *Id*. at 357. The Court flatly rejected the contention that the utility was a state actor because it was "subject to extensive state regulation." *Id*. at 350. "The mere fact that a business is subject to state regulation," the Court reasoned, does not make it a state actor, even if "the regulation is extensive and detailed, as in the case of most public utilities." *Ibid*. Accord *Blum*, 457 U.S. at 1011; *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 176-77 (1972).

The Court in *Jackson* concluded there was no state action even though the utility company's termination decision was authorized by a general tariff that had been filed with the state public utility commission. The Court reasoned that there was "no * * * imprimatur placed on the practice of [the utility] about which [the utility customer] complains." 419 U.S. at 357. For the government to *allow* a private party to take some action is not the same as the government forcing or instigating that action. The Court explained:

> The nature of governmental regulation of private utilities is such that a utility may frequently be required by the state regulatory scheme to obtain approval for practices a business regulated in less detail would be free to institute without any approval from a regulatory body. Approval by a state utility commission of such a request from a regulated utility, where the commission *has not put its own weight on the side of the proposed practice by ordering it*, does not transmute a practice initiated by the utility and approved by the commission into "state action."

Ibid. (emphasis added).

In *Rendell-Baker*, this Court held that the decision of an extensively regulated private school for maladjusted high school students to discharge staff — allegedly in response to public criticism of the school leveled by the staff and without due process — was not state action even though the school received "virtually all of [its] income * * * from governmental funding," obtained its students through referrals from public schools and other public entities, and was required to comply with numerous educational requirements that applied to public schools. 457 U.S. at 840, 843. The Court observed at the outset that the school was not unlike many private corporations "whose business depends primarily on contracts" to provide services to the government, and explained that the "[a]cts of such private contractors do not become acts of the government by reason of their significant or even total engagement in performing public contracts." *Id*. at 840-41. Next, the Court rejected the argument that the schools were state actors because they were subject to detailed and extensive regulation. The Court not only reaffirmed the holding of *Jackson* that extensive regulation is insufficient to transform a private business into a state actor, but also suggested that much of the regulation to which the private school was subject was irrelevant to the state action question, because "the decisions to discharge" the staff "were not compelled or even influenced by any state regulation." *Id*. at 841.

The Court also rejected the argument that the school qualified as a state actor because it served a "public function," explaining that while "the education of maladjusted high school students is a public function, * * * that is only the beginning of the inquiry." 457 U.S. at 842. Under its cases, the Court explained, a private entity will be deemed a state actor only for carrying out a public function that is the "exclusive province of the State"; the mere fact that the State had elected to pay for such education does not suffice. *Ibid*. The Court also dismissed the contention that the school was a state actor because it had a "symbiotic relationship" with the State. *Id*. at 842-43 (distinguishing *Burton* v. *Wilmington Parking Auth.*, 365 U.S. 715 (1961)).

Finally, in *Blum* the Court held that the decisions of private (but heavily regulated) nursing homes to discharge or transfer residents who were Medicaid recipients did not qualify as state action. The

nursing homes were required by federal law to establish a utilization review committee ("URC") to determine on an ongoing basis whether the care provided to each patient was medically necessary. 457 U.S. at 994-95. If a URC determined that a patient needed a less intensive level of care, it was obligated to file a form containing information about its decision with the State, and the resident was transferred (without notice or an opportunity to be heard) to a facility with a lower level of care. *Id*. at 995. In holding that there was no state action, the Court again focused narrowly on the "specific conduct of which the plaintiff complains" — the decision to transfer or discharge — and concluded that this conduct was not something for which the government was responsible. *Id*. at 1004, 1008, 1010.

Reversal of the decision below follows *a fortiori* from *Blum*. *Blum* involved administration of a public program (Medicaid); this case involves a private contract of insurance to cover the legal liability of private employers. *Blum* involved a utilization review program in which nursing homes were required to inform the State if a patient's level of care became medically inappropriate; in this case the State merely authorizes utilization review but leaves it up to insurers whether and when to invoke it. If the actions of nursing homes administering a public program are not subject to constitutional constraints, workers' compensation insurers cannot possibly be deemed state actors.

For state action purposes, there is no analytical difference between the withholding of insurance payments under Pennsylvania law and the termination of electric service in *Jackson*, the discharge of staff in *Rendell-Baker*, or the reduction or termination of care through patient discharges or transfers in *Blum*. The Pennsylvania statute does nothing more than permit private parties to withhold payments to health care providers during utilization review — something they are fully capable of doing without state assistance. The insurer's filing of a form with the State, and the State's forwarding a properly completed form to a utilization review organization, are purely formal steps in the process.

The Third Circuit sought to distinguish *Jackson*, *Blum*, and *Rendell-Baker* on the ground that those cases "do not * * * involve a comprehensive statutory scheme similar to that present in this case."

Pet. App. 18a. But that statement is at odds with the essential holdings of *Jackson* and *Blum*. Both the public utility regulation in *Jackson* and the Medicaid regulation in *Blum* were as extensive as, if not more so than, insurer regulation in Pennsylvania. For example, insurers, unlike public utilities, are neither granted monopoly status nor required by the State to provide universal service. The crux of *Jackson* and *Blum* is their holding that extensive regulation — whatever its precise nature — *does not* transform private enterprises into state actors unless it compels or enforces the specific conduct at issue. That is an eminently sensible conclusion: where state legislators have crafted a comprehensive regulatory scheme, judicial second-guessing of particular components of that scheme is rarely either necessary or desirable. For the court below to dismiss *Jackson*, *Blum*, and *Rendell-Baker* on the ground that they did not involve a "comprehensive statutory scheme" was tantamount to rejecting this Court's holdings. Unless this Court is prepared to overrule those decisions — and the plaintiffs have never suggested that course — the decision below must be reversed.

II. AN INSURER'S WITHHOLDING OF PAYMENT TO HEALTH CARE PROVIDERS FOR DISPUTED MEDICAL TREATMENT DURING UTILIZATION REVIEW DOES NOT VIOLATE THE EMPLOYEE'S RIGHT TO DUE PROCESS

The second issue before this Court is whether the Due Process Clause permits an insurer (assuming it is a state actor) to delay payment of a medical bill for approximately two months while an independent utilization review organization determines whether the medical care for which the bill was submitted was reasonable and necessary.[15] In the lower court, plaintiffs also successfully challenged

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[15] Petitioners urge this Court to reach the Third Circuit's due process holding even if it rules in petitioners' favor on state action. The State Workmen's Insurance Fund conceded before the Third Circuit that it is a state actor when it requests utilization review and withholds payment for disputed treatment pending its outcome, Pet. App. 12a, and the School District's status as a state actor has yet to be resolved. No. 97-2030 Pet. 5-6. Thus, the State Workmen's Insurance Fund, and possibly the School District, continue to be bound by the Third Circuit's due process ruling. If

certain features of the utilization review process itself, but petitioners have not sought review of those portions of the Third Circuit's decision. See pages 4-5 & n.3, *supra*; Pet. 22 n.12. The only issue before the Court is the constitutionality of the portion of 77 Pa. Stat. Ann.§ 531(5) that permits insurers to withhold payment for disputed medical care pending the outcome of utilization review.

Under Pennsylvania law, workers who have been injured on the job are entitled to "reasonable and necessary" medical treatment (which may include such unorthodox care as chiropractic manipulation, acupuncture, biofeedback therapy, physical therapy, and aquatic therapy). After the first ninety days following their initial treatment for injury, they obtain these services from the health care provider of their choice. The provider sends the bill directly to the workers' compensation insurance carrier, which is required to pay the bill within thirty days — *unless* the carrier questions the reasonableness and necessity of the treatment and submits the bill for review by an independent utilization review organization. Under Pennsylvania law (like that of 25 of 27 States whose utilization review provisions address the subject[16]), insurers are permitted to withhold payment of disputed bills pending this review, with an obligation to pay promptly

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this Court were to rule in petitioners' favor on the state action issue but leave undisturbed the Third Circuit's due process ruling, public employers and insurers would be subject to an entirely different set of rules for obtaining utilization review than are private insurers, a highly disruptive result within the context of this integrated regulatory scheme.

Furthermore, if not reversed, the Third Circuit's due process holding as applied to state actors will likely cause substantial injury to private insurers. Public insurers or self-insuring public employers that are required to pay for unreasonable or unnecessary care pending utilization review are entitled to reimbursement from a special fund, which is maintained by annual assessments on all workers' compensation insurers. 77 Pa. Stat. Ann. § 999. Thus, the petitioners could ultimately bear much of the cost imposed by the Third Circuit's due process holding.

[16] See S. ECCLESTON & C. YEAGER, WORKERS' COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 18-19, 72 (1997).

and with 10% interest if the utilization reviewer concludes the treatment was proper.

The Third Circuit held this provision unconstitutional on the theory that the delay in payment was tantamount to a denial of benefits, and thus in violation of *Mathews* v. *Eldridge*, 424 U.S. 319 (1976). Because a delay in payment is tantamount to a denial of benefits, so the theory goes, it is unconstitutional to allow the insurers unilaterally to invoke the utilization review process and withhold payment. There must be notice and an opportunity to be heard before the "deprivation," which is to say before the delay in payment. Under this reasoning, the insurer must pay the disputed claim within the ordinary 30-day period for undisputed payments and before the utilization review can take place. Since Pennsylvania prohibits insurers from recouping payments to medical providers once made, the holding below means that medical providers receive payment whether or not the treatment they provided was reasonable and necessary.

This decision defies both legal doctrine and common sense. We will offer three separate but related reasons why. First, the individual claimants have not suffered a "deprivation" in the sense that term is used in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), and its progeny. Unlike the claimant in *Goldberg*, the individual plaintiffs' eligibility for benefits has not been terminated or even challenged. They have received the medical care to which they are arguably entitled. All that is at issue is whether their health care providers will be paid — or more precisely, *when* their providers will be paid. Second, even if the individual plaintiffs could be said to have suffered a deprivation, the process provided easily passes muster under the three-part test of *Mathews*, 424 U.S. at 335. Third, to the extent that the due process balance takes its bearings from longstanding tradition and the practices of other states, it was extraordinary for the court below to hold unconstitutional a practice that accords with common law practice and is currently in use in the vast majority of the states.

A. Workers' Compensation Beneficiaries Have Not Suffered A "Deprivation" When Insurers Delay Payment Of Their Health Care Providers' Bills

A delay in payment pending utilization review cannot be characterized as a deprivation of the employee's property interest. Employees do not have the right to challenge the procedures used to determine the eligibility of third party providers, such as health care providers, for payment — even if employees suffer serious indirect consequences from such a determination. In addition, determination of the reasonableness and necessity of particular medical treatments does not affect the workers' legal entitlement, which is to receive reasonable and necessary medical care. It is more analogous to a decision about an initial application for benefits (which does not require interim payments under *Mathews*) than to a termination of eligibility for benefits.

1. Employees Have No Right To Challenge The Procedures Used To Determine The Eligibility Of Their Health Care Providers For Payment

This case was brought by or on behalf of injured workers entitled to medical treatment as part of their workers' compensation benefits. Yet the gravamen of the employees' case is that their health care providers have not been promptly paid for services already rendered. Plaintiffs assert, and the court below agreed, that the effect of this delay in payment is that the medical providers will terminate their medical treatment. Pet. App. 27a. In Section II.B.2, we will demonstrate that this assertion is factually incorrect. But a more fundamental objection to the plaintiffs' claim is that the Due Process Clause, as interpreted in *Goldberg* and its progeny, provides protection only for persons whose own legal entitlements are directly subject to revocation. It does not give them any right to challenge the procedures applicable to third-party providers.

This principle was articulated most clearly in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 786-87 (1980). *O'Bannon* involved a group of elderly patients who were eligible for Medicaid benefits and who brought suit after their nursing home was found to have violated the requirements for certification as a Medicaid

provider. *Id.* at 776-78. As a result of decertification, the nursing home could not receive payment for the care of Medicaid patients, and the patients were subject to mandatory transfer to a certified facility. *Id.* at 777, 780, 784 & n.16. Despite the obvious risk of emotional and physical harm to the patients that would flow from the nursing home's decertification, the *O'Bannon* Court explained that the patients had no constitutionally protected interest in certification of the home. The Court distinguished between "direct" benefit determinations — which involve the application of statutory or regulatory criteria to individuals themselves — and "indirect" benefit determinations — which involve the application of statutory or regulatory criteria to a third-party provider of services or benefits. *Id.* at 786-87. Where the third-party providers were the subject of regulation rather than the patients themselves, the Court explained, the patients had no protected interest in the regulatory outcome. *Id.* at 790.

Notably, the *O'Bannon* Court rejected the argument that the likelihood of injury resulting from decertification of the nursing home gave patients a constitutional right to participate in decertification proceedings. Although Justice Blackmun argued in his concurring opinion that indirect beneficiaries have a protected liberty interest where challenged procedures would cause them a "high risk of death or serious illness," 447 U.S. at 803, the majority opted instead for a bright-line distinction between direct and indirect beneficiaries. *Id.* at 787. Direct beneficiaries, who are the subject of the challenged decision, may be entitled to due process protections. *Id*. at 786-87. Indirect beneficiaries, who are not the subject of the challenged decision, have no protected interest in its outcome, even if they suffer an "immediate, adverse impact" from the challenged decision and even if the underlying program is intended solely for their benefit. *Id.* at 787. The *O'Bannon* Court *assumed* that decertification of the nursing home would cause patients "severe emotional and physical hardship" and injury. *Id.* at 784 n.16, 787. Despite this proximate but indirect link between decertification and injury to the patients, the Court held that the patients had no due process interest in certification. *Id.* at 790.

O'Bannon thus presented an entirely different type of claim than that in *Goldberg*. In *Goldberg*, the claimant's own eligibility for

benefits was at stake. In *O'Bannon*, the legal rights of a third party were directly at issue, and the effect on the claimant was indirect (even if powerful).

This Court's analysis in *O'Bannon* governs this case. Just as the patients in *O'Bannon* sought to challenge the decertification of the nursing homes where they resided because decertification would force them to move, plaintiffs in this case seek to challenge the delay in payment to their health care providers out of fear that the providers will no longer provide them treatment. In both cases, the claimants are only indirectly affected by application of rules that are intended to regulate the practices of their nursing homes or health care providers — here, in order to prevent excessive costs for unreasonable and unnecessary medical treatment. Under *O'Bannon*, therefore, plaintiffs have no protected interest in their providers' bill payment dispute, regardless of the practical consequences to the employees.[17]

The Third Circuit's equation of a delay in payment to a provider with a deprivation of benefits to a patient threatens to expand radically the scope of due process protection. Virtually every government decision has foreseeable, and sometimes dire, consequences for persons other than the direct target of the decision. Terminating a university's accreditation, for example, would imperil its students'

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[17] Section 8, the federal low-income housing assistance program, 42 U.S.C. § 1437f, contains a similar dual regulatory scheme. Under Section 8, the federal government makes payments directly to landlords on behalf of eligible tenants. See *Cisneros* v. *Alpine Ridge Grp.*, 508 U.S. 10, 12 (1993). In order to become and remain qualified as a Section 8 provider, a landlord must meet "housing quality standards for decent, safe, and sanitary housing." 42 U.S.C. § 1437f(o)(5). The lower courts have consistently held that tenants have a constitutionally protected interest in continued eligibility for Section 8. See *Davis* v. *Mansfield Metro. Hous. Auth.*, 751 F.2d 180, 184 (6th Cir. 1984), and cases cited therein. No court has ever held, however, that tenants have a right to notice and an opportunity to be heard before their landlord is disqualified for failure to maintain "decent, safe, and sanitary housing" — despite the fact that the latter determination will result in the termination of rental payments on behalf of the tenant. At least one court has recognized that such a claim would be barred by *O'Bannon*. See *Swann* v. *Gastonia Hous. Auth.*, 502 F. Supp. 362, 366 (W.D. N.C. 1980).

eligibility for grants and loans. Terminating a social service provider's eligibility for government funding is likely to injure those depending on its services. Disqualifying a Medicare or Medicaid provider on the basis of fraud will almost certainly cause harm to the provider's patients, who will be required to find a new provider or pay out-of-pocket for continued care. Under the Third Circuit's reasoning, each of these indirectly affected third parties is entitled to notice and an opportunity to be heard prior to the adverse decision. As the *O'Bannon* Court explained, due process has never been understood to reach so broadly. 447 U.S. at 778-89.

2. Procedures For Determining The Reasonableness And Necessity Of Heath Care Services Are More Analogous To An Initial Application For Benefits Than To A Termination Of Eligibility For Benefits

Under Pennsylvania law, an employee who is injured in the course of employment is entitled to benefits under the Pennsylvania Workers' Compensation Act, including replacement wages, compensation for permanent injury or disability, and payment to health care providers for treatment of the injury. 77 Pa. Stat. Ann. §§ 431, 531. An employee's eligibility for workers' compensation benefits does *not* mean, however, that the insurer must pay for any and all health care provided to the employee. Pennsylvania law expressly limits an employee's entitlement to reimbursement of the provider for medical care and services that are both "reasonable and necessary." *Id.* § 531(1), (5).

Administration of the workers' compensation system thus requires two separate steps: first, determining whether an employee is eligible for workers' compensation benefits; second, determining whether a particular medical bill submitted for reimbursement falls within the scope of the employee's right to provider reimbursement for medical benefits. If the insurer attempted to reconsider the *first* step — to declare the worker no longer eligible for workers' compensation benefits — we concede that (state action issues aside) this case would bear a resemblance to *Mathews*.[18]

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[18] Even a challenge to an employee's overall eligibility for workers' compensation benefits would not appear to require the full panoply of

The *second* step — determining the reasonableness and necessity of a particular medical treatment — is unrelated to the employee's overall eligibility for workers' compensation benefits. Each of the individual plaintiffs in this case remained eligible for continued benefits at all times after suffering a job-related injury, and nothing in the utilization review procedures could adversely affect their continued eligibility. In order to invoke utilization review, an insurer must concede the employee's eligibility for workers' compensation benefits. 34 Pa. Code §§ 127.404(b)-(d), 127.405(c), 127.479. A utilization reviewer is not permitted to consider issues that bear on the employee's eligibility, such as whether the patient's injury or disease is job-related or whether the patient's disability still exists. *Id.* §§ 127.406, 127.470. The *only* question at issue in the decision to request utilization review, and in the utilization review itself, is whether a particular medical treatment falls within the scope of the provider's right to reimbursement for reasonable and necessary medical expenses.

Goldberg, *Mathews*, and their progeny are therefore inapplicable to this case. In *Goldberg*, the named plaintiffs had met the criteria to receive and had been receiving financial aid under Aid to Families with Dependent Children and/or Home Relief. 397 U.S. at 256 & n.2. Similarly, in *Mathews*, the plaintiff had been found eligible for Social Security disability benefits and had been receiving those benefits for nearly four years. 424 U.S. at 323-24. In both cases, the government sought to change — to *terminate* — these previously established legal rights of the claimant, and the Court was accordingly required to decide what procedures were constitutionally mandated before an aid recipient could be divested of those rights. See *id.* at 332; *Goldberg*, 397 U.S. at 260.

In this case, by contrast, there has not been (indeed, could not be) a prior determination that the claimant was entitled to any particular medical service. That is an issue that generally can be resolved only

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procedural protections mandated in *Goldberg*. The challenge would be more similar to the termination of disability benefits at issue in *Mathews* than the termination of welfare benefits in *Goldberg* because, as the district court noted, eligibility for workers' compensation benefits is not based on financial need and an injured employee may have other sources of income. Pet. App. 69a-70a.

retrospectively,[19] and only with reference to the particular course of treatment. Utilization review thus does not result in the loss of a vested right, but is an initial determination of whether the particular service falls within the scope of the worker's entitlement. It is more closely analogous to an initial application for a benefit.[20] The employee has no vested entitlement to provider payment for a particular medical service until it is first determined to be "reasonable and necessary." As a consequence, there is no right to due process because there has been no deprivation of a protected right by virtue of the insurer's withholding of payment.

The flaw in the plaintiffs' logic is plain when one considers what would happen if Pennsylvania modified its procedures for reimbursement. Pennsylvania could provide that no bills are to be reimbursed until a utilization reviewer determines that the bill is for reasonable and necessary medical care. Pennsylvania could set a 60-day limit for making this decision, the same length of time given under current law for an insurer to deny reimbursability and for utilization review to take place. 77 Pa. Stat. Ann. §§ 531(5), (6)(ii). An argument that due process required the payment of bills during this 60-day period, before any determination of the reasonableness or necessity of the medical care at issue, would be frivolous. Yet in substance, this hypothetical procedure is identical to the actual Pennsylvania system, with the sole exception that insurers are required to pay *undisputed* bills within 30

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[19] Although Act 44 provides for prospective and concurrent utilization review, 77 Pa. Stat. Ann. § 531(6)(i), an insurer does not know prior to submission of a bill what medical services are being provided unless the provider or employee has asked for pre-approval of a particular course of treatment.

[20] This Court has never decided whether "applicants for benefits, as distinct from those already receiving them, have a legitimate claim of entitlement protected by the Due Process Clause * * *." *Lyng* v. *Payne*, 476 U.S. 926, 942 (1986); see also *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 312, 320 n.8 (1985); *Gregory* v. *Town of Pittsfield*, 470 U.S. 1018, 1021 (1985) (O'Connor, J., dissenting from denial of certiorari); *Peer* v. *Griffeth*, 445 U.S. 970, 970 (1980) (Rehnquist, J., dissenting from denial of certiorari).

days. This demonstrates that plaintiffs have not been subjected to deprivation of any legal right.

B. The Procedures Involved In This Case Easily Satisfy Due Process Under The *Mathews* Balancing Test

Even if one were to ignore the foregoing analysis and assume, contrary to law, that an insurer's decision to withhold payment deprives an employee of a protected right, due process does not require insurers to pay bills for disputed treatment pending the results of utilization review. In determining whether procedures are constitutional, the Court traditionally considers the private interests that will be affected, including the interests of both the party subject to official action and the party seeking the action;[21] the risk of an erroneous deprivation and the probable value, if any, of additional procedural safeguards; and the government's interest. *Connecticut* v. *Doehr*, 501 U.S. 1, 10-11 (1991); *Brock* v. *Roadway Express, Inc.*, 481 U.S. 252, 263 (1987); *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). The Court must also consider the brief duration of any deprivation, which weighs in favor of constitutionality. *Gilbert* v. *Homar*, 117 S. Ct. 1807, 1813 (1997) (in performing *Mathews* balancing, "account must be taken of 'the length' and 'finality of the deprivation'" in determining what process is due) (quoting *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 434 (1982)); *Santosky* v. *Kramer*, 455 U.S. 745, 758 (1982). On balance, these factors strongly support the conclusion that permitting the insurer to withhold payment for disputed treatment pending the outcome of utilization review comports with "fundamental fairness." *Lassiter* v. *Department of Soc. Servs.*, 452 U.S. 18, 24 (1981).

1. The Insurer's Interest

The insurer has a substantial private interest in not paying for unnecessary or unreasonable medical treatment pending the outcome of utilization review. Under Pennsylvania law, an insurer is not

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[21] The Third Circuit simply ignored the private interests of Pennsylvania workers' compensation insurers in retaining the statutory right to deny reimbursement for disputed care pending utilization review. See Pet. 23-24; Pet. Reply Br. 7.

permitted to recoup payments for unreasonable or unnecessary care. *Moats* v. *Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). Although insurers may seek reimbursement for excessive payments from a special fund, the fund is financed entirely from assessments levied on the insurers (and self-insured employers) themselves. 77 Pa. Stat. Ann. § 999. Thus, insurers — and ultimately employers and consumers — bear the cost of all payments for unnecessary and unreasonable treatment.

Utilization review — or some equivalent procedure — is essential for the prevention of fraud and abuse in the workers' compensation medical care system. Utilization review developed in response to academic studies demonstrating that "a significant fraction of medical care is inappropriate and unnecessary." Leape, *Practice Guidelines and Standards: An Overview*, QUALITY REVIEW BULLETIN 42, 42 (Feb. 1990); see also Kelly & Kellie, *Appropriateness of Medical Care*, 114 ARCH. PATHOL. LAB. MED. 1119, 1119 & nn.1-9 (1990).[22] Traditional fee-for-service plans give health care providers a financial incentive to provide medical care and services that do not improve patient health. See, *e.g.*, Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 214

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[22] One study found that utilization review reduced total medical expenditures by 8.3%. See Feldstein, *et al.*, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1312, 1314 (1988); see also Wickizer, *The Effect of Utilization Review on Hospital Use and Expenditures*, *in* REVIEW, REGULATE OR REFORM: WHAT WORKS TO CONTROL WORKERS' COMPENSATION COSTS 108, 133 (1994) (summari-zing studies of hospital utilization review under federal benefit programs and concluding that utilization review "reduces hospital inpatient days by somewhere between 5 and 10 percent"). The Pennsylvania Compensation Rating Bureau has recently estimated the "net direct savings attributable to utilization review before the Sullivan decisions at approximately $32 million per year," with even larger "indirect" effects. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>.

(1997); Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 493 (1997) ("Customary care under traditional insurance reflects severe moral hazard and hence overuse of costly services.").

The incentive to overuse medical services is heightened in the workers' compensation context, where medical insurance features that are used to discourage overutilization — such as employee-paid deductibles, co-payments, or dollar or duration limitations — are barred by state law requiring a workers' compensation insurer to pay the full cost of reasonable and necessary medical services. 77 Pa. Stat. Ann. § 531(1), (5). As a result, "[p]roviders have shifted costs from increasingly restrictive group health payers to less restrictive workers' compensation payers, primarily by providing more intensive and longer duration services to workers' compensation patients." Tracy, *The Importation of Managed Care to the Workers' Compensation System: Time for Re-evaluation and Re-direction*, 9 NO. 7 HEALTH LAW 16, 17 (1997); see also PA. LEGIS. J. — HOUSE, at 2020 (Dec. 11, 1991) (statement of Rep. Murphy, advocating adoption of medical cost-containment for workers' compensation because "the place where the health care costs are now moving to is to workers' compensation" in response to cost-containment in other health care programs). To make matters worse, employees may have an incentive to continue receiving medical care (regardless of its medical efficacy) in order to delay clearance to return to work, a particular problem in Pennsylvania since one-third of injured workers receive wage replacement benefits that are greater than their actual pre-injury wages. See D. BALLANTYNE, *supra*, at 25. Similarly, by consuming additional medical care and services, a worker may become eligible for a larger award for permanent disability.

Even under the current system, it is financially infeasible for insurers to invoke utilization review in every instance of unreasonable or unnecessary care, because the insurer must pay the cost of utilization review. 77 Pa. Stat. Ann. § 531(6)(iii). If the insurer is required to pay all bills received before the conclusion of utilization review of a particular course of treatment, the direct benefit of review will disappear, since the insurer is not permitted to recoup reimburse-

ment later determined to have been wrongful. Requiring payment of bills pending the outcome of utilization review thus substantially reduces the financial incentive for medical providers to limit themselves to reasonable and necessary care.

2. The Employee's Interest

The employee has an interest in timely reimbursement to his or her provider for reasonable and necessary medical care.[23] Because the medical care has already been provided, the employee's interest is attenuated,[24] but it stands to reason that greater uncertainty about payment could affect future treatment. Contrary to the arguments of plaintiffs and the assumption of the court below, however, a delay in payment is far from equivalent to a termination of medical care.

In light of the incentives of the system, an insurer will withhold payments only when it has reason to believe that the utilization reviewer, a neutral medical professional in the provider's own specialty, will conclude that the treatment was contrary to accepted medical protocols *and* when the amount saved by this determination will be greater than the cost of the utilization review. By the same token, a health care provider who believes that the care he or she is providing is medically necessary has every financial incentive — in addition to any ethical and professional obligations — to continue care, since a provider whose treatment decisions are upheld on utilization review is entitled to full retroactive payment with 10% annual interest. 77 Pa. Stat. Ann. § 717.1(a); 34 Pa. Code § 127.210. Thus, a provider will likely stop treatment during the pendency of utilization

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[23] As discussed above, this interest, being indirect, is not legally sufficient to give the claimant a right to challenge the procedures under *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773 (1980). See pages 32-35, *supra*. In this section, we show why plaintiffs' claim would fail even if it could survive that threshold difficulty.

[24] The real party in interest is the medical provider, but no one would argue that the provider's due process rights are violated by the relatively brief delay in payment at issue here.

review *only* if he or she expects an adverse review.[25] This inference is borne out by the actual experience of the named plaintiffs: at least five of the ten individual plaintiffs continued to receive disputed treatment months or even years after a request for utilization review. See J.A. 29, 30, 34, 36, 38. Moreover, even if the provider does discontinue treatment, the worker (who remains eligible for care) can go to another provider. If that provider provides reasonable and necessary care, the worker may be better off for the change. Finally, a patient who wishes to continue receiving a certain form of treatment even if it is found to be unreasonable or unnecessary can pay out-of-pocket to do so, as at least one of the named plaintiffs chose to do. See *id.* at 42. All these factors serve to protect the employee's interest in continued care.

3. The Value Of The Additional Safeguard

Obviously, employees (and their health care providers) would prefer to receive immediate payment for all treatment, without any scrutiny whatsoever. But for purposes of the due process balance, the proper question is to what extent requiring immediate payment will reduce the number of cases in which an injured worker's reasonable and necessary medical treatments have been erroneously terminated as a result of the delay in payment. Respondents have provided no reason to believe that that number is substantial, and there is every reason to believe that it is not.

An insurer that invokes utilization review and withholds payments must pay the entire cost of the review (regardless of its outcome) and must pay the entire bill, with 10% interest, if it is found to be necessary and reasonable, in a proceeding in which the insurer bears the burden of proof (see 34 Pa. Code § 127.471(b)). In light of these incentives, it is likely that insurers will invoke the procedure only when they have very strong reasons to think that their view of the treatment

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[25] Under 77 Pa. Stat. Ann. § 531(7), a provider is prohibited from "balance billing" an employee — attempting to collect the difference between the amount billed and the amount reimbursed by the insurer — for medical services determined to be unreasonable or unnecessary. See also 34 Pa. Code § 127.211 ("Balance billing prohibited").

will prevail. In fact, according to statistics compiled by the State, 69.14% of the requests for utilization review through early 1998 were found to involve medical care that was wholly or partially unreasonable or unnecessary. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (July 1, 1998), posted at <http://www.li. state.pa.us/wcletter.html>.[26] The great likelihood that a denial of reimbursement by an insurer will be upheld on utilization review supports the conclusion that no additional procedures are required. See *FDIC* v. *Mallen*, 486 U.S. 230, 242 (1988) (permissible length of delay before post-deprivation hearing depends on "likelihood that the interim decision may have been mistaken").

Moreover, it stands to reason that the cases in which the treatment is reasonable and necessary are the cases in which it is most likely that the providers would continue to provide services in the expectation that they will receive full retroactive payment with interest. Requiring immediate payment of disputed bills would therefore be tremendously costly and would greatly increase the incidence of health care fraud and abuse by providers, without significantly reducing the number of cases in which workers are deprived of necessary and reasonable medical services.

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[26] A copy of the July 1, 1998 Wisecarver letter was also lodged with the Office of the Clerk of the Supreme Court by *amicus curiae* American Insurance Ass'n *et al.*, simultaneous with the filing of their Brief in Support of the Petition for Certiorari, and is included as an Appendix to that Brief.

4. The Government's Interest

The government has substantial interests in permitting insurers to withhold payment for disputed treatment pending utilization review. As a regulator, the government has an interest in containing costs for Pennsylvania employers and insurers that participate in the workers' compensation program, in order to ensure the economic health of the business community and encourage in-state investment. Act 44 was "intended to greatly curtail the escalating medical costs associated with work-related injuries and illnesses." Dep't of Labor & Industry, *Workers' Compensation Medical Cost Containment,* PENNSYLVANIA BULLETIN 4875 (Vol. 25, No. 45, Nov. 11, 1995). Medical payments dropped 25% in the year after Act 44 was enacted, and as of 1996 employers had received average rate reductions of 18%. *Workers' Compensation Reform,* posted at <http://www.state.pa.us./PA_Exec/ Governor/wcleg3. html>.

This governmental interest goes beyond the interest of individual insurance companies in avoiding payment for unreasonable or unnecessary medical bills. The existence of an effective utilization review mechanism serves both as a deterrent to fraudulent and abusive claims and as a source of guidance and information to providers about what services are properly regarded as medically reasonable and necessary (and thus reimbursable). The Pennsylvania Compensation Rating Bureau has estimated these "indirect" effects of utilization review as "potentially much greater than the direct effects of these decisions" because "many more claims may be affected by such precedents [set by utilization reviews] than are required to establish them." Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>. If insurers receive no direct benefit from undertaking utilization review (because, under the decision below, they have to pay the bill for the disputed treatment before the review takes place and cannot obtain recoupment), they are far less likely to do so. This negates the indirect benefits of utilization review for the entire system. Since the Third Circuit's

decision, the number of utilization review requests has declined by almost 60%. *Ibid.*

The government's interest in cost containment is entitled to great weight. See *Parham* v. *J.R.*, 442 U.S. 584, 604-05 (1979) (State "obviously has a significant interest in confining the use of its costly mental health facilities to cases of genuine need"); *Mathews* v. *Eldridge*, 424 U.S. 319, 348 (1976) (noting government and public interest "in conserving scarce fiscal and administrative resources"). As the Court recognized in *Mathews*, requiring interim benefit payments to a recipient who ultimately is found to be undeserving "may in the end come out of the pockets of the deserving since resources available for any particular program of social welfare are not unlimited." 424 U.S. at 348; see also Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1276 (1975).

In addition, the government has significant interests in controlling the medical care given to Pennsylvania residents. This interest encompasses both a *parens patriae* interest in protecting employees from unreasonable or unnecessary medical procedures, see *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 323 (1985); *Parham*, 442 U.S. at 605, and a regulatory interest in ensuring that medical care provided to Pennsylvania residents complies with professional standards, see, *e.g.*, *Bigelow* v. *Virginia*, 421 U.S. 809, 827 (1975) (state has a "legitimate interest in maintaining the quality of medical care provided within its borders").

5. The Interest Balance

The balancing of interests in this case weighs decisively in favor of permitting an insurer briefly to withhold payment for disputed treatment pending the results of utilization review. The minor risk of an erroneous delay in payment for treatment that is reasonable and necessary, and the consequent possibility that a provider will discontinue reasonable and necessary treatment because of this delay, is greatly outweighed by the interests of the private insurer and government in permitting suspension of payment for disputed care.

A comparison with this Court's treatment of similar regulatory systems is instructive. In *United States Department of Labor* v. *Triplett*, 494 U.S. 715 (1990), for example, this Court upheld the

constitutionality of federal regulations governing attorneys' fees in black lung benefit cases under which an attorney was not permitted to accept any fees unless and until the claimant was successful in applying for benefits and all appeals had been resolved. *Id.* at 717. In applying the *Mathews* balancing test, the Court emphasized that delaying payment of fees until the conclusion of administrative proceedings and possible judicial review protected the employer, the insurance carrier, and the Black Lung Disability Trust Fund "from a depletion that would leave other claimants without a source of compensation." *Id.* at 722. The Court further noted that requiring payment of fees to an attorney "immediately upon success at every level, subject to recovery in the event the judgment in favor of the claimant is reversed at a higher level, would impose upon the payor the onerous task of seeking to obtain a refund." *Ibid.*[27] Thus, the Court concluded, the delay in payment of fees was fully consonant with due process. *Id.* at 726.

In *Heckler* v. *Ringer*, 466 U.S. 602, 619 (1984), this Court held that Medicare recipients challenging the denial of payment for surgery were required to exhaust an "often lengthy administrative review process" before seeking a judicial ruling that the surgery was "reasonable and necessary." If the lengthy delay in *Ringer* is permissible — despite the fact that, as the *Ringer* Court acknowledged, "some * * * surgeons may well decline to perform the requested surgery because of fear that the Secretary will not find the surgery 'reasonable and necessary' and thus will refuse to reimburse them," *id.* at 626 — then surely the extremely brief delay in payment at issue in this case is likewise permissible.

And in *Schweiker* v. *McClure*, 456 U.S. 188 (1982), this Court rejected a due process challenge to the regulations governing Medicare Part B reimbursement. Under the regulatory scheme at issue in *McClure*, health care providers who treated patients enrolled in Medicare Part B were required to submit bills to a private insurance

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[27] This reasoning applies *a fortiori* to this case, since workers' compensation insurers are precluded by law from recovering erroneous payments to medical providers. See page 3-4, *supra*. Thus, seeking a refund would be not only "onerous" but impossible.

carrier. *Id.* at 190-91. The carrier reviewed the bill and, if it found that the treatment was not medically necessary, denied payment subject to subsequent administrative review. *Id.* at 191. There was absolutely no hint in the Court's opinion that any delay in payment resulting from this procedure might violate due process. As the Court noted, "[a]ppellees simply have not shown that the procedures prescribed by Congress and the Secretary are not fair * * *." *Id.* at 200.

Triplett, *Ringer*, and *McClure* mandate the conclusion that due process permits the withholding of payment for disputed medical services pending the outcome of utilization review. Just as the attorneys in *Triplett* and the physicians in *Ringer* and *McClure* were required to bear the substantial burden of a delay in payment pending a final determination that payment should be made, so must health care providers under Pennsylvania's workers compensation system assume the modest risk that payment for reasonable and necessary services will be briefly delayed. But that risk is vastly outweighed by the risk on the other side — that the workers' compensation system would be required to pay for fraudulent, unnecessary, unreasonable, or otherwise abusive medical bills, with no hope of recovery. Requiring payment for disputed treatment pending utilization review is a classic example of a scenario in which "the marginal gains from affording an additional procedural safeguard * * * [are] outweighed by the societal cost of providing such a safeguard." *Walters*, 473 U.S. at 320-21.

C. Withholding Of Payment Pending Resolution Of Coverage Issues Comports With Traditional Practice Under State And Federal Law

The conclusion that due process permits the suspension of payment for disputed medical treatment pending review is buttressed by an examination of the "[h]istorical and contemporary practices" of other States. See *Doehr*, 501 U.S. at 16. As this Court has emphasized "from its first due process cases, traditional practice provides a touchstone for constitutional analysis." *Honda Motor Co.* v. *Oberg*, 512 U.S. 415, 430 (1994). The Court reiterated this principle just two Terms ago in *Washington* v. *Glucksberg*, 117 S. Ct. 2258 (1997), stating that "in all due-process cases," the "Nation's history, legal

traditions, and practices * * * provide the crucial guideposts for responsible decisionmaking that direct and restrain our exposition of the Due Process Clause."[28] *Id.* at 2262, 2268 (citations omitted). Where a practice enjoys the support of a large majority of the States, and the imprimatur of long experience, this Court has been extremely reluctant to strike it down under the Due Process Clause. See, *e.g.*, *Schall* v. *Martin*, 467 U.S. 253, 266-67 (1984); *Glucksberg*, 117 S. Ct. at 2269; *Burnham* v. *Superior Court*, 495 U.S. 604, 615 (1990) (plurality opinion).

Interpreted against "th[e] backdrop of history, tradition, and practice" (see *Glucksberg*, 117 S. Ct. at 2267), there can be no question that the challenged Pennsylvania scheme is constitutional. To begin with, reasonable delay to permit evaluation of disputed claims is a common insurer practice — and one permitted by private insurance contracts as enforced under the common law. See note 14, *supra*. Respondents' claim is equivalent to suggesting that the Constitution requires insurers (if state actors) to pay disputed claims *before* an independent decisionmaker determines whether they are covered by the governing contract. That has never been the law in *any* jurisdiction, much less a requirement of the Constitution.

Nor is Pennsylvania law inconsistent with modern practice under other States' laws. To the contrary, of the 41 States (and the District of Columbia) whose statutes or regulations specifically address the subject, at least 39 (including Pennsylvania) permit insurers to withhold disputed claims during the pendency of utilization review or the resolution of various disputes regarding the scope of treatment or amount of compensation. See S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSA-

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[28] *Glucksberg* was a substantive due process case, but it specifically made this point with reference to "all due-process cases." 117 S. Ct. at 2262. Indeed, the emphasis on practice and tradition arose in this Court's earliest due process cases, which were procedural in nature. *Murray's Lessee* v. *Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 277 (1856); *Missouri Pac. Ry. Co.* v. *Humes*, 115 U.S. 512, 521 (1885); *Hurtado* v. *California*, 110 U.S. 516, 535 (1884).

TION, A NATIONAL INVENTORY, 1997-1998, at 18-19 (1997).[29] Likewise, numerous States authorize unilateral suspension of payments for other reasons, such as when an employee returns to work, refuses to submit to reasonable medical examination, or declines to attend vocational rehabilitation or counseling. See Pet. 15 n.6 (collecting statutory authorities). Courts in at least five of the remaining ten States go even further, holding that insurers (or employers) may withhold payment without penalty *whenever* there exists a good faith belief that no payment is due. See *id.* at 24-25 (collecting authorities). The law in Pennsylvania thus accords with the "settled usages and modes of proceeding" in nearly all of the other States. *Hurtado* v. *California*, 110 U.S. 516, 528 (1884).

At the federal level, the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.*, permits insurers that voluntarily initiate benefits to injured workers subsequently to challenge the reasonableness or necessity of the workers' medical care. Federal regulations authorize the insurers to withhold payment and request government review of controverted treatment (20 C.F.R. § 702.233), and they are not required to give workers an opportunity to be heard before doing so. *Ibid*. Thus, viewed in light of both federal and state law, the subject statute involves not the slightest "deviation from established procedures," much less one "result[ing] in constitutional infirmity." *Oberg*, 512 U.S. at 430. To the contrary, our national "experience favors this legislation as the most efficient mode of preventing, with the least inconvenience," the expenditure of insurance funds for treatment that ultimately is determined to be unreasonable or unnecessary. See *Missouri Pac. Ry. Co.*, 115 U.S. at 523.

The nearly uniform practice of over 40 States and the federal government cannot be dismissed as unthinking or arbitrary. Our

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[29] The exceptions are North Carolina, where bills over $2,000 need not be paid until after receipt of approval by the Industrial Commission, and Oklahoma, where the Oklahoma Workers' Compensation Court makes case-by-case determinations on payment of disputed bills. S. ECCLESTON & C. YEAGER, *supra*, at 219, 232. Thus, even these exceptions are more apparent than real.

Nation's democratically elected officials are far better positioned than federal judges — who possess limited expertise and information, are less accountable to the people, and whose rulings lack the flexibility to adapt to changing circumstances — to determine fair procedures for resolving insurance claim disputes, the allocation of risk of mistake or fraud, and the efficacy of cost containment strategies. See *Glucksberg*, 117 S. Ct. at 2293 (Souter, J., concurring) ("Not only do [legislatures] have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions."). Indeed, given the Third Circuit's conclusion that Pennsylvania workers' compensation law is a "complex and interwoven regulatory web" (Pet. App. 14a), the court should not have substituted its own intuitions regarding the interests of workers, employers, insurers, and health care providers for the considered policy judgment of Pennsylvania's elected officials, and that of virtually every other State in the Union.

CONCLUSION

The judgment of the court of appeals should be reversed. The court of appeals held that the so-called "'unless' clause" of 77 Pa. Stat. Ann. § 531(5) is unconstitutional, and severed it from the remainder of the statute, leaving insurers under the obligation to pay all bills within 30 days even if they are seeking utilization review. Pet. App. 25a. If this Court reverses on the state action and due process questions, or on the due process question alone, that judgment should be reversed in its entirety. If this Court reverses on the state action question without reaching the due process question, the judgment below should be reversed as applied to private insurers and employers, leaving them free to withhold payments during the pendency of utilization review, as permitted under 77 Pa. Stat. Ann. § 531(5).

Respectfully submitted.

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