No.

In the Supreme Court of the United States

OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

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

PETITION FOR A WRIT OF CERTIORARI

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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 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 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(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 also include 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.

Pursuant to Rule 29.6, petitioners state the following:

American Manufacturers Mutual Insurance Company has no parent companies or nonwholly owned subsidiaries.

The parent companies of Commercial Union Insurance Company ("Commercial Union") are Commercial Union Corporation, Commercial Union Assurance Company plc (UK), and CGU plc (UK). Commercial Union has no nonwholly owned subsidiaries.

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

Continental Casualty Company has two parent companies — CNA Financial Corporation and Loews Corporation — and fifteen nonwholly owned subsidiaries: Omega Aseguradora de Riesgo de Trabajo, North American Crop Underwriters, Inc., RVI Guaranty Company Ltd., AMS Services, Inc., The Entertainment Coalition, Home Financial Network, CNA Surety Corporation, HealthPro Solutions, L.L.C., La Salle Re Holdings Limited, La Salle Re Limited, Insurance Reference Systems, Inc., Alliance for Productive Technology, Inc., Insurance News Network, L.L.C., Insurance Information Exchange, L.L.C., and InsWeb Corporation.

Donegal Mutual Insurance Company has no parent companies and one nonwholly owed subsidiary: Donegal Group, Inc.

Hartford Fire Insurance Company's parent companies are Nutmeg Insurance Company and The Hartford Financial Services Group, Inc., and its nonwholly owned subsidiaries are Hartford Life, Inc., CCS Commercial L.L.C., Hartford Calma Company, International Corporate Marketing Group, Inc., American Mutual Life Insurance Company, Hartford Life Insurance Company of Canada, Adapt, Inc., and Trumbull Marketing Resources, L.L.C.

The parent companies of Insurance Company of North America are INA Holdings, INA Financial Corporation, INA Corporation, CIGNA Holdings, Inc., and CIGNA Corporation. Rain and Hail Insurance Service Incorporated is a nonwholly owned subsidiary of Insurance Company of North America.

United States Fidelity and Guaranty Company has two parent companies — USF&G Corporation and The St. Paul Companies, Inc. — and the following nonwholly owned subsidiaries: Afianzandoro Insurgentes Serfin, S.A., Georgeson International, Inc., FGA Corporation, Premium Travel Services, Inc., Castle Pines Village Realty, Inc., and Ashley Palmer, Ltd.

Zurich Insurance Company has no parent companies or nonwholly owned subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners, eight private workers' compensation insurance companies, respectfully ask this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 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 (App., *infra*, 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 (App., *infra*, 62a-82a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 13, 1998. This Court's jurisdiction is invoked under 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 App., *infra*, 83a-103a.

STATEMENT

A. ***Pennsylvania's Workers' Compensation Statute And Recent Cost-Containment Initiatives***. Workers' compensation is a system under which employers are obligated to pay for certain medical care for employees who sustain work-related injuries or contract occupational diseases, as well as to pay specific sums as partial replacement of wages, without regard to fault. App., *infra*, 13a-14a. It is a 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 employees and employers (or their insurers). 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 administrative law judges ("ALJs"), 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 the workers' compensation laws.

To ensure that employers can meet their financial obligations, the statute requires them to "obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund ('SWIF') — or to self-insure." App., *infra*, 3a. If the employer contracts with a private insurer for coverage, the insurer "assume[s] the employer's liability" to pay workers' compensation benefits. 77 Pa. Stat. Ann. § 501(a)(1). 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. "[N]o 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 resolution of disputes over reimbursement for medical care. The law requires payment only for "reasonable" and "necessary" medical services. 77 Pa. Stat. Ann. § 531(1), (5). However, it includes within the definition of "medical services" not only "services rendered by physicians" but also the

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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 underwritten by the insurers themselves, *id.* § 1055. See also App., *infra*, 14a n.18.

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 the vast majority of disputes over the reasonableness and necessity of care. The individual respondents in this case, for example, include one worker whose twice-weekly chiropractic sessions were deemed unreasonable and unnecessary after two years of treatment (C.A. App. A97); one who was undergoing "aquatic therapy" (*id*. at A100); one who 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 A105-06); and one receiving psychological and biofeedback therapy (*id*. at A112). 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." App., *infra*, 31a.

Prior to 1993, insurers had no effective means to limit payments to "reasonable" and "necessary" care. The "spiraling costs of medical treatment for work-related injuries" (App., *infra*, 3a) became a "significant problem[] in the Pennsylvania system." D. BALLANTYNE & C. TELLES, *supra*, at 30. In an effort to control these costs, in 1993 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." App., *infra*, 3a. Among other things, the Act provided: "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). Under this provision, insurers were permitted — though not required — to withhold payments for disputed medical bills until after utilization review.[2] This was important because the law prohibits insurers

[2] The court of appeals called this delay in payment a "supersedeas" (App., *infra*, 2a, 13a), but that term does not appear in Section 531(5), as the district court noted. App., *infra*, 41a (stating that "plaintiffs' counsel

and employers from recouping any payments made to health care providers or employees, even if the treatment is later determined to be unreasonable or unnecessary. App., *infra*, 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. As a result, insurers and self-insured employers as a group ultimately bear all the costs of unnecessary or unreasonable medical treatment once payments have been made.

Utilization review must be initiated by an insurer (or employer) "within 30 days of the receipt of the bill and medical report for the treatment at issue." 34 Pa. Code § 127.404(b). It is triggered by the filing of a form with the Bureau. The Bureau conducts no substantive review of the form to determine whether utilization review is appropriate. It merely determines whether the form contains the information required and then forwards the form to a private utilization review organization ("URO") selected randomly by the Bureau from a list of approved review organiza-tions. 34 Pa. Code § 127.453. The Bureau also sends a notice to the employee, the employer (or insurer), and the provider, identifying the URO that will conduct the review. *Ibid.* The URO's review must be conducted 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). The URO gives notice to the medical care provider, who must be given an opportunity to discuss treatment decisions. 34 Pa. Code § 127.469. Utilization review applies "generally accepted treatment protocols," *id.* § 127.467, and a presumption that disputed treatment is reasonable and necessary. *Id.* § 127.471(b). The utilization review is "solely based upon the medical records of the treating medical provider and any discussions that the URO has had with th[at] provider" (App., *infra*, 7a); neither the employer nor the employee has any right to provide input directly in this process.

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characterize[d]" the statute "as an 'automatic supersedeas'").

Under the statute, the URO must issue a written decision within thirty days of a request, though in practice this typically takes about seventy days. The URO's decision may be challenged by filing a petition with an ALJ, who will conduct a hearing at which the employee may submit testimony. App., *infra*, 9a. If the URO determines that the disputed medical service was reasonable and necessary, the insurer must pay the bill immediately with 10% annual interest. 34 Pa. Code § 127.208(e); 77 Pa. Stat. Ann. § 717.1(a). If the URO decides that the medical service was unreasonable or unnecessary, then the insurer need not pay the bill unless that decision is overturned by the ALJ, the Board, or the courts.

Originally, Act 44 permitted reconsideration of the URO's determination through a second utilization review. In 1996, the Pennsylvania legislature eliminated such reconsideration through the passage of Act 57. App., *infra*, 8a-9a.

B. ***Proceedings In The District Court.*** Plaintiffs in this putative class action are ten individuals who were or are employed in Pennsylvania and two organizations that represent Pennsylvania employees. See page ii, *supra* (Rule 14.1(b) statement).[3] The private defendants are American Manufacturers Mutual Insurance Company and seven other workers' compensation insurance companies (petitioners here); the public defendants are various state officials and agencies. See *ibid.* Plaintiffs' 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. C.A. App. A84. They 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 "prior notice and opportunity to be heard." C.A.

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[3] The proposed plaintiff class "consists of more than 40,000 workers' compensation recipients" who "have been, or will be in the future, receiving medical benefits pursuant to the Pennsylvania Worker's Compensation [Act]" and whose benefits have been or will be suspended during utilization review. C.A. App. A79-A80, A84.

App. A76. They sought declaratory and injunctive relief, restoration of benefits, and compensatory and punitive damages.

The private insurers moved to dismiss on the ground that 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" within the meaning of 42 U.S.C. § 1983. After limited discovery, the district court granted the private insurers' motion on the state action issue on January 24, 1996. App., *infra*, 41a-61a. The court explained that the government's involvement in the private insurer's decision to invoke utilization review was minimal (*id*. at 59a):

> [T]he decision to cease paying medical benefits is entirely up to the insurer acting independent of any state involvement whatsoever. 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 * * * involves acquiescence and not compulsion on the part of the state.

The state officials who remained as defendants subsequently moved to dismiss on the ground that the statute does not violate procedural due process. On November 7, 1996, the district court granted that motion. App., *infra*, 62a-81a. The court concluded that plaintiffs' interest in continued receipt of medical benefits, while "significant" (*id*. at 70a), 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 "plaintiffs may have access to additional income sources such as wage replacement." App., *infra*, 70a. Moreover, the availability of ALJ review of the URO's decision as well as full retroactive relief, 10% interest, and attorneys' fees to the worker who successfully challenges an adverse decision "lessens the potential harm to the individual employees." *Ibid*.

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. App., *infra*, 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 which "more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." *Id*. at 19a.

The court acknowledged that the Fifth Circuit had concluded that private insurers are *not* state actors in the context of a similar dispute in Texas, see *Barnes* v. *Lehman*, 861 F.2d 1383 (1988), but stated "we do not share the Fifth Circuit's view." App., *infra*, 17a. The court also purported to distinguish *Barnes* on the basis of several possible differences in the specifics of Texas law.

Finally, the Third Circuit rejected the insurers' argument that a finding of no state action was dictated by *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982), *Flagg Bros.* v. *Brooks*, 436 U.S. 149 (1978), and *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974). Those cases, the court of appeals explained, are distinguishable because they "do not * * * involve a comprehensive statutory scheme similar to that present in this case." App., *infra*, 18a.

Turning to the due process issue, the Third Circuit first held that the notice provided to employees that payments might be withheld

from medical providers was constitutionally deficient. App., *infra*, 21a-25a. (That issue is not in dispute in this petition. See note 12, *infra*.) Next, the court evaluated whether payments for disputed medical services could be withheld pending utilization review. The court characterized this question as whether respondents are entitled to an opportunity to be heard prior to a deprivation. Applying the balancing test of *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), the court held that insurers are required to pay the disputed bills until workers are given "an opportunity and time to submit a personal statement in writing" to the URO "regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." App., *infra*, 33a. The court 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.

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. App., *infra*, 29a-30a. "On balance," however, the court explained, "we are not convinced that any governmental interest outweighs the private interest." *Id*. at 30a. The court accordingly struck down the portion of the statute allowing payments to be delayed pending utilization review.

REASONS FOR GRANTING THE PETITION

In conflict with four other federal courts of appeals (but in agreement with two district courts), the Third Circuit held that private companies voluntarily providing workers' compensation insurance to private employers are "state actors" for purposes of the Fourteenth Amendment. That holding effectively empowers judges to substitute their conception of proper risk allocation in the insurance industry for that of state legislatures and regulators and the private actors involved. When evaluating the procedural fairness of acts of state governments, judicial review is essential because the self-interest of the States involved requires review by an independent body. But there is no such justification for judicial intervention when the state governments are engaged in regulating and balancing the interests of

private parties (such as employers, workers, medical providers, and insurance companies). In such cases, the courts are simply substituting their own (often uninformed, and politically unaccountable) judgments for those of legislators, state regulators, and the private market. The expansive "state action" doctrine espoused by the court of appeals is thus a species of "*Lochner* in reverse." See *Lochner* v. *New York*, 198 U.S. 45 (1905). If the error of *Lochner* was to think that courts may second-guess legislatures in the fields of social and economic policy in the interest of minimal regulation, the error of the court below is to second-guess legislatures and private markets in the interest of more costly and intrusive regulatory requirements. Either way, this exceeds the bounds of proper judicial authority.

The court of appeals's expansive due process holding also warrants review. The Third Circuit imposed a costly and novel obligation on the insurers — the duty to pay disputed medical bills prior to a determination that the medical treatment is reasonable or necessary — on the theory that delayed payment of bills is tantamount to a governmental "deprivation" of medical treatment without notice and an opportunity to be heard. Because insurers are forbidden to recoup payments wrongfully made to medical providers, this means, in effect, that insurers have no means of limiting payment for past treatments to those medical bills that are for reasonable or necessary medical care. This judicially created payment obligation is inconsistent with the laws of (and established practices of insurers in) every other State, was imposed without a proper evaluation of the competing private interests at stake, and renders utilization review meaningless as a means of medical cost containment. It also conflicts with the decisions of this Court and the lower courts. The Third Circuit's interpretation of the Due Process Clause thus raises a constitutional question of both doctrinal and practical importance.

I. THE THIRD CIRCUIT'S STATE ACTION HOLDING WARRANTS FURTHER REVIEW

A. The Decision Below Conforms To No Coherent Theory Of State Action, And Conflicts With Decisions Of This Court

The decision of a private insurance company to postpone payment of a disputed claim until completion of utilization review has none of the hallmarks of "state action" identified by this Court's

precedents. See *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 939 (1982). Petitioners are private companies that have voluntarily entered into private contracts of insurance with private employers. The decision to withhold payment of disputed medical bills is made entirely by petitioners, with no coercion or encouragement by the State. The postponement of payments requires no assistance from state officials; in this respect it cannot be distinguished from the decision of any private party to withhold contract payments until a dispute is resolved. 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). To be sure, the underlying workers' compensation liability of the employer, which is the subject of the insurance, is mandated by the State, but that fact does not render the State responsible for the payment, or the insurer an arm of the State. Tort liability is also mandated by the State, but that does not make tort liability insurers state actors.

The Third Circuit's conclusion that petitioners are "state actors" is based on an undigested collection of considerations that do not — singly or together — add up to state action.

First, the court observed that the system is "mandatory" and "exclusive," making workers' compensation payments a "constitutionally protected entitlement," and even a "public benefit." App., *infra*, 14a-15a. Yet 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. The State's mandate runs to the employer, not the insurer (which is under no statutory obligation to provide coverage to the employer). Nor are the payments "public" in the sense of being obligations of the State. See *Dillard* v. *Industrial Comm'n,* 416 U.S. 783, 798 (1974) (workers' compensation funds "are private, not

public").[4] The tort system is no less "mandatory" or "exclusive" than workers' compensation, and valid tort claims have an equal claim to be described as "constitutionally protected entitlements," yet no one would say that insurance payments to a tort victim are "public benefits."

Second, the court described the workers' compensation system as "a complex and interwoven regulatory web" (App., *infra*, 14a), a "'system which the government alone administers'" (*id*. at 15a (quoting *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 622 (1991))). "The Act * * * inextricably entangles the insurance companies in a partnership with the Commonwealth * * * ." App., *infra*, 19a. It is, however, well established that state regulation — even "extensive and detailed" regulation — does not "convert [a private company's] action into that of the State for purposes of the Fourteenth Amendment." *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974).

Finally, the court of appeals relied on the fact that an insurance company (or employer) seeking utilization review must first file a form with the Bureau, which will be disapproved if it fails to include certain required information. According to the court, this means that "the insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth" (App., *infra*, 15a) and "the Commonwealth is intimately involved in any decision by an insurer to * * * suspend medical payments." *Ibid.* The requirement of filing a form, however, 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 URO to conduct the review) is purely ministerial. The Bureau reviews the 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." *Id.* at 5a; accord *id*. at 50a, 59a. The State has no

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[4] This distinguishes *West* v. *Atkins*, 487 U.S. 42 (1987), on which the court of appeals relied. App., *infra*, 16a-17a (analogizing workers to prisoners on ground that both are "locked into the system"). In *West*, the private party was engaged to fulfill constitutional obligations *of the State*.

involvement whatsoever in the substance of the decision either to seek utilization review or to withhold payments during that process. In addition, unlike in cases such as *Tulsa Professional Collection Services* v. *Pope*, 485 U.S. 478 (1988), the insurance company does not *need* the assistance of the State before postponing payment. Delay in paying disputed claims is a common insurer practice, permitted under private insurance contracts. The requirement of filing a form is a (modest) *limitation* on the insurer's natural freedom of action; it is not a form of encouragement, assistance, or joint participation by the State.

Under no coherent theory of state action could these slight connections between Pennsylvania and a private workers' compensation insurer lead to the conclusion that the latter "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 theory. Having cited the three factors just discussed, 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." App., *infra*, 19a. It then emphasized that its holding is "expressly limit[ed]" to the "unique context" of this case, as if that could substitute for a clear explanation of why the facts of this case fit within established principles of state action doctrine.

In fact, the Third Circuit's decision conflicts with key precedents of this Court, including *Jackson* v. *Metropolitan Edison Co.*, *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982), and *Flagg Bros.* v. *Brooks*, 436 U.S. 149 (1978). 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 services within its territory," and acted in terminating services pursuant to authority granted under a state-approved tariff. 419 U.S. at 354, 358. The 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 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 explained, 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.

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 whether the care provided to such residents was medically necessary. 457 U.S. at 994. Once the URC decided that a resident did not need the care being provided, the resident was transferred (without notice or an opportunity to be heard) to a facility with a lower level of care. In holding that there was no state action, the Court 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. Moreover, in *Blum*, the Court rejected the argument that there was state action because New York requires nursing homes to "complete patient care assessment forms and file them with state Medicaid officials." *Id.* 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. See also *Rendell-Baker*, 457 U.S. at 838 (decision of extensively regulated, state-funded school for maladjusted high school students to discharge staff not state action); *Flagg Bros.*, 436 U.S. at 157-66 (warehouseman's sale of goods entrusted to him for storage not state action).

For state action purposes, there is no analytical difference between the suspension of insurance payments under the Pennsylvania statute and the termination of electric service in *Jackson* 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 (a process conducted not by state officials but by medical professionals employed by private organizations). The insurer's filing of a form with the State, and the State's forwarding

a properly completed form to a URO, are purely formal steps in the process.[5]

The Third Circuit sought to distinguish *Jackson*, *Blum*, *Rendell-Baker*, and *Flagg Bros.*, on the ground that those cases "do not * * * involve a comprehensive statutory scheme similar to that present in this case." App., *infra*, 18a. But that rationale rests on a false premise and 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 not 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. Indeed, where state legislators have crafted a comprehensive regulatory scheme, there is rarely either need or justification for judicial second-guessing of particular components of that scheme.

B. The Question Presented Is The Subject Of Persistent Conflicts Among The Lower Courts

The Third Circuit's decision, though consistent with several district court cases, is in square conflict with decisions of four courts of appeals and the state courts of Pennsylvania: *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988); *Stanescu* v. *Aetna Life & Casualty Ins. Co.*, 1996 U.S. App. LEXIS 20834 (2d Cir. Aug. 16, 1996), cert. denied, 117 S. Ct. 1697 (1997); *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992); *Fleming* v. *Workers' Compensation Comm'n*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996) (per curiam), aff'g 878 F. Supp. 852 (E.D. Va. 1995); *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 278-80 (Pa. Commw. Ct. 1982). The Eleventh Circuit has

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[5] The courts of appeals have uniformly held that ministerial actions by the State are insufficient to give rise to state action. See, *e.g.*, *Gaskell* v. *Weir*, 10 F.3d 626, 628 (9th Cir. 1993) (upholding sanctions imposed for "patently frivolous" argument that court clerk's "ministerial role" in "accepting and filing * * * settlement documents" gives rise to state action).

identified the issue but not yet resolved it. *Cryder* v. *Oxendine*, 24 F.3d 175, 177 (11th Cir. 1994).[6]

The Fifth Circuit decision, *Barnes* v. *Lehman,* involved a worker whose temporary disability benefits under the Texas workers' compensation scheme were terminated by an insurance company on the basis of the treating physician's opinion that the worker was able to return to work. 861 F.2d at 1384-85. The worker sued the insurer, alleging that suspending his weekly disability payments without first affording him an opportunity to be heard violated due process. *Id.* at 1387. The district court dismissed the complaint on the ground that there was no state action. In unanimously affirming, the Fifth Circuit flatly rejected the argument adopted by the Third Circuit in this case: that an insurance company invokes the aid of state officials by "filing the forms incident to ceasing payments." *Ibid.* Citing *Blum*, the Fifth Circuit explained: "Regulations that dictate procedures, forms, or even penalties without dictating the challenged action do not convert private action into state action." *Ibid.* Because "[t]he decision to adopt [the physician's] opinion as final and to cease Barnes's benefits was a decision initiated and carried out by the insurer and not the state," the insurer cannot fairly be said to be a state actor. *Ibid.*

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[6] The state action issue arises with regularity because state workers' compensation laws authorize insurers (or employers) unilaterally to suspend payments in a variety of circumstances. For example, some States permit suspension where an employee returns to regular employment or his attending physician releases him to do so. See, *e.g.*, Colo. Rev. Stat. § 8-42-105(3); Mont. Code Ann. §§ 39-71-701, 39-71-712; Or. Rev. Stat. § 656.268(3). Many States authorize suspension of payments when an employee refuses to submit to reasonable medical examination. See, *e.g.*, Ariz. Rev. Stat. § 23-1026C; Colo. Rev. Stat. § 8-43-404(3); Conn. Gen. Stat. § 31-294f(a); Iowa Code § 85.39; Kan. Stat. Ann. § 44-518, § 45; N.H. Rev. Stat. Ann. § 281-A:39; R.I. Gen. Laws § 28-33-38; Wyo. Stat. Ann. § 27-14-609(c). Other States authorize suspension where the employee declines to attend either vocational rehabilitation or counseling, *e.g.*, Colo. Rev. Stat. § 8-43-404(3); Mass. Gen. Laws ch. 152 § 45, or to accept suitable employment, see, *e.g.*, Ga. Code Ann. § 34-9-240(b)(2); Iowa Code § 85.33; N.C. Gen. Stat. § 97-32.

The court below acknowledged the conflict with *Barnes*, but declared that "we do not share the Fifth Circuit's view." App., *infra*, 17a. In addition to rejecting the Fifth Circuit's reasoning, the Third Circuit sought to distinguish *Barnes* on several grounds:

> Clearly * * * the statutory provision permitting the termination of benefits in *Barnes* and the supersedeas provisions at issue here vary significantly. In *Barnes*, for instance, the insurance company was not compelled to resume the employee's benefits even after a State officer reviewing the case [so] recommended * * * . Thus, the employee was left with a cause of action under state law only. In addition, it is unclear whether employers and/or employees can opt-out of Texas' * * * scheme. In Pennsylvania * * * they cannot. Moreover, and perhaps most importantly, it is not clear that under Texas law the State involvement was required *prior* to the termination of benefits.

App., *infra*, 17a-18a (citation omitted). These distinctions are either based on a misunderstanding of Texas law or irrelevant to the state action issue. The Third Circuit's suggestion that an insurer need not comply with a state officer's recommendation refers to Texas' procedure for a meeting with a pre-hearing officer "to attempt to adjust and settle the claim amicably * * * ." Tex. Civ. Stat. Ann. art. 8307, § 10(b) (1987). But if the parties failed to agree, the Board would make a final decision, which *was* enforceable against all parties. Thus, the Third Circuit was simply wrong to suggest that the Texas system was merely advisory or that the worker "was left with a cause of action under state law only." App., *infra*, 18a.

As for the Third Circuit's reference to several features of the Texas system that were "unclear" — the right of employers and employees to opt out, and the timing of the State's involvement — those distinctions are simply irrelevant to the state action inquiry. It makes no difference whether an insurer is required to file a form before suspending benefits (as in Pennsylvania) or after (as in Texas).[7] Nor does it matter whether employers and employees may

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[7] Under the Texas scheme at issue in *Barnes*, an insurer that suspended payment of disputed benefits was required to file a statement of grounds for suspension with the Board within ten days. Tex. Civ. Stat. Ann. art. 8306, §

opt out of the system.[8] The utility customers in *Jackson* could not obtain electricity from another source, but that did not make the utility a state actor. In any event, the potential to opt out of the system as a whole does not alter the extent of state involvement, or the mandatory nature of state requirements, for those who do *not* opt out. And it has no bearing on the decision of a *private insurance company* — whose participation is voluntary in either case — to suspend payments. The insurer's decision is not attributable to the State merely because the State mandates participation in the system by employers and employees.

The Third Circuit's decision also conflicts with decisions of the Second, Fourth, and Ninth Circuits. The district court in *Fleming* v. *Workers' Compensation Comm'n*, 878 F. Supp. 852 (E.D. Va. 1995), aff'd, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996), held that a private insurer that suspended payments of workers' compensation benefits, including medical benefits, under the Virginia workers' compensation statute was not a state actor. The district court explained that the insurer "is authorized, but not required, to suspend benefits," and "the ultimate decision whether to suspend benefits rests with the insurer." *Id.* at 860-61. A panel of the Fourth Circuit unanimously affirmed, explaining that "[a]lthough [Virginia] created the underlying statutory and regulatory mechanism challenged in the instant proceeding, it did not compel or direct the suspension of Fleming's benefits." 1996 U.S. App. LEXIS 3858, at *5 (citing *Barnes*).

18a(b) (1987); see also Tex. Civ. Stat. Ann. art. 8307, § 11 (1987) (insurer required to give the Board "the name, number, and style of the claim, the amount paid thereon, and the reason for such suspension or stopping"). If the insurer failed to file this statement or to state fully the reasons for suspension, it faced a penalty of up to 15% of the compensation and benefit amounts past due. *Ibid.*; 28 Tex. Admin. Code § 53.35(b) (1985).

[8] Both employers and employees did have a right to opt out of the Texas workers' compensation system. See Tex. Civ. Stat. Ann. art. 8308, § 7 (1987) (employers); *id*. art. 8306, § 3a-3b (employees).

Similarly, in *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (July 9, 1992), the Ninth Circuit held that a private insurer that reduced payments for workers' compensation benefits based on a medical review panel's evaluation of the worker did not qualify as a state actor. The Ninth Circuit rejected the argument that "Montana and the insurers are joint participants in the workers' compensation scheme[] because the state mandates workers' compensation insurance, certifies and regulates workers' compensation insurance companies, and provides workers' compensation directly to a significant numbers of workers." *Id*. at **1. In words that apply with equal force to this case, the court of appeals explained that "there is no indication that the *state itself* has anything to do with a medical review panel decision or what the insurer decides to do based on its findings." *Ibid*. (emphasis added). See also *Freier* v. *New York Life Ins. Co*., 679 F.2d 780, 783 (9th Cir. 1982) (insurer's reduction of workers' compensation benefits held not to be action under color of state law (citing 42 U.S.C. § 1983)).

In *Stanescu* v. *Aetna Life & Casualty Ins. Co*., 1996 U.S. App. LEXIS 20834 (Aug. 16, 1996), cert denied, 117 S. Ct. 1697 (1997), the Second Circuit affirmed the dismissal of an action brought under 42 U.S.C. § 1983 by an employee whose workers' compensation benefits were suspended by an insurance company. The court held that the private insurer's suspension of benefits did not qualify as action "under color of state law" (which is coextensive with the state-action requirement). 1996 U.S. App. LEXIS 20834, at *3. The Second Circuit rejected the argument that Aetna was a state actor because the Connecticut Workers' Compensation Act provided the "exclusive remedy available" to the plaintiff. *Id.* at *3-*4.[9] See also *Gyadu* v. *Workers' Compensation Comm'n*, 930 F. Supp. 738, 750-51 (D. Conn. 1996) (no state action where insurer temporarily suspends workers' compensation benefits and "[t]here is nothing to

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[9] Although the unanimous opinions of the Second Circuit in *Stanescu*, the Fourth Circuit in *Fleming*, and the Ninth Circuit in *Grenz* are unpublished, other courts (including the district court in this case) have cited and relied upon them in published decisions. See App., *infra*, 56a-57a (citing and discussing *Grenz*); *Fleming*, 878 F. Supp. at 860 (same).

indicate that the [State] participated in this decision"), aff'd, 129 F.3d 113 (2d Cir. 1997).

The Third Circuit's decision is also in conflict with the Pennsylvania courts' resolution of the state action issue. In *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277 (1982), the Pennsylvania Commonwealth Court, which has exclusive jurisdiction over appeals from the Workmen's Compensation Appeal Board (subject to discretionary review by the Pennsylvania Supreme Court), held that a private insurer that suspends payments for workers' compensation benefits does not qualify as a state actor. *Id.* at 278-80. The Commonwealth Court reasoned that the employer and employee have "a private contractual relationship and, if the [Workers' Compensation] Act did not exist, the employer would be free to stop payments if it determined that the employee's disability had ended." *Id.* at 279. The court rejected the argument that a private insurer is a state actor because workers' compensation is "highly regulated" and the statute provides "the exclusive means" for suspending payments. *Ibid.*

Other federal and state courts have similarly concluded that insurers (or employers) are not state actors in the context of state workers' compensation laws. See, *e.g.*, *Koller* v. *Aetna Life Ins. Co.*, 717 F. Supp. 648, 649 (E.D. Wis. 1988) (insurer's refusal to pay for substantial portion of medical care not action "under color of law" within meaning of 42 U.S.C. § 1983, because decision "was a purely private one, notwithstanding that [insurers] are licensed and regulated by the state"); *Masel* v. *Industrial Comm'n,* 541 F. Supp. 342, 345 (N.D. Ill. 1982) (dismissing due process claim brought against insurer that withheld payments for medical care, on ground that insurer did not act "under color of law"); *Martin* v. *Rush's Fabricare Center, Inc.*, 590 So. 2d 707, 709-10 (La. Ct. App. 1991) (insurer's invocation of dispute resolution scheme not state action).[10]

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[10] Cf. *Mirabile* v. *State Farm Ins. Co.*, 1994 U.S. Dist. LEXIS 17841, at *4-*15 (E.D. Pa. Dec. 13. 1994) (private insurer that invokes peer review procedure under Pennsylvania Motor Vehicle Financial Responsibility Law to resolve dispute over medical treatments held not to be state actor); *Brownell* v. *State Farm Mutual Ins. Co.*, 757 F. Supp. 526, 539-41 (E.D. Pa. 1991) (same). As the *Mirabile* court explained, plaintiff's due process claim

The Third Circuit is not, however, alone in concluding that private insurers are state actors in this context. In *Davis* v. *Caldwell*, 53 F.R.D. 373 (N.D. Ga. 1971), a three-judge court held that the Georgia workers' compensation law violated due process by permitting an insurer to cease payments to a worker without a prior hearing. The court reasoned that workers' compensation is a "program of state-supervised benefits" that "carries out" public policy. *Id*. at 377. "It seems clear," the court concluded, "that there is 'state action' here" under 42 U.S.C. § 1983. *Ibid*. In *Baksalary* v. *Smith*, 579 F. Supp. 218, 230-31 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), another three-judge court held that a private insurer was a state actor when it ceased payments under a prior provision of the Pennsylvania workers' compensation statute. The *Baksalary* court refused to follow the Pennsylvania courts' decision in *Henderson* on the ground that "[d]ecisions by Pennsylvania courts on issues of federal law merit our respectful consideration" but "are not controlling." 579 F. Supp. at 230 & n.19.

In sum, the conflict in the lower courts is both deep and abiding. Only this Court can resolve the disagreement among the circuits.[11]

"amounts to an attempt to convert an arguable — and temporary — breach of contract by an insurer into a civil rights claim * * * simply because the insurer chose to invoke state statutory procedures to delay payment of medical expenses which plaintiff contends were covered under an automobile insurance policy. * * * [T]he fact that the state regulates automobile insurance contracts to some extent does not give rise to a constitutionally protected right to payment of claims and does not convert insurers * * * into state actors." 1994 U.S. Dist. LEXIS 17841, at *4.

[11] Twice before, this Court has entertained appeals to resolve the state action and due process issues raised when a private workers' compensation insurance company withholds payments on a disputed claim, but both times the case was resolved on other grounds or dismissed for want of jurisdiction. *Dillard* v. *Industrial Comm'n of Virginia*, 416 U.S. 783 (1974); *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985).

C. This Court's Review Is Needed To Bring Coherence To This Unsettled Area Of Law

This case offers a valuable opportunity to clarify state action doctrine, which, as the Third Circuit observed, is "one of the most troublesome issues of constitutional law." App., *infra*, 13a. 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.

Ibid. (emphasis added). The first "factor" under *Lugar* serves to exclude cases where the private entity acts in violation of state law. *Id*. at 940. But as one commentator has noted, the first *Lugar* factor is "of little practical importance" because "[i]f a private actor is breaking the law of the jurisdiction when he harms another individual, it is unlikely that the private actor will be the subject of a suit that centers on whether he had state action when he caused the harm." 2 R. ROTUNDA & J. NOWAK, TREATISE ON CONSTITUTIONAL LAW § 16.1(a), at 527 (2d ed. 1992). And, with all due respect, the second *Lugar* factor — whether the private party "may fairly be said to be a state actor" — is tautological.

Not surprisingly, many of the conflicting decisions cited above turn on conflicting interpretations of what the second "prong" of the *Lugar* test means. Compare *Baksalary*, 579 F. Supp. at 227-28, 230-33 (holding that insurers are state actors because they satisfy the second *Lugar* factor), with *Barnes*, 861 F.2d at 1386-87 ("declin[ing] to adopt" the *Baksalary* court's "broad interpretation" of the second *Lugar* factor); *id*. at 1387 (same), and *Grenz*, 1992 WL 158158, at *1 (rejecting argument that insurer and State satisfy second *Lugar* factor), and App., *infra*, 55-59a (suggesting that *Baksalary* relied on incorrect understanding of second *Lugar* factor). In the face of that confusion, the Third Circuit essentially threw up its hands, justifying its conclusion that private insurance companies are "state actors" by

reference to a congeries of seemingly unrelated factors, none of which is sufficient under this Court's precedents to support the conclusion. App., *infra*, 13a-17a. The court offered no analytical structure or theory to explain why any of the factors were relevant, or what might be the limits on its expansive notion of state action, and refused to be pinned down to any particular theory of "state action" that might explain its decision. Only this Court can clarify the *Lugar* test and bring order to this cacophony. See *Lebron* v. *National R.R. Passenger Corp.*, 513 U.S. 374, 378 (1995) ("It is fair to say that 'our cases deciding when private action might be deemed that of the State have not been a model of consistency.'") (quoting *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 632 (1991) (O'Connor, J., dissenting)).

II. THE LOWER COURT'S DUE PROCESS HOLDING ALSO MERITS REVIEW BY THIS COURT

The Third Circuit held that the Pennsylvania law violates procedural due process because affected workers are not provided with notice and an opportunity to be heard before an insurer or employer withholds payments for disputed medical treatments.[12] That holding, and the analysis underlying it, is inconsistent with *Connecticut* v. *Doehr*, 501 U.S. 1 (1991), and in conflict with decisions of the Ninth and Eleventh Circuits and other federal courts. Because the due process issue, like the state action issue, is important and recurring, this Court should review it as well.

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[12] Petitioners do not challenge the courts of appeals' holding concerning notice. Following the Third Circuit's decision, the Bureau modified the form that it sends to the affected employee when a utilization review is assigned to a URO. That form now provides notice of the employee's right to submit a written statement to the URO and to appeal an adverse URO decision. See Notice of Assignment of Utilization Review Request (Mar. 1998) (attached as Exh. A to Motion of Insurer Defendants/ Appellees for Stay of Court of Appeals' Mandate (filed Mar. 31, 1998)).

A. The Third Circuit's Due Process Analysis Is Inconsistent With *Doehr* And The Decisions Of Other Courts

1. *Doehr* involved a Connecticut statute authorizing prejudgment attachment of real estate based solely on the submission of an affidavit to a state court (and without any showing of extraordinary circumstances). The Court ruled that the statute violated due process because it permitted attachment without affording the property owner prior notice and an opportunity for a hearing. Two features of the Court's decision are germane here. *First*, the Court's analysis was substantially informed by a review of "[h]istorical and contemporary practices" concerning prejudgment attachment, including a "survey of state attachment provisions." 501 U.S. at 16-17. The fact that prejudgment attachment "is a remedy unknown at common law" and that "nearly every State requires either a preattachment hearing, a showing of some exigent circumstance, or both, before permitting an attachment to take place," this Court explained, "confirm[s] our view that the Connecticut provision * * * clearly falls short of the demands of due process." *Id*. at 16-18. See also *Honda Motor Co*. v. *Oberg*, 512 U.S. 415, 430 (1994) ("traditional practice provides a touchstone for constitutional analysis" and the State's "abrogation of a well-established common-law protection * * * raises a presumption that its procedures violate the Due Process Clause"); *Burnham* v. *Superior Court*, 495 U.S. 604, 621-22 (1991) (opinion of Scalia, J.); *Schall* v. *Martin*, 467 U.S. 253, 268 (1984).

Second, the Court held that the three-part balancing test of *Mathews* v. *Eldridge*, 424 U.S. 319, 334-35 (1976), must be modified in evaluating due process challenges to "[p]rejudgment remedy statutes" because such statutes "ordinarily apply to *disputes between private parties* rather than between an individual and the government." *Doehr*, 501 U.S. at 10-11 (emphasis added). Because "any burden that increasing procedural safeguards entails primarily affects not the government, but the party seeking control of the other's property," the "relevant inquiry requires * * * , in contrast to *Mathews*, principal attention to the interest of the party seeking the prejudgment remedy, with, nonetheless, due regard for any ancillary interest the government might have" in forgoing additional procedures. *Id*. at 11.

The Third Circuit's decision is inconsistent with both of these teachings of *Doehr*. The court failed to grasp that *Doehr* "adjust[ed] the third prong of the *Mathews* test to include an analysis of a private party's interest in the remedy when a private party as opposed to the government is acting to effect a deprivation." *Shawmut Bank* v. *Costello*, 643 A.2d 194, 199 (R.I. 1994); accord *Connecticut Natural Gas Corp*. v. *Miller*, 684 A.2d 1173, 1178 (Conn. 1996). Insofar as they govern payment of insurance claims, workers' compensation laws, like prejudgment remedy statutes, "ordinarily apply to disputes between private parties rather than between an individual and the government." *Doehr*, 501 U.S. at 10-11. At bottom, the private insurer's dispute is with a third party beneficiary — the injured employee, or the medical provider — over whether certain medical care, whose reasonableness or necessity the insurer disputes, is covered by the insurer's contract with the employer. Because this case involves a dispute between private parties with conflicting property interests, the Third Circuit was wrong to refuse categorically to "consider the conflicting private interest of the insurance companies." App., *infra*, 27a. That refusal was contrary to *Doehr*.

The Third Circuit's due process analysis also failed to take into account the legislative judgments and traditional practices of the States. Of the forty-one States (and the District of Columbia) whose statutes or regulations specifically address the subject, at least thirty-nine (including Pennsylvania) permit insurers (or employers) to withhold disputed portions of claims during the pendency of utilization review or the resolution of various other 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' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 18-19 (1997); note 6, *supra*.[13] Courts in at least five of the remaining

[13] The exceptions are North Carolina, where bills over $2,000 need not be paid until after receiving 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.

ten States, moreover, have held that insurers (or employers) may withhold payment without penalty whenever there exists a good faith belief that no payment is due. See, *e.g.*, *Holmes* v. *Alachua County Adult Correctional Inst.*, 404 So. 2d 198 (Fla. Dist. Ct. App. 1981); *Martin* v. *H.B. Zachry Co*, 424 So. 2d 1002 (La. 1982); *Cruz* v. *Liberty Mut. Ins. Co.*, 889 P.2d 1223 (N.M. 1995); *Mayes* v. *Genesco, Inc.*, 510 S.W.2d 882 (Tenn. 1974); *Norfolk/Dep't of Fire* v. *Lassiter*, 324 S.E.2d 656 (Va. 1985); see also 8 A. LARSON, WORKERS' COMPENSATION LAW § 83.41(b)(2) (1997) ("Generally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty.").

At the federal level, the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.*, permits an insurer (or employer) that has voluntarily initiated benefits to an injured worker subsequently to challenge the reasonableness or necessity of medical care. Federal regulations authorize the employer or insurer to suspend payment and request government review of controverted treatment. 20 C.F.R. § 702.233. The insurer or employer is not required to give the worker an opportunity to be heard before suspending payments. *Ibid.* Thus, federal law and the laws of some forty-five States and the District of Columbia permit withholding of payments in the manner implicated here.

The Third Circuit imposed its own untutored intuition about fair procedures in place of the longstanding and considered judgments of the federal government and most of the fifty States. This raises a jurisprudential issue of the highest importance. The recent decisions of this Court — including *Doehr* — have sought to return to the historical roots of the Due Process Clause in the "settled usages and modes of proceeding" of our legal system. *Hurtado* v. *California*, 110 U.S. 516, 528 (1884); *Murray's Lessee* v. *Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 277 (1856). This insistence that the Due Process balance be informed by the actual "[h]istorical and contemporary practices" of the States (*Doehr*, 501 U.S. at 16) is not mere antiquarianism. Rather, it ensures that the courts' constitutional judgments — which, because of stare decisis, are exceedingly difficult to change — will be based on the solid ground of experience, rather than on the untested ideas, however well-meaning, of federal judges. There is no reason to suppose that

the three life-tenured judges on the Third Circuit panel were in a better position to balance the interests of injured workers, employers, medical providers, insurers, and the public than the consensus of officials elected and appointed by the people for the purpose of making legislative judgments of that sort.

2. The Third Circuit's due process holding conflicts with *Cryder* v. *Oxendine*, 24 F.3d 175 (11th Cir. 1994), and with decisions of other federal and state courts.

a. *Cryder* was a challenge to a provision of the Georgia workers' compensation statute authorizing an insurer to suspend payments after filing with the Board of Workers' Compensation a medical report of the treating physician stating that the worker had fully recovered. The Eleventh Circuit rejected the argument that this provision violated due process because it did not allow the affected worker to be heard prior to the suspension of payments. 24 F.3d at 177-78. The court emphasized the availability of a post-termination hearing before an ALJ at which the worker could be heard, further administrative and judicial review of the ALJ's decision, and "full retroactive relief" as well as "statutory penalties" if the worker ultimately prevails — all features of the Pennsylvania scheme as well. *Ibid*.

Similarly, the Third Circuit's decision is at odds with *Sauceda* v. *Department of Labor & Indus*., 917 F.2d 1216 (9th Cir. 1990), and other federal and state decisions. In *Sauceda*, the Ninth Circuit held that workers' compensation benefits may be suspended for failure to attend vocational training or mandatory physical examination without first giving the employee an opportunity to be heard. 917 F.2d at 1219. See also *Gyadu* v. *Workers' Compensation Comm'n*, 930 F. Supp. 738, 751 (D. Conn. 1996) (due process not violated by temporary suspension of workers' compensation benefits without prior opportunity to be heard), aff'd, 129 F.3d 113 (2d Cir. 1997); *Masel* v. *Industrial Comm'n*, 541 F. Supp. 342, 345 (N.D. Ill. 1982) (rejecting due process challenge to provision authorizing hearing after employer fails to pay for medical treatment); *Sandoval* v. *Industrial Comm'n*, 559 P.2d 688, 692 (Ariz. Ct. App. 1976) (due process not violated by suspension of disability and medical benefits without prior opportunity to be heard), cert. denied, 432 U.S. 906 (1977); *Depart-*

ment of Labor & Indus. v. *Workmen's Compensation Appeal Bd.*, 427 A.2d 1277, 1278 (Pa. Commw. Ct. 1981) (same for suspension of workers' compensation benefits).[14]

Various courts have rejected analogous due process challenges in the context of Medicare or Medicaid. See, *e.g.*, *Himmler* v. *Califano*, 611 F.2d 137, 146 (6th Cir. 1979) (due process satisfied if Medicaid beneficiary is given post-deprivation opportunity to challenge non-payment on grounds of medical nonnecessity); cf. *Gray Panthers* v. *Schweiker*, 652 F.2d 146 (D.C. Cir. 1980) (holding that due process requires explanation of why payment for Medicare treatment was denied, but in no way suggesting that government must continue payment of disputed claims until beneficiary is given opportunity to be heard).

b. The Third Circuit's decision is, however, neither isolated nor aberrational. Four state supreme courts have ruled that it is unconstitutional to suspend payment of workers' compensation benefits before the employee is given an opportunity to be heard. *Beckler* v. *North Dakota Workers' Compensation Bureau*, 418 N.W.2d 770, 774-75 (N. Dak. 1988); *Carr* v. *SAIF Corp*., 670 P.2d 1037, 1045-46 (Or. 1983) (en banc); *Mitchell* v. *State Workmen's Compensation Comm'r*, 256 S.E.2d 1, 9-10 (W. Va. 1979); *Auxier* v. *Woodward State Hospital-School*, 266 N.W.2d 139, 142-43 (Iowa), cert. denied, 439 U.S. 930 (1978). The opinion below is also consistent with *Baksalary* and with *Davis* v. *Caldwell*, 53 F.R.D. 373 (N.D. Ga. 1971) (three-judge court).

In the analogous Medicaid context, moreover, some courts have reached the same conclusion. *Yaretsky* v. *Blum*, 629 F.2d 817, 821 (2d Cir. 1980), rev'd on other grounds, 457 U.S. 991 (1982);

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[14] In *Colorado Compensation Ins. Authority* v. *Nofio*, 886 P.2d 714, 719 (1994), the Colorado Supreme Court held that due process was simply *not implicated* where the medical treatment given to an employee covered under the state workers' compensation program was subject to utilization review, notwithstanding that review could result in termination of treatment. Since the workers' compensation program entitled the employee only to reasonably necessary care, the court explained, the employee had no protected interest in receiving a specific type of treatment. *Ibid*.

Haymons v. *Williams*, 795 F. Supp. 1511, 1524 (M.D. Fla. 1992); *Kendall* v. *Brock*, 689 F. Supp. 354, 364-65 (D. Vt. 1987); *Martinez* v. *Bowen*, 655 F. Supp. 95, 98, 102-03 (D.N.M. 1986); *Moffitt* v. *Austin*, 600 F. Supp. 295, 297 (W.D. Ky. 1984). To resolve this pervasive conflict, further review is warranted.

B. The Due Process Holding Threatens To Disrupt Cost Containment Reform

The past decade has seen an explosion in the costs of workers' compensation, and of medical insurance programs more generally. In an attempt to contain these costs, federal and state officials, as well as employers and private insurers, have begun to experiment with various ways of controlling fraud and abuse, and of confining payments to cases of genuine need. Utilization review is one of the most common strategies for cost containment.

Utilization review is the result of research indicating that many physicians provided unnecessary care to patients with no corresponding improvement in patient health. E. Hirshfeld & G. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 18-19 (1996). Utilization review attempts to counter the financial incentive created by traditional fee-for-service plans for physicians — or, as in many cases entailing utilization review, chiropractors, physical therapists, acupuncturists, or other providers of unorthodox health care services — to provide services beyond the point of further benefit to the patient. See A. Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 217 (1997); P. 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."). Utilization review is of particular importance in the workers' compensation context, where health costs have risen in recent years at a higher average annual rate than overall national medical costs and where patients have no incentive to avoid overuse. S. ECCLESTON & C. YEAGER, *supra*, at 3-4; G. 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) (overuse of medical services is a particular problem in workers' compensation context, as providers "shift[] costs from increasingly restrictive group health payers to less restrictive workers' compensation payers" by "providing more intensive and longer duration services"). Unlike standard health insurance, workers' compensation insurance does not require co-payments or include dollar, duration or pre-existing condition limitations. In addition, injured workers who are receiving temporary total disability ("TTD") benefits (which are limited in duration) have a strong incentive to consume additional medical services in order to support a higher award for permanent disability benefits once TTD benefits end.

Yet the holding below renders utilization review almost useless. Under the Third Circuit's decision, payments must be made for disputed treatment before utilization review; once payments are made, they cannot be recouped even if reviewers ultimately conclude that the treatment was unreasonable or unnecessary. See pages 3-4, *supra*.

Due process does not compel such a result. The Third Circuit was misled by its characterization of the issue as a "deprivation" of "medical benefits" (App., *infra*, 27a), when the only real question is the timing of payments to medical providers for services already received. See *Califano*, 611 F.2d at 146. A mere *delay* in payment for medical services is not the same as a *final termination* of medical benefits. A short delay during the utilization review does not require a health care provider to terminate treatment; indeed, the provider has certain legal and ethical duties to continue to provide needed care. And since the insurer is required to make full payment, with 10% interest, to the provider if the utilization review confirms the reasonableness and necessity of the treatment, the provider has every incentive to continue care if it is consistent with standard medical practice. Moreover, the Third Circuit plainly overstated the value of participation by the injured worker in a utilization review process that is conducted by medical experts and based solely on whether the treatment received conforms to standard medical protocols. See *Cryder*, 24 F.3d at 178; *Califano*, 611 F.2d at 147.

Most fundamentally, the court below erred in transforming these issues of legislative and regulatory policy into questions of constitu-

tional law. The procedures for resolving insurance claim disputes, the allocation of risk of mistake or of fraud and abuse, and the efficacy of cost containment strategies are quintessentially matters for legislative judgment. The Constitution does not impose any one approach to balancing the interests of workers, employers, insurers, and health care providers under state workers' compensation schemes. Federal judges lack the information and expertise to make wise judgments about risk allocation and cost containment strategies; constitutional rulings lack the flexibility needed to adapt to new information and changing circumstances; and the entire system of constitutional law lacks accountability to the people. This Court's wise resolution not to second-guess legislatures on matters of social and economic policy (see *Ferguson* v. *Skrupa*, 372 U.S. 726 (1963); *United States* v. *Carolene Prods. Co.*, 304 U.S. 144 (1938)) does not lose its force simply because the policy issue comes wrapped in "procedure."

The Third Circuit's state action and due process holdings are therefore of a piece. The state action holding transfers authority from legislatures and private contract to the federal courts by defining private companies as state actors, and the due process holding sweeps aside a carefully considered legislative reform (joined by the federal government and at least forty-four States) on the basis of the court's own, unguided opinion about the proper allocation of risk in the context of workers' compensation medical coverage. Unfortunately, the court below is not alone: there is a persistent conflict among state and federal courts on both the state action and the due process issues. This Court's review is imperative to resolve these conflicts and to correct this case of serious judicial overreaching.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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