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.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTIONS PRESENTED

1. Whether a private insurer's decision to defer payment of medical bills pursuant to the utilization review provisions of Pennsylvania's Workers' Compensation Act, Pa. Stat. Ann. tit. 77, § 531(5), (6) (West Supp. 1998), constitutes "state action" under the Fourteenth Amendment.

2. Whether the insurer's decision to withhold payment of medical bills without first providing the employee with an opportunity to submit a written statement violates due process.

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INTEREST OF THE UNITED STATES

The court of appeals held that (1) private workers' compensation insurers are state actors insofar as they choose to defer the payment of medical bills pursuant to the utilization review provisions of the Pennsylvania Workers' Compensation Act, and (2) such decisions violate due process if made without first obtaining a written statement from the affected employee.

The United States administers a number of programs in which the decisions of private participants affect payments and services to individuals, and is generally interested in the faithful application of the state action requirement and due process principles. The Department of Labor administers the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901-950, which establishes a system of workers' compensation for those engaged in maritime employment. Under Section 14(c) of that Act, 33 U.S.C. 914(c), an employer that voluntarily pays LHWCA compensation to an employee in the absence of a formal compensation award is permitted to suspend or terminate those payments with-

out a prior hearing; the employer need only file a timely notice of that action with the Department. 20 C.F.R. 702.234-702.235. That provision is currently the subject of a constitutional challenge similar to the one at issue here. See *Kreschollek* v. *Southern Stevedoring Co.*, No. 93-3903 (D.N.J. Sept. 30, 1997). In addition, utilization review with regard to medical determinations has historically been part of the Medicare Program. See, *e.g.*, 42 U.S.C. 1395cc. Similar state action and due process questions have arisen in connection with health maintenance organization decisions respecting the provision of medical services to individuals covered by the Medicare Program, 42 U.S.C. 1395 *et seq.* See, *e.g.*, *Grijalva* v. *Shalala*, 152 F.3d 1115 (9th Cir. 1998).

STATEMENT

1. Beginning in the early twentieth century, numerous state legislatures concluded that the common law was inadequate to address liability and compensation issues arising from the increasingly frequent and severe work-related injuries that accompanied industrialization. See *New York Cent. R.R.* v. *White*, 243 U.S. 188, 197 (1917) (discussing perceived faults in common-law system); 1 A. Larson, *Larson's Workers' Compensation Law* §§ 5.20-5.30, at 2-15 to 2-25 (1998). As a result, by 1920 most States had enacted workers' compensation laws—laws that require employers to compensate their employees for work-related injuries without regard to fault and without regard to the common-law doctrines that previously barred liability. See generally 1 A. Larson, *supra*, § 5.30, at 2-25.

Pennsylvania's Workers' Compensation Act, Pa. Stat. Ann. tit. 77, §§ 1 *et seq.* (Act or Pa. Stat.), first enacted in 1915, follows that model, replacing traditional tort remedies with an exclusive system of no-fault liability for work-related injuries. 77 Pa. Stat. §§ 431, 481(a) (Supp. 1998). All employers subject to the Act must purchase workers' compensation insurance—from a private insurer or from the

State Workers' Insurance Fund (SWIF)—or obtain permission from the State to self-insure. 77 Pa. Stat. § 501(a) (Supp. 1998).

When an employee is disabled by a work-related injury—and liability under the Act is not contested or no longer at issue, Pa. Code §§ 127.404(b), (c), 127.405(a) (1998)—the employer or its insurer must pay "for reasonable surgical and medical services," and do so "within thirty (30) days of receipt of [the] bills." 77 Pa. Stat. § 531(1)(i), (5) (Supp. 1998). If the "employer or insurer disputes the reasonableness or necessity of the treatment provided" for a covered injury, however, it may defer payment and file a request for "utilization review" with the Workers' Compensation Bureau of the Pennsylvania Department of Labor and Industry (Bureau). *Id.* §§ 531(5), (6)(i) (Supp. 1998); 34 Pa. Code § 127.208(e).

When such a request is filed, utilization review is conducted by authorized "utilization review organizations" (UROs), private organizations consisting of "impartial" healthcare providers, 77 Pa. Stat. § 29 (Supp. 1998), who are "licensed in the same profession and hav[e] the same or similar specialty as that of the provider of the treatment under review," *id.* § 531(6)(i) (Supp. 1998); 34 Pa. Code § 127.466. The only issue addressed in utilization review is "whether the treatment under review is reasonable or necessary for the medical condition of the employee" in light of "generally accepted treatment protocols." 34 Pa. Code §§ 127.470(a), 127.467. Reviewers must "assume the existence of a causal relationship between the treatment under review and the employe[e]'s work-related injury," and "may not consider or decide issues such as whether the employe[e] is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees." *Id.* §§ 127.470(b), 127.406.

Reviewers must examine the treating provider's medical records, 34 Pa. Code §§ 127.459, 127.460, and are required to

give the treating provider an opportunity to discuss the treatment under review, *id.* § 127.469. The URO may not request (and the insurer, employer, employee, and physician alike are all forbidden from supplying) any "reports of independent medical examinations." *Id.* § 127.461. If the URO determines that the treatment is reasonable or necessary, the employer or insurer must pay the disputed bill, with interest computed at an annual rate of ten percent, even if the insurer or employer seeks further review. 77 Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code §§ 127.208(f), 127.210(d), 127.479. In addition, the employer or insurer is required to pay the cost of utilization review, whether or not its position is sustained. 77 Pa. Stat. § 531(6)(iii) (Supp. 1998). UROs are required to issue a written report of their findings within 30 days of a request, *id.* § 531(6)(ii) (Supp. 1998), and usually do so within 70 days, Pet. 5.

Any party that disagrees with the URO's determination may seek a determination from the Bureau within 30 days.[1] The matter is then assigned to a workers' compensation judge, who may hold a hearing, for a de novo determination of reasonableness or necessity. 77 Pa. Stat. § 531(6)(iv) (Supp. 1998); 34 Pa. Code § 127.556. If payment is required following utilization review but the judge later rules in favor of the employer or insurer, the employer or insurer may recover the excess payments from the Workmen's Compensation Supersedeas Fund, which is financed by annual assessments on insurers and self-insurers subject to the Act. 34 Pa. Code § 127.208(f); see 77 Pa. Stat. § 999(a), (b). An employee who prevails before a workers' compensation judge is entitled to costs and attorney's fees if the employer or

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[1] Previously, Pennsylvania law permitted a party dissatisfied with a URO determination to file for reconsideration by another URO before seeking a determination by a workers' compensation judge. That additional layer of review was eliminated in 1996. See Pet. App. 8a-9a, 64a-65a.

insurer fails to demonstrate a reasonable basis for contesting the bill. 77 Pa. Stat. § 996 (Supp. 1998).

2. Respondents are ten individual employees and two organizations representing employees who have been found to be disabled under the Pennsylvania Workers' Compensation Act, and who claim that payment of particular medical bills was deferred under the Act in violation of their due process rights. See J.A. 25-42 (Complaint). They filed suit in federal district court under 42 U.S.C. 1983 against a number of private insurance companies who provide workers' compensation insurance in Pennsylvania, as well as the School District of Philadelphia (which self-insures), various Pennsylvania officials who administer the Act, and the director of the SWIF.

After limited discovery, Pet. App. 47a-48a n.1, the district court dismissed the private insurance company defendants from the case on the ground that they are not state actors. *Id.* at 59a. The court explained that "the decision to cease paying medical benefits" under the Act "is entirely up to the insurer acting independent of any state involvement whatsoever." *Ibid.* Moreover, the court emphasized, "[t]he state takes no substantive step to promote, support or encourage" the insurer's decision, 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." *Ibid.*

The district court later dismissed the claims against the state defendants on the ground that the Act does not violate respondents' due process rights. The court held that respondents have a constitutionally protected property interest in their workers' compensation medical benefits, Pet. App. 68a, but, applying the three-part test set forth in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), concluded that the Act provides adequate process. Pet. App. 69a-75a. The court observed that, while respondents' interest in avoiding interruption of their medical benefits is "without a doubt signifi-

cant," *id.* at 70a, that interest is "adequately protected by the procedures in place," *id.* at 71a. The risk of erroneous decisions, the court found, is "minimal" because the Act requires utilization review to be "based on a medical determination" grounded in the treating physician's testimony and medical records. *Id.* at 72a. The court also emphasized the government's interest in controlling the "high costs of medical treatment" and "the corresponding high cost of insurance" under the Act. *Id.* at 75a.

3. The court of appeals reversed both rulings. Pet. App. 1a-37a. The court acknowledged that "insurance companies are private entities," but it held that "when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements." *Id.* at 14a-15a. "In effect," the court stated, the insurers "become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." *Id.* at 15a. In the court's view, Pennsylvania "is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau." *Ibid.* Because "[t]he Act mandates compliance by employers, employees, and insurance companies and inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme," the court concluded that "the private insurers are state actors." *Id.* at 19a.

Addressing the due process issue under *Mathews* v. *Eldridge*, the court of appeals found "the employees' private interest in receiving uninterrupted medical benefits" to be "a weighty and significant factor in the pretermination calculus." Pet. App. 28a. The court acknowledged that "the Act does not proscribe a medical provider from continuing to treat an employee during the utilization review process," but

assumed that "medical benefits are typically terminated upon invocation of utilization review." *Id.* at 27a. "Although a monetary award may compensate an individual for financial losses," the court observed, "a monetary award cannot be deemed an adequate * * * substitute for relieving an employee's disability or pain," or for "necessary medical care." *Id.* at 28a.

The court of appeals also found the risk of erroneous deprivation to be "significant." Pet. App. 29a. Recognizing that the utilization review process affords the employee's physician an opportunity to discuss the employee's treatment, the court nonetheless found itself "hard-pressed to believe that the portrait of the employee's illness and treatment is complete without a statement or other input from the employee himself." *Ibid.* The court acknowledged that the government has legitimate interests in ensuring that only "reasonable and necessary medical treatment[s]" are reimbursed and "in containing the rising costs of medical care and insurance payments," *id.* at 29a-30a, but it was "not convinced that any governmental interest outweighs the private interest" in favor of further process. *Id.* at 30a. The court therefore concluded that, before payments are "suspended" pending or through utilization review, a disabled employee must be given "an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." *Id.* at 33a.[2]

SUMMARY OF ARGUMENT

1. The actions of private parties will ordinarily be attributed to the State for purposes of the Fourteenth Amend-

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[2] The court of appeals also identified a number of deficiencies in the notice provided to employees. Pet. App. 21a-25a, 33a. Following its decision, the State modified the notice provided to employees, and petitioners do not challenge the court of appeals' holding regarding notice. Pet. 22 n.12.

ment only when the parties have wielded uniquely governmental authority delegated to them by the State, or the State "has provided such significant encouragement" that the private decision "must in law be deemed to be that of the State." See, *e.g.*, *Blum* v. *Yaretsky*, 457 U.S. 991, 1004-1005 (1982). In this case, the Pennsylvania Workers' Compensation Act requires private insurers to pay the medical bills of a disabled employee within 30 days of receipt, unless the insurer challenges the reasonableness and necessity of the treatment by filing a request for utilization review. The Act does not, however, confer upon insurers a power traditionally entrusted to government; on the contrary, it limits an insurer's power, which pre-dated the Act, to suspend payment pending resolution of a contractual dispute. Nor does the Act, by requiring prompt utilization review, so significantly encourage insurers to suspend payments that their decision to do so must be attributed to the State. State law does not require insurers to challenge the reasonableness or necessity of any medical treatment, or to suspend payments when they do so. Indeed, there are distinct disincentives to seeking utilization review. The insurer must pay the costs of the review, pay any bills that are found to be reasonable or necessary in review (plus interest at an annual rate of ten percent), and subjects itself to potential liability for a prevailing employee's litigation costs (including attorney's fees) if a workers' compensation judge ultimately rules in favor of the employee. The most that can be said is that deferring payment of medical bills is an option for insurers that Pennsylvania law does not prohibit. But "[m]ere approval of or acquiescence in" private initiatives "is not sufficient to justify holding the State responsible for those initiatives under the terms of the Fourteenth Amendment." *Blum*, 457 U.S. at 1004-1005.

2. The Pennsylvania workers' compensation scheme provides constitutionally sufficient process. As an initial matter, respondents do not have a "property" interest in the

payment of bills before the propriety of those bills has been resolved. Respondents are mere applicants for payment, and lack an established entitlement to the funds they seek. Respondents may have a property interest in their *claims* for payment. But deferring payment pending utilization review does not deprive respondents of their claims. After review is conducted, respondents may still assert their claims for payment by presenting them to the Bureau for adjudication before a workers' compensation judge. Because deferring payment for a reasonable period thus does not deprive respondents of property in which they have a cognizable interest, it is not inconsistent with the Fourteenth Amendment.

In any event, Pennsylvania law accommodates both the employee's interest in payment for reasonable and necessary medical expenses, and the insurer's interest (as well the State's) in ensuring that unreasonable and unnecessary treatment is not reimbursed. Pennsylvania limits the insurer's ability to withhold payment to those situations in which it challenges the reasonableness and necessity of medical treatment, and provides prompt review of insurer decisions by impartial healthcare providers of an appropriate specialty. That review includes examination of the treating provider's records and discussions with the provider. It is difficult to see how that prompt review—which by law must take place within 30 days and in practice takes about 70 days—is insufficient for due process purposes when the employee, if dissatisfied with the decision, may then seek review by the Bureau and demand a de novo hearing before a workers' compensation judge.

The principal requirement added by the court of appeals—that payments not be deferred until the employee is heard in the utilization review process—would not enhance the system's accuracy. Because utilization review is based on medical judgments, it is unclear what the employee, who has no medical training, might add that his treatment provider

cannot. Requiring employee participation, moreover, would threaten the streamlined nature of utilization review, and prohibiting the deferral of payments until after utilization review would virtually destroy the system's cost-containment purpose. As this Court has recognized, see *Mathews* v. *Eldridge*, 424 U.S. 319, 347 (1976), there are substantial real-world difficulties associated with the recovery of excess payments from individual claimants. Without a means for postponing payment pending at least initial review, bills for unreasonable and unnecessary treatment would irretrievably be paid. Pennsylvania has determined that so doing imposes unacceptable costs on the workers' compensation system and on employers and insurers generally. It was not for the court of appeals to second-guess that reasonable legislative determination.

ARGUMENT

I. A DECISION BY A PRIVATE INSURER TO DEFER PAYMENT PENDING UTILIZATION REVIEW IS NOT STATE ACTION

The Fourteenth Amendment's prohibition against deprivations of property without due process applies only to actions that are properly attributable to the State. See, *e.g.*, *NCAA* v. *Tarkanian*, 488 U.S. 179, 191 (1988); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 349 (1974).[3] This Court has repeatedly acknowledged the importance of this state action requirement, because it both "preserves an area of individual freedom by limiting the reach of federal law and federal judicial power" and "avoids imposing on the State,

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[3] In addition, 42 U.S.C. 1983, under which respondents brought suit, is limited to deprivations of constitutional rights "under color of" state law. Where deprivations of rights under the Fourteenth Amendment are concerned, however, "the under-color-of-state-law requirement does not add anything not already included within the state-action requirement of the Fourteenth Amendment." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 935 n.18 (1982).

its agencies or officials responsibility for conduct for which they cannot fairly be blamed." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 936 (1982).

In recent cases, the Court has articulated two prerequisites to a finding of "fair attribution." *Lugar*, 457 U.S. at 937. First, the challenged 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." *Ibid.* Second, "the party charged with the deprivation must be a person who may fairly be said to be a state actor." *Ibid.* Accord *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 620 (1991); *West* v. *Atkins*, 487 U.S. 42, 49 (1988).

In this case, Pennsylvania limits the ability of a private workers' compensation insurer to defer payment of a medical bill by compelling payment within 30 days unless the insurer files a request for utilization review, and by compelling payment thereafter if the insurer's position is not sustained in utilization review. 77 Pa. Stat. § 531(5), (6) (Supp. 1998). But the statute's *restrictions* on the ability of private insurers to defer payment pending a challenge to the reasonableness or necessity of treatment is not challenged in this case. No party contends that Pennsylvania lacks the power to impose those restrictions on insurers. Instead, respondents' contentions center on the decisions of insurers, within those restrictions, to defer the payment of medical bills pending utilization review, an action that the State neither prohibits nor requires. The question before the Court is whether that decision to withhold payments—made by concededly privately owned and controlled institutions, Pet. App. 15a; see Pet. ii-iii[4]—can be fairly attributed to the State. In our view, the answer is "no."

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[4] By contrast, the State Workers' Insurance Fund (SWIF) is established and administered by the State. See 77 Pa. Stat. § 2604 (Supp. 1998). The court of appeals assumed (Pet. App. 12a) that SWIF is a state actor

A. Although this Court has not followed an unwavering line in its state-action determinations, "certain principles of general application" emerge. *Edmonson*, 500 U.S. at 621. Thus, for example, the State "normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Blum* v. *Yaretsky*, 457 U.S. 991, 1004 (1982); accord *San Francisco Arts & Athletics* v. *United States Olympic Comm.*, 483 U.S. 522, 546 (1987); *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 840 (1982). Similarly, state action may be found where a private entity exercises functions that are "traditionally the exclusive prerogative of the State." *Jackson*, 419 U.S. at 353; accord *San Francisco Arts & Athletics*, 483 U.S. at 544. As this Court summarized in *Edmonson*, the Court normally looks to "the extent to which the actor relies on governmental assistance" in effectuating its will, "whether the actor is performing a traditional governmental function," and "whether the injury caused is aggravated in a unique way by the incidents of governmental authority." *Edmonson*, 500 U.S. at 622. None of those factors suggests that insurer decisions to defer payment of medical bills, pending further review, constitute state action here.

1. Respondents do not assert that the State "exercise[s] coercive power" or "significant[ly] encourage[s]" private insurers to withhold payment of bills pending further review. *Blum*, 457 U.S. at 1004. Nor could they. As the court of appeals recognized (Pet. App. 5a), the Act permits but does not require an insurer to defer payment pending resolution of a request for utilization review. See 77 Pa. Stat. § 531(5)

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for purposes of the Fourteenth Amendment and that SWIF acts under color of state law within the meaning of 42 U.S.C. 1983. See *Lebron* v. *National R.R. Passenger Corp.*, 513 U.S. 374, 400 (1995). Because SWIF is not a petitioner in this Court, its status is not at issue here.

(Supp. 1998). Indeed, far from providing "significant encouragement" to withhold bills, *Blum*, 457 U.S. at 1004, the State restricts the ability of insurers to do so, and provides distinct disincentives as well.

Thus, insurers are required to pay medical bills within 30 days, except when they dispute the reasonableness or necessity of the treatments. 77 Pa. Stat. § 531(6) (Supp. 1998); 34 Pa. Code § 127.452. An insurer may not defer payment based on challenges to the employee's disability, belated concerns about the cause of the injury, or disputes over the size of the fee. Moreover, if an insurer does withhold payment based on a challenge to reasonableness or necessity, that decision is promptly subjected to utilization review, and the insurer must bear the cost of the review, regardless of the outcome. 77 Pa. Stat. § 531(6)(iii) (Supp. 1998). In the event the URO determines that the medical treatment was reasonable or necessary, the insurer must pay the bill immediately, plus interest at an annual rate of ten percent. 77 Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code § 127.210(d). And, if the matter comes before a workers' compensation judge, the insurer may ultimately be liable not only for interest, but for attorney's fees and costs as well. 77 Pa. Stat. § 996 (Supp. 1998). Given those distinct restrictions and disincentives, it cannot be said that the State compels, or even encourages, an insurer to defer payment of a particular claim pending utilization review.

2. Nor can it be said that insurers, in withholding payments pending utilization review, exercise a delegated "power[] traditionally exclusively reserved to the State." *Jackson*, 419 U.S. at 352. This case does not involve the running of an election. Contrast *Smith* v. *Allwright*, 321 U.S. 649, 663 (1944). It does not involve the governance of a city or town. Contrast *Marsh* v. *Alabama*, 326 U.S. 501 (1946). Nor does it involve the selection of jurors who serve the governmental function of conclusively resolving legal disputes. See *Edmonson*, 500 U.S. at 624 (selection of jury, "a quin-

tessential governmental body, having no attributes of a private actor," is state action, where a state actor (the judge) impanels and dismisses the jurors). Rather, it involves the sort of uniquely private decision that insurers of all varieties —and members of the public generally—must make on a regular basis: whether to pay a bill submitted for payment, or instead to withhold payment and dispute the bill.

Under our system of ordered liberty, it is normally the individual seeking to obtain property from another who bears the burden of invoking the State's adjudicatory machinery and coercive powers to compel transfer; rare is the system that compels private individuals to transfer property to another first, and litigate the propriety of transfer later. Thus, if an employer had entered into a contract to insure against claims for reasonable or necessary medical expenses by injured employees *before* Pennsylvania enacted its workers' compensation statute, the insurer could have refused to pay a bill (based on a disagreement as to its reasonableness or necessity) without calling upon the State's authority to do so.[5] Under that scenario, it would be clear that the private insurer has not engaged in state action, because the State would have no involvement whatsoever in the insurer's decision to withhold payment of the disputed bill. For the same reason, an insurer's decision to defer payment in conformity with the Pennsylvania Workers' Compensation Act—which merely preserves (in part) the pre-existing power of insurers to defer payment—is not state action either.

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[5] See *Silas* v. *Smith*, 361 F. Supp. 1187, 1194 (E.D. Pa. 1973) ("Absent a statute, the party required by the terms of the agreement to make the payments had the power to stop making those payments whenever it felt they were no longer required under the terms of the agreement."); *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 279 (Pa. Commw. Ct. 1982) ("[I]f the Act did not exist, the employer would be free to stop payments if it determined that the employee's disability had ended.").

Of course, Pennsylvania has departed somewhat from the usual model by limiting the right of insurers to defer payment of disputed bills, and by adding strong incentives against so doing. See p. 13, *supra*. Respondents' complaint, however, is not that the Commonwealth has restricted the insurers' ability to defer payment, but rather that it has not restricted that ability enough, because it does not require insurers to pay bills pending utilization review and the employee's participation therein. Consequently, as in *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 166 (1978), "the crux of [the] complaint" here "is not that the State *has* acted, but that it has *refused* to act." A State's refusal to act, however—and its refusal to compel the payment of disputed bills in advance of their resolution—does not constitute "state action" under the Fourteenth Amendment, even if the State announces in advance "the circumstances under which" it "will not interfere with private" decisions. *Ibid.*; see also *Blum*, 457 U.S. at 1004-1005 (mere "approval of or acquiescence in the initiatives of a private party" is insufficient).

This Court's decision in *Flagg Brothers* is thus highly instructive. There, the plaintiff argued that a warehouseman's proposed sale of stored goods pursuant to New York's commercial code could be properly attributed to the State. But, as the Court explained, the New York statute did "nothing more than authorize (and indeed limit)—without participation by any public official—what Flagg Brothers would tend to do, even in the absence of such authorization, *i.e.*, dispose of respondents' property in order to free up its valuable storage space." 436 U.S. at 162. The Court observed that the State's provision of a "system of rights and remedies, recognizing the traditional place of private arrangements in ordering relationships in the commercial world," did not "delegate[] to Flagg Brothers an exclusive prerogative of the sovereign." *Id.* at 160. In similar fashion, the Pennsylvania Workers' Compensation Act merely fails to eliminate the ability of private insurers to act as they "would

tend to do," *i.e.* defer payment of disputed bills, "even in the absence of" its provisions. *Id.* at 162. As a result, it does not constitute a delegation of traditionally exclusive state powers.

3. Finally, it cannot be said that the injury asserted by respondents "is aggravated in a unique way by the incidents of governmental authority." *Edmonson*, 500 U.S. at 622. This is not a case involving the sort of dignitary harm—such as that caused by racial discrimination—that can be exacerbated by an appearance of governmental endorsement. See *id.* at 628 (injury from racially-discriminatory conduct is aggravated where it is effectuated by public officials in a public building that constitutes a "real expression of the constitutional authority of the government"); see also *Shelley* v. *Kraemer*, 334 U.S. 1, 19-22 (1948). Instead, this is a case about a commercial dispute—a contest between a private insurer, which has temporarily withheld payment, and an injured employee, who demands immediate payment—in which the government has initially declined to take part. In such a case, there can be no "unique" aggravation of the injury from the "incidents of governmental authority," because the injury is not dignitary and because there is no outward sign of governmental authority to aggravate it.

B. The court of appeals' contrary conclusion does not withstand scrutiny. Asserting that private insurance companies "become an arm of the State" when they "act under the construct of the Workers' Compensation system," the court characterized workers' compensation as a system "of public benefits which honor State entitlements," and likened private insurers to administrators of that system. Pet. App. 14a-15a. In particular, the court of appeals reasoned that the power to terminate the payment of public benefits is a "power * * * traditionally" held by the State, and one an insurer could not exercise "without the permission and participation of the Commonwealth." *Id.* at 15a That analysis is incorrect, for several reasons.

1. State workers' compensation statutes do not create public benefits; instead, they regulate obligations arising out of private employment relationships, just as tort law did before workers' compensation statutes were enacted. Of course, Pennsylvania's workers' compensation statute, like most others, substitutes a system of no-fault liability, backed by mandatory insurance, for the previous system of tort liability in the context of work-related injuries. But nothing about that substitution converts private insurance companies into state actors. To the contrary, time and again this Court has held that "[t]he mere fact that a business is subject to state regulation"—even extensive regulation—"does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment." *Blum*, 457 U.S. at 1004 (quoting *Jackson*, 419 U.S. at 350).

For example, if a State makes automobile insurance mandatory—and regulates the industry heavily, specifying the terms of coverage—insurer decisions regarding the payment of accident claims based on coverage or liability concerns remain private rather than state action. The same is true of the decisions of workers' compensation insurers. Although the purchase of insurance is mandatory, and the terms of coverage are regulated, the decision to withhold payment pending resolution of a disputed claim remains the insurer's and the insurer's alone.

In fact, the "mandatory" and "exclusive" nature of workers' compensation (Pet. App. 14a) seems particularly irrelevant, as there is no suggestion that those attributes of the system had any affect on the decisions by insurers to suspend payment for particular bills. Cf. *Jackson*, 419 U.S. at 351-352 (finding an "insufficient relationship between the challenged actions of the entities involved and their monopoly status"). Besides, obligations arising in tort are, as a general matter, mandatory rather than voluntary. Yet a private party's decision to defer payment of a potential debt

arising from tort law has never, to our knowledge, been considered "state action" under the Fourteenth Amendment.

The court of appeals' conclusion that the workers' compensation system allocates "public benefits" also flies in the face of the system's structure. See also *Crowell* v. *Benson*, 285 U.S. 22, 51 (1932). Respondents do not assert a right to *public funds* located in the state treasury. Nor will their claims be paid from the public fisc. Instead, they assert a right to *private funds* that are held by private insurers and that will remain the private insurers' unless respondents' claims are sustained. Because a private insurer's satisfaction of a claim with its own funds is not the payment of a "public benefit," its decision to defer payment pending review of a disputed claim is not properly attributed to the State. That is true even if the State pays for the underlying insurance policy, because individual payment determinations are made by, and the financial consequences of those decisions are borne by, the private insurer and not the State. See *Blum*, 457 U.S. at 1011 (rejecting contention that decisions made by physicians and nursing homes are attributable to the State, despite state "subsidization of the operating and capital costs of the facilities" and coverage for "the medical expenses of more than 90% of the patients").

2. Even if payments by private insurers could properly be characterized as public benefits, it would not follow that a private decision resulting in a deferral of payment constitutes "state action." In *Blum*, for example, this Court held that medical necessity decisions made by a physician— decisions that caused the State to adjust the patient's Medicaid benefits—were not properly attributed to the State. 457 U.S. at 1006-1007. The medical necessity determinations, the Court explained, were not made by state officials. Nor were they made based on criteria established by the State. Instead, they were "made by physicians and nursing home administrators, all of whom are concededly private parties" and who were not "influenced in any degree by the State's

obligations." *Id.* at 1005. Because such determinations regarding medical necessity "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State," *id.* at 1008, the Court held that those decisions could not be attributed to the State, *id.* at 1009; see also *id.* at 1009 n.19 ("[T]he judgment, made by concededly private parties, that [the individual] is receiving expensive care that he does not need" is "a medical one.").

The same analysis forecloses respondents' contentions here. As in *Blum*, the initial determination whether a certain treatment is reasonable and necessary—and thus should be paid immediately—is made not by state officials but by a private insurer. Here, as in *Blum*, that decision is made based not on state criteria but rather "on medical judgments * * * according to professional standards that are not established by the State," 457 U.S. at 1008. See 34 Pa. Code §§ 127.470(a), 127.467 (reasonableness and necessity determinations to be based on "generally accepted treatment protocols"). In *Blum*, those factors led the Court to determine that the privately-made medical necessity decisions were not state action. Those same factors compel a like result here.

3. Alternatively, the court of appeals relied on the "rather vague generalization," *Blum*, 457 U.S. at 1010, that the Pennsylvania statute "inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme." Pet. App. 19a. In *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715, 725 (1961), this Court stated that where "[t]he State has so far insinuated itself into a position of interdependence with" a private actor, the State may be held to be "a joint participant in the challenged activity" of racial discrimination. The facts in this case do not support a like conclusion. Unlike *Burton*, this case does not involve the dignitary injury that flows from racial discrimination, which can be "uniquely aggravated" by

governmental involvement or endorsement. *Edmonson*, 500 U.S. at 622. Nor does this case involve interdependent joint activity. Pennsylvania merely oversees a workers' compensation system that allows a private insurer to postpone payment pending review of the reasonableness or necessity of the treatment involved. Because the applicable statutes and regulations leave payment-withholding decisions to the insurer's judgment, it cannot fairly be said that the State jointly participates in those decisions. See *San Francisco Arts & Athletics*, 483 U.S. at 547 n.29; *Jackson*, 419 U.S. at 357-358.

4. Finally, it makes no difference that Pennsylvania requires insurers to file requests for utilization review on "a form prescribed by the [state workers' compensation] Bureau." 34 Pa. Code § 127.452(a); see 77 Pa. Stat. § 531(5), (6) (Supp. 1998). As this Court held in *Blum*, the State is not rendered responsible for private action "by requiring completion of a form." 457 U.S. at 1006-1007, 1010. See also *Barnes* v. *Lehman*, 861 F.2d 1383, 1387 (5th Cir. 1988) ("Regulations that dictate procedures, forms, or even penalties *without dictating the challenged action* do not convert private action into state action." (emphasis added)). Under the Pennsylvania statute, the Bureau reviews the form simply "to ensure that it is properly completed," and not to "address the legitimacy or lack thereof of the request for utilization review." Pet. App. 5a; see also *id.* at 58a ("the Bureau makes no determination as to whether the medical costs are reasonable or necessary"). In short, in temporarily withholding payment, a private insurer exercises a "choice allowed by state law." *Jackson*, 419 U.S. at 357. Because the "initiative comes from it and not from the State," its action is not "'state action' for purposes of the Fourteenth Amendment." *Ibid.*

II. AN INSURER'S DECISION TO DEFER PAYMENT OF A DISPUTED CLAIM PENDING UTILIZATION REVIEW COMPORTS WITH DUE PROCESS

Even if the decisions of private insurers at issue here were determined to be state action under the Fourteenth Amendment, deferring payment of disputed claims pending further review does not violate respondents' due process rights.

A. Although the court of appeals analyzed the degree of process "due" by balancing the parties' interests under *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), such a test—and the due process inquiry generally—normally applies only when a state actor seeks to "deprive" an individual of a "property interest." See U.S. Const. Amend. XIV, § 1 ("nor shall any State deprive any person of life, liberty, or property, without due process of law"); *Mathews*, 424 U.S. at 332 ("Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests."). Although this Court has determined that the right to *continued* payment of an existing stream of benefits becomes a "property interest" once the claimant establishes entitlement, it has not held that the mere anticipation of receiving such benefits, before an application or request for them has been approved, gives the applicant a property interest in the payments requested. See *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 320 n.8 (1985) (reserving the issue). Indeed, to say that the mere submission of a claim for payment is sufficient to give the applicant a "property" right in the requested payment itself, before the insurer, the State, or any decision-making body has passed on the propriety of payment, would in our view expand the notion of "property" beyond reasonable bounds.

That does not mean, of course, that the State could reject applications for benefits randomly or with no process at all. Even if an applicant for payment does not have a property

interest in the payment as such, the applicant does have a property interest in the *claim for payment, i.e.*, in the pending application that represents the possibility of, or demand for, payment. Such a claim for payment is akin to a legal claim or "chose in action," which may constitute a property interest. See, *e.g.*, *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 431 (1982); see *Schvartzman* v. *Apfel*, 138 F.3d 1196, 1199 (7th Cir. 1998) (discussing *Zimmerman*). A final decision rejecting a claim for payment, without further review, has the effect of terminating that claim or chose in action, and thus terminates the individual's "property right" therein. Consequently, we may assume that where a State finally rejects a claim for new benefits under a statutory scheme, it must comply with minimum procedural due process requirements. *Logan*, 455 U.S. at 431. But intermediate steps, which do no more than give rise to reasonable delays in the final adjudication of the claim for payment, do not destroy the claim (or chose in action) itself, and thus do not deprive the individual of "property" for purposes of due process. To the contrary, they merely deprive the applicant of *immediate* payment, something in which the applicant does not have a distinct property interest, and to which the Due Process Clause therefore does not, without more, apply.

Under that analysis, it is evident that the procedure to which respondents object—the temporary withholding of payment pending utilization review—does not raise due process concerns. Respondents have no property interest in immediate payment of individual medical bills, because nothing in the Act promises them a stream of payments for all medical treatments. Instead, the Act promises payment only if the treatment is reasonable or necessary, and respondents have yet to establish those pre-requisites to entitlement. Thus, unlike the recipients of fixed, monthly benefits such as social security, who obtain an unconditional right to receive payments once their entitlement status is established (subject to defeasance only if proper procedures are

employed), respondents' entitlement to payment for individual medical treatments arises only once those treatments are determined to be necessary or reasonable on a bill-by-bill basis. Since deferring payment for a reasonable interval to determine reasonableness and necessity does not deprive respondents of anything in which they have a distinct property right, doing so is consistent with the Fourteenth Amendment.

Finally, it cannot be argued that deferring payment for a reasonable time pending utilization review destroys respondents' claims for payment, in which they do have a property interest. Even after the insurer withholds payment, and if the URO upholds that decision, respondents' claims for payment remain viable, and respondents may still present them to a workers' compensation judge, who will hold a hearing and determine the matter de novo. 77 Pa. Stat. §§ 531(6)(iv), 711.1(a) (Supp. 1998); 34 Pa. Code § 127.556. Moreover, because the delays resulting from utilization review are quite modest, it cannot be argued that the delays have the effect of destroying or substantially diminishing the value of respondents' property interests in their claims for benefits. Cf. *First English Lutheran Evangelical Church* v. *County of Los Angeles*, 482 U.S. 304, 321 (1987) (normal regulatory delays do not effect a "taking" of property). Protracted delays that prevent claims from ever ripening into payment, of course, might be said to destroy the individual's interest in the claim itself, for a claim to payment is valueless if, because of such delays, payment effectively cannot be received. Here, however, the law requires utilization review to be completed within 30 days, 77 Pa. Stat. § 531(6)(ii) (Supp. 1998), and in practice review is usually completed within 70 days, see Pet. 5. Moreover, Pennsylvania law compensates for delay, offering interest at a generous rate. Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code §§ 127.208(f), 127.210(d), 127.479. Because Pennsylvania's system merely defers payment for a reasonable interval pending further review, and

compensates for delay, it does not deprive respondents of any property in which they have a right.

That conclusion becomes especially apparent upon consideration of what the result would be if Pennsylvania, rather than employing its elaborately protective procedures, simply required insurers to make an initial determination regarding payment within 120 days, and permitted employees to seek review of adverse decisions before an administrative law judge after expiration of the 120-day period. In such a case, it would be apparent that the 120-day processing time, during which payment was not made, did not deprive respondents of "property" without "due process." It is therefore difficult to understand how the more protective system the Commonwealth established here—which offers the possibility of payment much earlier (within 30 or 70 days), affords prompter recourse to a workers' compensation judge, and compensates for delays—deprives respondents of "property" without "due process" in violation of the Fourteenth Amendment. Compare *Mathews*, 424 U.S. at 341-342 (delays of 10 to 11 months between request for ALJ hearing and decision).

B. Even if we assume, *arguendo*, that respondents have been deprived of a "property" interest in some measure, Pennsylvania's workers' compensation system affords respondents all the process that is due. Due process "is not a technical conception with a fixed content unrelated to time, place and circumstances," *Cafeteria Workers* v. *McElroy*, 367 U.S. 886, 895 (1961), but rather "is flexible and calls for such procedural protections as the particular situation demands," *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972). See *Gilbert* v. *Homar*, 117 S. Ct. 1807, 1812 (1997). The "fundamental requirement" of due process "is the opportunity to be heard 'at a meaningful time and in a meaningful manner,'" *Mathews*, 424 U.S. at 333 (quoting *Armstrong* v. *Manzo*, 380 U.S. 545, 552 (1965)).

In determining whether the requirements of due process have been met, this Court has typically looked to three factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

424 U.S. at 335. Where, as here, the dispute is over the sufficiency of the procedures applicable to disputes between private parties, application of the third *Mathews* factor requires "principal attention" to the interest of the party desiring to utilize the challenged procedures, "with * * * due regard for any ancillary interest the government may have in providing the procedure or forgoing the added burden of providing greater protections." *Connecticut* v. *Doehr*, 501 U.S. 1, 11 (1991).

1. *The Employee's Interest.* The court of appeals, in our view, accorded greater weight to the employee's interest than is warranted. The insurer's temporary withholding of payment for a particular treatment does not affect the employee's disability status, or, therefore, the employee's entitlement to be reimbursed for other services that *are* found to be reasonable and necessary. *Mathews*, by contrast, involved a complete termination of disability benefits. 424 U.S. at 332, 340. Moreover here, as in *Mathews*, 424 U.S. at 340-341, eligibility for benefits is not based on need.

Although the employee's interest in payment for a particular treatment is (like the insurer's) partially financial, a deferral of payment may to some degree affect the employee's receipt of further treatment while utilization review

is pending.[6] See Pet. App. 27a-28a (deferral of payment might sometimes affect continuation of medical treatment). Pennsylvania, however, does not require providers to terminate treatment when bill payments have been deferred pending review, and some respondents acknowledge that they continued to receive treatment even though payment of their bills had been delayed. See *id.* at 27a; J.A. 29, 27, 36, 42.[7] The period of deferral is, after all, relatively brief. And it is of some significance that, if there is on occasion some delay in receiving further treatment while utilization review is under way, the result for the employee is the same as if the provider had itself chosen to consult with peers, or outside experts, before continuing treatment.

For present purposes, however, we may assume that an employee's interest in prompt payment may sometimes be substantial. That interest, however, is not so weighty as to support the finding of a due process violation, especially when the remaining two factors are considered.

2. *The Interests of Insurers and the Government.* Insurers and the Commonwealth alike have a direct and substantial interest in avoiding payment of bills for medical treatments that are not reasonable or necessary. That interest cannot be fully protected without some sort of deferral mechanism: If the bills are paid before utilization review is completed, the money is unlikely to be recovered even if the insurer later prevails on its claim. See *Mathews*, 424

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[6] This assumes that an employee has an interest in the payment of his provider's bills, even if the employee has no direct liability, because future treatments may be disrupted as a result. But cf. *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773 (1980) (patients in nursing home lack due process rights with respect to decertification of nursing home, even if decertification may affect them indirectly by requiring them to move).

[7] It is possible, of course, that a provider will withhold further treatment only for those patients about whom it is most uncertain of having its bills approved, and that treatment will continue to be provided when the provider is more confident that the treatment is reasonable and necessary.

U.S. at 347. Indeed, in apparent recognition of that problem, Pennsylvania forbids the collection of excess workers' compensation payments from individual employees, and requires insurers to recover from the state Supersedeas Fund instead. See *Moats* v. *Workmen's Compensation Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991); 77 Pa. Stat. § 999. When insurers are forced to pay for unnecessary medical treatments, everyone suffers. The insurers' costs are passed along to employers in their workers' compensation premiums, and the employers in turn pass those costs on either to workers generally through decreased wages or to society through increased prices.[8]

3. *The Risk of Erroneous Deprivation*. There is no significant risk that legitimate payments will be improperly delayed or denied with much frequency under Pennsylvania's statutory scheme.

a. The Pennsylvania utilization review process is structured to obtain an objective determination on a narrowly focused issue: the reasonableness or necessity of the employee's medical treatment. 34 Pa. Code § 127.470. Because the process relies upon the written records of the employee's own healthcare provider, *id.* §§ 127.459, 127.461, and reviewers are required to discuss treatment with the provider, *id.* § 127.469, insurers are unlikely to seek utilization review (and thereby to defer payment) unless they have fair grounds for disputing the bills. Indeed, the statute imposes significant costs on an insurer that requests utilization review. The insurer not only has to bear the costs of review, 77 Pa. Stat. § 531(6)(iii) (Supp. 1998), but risks eventual re-

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[8] That remains true even when the cost of unnecessary medical procedures is covered by the Supersedeas Fund. Because that fund is financed "by annual assessments on insurers and self-insurers" subject to the Act, 77 Pa. Stat. § 999(b), the costs are passed back to employers in the price of insurance, and thus eventually to employees and society at large.

payment of the bills with interest, *id.* § 717.1(a) (Supp. 1998); 34 Pa. Code § 127.210(d). And, if the matter goes before a workers' compensation judge and the employee prevails, the insurer risks having to pay the employee's litigation costs, including attorney's fees, if it cannot show that it had a reasonable basis for contesting payment. 77 Pa. Stat. § 996 (Supp. 1998).

Moreover, the utilization review process is designed to identify promptly any errors in the insurer's initial judgment. Utilization reviewers must be "impartial," 77 Pa. Stat. § 29 (Supp. 1998), and "licensed in the same profession and hav[e] the same or similar specialty as that of the provider of the treatment under review," *id.* § 531(6)(i) (Supp. 1998); 34 Pa. Code § 127.466. They must justify their decisions based on "generally accepted treatment protocols." 34 Pa. Code §§ 127.470(a), 127.467. And they must review the employee's medical records, 34 Pa. Code §§ 127.459, 127.460, and discuss the matter with the treating physician, *id.* § 127.469. Given the incentives that treatment providers have to justify their medical judgments—and thus their fees as well—it seems unlikely that sound justifications for treatment will be overlooked.

b. Despite those protections, the court of appeals concluded that due process prohibits the withholding of payments unless the employee has been permitted to participate in utilization review. Pet. App. 29a, 32a. "Without some sort of indication from the very individual who is receiving the questioned medical treatment as to its success," the court concluded, "the risk of erroneously terminating an employee's medical benefits is too high." *Id.* at 31a.

The court of appeals' rationale for that conclusion is little more than conjecture. The court suggested that the employee's input might be critical where the treatment is only marginally effective but is the sole possible treatment, or that it might prove critical where the URO does not understand how the treatment fits in with the overall

medical care related to the disability. Pet. App. 31a-32a. It is reasonable to expect, however, that concerns regarding effectiveness of a treatment and available alternatives, as well as how the treatment fits in with the overall medical care of the employee, would appear in the employee's medical records or in general treatment protocols the reviewers must consult. And even if they did not, the treating provider, with whom utilization reviewers must consult, would surely discuss those matters.

Nor is it likely that the employee's participation would appreciably reduce the risk of error. Utilization review determinations are concerned with objective medical judgments, not questions of credibility. See Pet. App. 31a; see also *Mathews*, 424 U.S. at 344; *Richardson* v. *Perales*, 402 U.S. 389, 407 (1971). The statement of an employee, who is not schooled in medicine, is unlikely to add anything significant to the input of his provider. The employee, in any event, is given a full opportunity to be heard when the matter comes before a workers' compensation judge, after the expedited utilization review procedures are completed. See 77 Pa. Stat. §§ 801-836.

Finally, while permitting an employee to submit a personal statement would not necessarily be "unduly onerous or administratively burdensome to implement," it would frustrate prompt utilization review. See 77 Pa. Stat. § 531(6) (ii) (Supp. 1998) (time limit of 30 days for decision). If the employee were permitted to submit a statement or other additional evidence to the URO, fairness might suggest that the insurer should be permitted to do so as well. The purpose of utilization review, however, is to provide an initial and streamlined check on insurer withholding decisions, using objective and available medical evidence, not to conduct a mini-trial. To the extent adversarial presentations by the interested parties (the employee and the insurer) may eventually be required, Pennsylvania has reasonably determined that they should be reserved for a hearing before the

workers' compensation judge, after the initial utilization review procedures have been completed. The court of appeals' requirement that insurers pay for medical treatment until utilization review is completed and the employee's perspective is heard would undercut the very reason for permitting insurers to withhold payment pending review—to enable them to avoid paying for medical treatments that in fact are neither medically necessary nor reasonable.

c. If there is any remaining doubt regarding the requirements of due process in this setting, "substantial weight" should be given to Pennsylvania's determination "that the procedures [it has] provided assure fair consideration of the entitlement claims of individuals." *Mathews*, 424 U.S. at 349. That is especially so considering the widespread use of utilization review procedures and the nearly uniform state practice of permitting insurers to withhold payment pending review. See Pet. 24 (39 of 41 surveyed jurisdictions permit pre-review deferral of payment); compare *Doehr*, 501 U.S. at 17-18. While the concerns identified by the court of appeals are appropriate for the Pennsylvania Legislature to consider, they are an insufficient basis on which to overturn that body's judgment regarding the most appropriate procedures to employ.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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