Medicare Managed Care: A New Constitutional Right to Due Process for Denials of Care Under Grijalva v. Shalala

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NOTE

MEDICARE MANAGED CARE: A NEW CONSTITUTIONAL RIGHT TO DUE PROCESS FOR DENIALS OF CARE UNDER GRIJALVA V. SHALALA

[Common sense often makes good law.]

I. INTRODUCTION

Medicare is a federal health insurance program enacted by Congress in 1965 as an attempt to ensure that the aged and disabled across the nation would have access to adequate health care. In this age of cost containment and a quest for the most health care for the least premium dollar, managed care has offered a tempting alternative to fee-for-service or indemnity plans for most health care consumers. Why should the Medicare program and the federal government be any different? In an attempt to reduce the escalating costs of providing health care to the rapidly aging population, the federal government has encouraged Medicare beneficiaries to enter managed care. Elderly recipients responded,

3. For a thorough discussion of the public policy and political context of federal action with regard to our aging population, see Robert H. Binstock, Public Policies on Aging in the Twenty-First Century, 9 STAN. L. & POL'Y REV. 311, 312-16 (1998). After the passage of the Medicare bill, President Lyndon Johnson stated: "'No longer will older Americans be denied the healing powers of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in later years.'" Eleanor D. Kinney, Medicare Managed Care from the Beneficiary's Perspective, 26 SETON HALL L. REV. 1163, 1164 (1996) (citing Remarks at the Signing of the Medicare Bill, 2 Pub. Papers 811, 813 (July 30, 1965)).
4. See Kinney, supra note 3, at 1163 ("Capitated managed care is fast becoming the predominant model for the delivery of health care services in the United States today as both public and private payers seek to control the escalating costs of health care services.").
5. Medicare beneficiaries have had access to Medicare HMOs since the passage of section 114(a) of the Tax Equity and Fiscal Responsibility Act of 1982. See 42 U.S.C. § 1395mm (1994).
6. See Jonathan B. Oberlander, Managed Care and Medicare Reform, 22 J. HEALTH POL. POL'IY & L. 595, 595 (1997) ("A primary goal of many Medicare reform proposals is to move pro-
as fourteen percent of beneficiaries are currently serviced by Medicare health maintenance organizations ("HMOs"), and enrollment leapt by more than twenty-five percent annually over the last three years. Although it offers an obvious, immediate economic benefit to the federal government, the harm that managed care causes is not readily measurable in mere dollars and cents. By encouraging the elderly to enroll in HMOs and to participate in managed care under the Medicare program, the federal government has been doing a disservice to the idea that it is our responsibility, as a nation, to provide adequate, quality health care to our aging citizens.

II. MANAGED CARE AND THE MEDICARE SYSTEM

A. Managed Care and Health Maintenance Organizations

Managed care differs from what may be considered "traditional" or fee-for-service health insurance. Under traditional health insurance, policyholders pay a yearly premium for coverage, may have a deductible, and may see the doctor of their choice upon getting ill or injured, with the bill ultimately submitted directly to the insurance company.

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8. See Bill Walsh, Senior Citizens Get Lost in HMO Jumble, NEW ORLEANS TIMES, June 8, 1998, at A1; see also Trish Riley, States' Perspective on Managed Care for the Elderly, GENERATIONS, Summer 1998, at 69 ("[E]nrollment of elders in Medicare managed care programs is growing rapidly."). According to the Health Care Financing Administration ("HCFA"), "[a]bout 16% (6 million) of Medicare's 38 million beneficiaries are enrolled in one of the more than 400 federally qualified managed care plans." Julie A. Jacob, Broken Promises: Medicare HMOs Are Leaving Rural Areas, Citing Payment Woes, AM. MED. NEWS, Sept. 7, 1998, at 16.
10. "Traditional indemnity insurance gave patients unrestricted choice of providers and reimbursed providers on a fee-for-service basis." Patricia M. Danzon, Tort Liability: A Minefield for Managed Care?, 26 J. LEGAL STUD. 491, 492 (1997).
11. This fee-for-service reimbursement scheme was the prevalent form of health insurance
Under this system of health care delivery and reimbursement, the patients are not restricted in their choice of physician. The physicians are usually independent from the insurance company and the insurance company reimburses any provider that provides services to the patient.

In contrast to the traditional model, a managed care organization ("MCO") is a health care delivery system that finances and either provides or delivers health care services to those enrolled in the MCO. While managed care is an attractive form of providing health insurance, as it purports to offer full medical services at a reduced cost, this cost is gained at the price of restricting the patient's access to both providers and treatment. The most recognizable and popular form of managed care is the health maintenance organization ("HMO"). This is the most prevalent form of managed care.

An HMO has been defined as "a type of group health care practice that provides health maintenance and treatment services to members who pay a flat, regular fee that is set without regard to the amount or kind of services received." Because the flat fee for the time period has no correlation to the amount of services actually rendered to the patient, any overuse of the services is a cost that the HMO must bear. Generally, there are five common types of HMOs, with the only difference until the advent of managed care. See Allison Faber Walsh, Comment, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations, 31 J. MARSHALL L. REV. 207, 211 (1997).

12. See id. at 212-15.
13. See Danzon, supra note 10, at 492.
14. See L. Frank Coan, Jr., Note, You Can't Get There From Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs, 30 GA. L. REV. 1023, 1027-29 (1996). MCOs have been defined further as "[a]ny type of intervention in the delivery and financing of health care that is intended to eliminate unnecessary and inappropriate care and to reduce costs." Deven C. McGraw, Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients? 83 Geo. L.J. 1821, 1825 (1995) (alteration in original).
19. The enrollment fee remains set regardless of the actual costs of the services utilized by any individual subscriber. See Barbara A. Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 MERCER L. REV. 1219, 1223 (1997).
between them pertaining to the relationship between the health care provider and the HMO. These include the staff model, the group practice or group model, the network model, the individual practice association model, and the direct contract model. Recently, another type of managed care entity, the preferred provider organization, has emerged as a popular form of health care delivery.

The main philosophy driving managed care as a form of health insurance is cost-containment. By contracting with physicians to deliver care to a large number of patients, HMOs are able to negotiate lower fees than traditional insurance. Additionally, health care expenses are reduced by limiting the patients' access to providers and treatment. By limiting choice, the organization can lower the cost of delivering care to its consumers. HMOs and other such plans generally limit patients' choice of doctors, thus offering lower out-of-pocket costs than patients get under traditional insurance; these plans include a "gatekeeper" to coordinate treatment and determine its medical necessity.

20. In a staff model HMO, the physicians providing care to the enrollees or members are actually employees of the HMO and the HMO pays the physician a salary with the possibility of bonuses or financial incentives for cost-containment. See YOUNGER ET AL., supra note 18, at 3-4. "In the 'staff' model, the HMO directly employs its physicians, who work in a centralized care facility and receive salaries from the HMO [based on performance and productivity]." Noah, supra note 19, at 1223.

21. The HMO contracts with a group of physicians who are organized as a professional organization and work at one or a number of limited locations. In contrast to the staff model HMO, the physicians are employed by the group practice and not the HMO, and the HMO contracts with the group practice rather than the individual doctors. See YOUNGER ET AL., supra note 18, at 4, 14.

22. In a network model HMO, the managed care organization contracts with a number of group practices, rather than just one, to provide medical services to its members. See id. at 6.

23. The HMO contracts with an individual practice association ("IPA") to provide services to its members. The physicians remain independent from the HMO, continue to see their own non-HMO patients and usually have their own offices, unaffiliated with the HMO. See id.

24. The HMO directly contracts with an individual physician to provide services to its members, much like an IPA. See id. at 8.

25. Like an HMO, hospitals and physicians contract to provide services to those enrolled in the plan, and while members of the health care plan are not obligated to see the "preferred providers" members are encouraged to do so through the use of reduced premiums. See William A. Chittenden III, Malpractice Liability and Managed Health Care: History and Prognosis, 26 TORT & INS. L.J., 451, 452-53 (1990).

26. See Noah, supra note 19, at 1225.


28. See id.

29. See Noah, supra note 19, at 1225. The "gatekeeper" for managed care is usually the patient's primary care physician. "[T]he gatekeeper function of primary care physicians, who must evaluate enrolled patients before determining the necessity of referrals to specialists, plays an essential role in keeping costs low." Id. For a complete discussion of what constitutes "medical necessity," see Mark A. Hall & Gerard F. Anderson, Health Insurers' Assessment of Medical Ne-
One of the methods employed by managed care to reduce cost is utilization review, which is an independent evaluation of a patient's treatment to determine the "necessity and appropriateness of medical care." Under traditional fee-for-service plans, since the patient receives treatment and then seeks reimbursement, the utilization review is retrospective. However, in most MCOs, the utilization review is either prospective or concurrent. If the treatment is authorized, then it is covered and paid for; if it is not authorized, the patient may find that the HMO will pay for only a portion of the treatment, if at all. Utilization review attempts to reduce the cost of providing health care coverage by reducing the number of unnecessary medical procedures before they are performed. The MCO employs either a physician or a nurse who reviews the patient's records and determines whether the proposed treatment is "medically necessary." In summary, "utilization review allows the managed care plan to coordinate patient treatment, monitor quality of care, minimize inappropriate use of services, track providers' utilization patterns, and make medical necessity determinations with respect to payment."
B. Medicare Managed Care

The Medicare system is governed by the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services ("HHS"), and with a budget of 200 billion dollars, it is the "single largest purchaser of health care in the United States." Since 1985, a person eligible for Medicare may enroll in an HMO to receive her health insurance coverage. An HMO that contracts with the HCFA to serve a Medicare beneficiary must offer the full complement of services available under traditional, fee-for-service coverage. Generally, there are two types of Medicare HMOs: risk-basis and cost-basis. A risk-basis HMO provides all of the benefits that traditional Medicare provides for a fixed monthly payment per enrollee. A cost-basis HMO, a less attractive alternative for the federal government, is reimbursed based upon enrollee usage of health care services, which is usually less than the actual cost of the provided services. HCFA will only reimburse the cost-basis HMO if the services are proper and necessary, reasonable in price, and appropriately apportioned among enrolled members.

37. For a complete discussion of the governance of Medicare, see Jost, supra note 7, at 82-88.
41. See 42 U.S.C. § 1395mm(b)(2). Traditional Medicare is broken up into two parts: Part A and Part B. Part A covers health service provided by institutions, including hospitals, home health care agencies, and nursing homes. See id. § 1395d. Part B covers treatments rendered by physicians and other professionals, diagnostic tests and supplies. See id. § 1395k.
44. See 42 U.S.C. § 1395mm(h); see also Mayo, supra note 9, at 27-28 (detailing the operation of a cost-basis HMO).
45. See 42 C.F.R. § 417.532(a); see also Baker, supra note 43, § III(C)(2), at 118 (outlining

http://scholarlycommons.law.hofstra.edu/hlr/vol28/iss1/5
In 1997, President William J. Clinton signed the Balanced Budget Act of 1997 ("BBA"), which restructured the Medicare program and created Medicare Part C, or Medicare+Choice. Under Medicare Part C, existing Medicare HMOs would become an option under numerous Medicare managed care plans and programs available to the beneficiary. For the purposes of this discussion, the focus will be on the Medicare HMO.

Medicare HMOs are generally considered to have four basic advantages over the traditional fee-for-service delivery system: (1) they provide medical care at a substantially lower cost than fee-for-service plans; (2) they provide broader benefits than traditional Medicare; (3) the quality of medical care is improved through the utilization of managed care; and (4) the use of HMOs reduces the regulatory burden placed on the federal government in the administration and regulation of Medicare.

As discussed above, the obvious attraction of managed care for HCFA, the federal agency responsible for administering Medicare, is that this method of health care delivery is primarily designed to save money for those who pay for health insurance. While HCFA requires Medicare HMOs to provide all the benefits that traditional Medicare requires, the HMOs use a "medically necessary" standard to decide whether the HMO will cover a certain service or treatment. This, in turn, discourages the overutilization of Medicare benefits and services. In an attempt to control the cost of providing health care, Medicare

the Medicare cost-based HMO).

47. See Baker, supra note 43, § I, at 112. These new managed care options include Provider-Sponsored Organizations, Preferred Provider Organizations, Medical Savings Accounts, and Private Fee-For-Service. See id. §§ II(A)(1)-(3), at 112-13.
48. The fixed rate for each HMO enrollee is set at 95% of the average cost for Medicare beneficiaries. See 42 U.S.C. § 1395mm(a)(1)(C) (1994). In addition, this cost saving is passed on to the enrollee, resulting in lower out-of-pocket expenses as compared to traditional fee-for-service Medicare. See Baker, supra note 43, § III(A)(1), at 114.
49. See Eleanor D. Kinney, Consumer Grievance and Appeal Procedures in Managed Care Plans, HEALTH L. 1998, at 17, 17 ("Specifically, HMOs had lower hospital utilization rates, offered more preventive services, and appeared to provide quality care in a more cost-effective manner.").
50. See Oberlander, supra note 6, at 603.
51. See id.
52. See Mayo, supra note 9, at 28.
HMOs “practice cost containment by restricting provider selection, regulating access procedures, undertaking utilization and peer review, and offering financial incentives to physicians.” The federal government and HMO advocates have argued that “managed care plans, especially health maintenance organizations . . . can save substantial money . . . while also improving the quality of medical care and scope of covered benefits for Medicare enrollees.”

Enrollment in a Medicare HMO, more times than not, provides greater benefits to the beneficiary than the traditional combination of Part A and B. As HMOs typically stress preventive care, it is important for them to provide health care services and treatments designed to ensure a healthier patient. This philosophy translates into increased benefits and greater access to health care services for the Medicare beneficiary. These expanded benefits may include limited prescription coverage, dental care, routine physicals, immunizations, foot care, and vision and hearing care, all of which are unavailable under traditional coverage. Theoretically, the emphasis on preventive care, and the HMOs’ incentive to keep a healthy enrollee, seem to encourage an increase in the overall quality of care. Consequently, “[m]ost studies have found that the quality of care received by Medicare beneficiaries in HMOs is comparable to or better than that received in [fee-for-service] settings.”

An additional incentive, at least for the Medicare beneficiary, is that Medicare HMOs obviate the need to purchase supplemental, or Medigap, insurance because they provide a full range of covered services. Rather than pay a monthly premium, HMO beneficiaries’ only

55. Id. at 35.
56. Oberlander, supra note 6, at 595.
57. See id. at 602.
58. See Jimenez, supra note 40, at 1197. Another benefit for our elderly population is that most HMOs offer a variety of services at one location, eliminating the need for numerous trips to different offices. See Rovner, supra note 42, at 41.
59. See Baker, supra note 43, § III(F)(2), at 118; see also Diane Rowland et al., Managed Care for Low-Income Elderly People, GENERATIONS, Summer 1998, at 43, 46 (reporting that “97 percent of plans offer physical exams, 90 percent offer eye exams, and 68 percent offer prescription drug coverage to their enrollees”).
60. See Oberlander, supra note 6, at 603. It has been argued that HMOs will increase the quality of care by offering alternative procedures, such as home care and outpatient services, and intensive case management, as well as providing “one stop shopping” by offering all necessary medical services in one location. See id.
61. Id. at 610.
62. See Baker, supra note 43, § III(F)(1), at 118; see also Leigh Page, Medicare HMOs Winning over Seniors: For Some, Though, Care Falls Short, AM. MED. NEWS, Feb. 12, 1996, at 3 (reporting that by not having to pay for Medigap insurance, seniors may save between 30 and 150
financial requirement is the payment of a small co-payment of five to twenty dollars per visit. The reduction in premium is accompanied by a reduction in the necessary paperwork for the beneficiary, because the HMOs process all of the insurance forms. Once enrolled in a Medicare HMO, most beneficiaries will no longer have to complete and submit the complicated insurance forms that were mainstays of the traditional fee-for-service system. Finally, managed care reduces the regulatory burden on the federal government by requiring it to pay a flat, capitated fee to the Medicare HMO. By paying only a flat fee per beneficiary, HMOs do not require the government to determine the reasonable reimbursement for health care services under the diagnosis related groups or the relative value scale. Thus, this streamlined approach to reimbursement reduces the regulatory burden on the federal government.

III. MEDICARE APPEALS PROCESS

An MCO's primary objective is to reduce the costs associated with providing health care to each individual Medicare beneficiary. Unfortunately, to achieve this objective "HMOs have an inherent tendency toward underservicing enrollees, especially with regard to more expensive services," resulting in an inordinate number of denials of care. However, the Medicare statute and accompanying regulations provide a detailed appeals process to those beneficiaries who are denied requested medical services. Effective September 1, 1998, HCFA promulgated new

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64. See Espinoza, supra note 63, at 122.

65. See Mayo, supra note 9, at 43 (stating that under Medicare managed care, "there are no claim forms to be filled out"); Rovner, supra note 42, at 41.

66. See Oberlander, supra note 6, at 603.

67. See id.

68. Costs are reduced by using a process known as "utilization management," which attempts to ensure that the HMO only pays for those services that are medically necessary. See Stayn, supra note 53, at 1679.


regulations applicable to the upcoming Medicare Part C managed care program, including Medicare HMOs.\footnote{71}

The first protection provided by the Medicare statute and accompanying regulations is that each participating HMO must "provide meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled."\footnote{72} Under the Medicare statute, a beneficiary may utilize the internal HMO appeals and grievances process for a variety of reasons, including the "HMO's failure to provide treatment in a timely manner . . . or a health care provider's improper demeanor or behavior."\footnote{73}

Beyond the internal processes established by the individual HMOs to resolve grievances, each beneficiary enrolled in managed care is entitled to the external Medicare appeals process when dissatisfied with organizational determinations.\footnote{74} "An organizational determination involves any decision concerning the rights of an enrollee with regard to services payable by Medicare that are furnished by an HMO."\footnote{75} Organizational determinations that trigger the appeals process can include HMO decisions regarding: (1) "emergency services, post-stabilization care, or urgently needed services";\footnote{76} (2) "[p]ayment for any other health services furnished by a provider other than the [HMO] . . . that the enrollee believes—(i) [a]re covered under Medicare; or (ii) [i]f not covered under Medicare, should have been furnished, arranged for, or reimbursed by the [HMO] organization";\footnote{77} (3) "[t]he [HMO]'s . . . refusal to provide services that the enrollee believes should be furnished or arranged for by the [HMO] . . . when the enrollee has not received the services outside the [HMO]";\footnote{78} or (4) "[d]iscontinuation of a service, if the enrollee disagrees with the determination that the service is no longer medically necessary."\footnote{79} When a requested medical treatment has

\footnote{71. While the rules were promulgated and dated effective September 1, 1998, HCFA has declared that they are not effective until January 1, 1999. See Wendy L. Krasner & Barbara W. Mayers, Will Grijalva Ruling Open the Medicare Managed Care Exit Door?, MANAGED MEDICARE & MEDICAID, Aug. 31, 1998, available in 1998 WL 9852609.}

\footnote{72. 42 U.S.C. § 1395mm(c)(5)(A) (1994); 42 C.F.R. § 422.560(a)(1) (1998) (stating that "Section 1852(f) of the [Balanced Budget] Act provides that a M+C organization must establish meaningful grievance procedures"); 42 C.F.R. § 422.564(a)(1) (stating that "[e]ach M+C organization must provide meaningful procedures for timely hearing and resolution of grievances").}

\footnote{73. Stayn, supra note 53, at 1691.}

\footnote{74. See 42 C.F.R. § 422.566(a).}

\footnote{75. Mayo, supra note 9, at 40.}

\footnote{76. 42 C.F.R. § 422.566(b)(1).}

\footnote{77. Id. § 422.566(b)(2)-(2)(ii).}

\footnote{78. Id. § 422.566(b)(3).}

\footnote{79. Id. § 422.566(b)(4).}
been denied or discontinued by the HMO, the Medicare beneficiary may avail herself of the protections of the Medicare appeals process.

Any HMO that contracts with HCFA must be in compliance with all Medicare regulations. When an HMO denies treatment to a beneficiary, such denial or determination must be issued “as expeditiously as the enrollee’s health condition requires, but no later than 14 calendar days” after the request.60 The HMO’s denial of services or payment must be sent to the beneficiary in writing61 and it must state the specific reason for the determination.62 Additionally, the denial of services must be written in “understandable language.”63 Materials must accompany the notification of denial of services informing the beneficiary that she has the right to request a reconsideration,64 and these materials must include clear details on how to appeal the decision and provide information regarding the availability of free legal services.65 Furthermore, an enrollee now has the right to request an expedited determination for denied and discontinued services.66

A beneficiary’s request for reconsideration must be filed in writing with either the HMO or a Social Security office within sixty days of the receipt of the denial.67 Much like initial determinations, the new regulations provide for an expedited reconsideration in certain circumstances.68 In addition, unlike appeal procedures in the past, the HMO must present the enrollee with a “reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing.”69 If the beneficiary files the reconsidera-

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80. Id. § 422.568(a). The HMO may extend the time of the decision another 14 days either at the request of the beneficiary or if the HMO feels that the delay is in the interest of the enrollee. See id.
81. See id. § 422.568(c).
82. See id. § 422.568(d)(1).
83. Id.; see also Jimenez, supra note 40, at 1209 (stating that “a general statement that Medicare does not cover the service is not sufficient to meet this requirement”).
84. A reconsideration is “a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit.” 42 C.F.R § 422.580 (1998).
85. See id. §§ 422.568(d)(2)-(4); see also Baker, supra note 40, § 1(J)(1)(a), at 114 (outlining the appeals process including the availability of free legal services).
86. See 42 C.F.R. §§ 422.570-.572. Generally, a Medicare beneficiary may request an expedited appeal if her life or health is in serious jeopardy because of not receiving the requested care. Such determinations must be completed within 72 hours after receiving the request. See id. § 422.572.
87. See id. §§ 422.582(a)(1)-(2) & (b).
88. See id. § 422.584. Either the enrollee or the enrollee’s physician may request an expedited reconsideration if the enrollee’s life or health is in serious jeopardy. See id.
89. Id. § 422.586.
tion with the HMO, the HMO must render a decision, favorable or not, as soon as the enrollee’s health condition requires, but no later than thirty days after the request for reconsideration.\(^9\) If the reconsideration decision is adverse to the enrollee, the HMO must “prepare a written explanation and send the case file to the independent entity contracted by HCFA.”\(^9\)

The independent entity is an impartial organization that contracts with HCFA to “review HMO reconsiderations and to identify quality of care problems.”\(^9\) Again, the independent entity “must conduct the review as expeditiously as the enrollee’s health condition requires,” but the length of the review process may not exceed the time agreed to in the contract with HCFA.\(^9\) If the independent entity renders an unfavorable decision for the Medicare beneficiary, it must identify the factors considered and inform the beneficiary of further appeal rights.\(^4\)

If the independent entity makes an unfavorable decision and the dispute is in excess of one hundred dollars, the beneficiary has the right to request a hearing in front of an administrative law judge (“ALJ”).\(^9\) The petition for the hearing must be filed, in writing, within sixty days from the time of the reconsideration, and it must be filed with the same entities that may review a reconsideration determination.\(^9\)

Next, if the ALJ’s determination is unfavorable toward the beneficiary, she then may request a review of the determination by the Departmental Appeals Board (“DAB”) of the Social Security Administration.\(^9\) If the DAB denies the request for a hearing or renders an unfavorable decision, and the controversy is more than one thousand dollars, the beneficiary’s last option is to request a judicial review in a federal district court within sixty days of the DAB decision.\(^9\)

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90. See id. §§ 422.590(a)(1)-(2). In the case of an expedited reconsideration, the HMO must render a decision within 72 hours of receiving the request. See id. § 422.590(d)(1).
91. Id. § 422.590(2). The new regulations also require the HMO to assist in the gathering and forwarding of information to the independent entity. See id.
95. See 42 C.F.R. § 422.600(a). A hearing may take from six months to a year to be scheduled. See Baker, supra note 43, § III(H)(3), at 126.
96. See 42 C.F.R. §§ 422.602(a)-(b).
97. See id. § 422.608; see also 20 C.F.R. §§ 404.967-984 (detailing the regulations concerning the Social Security Administration Appeals Council review which apply).
98. See 42 C.F.R. §§ 422.612(a)-(b); Baker, supra note 43, § III(H)(5), at 126.
IV. **Medicare Managed Care Has Failed to Provide Adequate Health Care to Our Nation's Senior Citizens**

With all of the advantages outlined in Part II, as well as the internal and external appeals process, why has Medicare managed care failed in its effort to provide adequate health care to our nation's elderly?

One of the first deficiencies of any managed care program that must be recognized is that "companies that run HMOs are profit-oriented and must control costs to maintain profits." In this regard, MCOs may be making decisions as to the reasonableness of medical treatment not based on the medical necessity, but rather on the basis of economics. "Health care rationing—allocation decisions based on cost—occurs in settings besides HMOs but is inherent in the HMO incentive structure." This rationing of services has threatened the overall quality of care provided to beneficiaries, as the financial incentives of managed care organizations "foster [the] undertreatment of patients."

The elderly typically require more medical treatment than the average HMO participant. The capitation and cost-containment strategies employed by HMOs threaten to restrict Medicare beneficiaries from receiving the level of health care they require, thus lowering the overall quality of health care provided. This accusation has been supported by

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100. See id. at 28-29 (explaining that many "advocates [are] ... concerned that health care decisions may be made on the basis of economics rather than on the beneficiary's health care needs").
101. Stayn, supra note 53, at 1686 (citation omitted).
102. Binstock, supra note 3, at 317; see Oberlander, supra note 6, at 604.
103. See Oberlander, supra note 6, at 604; Ellyn E. Spragins, Does Managed Care Work?, NEWSWEEK, Sept. 28, 1998, at 60, 66 ("Most are for-profit enterprises, and many have trouble making money while serving the nation's most expensive patients.").
104. Eleanor Kinney suggests that the initial hesitancy by the federal government to encourage elderly Medicare beneficiaries into managed care is based upon the theory that "HMOs may not serve well a population that has a high incidence of chronic disease and disability." Kinney, supra note 3, at 1173; see also Lesson for HMOs: Time with Patients Is Profitable: For Sake of All Parties, Complaints Should Be Heeded, L.A. TIMES, Dec. 8, 1997, at B4 (recounting the results of a Harvard University study which found that 51% of Americans believed that managed care was eroding the quality of care).

A recent report released by the Department of Health and Human Services detailed the rise in beneficiary premiums with a corresponding decrease in accessibility to prescription drugs. See Gore Report Criticizes HMOs, BESTWIRE, Sept. 23, 1999 available in LEXIS, News Library, Curnws File.

In a sharp reversal of recent trends, none of the 262 HMOs that accept Medicare patients next year will cover the full cost of those patients' medicine. In addition to requiring patients to pay for part of each prescription, many plans are setting new limits on how much medicine they will cover, with nearly one third refusing to pay more than $500 worth of drugs a year.
comprehensive studies demonstrating that medical outcomes for older people are worse for those enrolled in HMOs than in fee-for-service plans. Concerns about the quality of care were even raised publicly by the Administrator of HCFA. Financial incentives employed by HMOs “help explain why [these] recent studies show that chronically ill beneficiaries or those who develop a chronic, expensive illness are not as well-served in an HMO as in traditional, indemnity insurance.” One explanation, in contrast to a straight cost-control argument, is that many Medicare HMOs use their own utilization review standards to determine whether a particular treatment is covered. These standards may not include all of the services covered by Medicare and the beneficiary may not be getting a service that is “required to be covered by the HMO.”

Another measure of quality of care may be consumer satisfaction, and as one commentator states: “Considering the population which Medicare serves, a consumer-friendly system should be a goal for the Medicare program.” However, it seems that Medicare has failed in this respect. Studies show that most Medicare HMO enrollees are not satisfied with their coverage, and “on virtually every dimension . . . enrollees were significantly less likely . . . to rate their care as excellent.” The many services that enrollees are dissatisfied with include “attention received as a patient, physician explanations, ease of obtaining care, . . . thoroughness of examinations, and overall results of care.”

Although it would seem that Medicare managed care beneficiaries would be adequately protected by an HMO grievance procedure and a

Amy Goldstein, Elderly Face Health Premium Hike; Managed-Care Trends Could Pose Trouble for Medicare, WASH. POST. Sept. 23, 1999, at A10.

105. See Peter W. Shaughnessy et al., Home Health Care Outcomes Under Capitated and Fee-for-Service Payment, HEALTH CARE FINANCING REV., Fall 1994, at 187, 219-20 (1994); John E. Ware et al., Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study, 276 JAMA 1039, 1039 (1996).


108. Id. § III(F)(5)(d), at 124.

109. Visocan, supra note 54, at 32.

110. Oberlander, supra note 6, at 612 (quoting from R.S. Brown et al., Do Health Maintenance Organizations Work for Medicare?, 15 HEALTH CARE FINANCING REV. 7 (1993), and D.G. Clement et al., Access and Outcomes of Elderly Patients Enrolled in Managed Care, 271 NEW ENG. J. MED. 1487 (1994)).

111. Id.; see also Page, supra note 62, at 3 (describing a California study which found that “satisfaction rates were lower among sicker risk enrollees: 56% of those in fair or poor health were satisfied, vs. 75% of those in excellent health”).
Medicare appeals process, the reality is that this is not true. The Medicare appeals process has been described as both vague and involving frequent delays. A common complaint under the old appeals system was that because the HMO had the ability to delay notification of an adverse decision for up to sixty days, it further lengthened the amount of time for initiating the appeals process.

Furthermore, it has been documented that Medicare HMOs commonly do not provide written notice to beneficiaries of determinations to reduce, delay, or deny services, and if they do, they fail to do so in an expeditious manner. Even if the requisite notice of the organizational determination is given, more times than not, it fails to explain the reason for the denial or the fact that the beneficiary may appeal the decision. A further detriment to the consumer in the appeals process is that many beneficiaries are "ill-advised by HMO employees during the appeals process," which has resulted in ninety percent of them submitting "no evidence in support of their appeals to the HMO." Elderly enrollees, restricted by sickness or a lack of financial support, feel ill-equipped to wage battle with the HMO in a system structured against the beneficiary. Enrollees complain that they cannot determine whether they actually need a specified treatment, whether they can

112. See Mayo, supra note 9, at 43.
113. See id.; see also Baker, supra note 43, § III(A)(2), at 114 (informing that there "may be inordinate delays in getting claims through the HMO appeals process"); Jimenez, supra note 40, at 1211 (criticizing the appeals process as being "grossly inadequate to meaningfully address quality of care and access to care problems and claims").
116. See id. at 127; see also Jimenez, supra note 40, at 1211 (noting that many managed care organizations are not always aware that they are making an organizational determination, thus, necessitating the need for a written explanation). But cf. Archer, supra note 114, § VIII(C), at 79 (arguing that "HMOs do not comply with the requirement that they provide enrollee notices when services are denied"); Espinoza, supra note 63, at 126 (commenting on a 1995 General Accounting Office report which found that some HMOs were holding onto appeals for as long as 200 days).
117. See Jimenez, supra note 40, at 1211. Despite the adoption of stricter federal regulations, HMOs have continuously failed to notify elderly beneficiaries of their appeal rights. See Geri Aston, Court Mandates Stronger Appeals Rights for Medicare HMO Patients, Am. Med. News, Sept. 7, 1998, at 1 (finding that "the biggest problem was that beneficiaries didn't get a notice, and the second problem was that if they did get it, it didn't have much information" (quoting Sally Hart, an attorney at the Center for Medicare Advocacy)); Lindy Washburn, More Controls Urged for HMO Medicare—Watchdog Finds 'Rampant Confusion', RECORD (N. N.J.), Sept. 26, 1998, at A9, available in 1998 WL 5820455.
118. Archer, supra note 114, § VIII(C), at 80.
119. Id.
120. See id.
gathering the needed medical documentation for appeal, or whether they have the requisite access to legal services needed to win a Medicare dispute. Consequently, many enrollees are unaware of the basis of the denial, their right to appeal, or how to pursue it. "[A] recent survey by the Office of the Inspector General (OIG) reported that one-third of Medicare HMO beneficiaries did not know or were not sure of their right to complain about specific problems for which filing a grievance or appeal is possible."

These deficiencies have proven to be a bane to those enrolled in Medicare managed care. As one commentator notes: "[T]he appeal process available to Medicare managed care beneficiaries does not lend itself to the resolution of disputes regarding present or future provision of necessary care." In light of such widespread ignorance regarding the appeals process among the elderly population, as well as the abuses by Medicare HMOs, it is unlikely that HMOs are delivering quality health care needed by our aging citizens.

V. GRIJALVA V. SHALALA: FIGHTING FOR ADEQUATE HEALTH CARE

In an attempt to improve the Medicare HMO appeals process, and to ensure fair treatment of elderly Medicare patients, a group of enrollees filed a class action lawsuit against the Secretary of Health and Human Services, Donna Shalala ("Secretary"), and the HCFA. In addition to claiming that risk-based HMOs denied medical services to elderly beneficiaries, the plaintiffs alleged that the Secretary had "shirked her duty and responsibility to administer the Medicare program" by failing to implement and ensure effective notice, hearing, and appeal procedures for denials of medical care by HMOs who con-

121. See Stayn, supra note 53, at 1700-01.
122. See Archer, supra note 114, § VIII(C), at 79; see also Stayn, supra note 53, at 1700 (finding that "many Medicare HMO enrollees are unaware of their rights or how to exercise them").
125. For a thorough discussion of class action lawsuits in the area of managed care, see Kathy L. Cerminara, The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting, 24 AM. J.L. & MED. 7 (1998).
127. See id.
128. Id.
tracted with HCFA to provide services for Medicare patients. Neither monetary damages nor denied benefits were sought. Rather, the plaintiffs requested injunctive and declaratory relief ordering the Secretary to implement effective notice, hearing, and appeals procedures for HMOs to follow when they issue service denials.

The class action suit, brought on behalf of five Tucson women by the Center for Medicare Advocacy, Inc., was led by Gregoria Grijalva. Seventy-two year-old Grijalva was stricken with diabetes and battled her Medicare HMO to receive medical services. The HMO denied Ms. Grijalva the nursing home care she desperately needed, the plan never sent a written denial, and “she never knew that there was an appeals process.” The other plaintiffs faced similar situations, which all seemed to revolve around a core nucleus of common facts: an outright denial of covered services coupled with the absence of a written explanation. Although Ms. Grijalva ultimately received the nursing home care with the help of a consumer advocacy group, the court allowed the class action to go forward for those beneficiaries similarly situated, to guard against similar problems in the future.

The court certified the class action as including anyone “who [was] enrolled in Medicare risk-based [HMOs] . . . during the three years prior to the filing of [the] lawsuit.” The action also included two subgroups,
those class members "denied services by an HMO, with or without notice, ... seeking reconsideration ... or by filing some other form of appeal or objection,"140 and class members "who were not given adequate notice or appeal rights."141

The common argument that bonded the group together was not simply that Medicare HMOs denied them covered medical services, but also that the HMOs failed to provide timely notice of the denial, and when they did give notice, it was improperly stated or did not fully explain the reasons for the denial.142 Additionally, all of the plaintiffs had similar problems with the grievance and appeals process. The class argued that they had "received insufficient notice of appeal rights, and were ultimately subjected to an ineffective appeals process."143 Furthermore, the plaintiffs argued that the "[United States] Constitution requires an expedited hearing before an HMO can deny services and that HMOs carry the burden of proof for Medicare denials."144

Within the year, on cross-motions for summary judgment, a federal district court empowered Medicare beneficiaries with a new constitutional right to due process in their fight with HMOs for adequate health care.

A. The 1996-1997 Litigation: Medicare HMOs Found to be State Actors

After dismissing a jurisdictional objection by the defendants,145 the district court addressed the pivotal question of whether the actions of Medicare HMOs could be held to be state actions, therefore requiring procedural due process under the Fourteenth Amendment of the United States Constitution.146 The defendants argued that the HMOs were private, non-governmental entities,147 and as such, their actions could not

as a class, only a few cases will find their way ... into the courts and even if plaintiffs prevail ... the majority of Medicare beneficiaries enrolled in HMOs will continue to be subjected to the procedures challenged here."

Id. at 45,476.
140. Id. at 45,480.
141. Id.
142. See id. at 45,476.
143. Id.
146. See id. at 751-53; see also Shelley v. Kraemer, 334 U.S. 1, 13 (1948) (holding that only state actors could be held liable for violations of the Due Process Clause of the Fourteenth Amendment).
147. See Grijalva, 946 F. Supp. at 751. The defendants argued that the HMO's actions fell within protected activity under Blum v. Yaretsky, 457 U.S. 991 (1982). See id. in Blum, nursing
violate constitutional due process rights unless those actions could fairly be attributed to the state.\textsuperscript{146} The court employed a mode of analysis that had recently been adopted by the Second Circuit Court of Appeals, and found that the HMOs, in fact, were state actors.\textsuperscript{149} Finding it unreasonable to allow the Secretary to delegate the decision-making regarding covered services to the HMO and then disclaim responsibility for the HMO’s actions, the court observed:

1) the government pays for covered services; 2) the government regulates HMOs’ activities as they apply to Medicare beneficiaries, especially benefit coverage determinations; 3) the Secretary issues regulations and directives which cannot be ignored; the Secretary creates the legal framework which governs the activities complained of by Plaintiffs; and 4) Medicare beneficiaries appeal . . . directly to the Secretary, who has the power to overturn the HMO decision.\textsuperscript{159}

Under the analysis set forth by the Court of Appeals for the Second Circuit, the court found HMO denials of Medicare services, or organizational determinations, to be state actions;\textsuperscript{151} therefore, the court concluded that the beneficiaries could not be denied health care services from Medicare HMOs without triggering constitutional due process of law.\textsuperscript{152}

The court embarked on an exhaustive review of the Medicare HMO appeals process before declaring that the “Medicare statute, the Secretary’s regulations, and the Due Process Clause of the Constitution

\textsuperscript{146} See Grijalva, 946 F. Supp. at 751 (citing Shelley v. Kraemer, 334 U.S. 1, 13 (1948)).

\textsuperscript{149} See id. at 752 (citing Catanzano v. Dorling, 60 F.3d 113 (2d Cir. 1995)). In Catanzano, the court held that Medicaid recipients were denied due process rights when they were denied services by non-governmental home health agencies. See id. (citing Catanzano v. Dorling, 60 F.3d 113 (2d Cir. 1995)) The court recognized that “[i]t is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.” Id. at 752 (quoting Catanzano v. Dorling, 60 F.3d 113 (2d Cir. 1995), quoting J.K. v. Dillenberg, 836 F. Supp. 694, 699 (D. Ariz. 1993)). In J.K. v. Dillenberg, 836 F. Supp. 694, 698-99 (D. Ariz. 1993), the court distinguished Blum, and held that where a state delegates its duty to a private organization, that organization’s action can fairly be construed to be state action.


\textsuperscript{151} See id. at 753.

\textsuperscript{152} See id.; Judge Rules Medicare Members Are Shortchanged by HMOs on Complaints, 9 LOY. CONSUMER L. REP. 4, 5 (1997) [hereinafter Judge Rules].
unequivocally provide that a Medicare beneficiary is entitled to notice and hearing when an HMO denies services based on coverage determinations." In determining what process a Medicare beneficiary is entitled to by an HMO, the court looked to a balancing test of interests as set forth by the Supreme Court in *Mathews v. Eldridge.* In *Mathews,* the Court established the process owed to a Medicare beneficiary, which, it explained, is determined by examining three factors: (1) the private interest at stake; (2) the risk of an “erroneous deprivation” and “the probable value, if any, of additional or substitute procedural safeguards;” and (3) “the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.”

Distinguishing *Mathews,* the *Grijalva* court found that Medicare beneficiaries have a substantial interest in receiving timely services, that HMO denials typically prevent the receipt of medical care, and that “the deprivation suffered . . . cannot so easily be remedied by retroactive recoupment of benefits.” The court continued, stating: “When Medicare services are denied, they are often foregone and, depending on the medical condition, final adjudication may come too late to rectify the situation, especially if the deprivation contributed to or resulted in unnecessary pain and suffering or death.” In holding for the plaintiffs, the court found that “[d]ue process requires that beneficiaries have a 'meaningful opportunity to present [their] case at a meaningful time.”

The court reviewed a number of denial notices sent by Medicare HMOs and found that they “failed to provide adequate reasons for the denials,” which ultimately resulted in an unconstitutional deprivation of due process rights to the beneficiary. The notices failed to state specifically the reason for the denial, failed to notify the beneficiaries that

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154. 424 U.S. 319, 334-35 (1976); see also *Grijalva,* 946 F. Supp. at 756 (concluding that in determining what is owed under a procedural due process analysis, the court must look to the “private interest at stake; the risk of an erroneous deprivation; the probable value of additional or substitute procedural safeguards, and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail”).
157. *Id.*
160. One example used by the court included a denial notice which stated: “[B]eneficiary no longer receiving "skilled nursing care" and therefore, based on the HMO's "understanding of Medicare coverage policies," the HMO would not continue to provide the care.” *Grijalva,* 946 F.
they had the right to present additional evidence at a reconsideration hearing,\textsuperscript{161} and were unreadable, vague, and ambiguous.\textsuperscript{162} In the court’s opinion, notice and hearing requirements were “all but ignored,”\textsuperscript{163} and due process ensured by subsequent administrative review procedures “comes too late in many cases.”\textsuperscript{164} The court recognized that all of this resulted in rendering the elderly beneficiary virtually unable to begin, much less win, an appeal.\textsuperscript{165} Finding that existing reconsideration procedures failed to secure minimum due process for Medicare beneficiaries, the court stated: “[C]urrent procedures allotted to the elderly Medicare claimant, probably disadvantaged by disability and poverty, resemble playing against a stacked deck . . . [and result] in a significant possibility of deprivation.”\textsuperscript{166} The court easily found that the existing appeals process violated the beneficiaries’ due process rights under the Fourteenth Amendment;\textsuperscript{167} therefore, the court concluded that Medicare beneficiaries are “entitled to notice and hearing when an HMO denies services based on coverage determinations.”\textsuperscript{168} Such protections are important in an aging society, and in recognition of this point the court stated: “Congress . . . has repeatedly recognized that the elderly . . . are less able than the general populace to deal effectively with legal notices . . . “due to inattention or inability to manage their affairs.””\textsuperscript{169}

Finding that the current appeals process followed by HMOs failed to secure minimum due process rights for Medicare beneficiaries, the court declared that the Secretary would be violating the Medicare statute if she entered into a contract with any HMO that did not meet a set of requirements set forth by the court.\textsuperscript{170} In addition, the court restricted the Health Care Financing Administration (“HCFA”) from contracting with HMOs that retaliate against their physicians for supporting patient

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\textsuperscript{161} See id.

\textsuperscript{162} See id. at 757 (finding that 52\% of the denials reviewed were illegible, 74\% of the denials provided vague, nonspecific reasons, and that only 41\% of the denials provided an explanation of personal liability).

\textsuperscript{163} Id. at 759.

\textsuperscript{164} Id.

\textsuperscript{165} See id.

\textsuperscript{166} Id. (quoting Gray Panthers v. Schweiker, 652 F.2d 146, 172 (D.C. Cir. 1980)) (alteration in original).


\textsuperscript{168} Id.; see Judge Rules, supra note 152, at 4.

\textsuperscript{169} Grijalva, 946 F. Supp. at 758 (quoting Gray Panthers 652 F.2d at 169 (quoting S. Rep. No. 1230, 92d Cong., 2d Sess. 38 (1972)).

\textsuperscript{170} See id. at 760.
appeals.\textsuperscript{171} The court also placed the burden of drafting proposed appeal rules on the plaintiffs.\textsuperscript{172} With the plaintiff's proposal under consideration, the court issued a formal opinion six months later, which laid out the changes that must be made by the Secretary in the Medicare appeals process to prevent violating the due process rights of its beneficiaries, as well as the explicit order of the court.\textsuperscript{173} Giving HCFA a July 1, 1997 deadline, the district court set forth the minimum standards that HMOs must meet in notifying members of their appeal rights and ordered the Secretary to make the following changes in the Medicare appeals process:

1. An HMO must give its enrollees written notice whenever a service or referral is delayed or denied or an ongoing treatment is reduced or terminated. The notice must be in clear, readable form and in twelve point type.\textsuperscript{174}

2. Plans must issue such notices promptly but no more than five working days after a written or oral request for a service or referral, and at least one day before reduction or termination of a course of treatment.\textsuperscript{175}

3. Denial notices must include specific medical facts, the reason for denial (in lay-person language), and directions for the regular and expedited appeal process, including an explanation of the Peer Review Organization ("PRO") complaint and quality review process. Notices shall also include a description of the additional evidence needed by the beneficiary, information regarding how to obtain such evidence (which shall be freely provided by the HMO), and how and when the enrollee may submit such evidence.\textsuperscript{176}

4. Provide for an expedited appeal process when services are urgently needed and are denied or terminated. An enrollee can establish such urgency by providing a written explanation from her doctor.\textsuperscript{177}

5. An expedited decision by the HMO must be issued within three working days of the request. If the plan denies coverage, the appeal is


\textsuperscript{172} See Grijalva, 946 F. Supp. at 761-62.


\textsuperscript{174} See id. at 53,176.

\textsuperscript{175} See id.

\textsuperscript{176} See id.

\textsuperscript{177} See id.
forwarded to Medicare for expedited review and a decision is rendered within ten working days of the request. 178

6. In an expedited appeal, services must continue until a final reconsideration decision has been issued. 179

7. The Secretary must establish that the first level of reconsideration shall include informal, in-person communication with the reconsideration decision-maker. In addition, in the case where services are urgently needed, an expedited reconsideration process must be available. 180

8. If plans fail to substantially comply with these requirements, the federal agency charged with oversight is prohibited from renewing or entering into a subsequent Medicare contract with the HMO. The Secretary must monitor the plans and may not contract with any HMO that has retaliated against a doctor for supporting or presenting evidence in a beneficiary’s appeal process. 181

B. Aftermath of Grijalva

The *Grijalva* decision was heralded as a victory among political activists, Medicare beneficiaries, and consumer groups. 182 In April of 1997, partly in response to the result in *Grijalva*, the HCFA published new rules that replaced the appeals system which had created such dissatisfaction for Medicare beneficiaries. 183 The rules addressed a variety of the grievances brought to the HCFA’s attention, not only through the *Grijalva* case, but also by lobbying groups and beneficiaries’ complaints. 184 The April 1997 regulations required HMOs to thoroughly explain and notify beneficiaries of their new expedited appeal rights; created an expedited appeals process that would require health plans to respond to appeals within seventy-two hours if the beneficiary’s life or

178. See id.
179. See id. at 53,177.
180. See id. at 53,176. Such urgency may be proven by either a doctor or, in certain circumstances, lay testimony. See id.
181. See id. at 53,177.
182. See Jane Erikson, Judge Tightens Rules on Coverage Denial by Medicare HMOs, ARIZ. DAILY STAR, Oct. 26, 1996, at 1A.
184. These groups included Congress’s General Accounting Office, the Health and Human Services’s Inspector General’s Office, the Physician Payment Review Commission, the Institute of Medicine, the American Medical Association, the American Society of Internal Medicine, and the National Association of Insurance Commissioners. See Sharon Mollring, Judge, Patients Urge Changes to Medicare HMO Appeals, AM. MED. NEWS, Nov. 25, 1996, at 1.
health were in jeopardy;\footnote{This regulation was in compliance with the court's mandated changes. See Julie Rovner, \textit{Court Rules Medicare Must Expand Appeals}, 352 LANCET 887, 887 (1998).} required HMOs to accept appeals from both beneficiaries and physicians; and required Medicare HMOs to train their personnel in the new appeals process.\footnote{See 42 C.F.R. §§ 417.600-.694, 466.1, 473.10-.48 (1997); \textit{Federal Court Orders Medicare HMO, HHIS to Beef up Appeals and Grievance Process}, MANAGED MEDICARE \& MEDICAID, Mar. 17, 1997, available in 1996 WL 9411138 [hereinafter \textit{Federal Court Orders}].} The managed care industry was satisfied with the changes in the appeals process.\footnote{A spokeswoman for the American Association of Health Plans related: "We were comfortable with the Medicare rules issued in 1997. They made important changes that responded to beneficiaries' concerns. We want to study the court's decision to compare it with those rules." Medicare Patients Win Right to Fight HMO Denials, STAR TRIB. (Minneapolis-St. Paul), Aug. 14, 1998, at A4 [hereinafter \textit{Medicare Patients Win}] (quoting Karen Ignani, president of the American Association of Health Plans).} Although it amounted to an overall improvement from the prior appeals system, HCFA failed to address all of the requirements that the district court mandated in its memorandum decision and order.\footnote{See \textit{Federal Court Orders}, supra note 186.}

Possibly with this in mind, the government filed an appeal of the \textit{Grijalva} decision and was granted a stay to halt the implementation of the court ordered appeals rules.\footnote{See Geri Aston, \textit{New Medicare Appeal Rules: Federal Court Ruling May Force Even More Revisions}, \textit{Am. Med. News}, May 26, 1997, at 1. The Secretary's appeal asked the Court of Appeals to review four issues: "Whether the Secretary's regulations regarding adverse service or payment determinations by health maintenance organizations, as well as further review of such determinations, satisfy fundamental standards of procedural fairness." "Whether such determinations made by private HMOs, prior to any involvement by the Secretary or her agents, are subject to the Due Process Clause of the Fifth Amendment." "Whether, even assuming that the Secretary's procedural regulations were inadequate, it was proper for the district court to prescribe a detailed set of new procedures, rather than remanding for rulemaking." "Whether the district court's order improperly intrudes on the Secretary's enforcement discretion." \textit{HHS Secretary Appeals Ruling on Expanded Medicare Rights, Says No Basis for Injunctive Relief, Court Interference}, MEALEY'S LITIG. REP.: MANAGED CARE, Aug. 1, 1997, at 5, 5 [hereinafter \textit{HHS Secretary Appeals}] (quoting from Donna Shalala's Brief on appeal).} The stay pending appeal was important to HCFA. If the stay was not granted, the agency would have had to implement all of the changes required by the court order, while simultaneously running the risk of having to change them all back if the government won the appeal. The government was confident that the recently enacted regulations would have ""important ramifications for the disposition of [the] appeal" because they . . . 'provide HMO enrollees with many of the sorts of protections that the district court thought nec-
In reference to the appeal, the Secretary voiced her continuing disapproval of the district court’s ruling, stating that the court’s holding “was both unnecessary and erroneous.”

While the appeal to the Ninth Circuit was pending, Congress passed the Balanced Budget Act of 1997 (“BBA”), which brought major changes to the Medicare system. In addition to creating the Medicare+Choice Program or Medicare Part C, the BBA mandated the adoption of new rules and regulations concerning the Medicare appeals process. Although it makes great strides in protecting the elderly from HMO abuse, “the BBA does not incorporate all of the recent changes and protections [required by Grijalva] for Medicare beneficiaries.”

The current appeals process, as detailed in Part III, was implemented by the BBA and designed to “heighten [the] awareness of Medicare beneficiaries that they have the ability to challenge decisions made by health plans.” Though a major step in the right direction, the regulations failed to incorporate all of the protections mandated by the Grijalva ruling. Initially, the court order required that all written denials of treatment must be in twelve point type and contain an explanation in lay language of the basis for the denial “that is sufficiently detailed to allow the enrollees to understand the decision and argue their cases, a description of the additional evidence needed to support an appeal, and an explanation of how to obtain a second opinion.” The current Medicare regulations require only that the denial be in understandable language and that it describe the appeals process. Turning to the timeliness of complaints, the Grijalva court order mandated that all of the HMO’s decisions be made within five days of the request by the beneficiary. The present regulations allow the HMO fourteen days to make the decision, with the possibility of fourteen additional days if the HMO is able to justify such a delay. Other areas not addressed by the new regulations include the due process requirement that services must con-
tinue during the pendency of a termination determination and the requirement that the first level of reconsideration be informal and in-person with the decision-maker.  

Although the new appeals process made it easier for beneficiaries to appeal coverage decisions, commentators still forecasted that Medicare HMOs would not change their current methods unless the decision in Grijalva was upheld by the Ninth Circuit Court of Appeals. Specifically, the requirement that the Secretary must discontinue contracts with non-complying managed care organizations presented the HMOs with the most bite. It seems that the commentators were correct. In a recent report released from the Medicare Rights Center ("MRC"), an analysis of 179 complaints made to the MRC over a six-month period demonstrates that, in nearly one-half of the cases, the plans violated Medicare rules governing "'premature termination of home care, denial of coverage for emergency care and slow or improper handling of appeals and requests for approval of medical services.'" Clearly, despite all of the changes in the Medicare appeals process, "'[m]any people in Medicare HMOs are not getting the care they are entitled to.'"

C. Decision of the Court of Appeals

In a decision that may have taken the federal government by surprise, the Ninth Circuit Court of Appeals unanimously affirmed the district court's finding that an HMO's denial of medical services to recipients was federal action, as well as the conclusion that beneficiaries were not provided with adequate procedural safeguards and protections under the current Medicare appeals process.

The Court of Appeals declined to consider the appeal in light of the recently promulgated regulations, but rather reviewed it in the context of the original regulations. In doing so, the court generally accepted

201. See Fuerst, supra note 133, at 7.
203. Washburn, supra note 117, at A9 (quoting Joe Baker, Associate Director of the Medicare Rights Center, who feels that "the government is not adequately overseeing or sanctioning the Medicare HMOs").
204. See Grijalva v. Shalala, 152 F.3d 1115, 1117 (9th Cir. 1998).
205. See U.S. Government Appeals 9th Circuit Grijalva Decision, MEALEY'S MANAGED CARE
the district court's constitutional due process analysis, finding that scrutiny can only attach to private actors, such as HMOs, when their actions "can fairly be considered government action." The court stressed such factors as: (1) the Secretary's regulation of the provision of services by Medicare HMOs; (2) the requirement that HMOs comply with all federal laws and regulations; (3) the Secretary's payments to the HMOs for each enrolled beneficiary; (4) the Secretary's requirement that HMOs provide adequate notice and meaningful appeal procedures; and that (5) the federal government had created the legal framework from which the HMO handles appeals and determinations. The court found that these factors combined sufficiently to establish state action on the part of Medicare HMOs. The court concluded that "in the circumstances of the Secretary's regulation of and delegation of Medicare coverage decisions to HMOs, HMO denials of services to Medicare beneficiaries with inadequate notice constitute federal action."

Next, the court discussed whether current appeals procedures provided adequate due process protection, ultimately determining that they did not. The court stressed that Medicare beneficiaries needed additional procedural protection in the areas of "adequate notice of service denials, including the specific reason for the denial and an explanation of appeal rights, and expedited review for critical care denials." Much like the reasoning employed by the district court, the Ninth Circuit recognized that because of HMO abuse, as well as human frailty, the elderly require more protection than the average health care consumer.

In her appeal, the Secretary "vociferously" criticized the order and injunction granted by the district court, stating that it was "widely and irrationally broad in scope." The Secretary ridiculed the necessity of twelve-inch type for all service denials. Reviewing the Secretary's ar-

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206. Grijalva, 152 F.3d at 1119. "Government action exists if the challenged private action occurs under government compulsion." Id. at 1120; see also Aston, supra note 117, at 1 (reporting that the Ninth Circuit Court of Appeals "agreed with the lower court's conclusion that the government's Medicare HMO appeals rules and its failure to monitor health plan service denials to beneficiaries fail to meet the due process standard").

207. See Grijalva, 152 F.3d at 1120.

208. See id. Defending its decision from attack by the defendants, the court stated that HMOs "are making decisions as a governmental proxy—they are deciding that Medicare does not cover certain medical services." Id.

209. Id.

210. See id. at 1121-23.

211. Id. at 1123.

212. Id.

213. See id.
arguments, the court was unable to find one instance in which the court’s
order had constituted an abuse of discretion, concluding that “[a]n
abuse of discretion is not apparent in these requirements.” Moreover,
the court reasoned, “many of them are already required by the Medicare
statute or the Secretary’s regulations.” The Secretary further attacked
the ruling, contending that since the time of the initial order and injunc-
tion, she had promulgated new rules and regulations addressing many of
the points discussed by the district court, which had succeeded in pro-
viding greater procedural protections for Medicare beneficiaries. The
Secretary asked the Court of Appeals to review and modify the injunc-
tion, which it declined to do, stating that the district court held continu-
ing jurisdiction over the aspects of the injunction.

After first requesting a reconsideration hearing en banc by the full
Ninth Circuit Court of Appeals, the HHS has appealed the decision to
the Supreme Court, opposing the notion that a federal court, rather than
Congress, is empowered to create such “‘detailed, burdensome and un-
necessary procedural requirements.’” In her petition, the Secretary ar-
gues that because of the recent regulations promulgated in connection
with the Medicare+Choice program, “the challenge to the regulations
are moot.” The Secretary also is requesting the consideration be put
on hold until the Court rules on a similar case, which was argued in
early 1999.

In affirming without modification, the Ninth Circuit Court of Ap-
peals solidified the theory that “elderly people are not at their HMOs’

214. See id.
215. Id. at 1124.
216. Id. The court stated that the district court’s decision may be “redundant, but [that] does
not make [it] an abuse of discretion.” Id.
217. See id.
218. See id.
219. See U.S. Department of Health Demands Rehearing of 9th Circuit Due Process Ruling,
9851208 (quoting a statement by HHS). HHS argued that “[a]ppeals rights must be tailored to the
divergent circumstances arising under the many new health options available under the Medi-
care+Choice program . . . . That in turn requires that procedural rules be formulated by public con-
sultation and expert deliberation.” Steven Brostoff, HHS Asks Court Rehearing on HMO Case,
NAT’L UNDERWRITER & HEALTH-FIN. SERVICES EDITION, Nov. 2, 1998, available in Westlaw,
1998 WL 20199428 (quoting a statement by HHS). The request for the en banc hearing is pre-
dicted to be the precursor for an appeal to the Supreme Court. See id.
222. See id. The pending case, American Manufacturers Mutual Insurance Co. v. Sullivan,
No. 97-2000, U.S. Sup. (1999), involves a decision made by the Third Circuit Court of Appeals
that “payment decisions made by workers’ compensation insurers were both attributable to the
state and inconsistent with due process.” See U.S. Government Appeals, supra note 205, at 3.
mercy but have constitutional rights when dealing with a denial of care and the subsequent appeals process. If the proposition is that the Secretary had not been adequately monitoring the HMOs' treatment of Medicare beneficiaries, then the decision is "an example of a court, dissatisfied with administrative regulations and enforcement of same, telling an administrative agency how to do its job." Although the plaintiffs did not seek monetary damages, the appellate court affirmed the lower court's decision, holding that the United States' nearly six million Medicare beneficiaries are entitled to the due process rights guaranteed by the Constitution. Whether or not the court's decision will increase the quality of care to Medicare beneficiaries remains to be seen; however, the strict procedural due process protections may ensure that more seniors citizens will competently appeal denials of care.

While some are describing the case as a major victory for consumers and others are calling it "the most significant constitutional ruling affecting the Medicare program in years," the Ninth Circuit's decision may have some unintended negative consequences. Ultimately, the decision may require more change to the Medicare appeals regulations unless a compromise between the Secretary, the defendants, and the district court is reached. As discussed in Part V.B, there is apparent conflict between the stringent rules imposed by the court and the recent regulations promulgated by the HCFA. What is the time period in which an HMO has to respond to a request for services by a beneficiary—is it the five days mandated by the court's injunction or the fourteen days set forth by the recent regulations? The new regulations also have fallen short in attempting to meet the standards set forth in Grijalva. The regulations fail to address and provide for the continuation of services pending an expedited appeals process, thus leaving ill beneficiaries without health care while their appeal is pending. If the appeal to the Supreme Court fails, HCFA seems to be left with two options: amend

226. By the year 2002, the number of our elderly enrolled in Medicare HMOs is predicted to be 10 million, or 25% of the Medicare population. See Medicare Patients Win, supra note 187, at A4.
228. Jost, supra note 7, at 115.
the regulations to adhere to the injunction, or revisit the district court and plead with the judge to amend the ruling to comply with the recently enacted regulations.\footnote{229} The latter is an option that the Secretary has refused to consider.

Additionally, the court order imposes some financially detrimental requirements for Medicare and its contracted HMOs,\footnote{230} including in-person reconsiderations,\footnote{231} payment for services while appeal decisions are being considered,\footnote{232} and supplying a description of the evidence needed to win an appeal, with such evidence being "freely provided by the HMO."\footnote{233} With a promise of expanded constitutional due process rights pertaining to every decision made by an HMO, it is predicted that attorneys will become more involved in the appeals process, thereby driving up the costs associated with appeals.\footnote{234} With a large number of HMOs currently dropping out of the Medicare managed care program due to financial difficulties,\footnote{235} citing profitability as the sole reason,\footnote{236} the imposition of additional regulations could be disastrous for the health of the industry.\footnote{237} The reaction to the ruling has been so strong

\footnote{230. See Gail Diane Cox, Suddenly, Courts Have Made It Easier to Sue HMOs, NAT'S L.J., Aug. 31, 1998, at A10 (reporting that the lead counsel for HCFA stated that while his boss may have been the defendant, "[i]t may well be that any extra expenditures, for notices and such, would fall to the HMOs").}
\footnote{231. HCFA reports that it may already be able to handle such face-to-face hearings. See id.}
\footnote{232. This provision has an immediate cost impact and may result in the HMOs' reducing benefits or dropping Medicare patients. See id.}
\footnote{234. See Wendy L. Krasner & Barbara W. Mayers, Will Grijalva Ruling Open the Medicare Managed Care Exit Door?, MANAGED MEDICARE & MEDICAID, Aug. 31, 1998, available in 1998 WL 9852609; AAFP Brief Urges High Court to Vacate Grijalva Judgment, MEALEY'S MAN. CARE LIAB. REP., May 12, 1999 available in LEXIS, News Library, Curnws File (stating: "[e]ach additional due process requirement imposed by courts will create more financial and administrative burdens on HMOs, resulting in decreased benefits").}
\footnote{235. "By the end of 1998, more than forty HMOs insuring 440,000 beneficiaries had pulled out of Medicare." Jost, supra note 7, at 113 n.393; see also Laurie McGinley, Quick-Fix Push May Derail Long-Term Medicare Plan, WALL ST. J., Jan. 5, 1999, at A24 (detailing the rush of companies out of the Medicare managed care program).}
\footnote{236. See Bernard Leo Remakus, On Managed Care: The Opera, INTERNAL MED. WORLD REP., Nov. 1998, at 27, 27.}
\footnote{237. Some of the plans dropping Medicare HMOs include Aetna U.S. Healthcare, Anthem, Foundation, Humana, Oxford Health Plans, Pacificeare, Prudential, and United Healthcare. See Do Growing Medicare+Choice Headaches Mean Program is Seriously Ill? . . . , MED. & HEALTH, Sept. 7, 1998, at 1; Remakus, supra note 236, at 27 (commenting that the recent abandonment of patients by profit motivated HMOs is "disgraceful" and that managed care's greed has "never been more apparent"); Molly Tschida, Packing It in: Managed-Care Powerhouses Bail out of Medicare Plans, MOD. PHYSICIAN, Oct. 1998, at 16 (reporting that HMOs are pulling out of Medicare man-}
that commentators argue that "[i]f the Grijalva ruling is not overturned, it may be the watershed that pushes health plans out of Medicare."238

Although some may find it hard to find sympathy for HMOs, the decision ultimately may be a double-edged sword for beneficiaries. The court’s requirement that the Secretary may not contract with HMOs who fail to comply with the new requirements could mean that many such contracts will be terminated with participating HMOs, leaving many elderly persons without their managed care coverage.239 Certainly, from some ill senior citizens point of view, denied or delayed care is better than no care at all. In addition, many of the elderly have entered HMOs because their family doctors, who they have been seeing for a long time, are part of the plan.240 When the contract is terminated with the HMO, these senior citizens must either find a new doctor, or pay for health care themselves. As one commentator laments on the downfall of Medicare managed care:

America’s future health care delivery system cannot be one that compromises the health of its elderly and chronically ill patients or one that is unable to render health care to such patients in a cost-effective manner. Multiyear, multicenter studies have clearly demonstrated that the health of the majority of elderly and chronically ill patients de-

238. Krasner & Mayers, supra note 234. The most disturbing notion is that the Medicare appeals process, as it stands right now, may be one of the nation’s best. See Administration Goes Both Ways on Patients’ Appeals, CONGRESS DAILY A.M. Sept. 3, 1998, available in 1998 WL 12689974 (describing the statement of a representative from the American Association of Retired Persons, who stated that “[c]ompared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings”).

239. This provision has been held to be the most important point of the court’s ruling. See Managed Care Briefs, MANAGED CARE WK., Aug. 17, 1998, available in 1998 WL 9851146.

clines when they are enrolled in Medicare HMOs and that the cost of providing health care to elderly patients is not reduced when Medicare HMOs are allowed to take over their care.

By the year 2005, the United States will be home to twice as many elderly citizens as teenagers. America's future health care delivery system must be capable of providing competent care to an ever-increasing number of elderly patients.

VI. CONCLUSION

While it cannot be ignored that Medicare HMOs have been drastically abusing the appeals process and denying health care to beneficiaries indiscriminately, the cure may have been worse than the disease. The plaintiffs in Grijalva simply wanted to receive adequate health care, an improvement in the appeals process, and increased oversight of HMOs by the Secretary and HCFA. Certainly, the courts responded by granting them a new constitutional right to due process under the United States Constitution. The same can be said for Secretary Donna Shalala, who promulgated two sets of Medicare regulations within the last three years, drastically improving the appeals process. However, the increase in the quality of care and the right to fair appeals may be the beginning of the end for Medicare managed care. The stringent regulations, especially those upheld by the Ninth Circuit Court of Appeals, may result in great economic hardship for participating HMOs and may increase the current flight of such organizations from the Medicare program. This flight would be increased by the Supreme Court's affirmance. While the rules imposed by the court will certainly ensure procedural due process for beneficiaries enrolled in HMOs, they may be all for naught if Medicare managed care becomes a thing of the past. Despite such hardship on the profit margins of HMOs, Medicare enrollees now have a new constitutional right to due process in their fight for adequate health care.

POSTSCRIPT

Since the time this Note was written, the case of Grijalva has continued to proceed through the appellate process and spark controversy along the way.

241. Remakus, supra note 236, at 27.
A. The Supreme Court and Ninth Circuit
Avoid the Issue

In a somewhat surprising and disheartening move, the Supreme Court completely dodged the concerns of Medicare patients by sending the case back to the Ninth Circuit Court of Appeals. In a two sentence opinion handed down on May 3, 1999, the Supreme Court remanded the case to the Ninth Circuit “for further consideration in light of American Manufacturers Mutual Insurance Co. v. Sullivan,... Sections 4001 and 4002 of the Balanced Budget Act of 1997,... and the regulations of the Secretary of Health and Human Services implementing those provisions.”

On September 1, 1999, a scant four months from the time the Supreme Court passed on the constitutional rights of Medicare beneficiaries, the Ninth Circuit Court of Appeals followed suit in avoiding the same issue. With the same reckless abandon as its appellate parent, the Ninth Circuit remanded the case to the district court for further review in light of Sullivan, the Balanced Budget Act, and the accompanying regulations. In little more than two years from the time United States District Judge Alfredo Marquez made constitutional history by declaring Medicare beneficiaries were entitled to protection under the Due Process Clause of the Fifth and Fourteenth Amendments, the same issue was presented back to him for further consideration.

B. American Manufacturers Mutual
Insurance Co. v. Sullivan

The fate of the Medicare HMO appeals process depends largely, in part, on Judge Alvarez’s interpretation of the Supreme Court’s recent decision in American Manufacturers Mutual Insurance Co. v. Sulli-
The importance of Sullivan’s effect on the future of the class action in Grijalva requires a close examination of the findings in this case.

Sullivan, another class action, addressed the question whether Pennsylvania’s Workers’ Compensation system in which “an employer or insurer may withhold payment for disputed medical care pending an independent review to determine whether the treatment is reasonable and necessary” constituted state action?248

To provide coverage for injuries which occur during or as a result of employment, the workers’ compensation statute in Pennsylvania mandates employers must either “(1) obtain workers’ compensation insurance from a private insurer, [or] (2) obtain such insurance through the State Workers’ Insurance Fund.” Under this system, an employer is only liable for medical care that is “reasonable” and “necessary” for a work-related injury.249 In order to ensure that insurance companies were only paying for appropriate medical treatment, the Pennsylvania workers’ compensation statute includes a utilization review procedure which determines the “reasonableness and necessity of an employee’s past, ongoing, or prospective medical treatment . . . before a medical bill must be paid.” Until a determination of whether a particular treatment is reasonable and necessary, an insurer could withhold payment for the services being challenged.250 The Pennsylvania Workers’ Compensation Bureau (“Bureau”) utilized private organizations composed of health care providers, deemed “utilization review organization[s],” to make these decisions.251

The plaintiffs in Sullivan were employees who claimed to have had benefits withheld from them when their private insurers invoked the utilization review process.252 Arguing that the defendants were acting under the color of state law, the plaintiffs alleged that in withholding the workers’ compensation benefits without notice and an opportunity to be heard, the defendants deprived them of due process.253 The district court,
holding that they were not state actors, dismissed the private insurance companies who provided coverage for workers' compensation.256

The Third Circuit Court of Appeals reversed the district court's decision, finding 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."257

In overturning the decision of the Third Circuit, the Supreme Court, in an opinion written by Chief Justice William Rehnquist, addressed the question of whether "a private insurer's decision to withhold payment for disputed medical treatment may be fairly attributable to the State as to subject insurers to the constraints of the Fourteenth Amendment."258 The Court initially recognized that a private entity will not be held up to constitutional standards and held to be a state actor unless there is such a "close nexus" between the challenged action and the state so that the private actor could be characterized as the state itself.259

The Court dismissed, in turn, each of the employee's arguments in support of declaring that private insurance companies were state actors. The Court discharged the idea that the decision to withhold payments could be attributed to the state because it "coerced" or "encouraged" private insurance companies to utilize the utilization review process. The Court held "[w]e have never held that the mere availability of a remedy for wrongful conduct, even when the private use of that remedy serves important public interests, so significantly encourages the private activity as to make the State responsible for it."260 The Court further rejected the idea that insurers were state actors because they must obtain authorization or permission from the Bureau before withholding pay-
ment,\textsuperscript{261} by stating that such “paper shuffling” has never been interpreted to constitute state action.\textsuperscript{262}

The employees in \textit{Sullivan} argued the actions of the insurance companies could be attributed to the state because they engaged in “‘powers traditionally exclusively reserved to the State,’”\textsuperscript{263} thus claiming that the provision of workers’ compensation insurance was a governmental function.\textsuperscript{264} In dismissing this argument, the Court held that neither the Pennsylvania constitution nor statutory scheme obligated the state to provide medical services or workers’ compensation benefits.\textsuperscript{265} While the state law “imposes that obligation on employers,” it does not “impose [any] such obligation on the State.”\textsuperscript{266}

Finally, the Court dismantled the employee’s assertion that the insurance companies and the state were such “joint participants” in the provision of workers’ compensation benefits that “they [the insurance companies] become an integral part of the state in administering the statutory scheme.”\textsuperscript{267} Citing its own prior decisions, the Court held that “privately owned enterprises providing services that the State would not necessarily provide, even though they are extensively regulated, do not fall within the ambit of [state action].”\textsuperscript{268} In conclusion, the Court held “an insurer’s decision to withhold payment and seek utilization review of the reasonableness and necessity of particular medical treatment is not fairly attributable to the State.”\textsuperscript{269}

\textbf{C. Does Sullivan Really Answer the Issue Raised in Grijalva?}

While some have lauded the action of the Supreme Court in remanding the \textit{Grijalva} case back to the Ninth Circuit (and then to the district court),\textsuperscript{270} others are not so appreciative.\textsuperscript{271} The goal of the Su-

\textsuperscript{261} Under the Pennsylvania system, in order for a private insurance company to institute the utilization review process, it must first file a one page form with the Workers’ Compensation Bureau. \textit{See id.} at 983; PA. STAT. ANN § 531(6)(i) (Purdon Supp. 1998).
\textsuperscript{262} \textit{See Sullivan}, 119 S. Ct. at 987.
\textsuperscript{263} \textit{Id.}
\textsuperscript{264} \textit{See id. at 988.}
\textsuperscript{265} \textit{See id.}; San Francisco Arts & Athletics, Inc. v. United States Olympic Comm., 483 U.S. 522, 544 (1987) (holding the “fact ‘[t]hat a private entity performs a function which serves the public does not make its acts [governmental] action’
\textsuperscript{266} \textit{Sullivan}, 119 S. Ct. at 988.
\textsuperscript{267} \textit{Id.}
\textsuperscript{268} \textit{Id.} at 988-89 (citing Blum v. Yaretsky, 457 U.S. 991, 1011 (1982) and Jackson v. Metropolitan Edison Co., 419 U.S. 345, 357-58 (1974)).
\textsuperscript{269} \textit{Id.} at 989.
\textsuperscript{270} \textit{See Supreme Court Boots Grijalva Case on Enrollee Appeals to Lower Court, MANAGED
Supreme Court's remand was to have the issues that arose in *Grijalva* re-evaluated in light of recent developments affecting the Medicare system. While the Balanced Budget Act of 1997 and accompanying regulations have certainly improved the Medicare appeals process, they do not address all of the concerns raised in *Grijalva*. The greater threat, however, comes from *Sullivan*. A cursory analysis of the issues addressed and the holding of *Sullivan* may give the impression that the fate of *Grijalva* is sealed, doomed to being completely overturned with a finding that Medicare HMOs are not state actors. There are certainly similarities between the two systems which could give rise to an argument mandating a like result.

For example, for certain appeals, the Medicare program contracts with outside utilization review companies to determine the medical necessity of requested services using professionally recognized standards of health care. Furthermore, as discussed in length previously, contracting HMOs are required to provide their enrollees with procedures for hearings and resolving grievances within the HMO system. These rights are triggered when an HMO makes an "organization determination," such as finding that a medical service is not covered or that it is not medically necessary. The parallels to the workers’ compensation system in *Sullivan* are apparent.

There are some distinguishing features, however, that may tend to separate the two cases, necessitating a different outcome. First, the challenged actors in *Sullivan* were insurance companies providing workers’ compensation insurance funded by private companies. The HMOs in *Grijalva* were reimbursed by the federal government with public funds, leaning the scales in favor of finding they were, in fact, state actors.

Second, the scope of the determinations being made by the private actors are drastically different. In *Grijalva*, the participating HMOs en-

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272. These, of course, include the Balanced Budget Act of 1997, the accompanying regulations, and the holding in *Sullivan*. *See Supreme Court Boots Grijalva Case on Enrollee Appeals to Lower Court*, supra note 270.

gaged in the actual determination whether a certain medical procedure or treatment would be covered under the Medicare system. In stark contrast are the insurance companies in *Sullivan*, whose only decision-making authority was whether to delay payment pending the determination of an independent utilization review provider. Clearly, HMOs making coverage determinations on whether a Medicare participant will, or will not, receive medical treatment, implies greater authority and, in turn, greater accountability.

Finally, the greatest argument in attempting to distinguish *Sullivan*, and which in actuality may support a finding of state action in *Grijalva*, is to be found in the Supreme Court’s dicta. As discussed previously, the insurance companies in *Sullivan* merely made a decision whether to withhold payment while an independent utilization review organization determined whether that treatment was “reasonable” and “necessary.” However, the Supreme Court, in addressing the role of the separate utilization review organizations, held that “the decision of [a utilization review organization], like that of any judicial official, may properly be considered state action.” This statement alone could be the sole hope for the *Grijalva* appeal. The Medicare HMOs providing services to participating beneficiaries make the initial decisions to either provide or deny care, unlike the insurance companies in *Sullivan*, whose sole decision was only whether to postpone the payment of the care. In *Grijalva*, the decisions of the HMOs may be likened to those of the utilization review organizations, as they are both making the ultimate decisions on whether to provide care or not. As the attorney for the class action argued:

“Unlike *Sullivan*, where the state action inquiry focused on private decisions to withhold payment for medical care based on professional standards, with no state obligation to pay or provide benefits . . . the state action inquiry in the present case turns on HMO coverage deter-

274. See *Sullivan*, 119 S. Ct. at 982.
275. Id.
276. Despite the similarity of this situation to *Blum v. Yaretsky*, 457 U.S. 991 (1982), where the decisions of nursing home administrators and physicians could not be attributed to the government, this case may also be distinguished. In *Blum*, the decisions of the physicians and administrators were appealed to an independent utilization review organization who had the final decision. In most Medicare HMOs, a doctor may make a decision that a particular treatment is not medically necessary, and that decision is appealed to the own HMOs internal appeals process. Thus, in reality, the decision and the appeal are being decided by the same entity. This is what separates the participating HMOs in *Grijalva* from the alleged state actors in both *Sullivan* and *Blum*.
ominations which are based on federal law and the governmental obligation to provide benefits. That is the critical difference.277

The hope of the Grijalva plaintiffs may hang on this seemingly harmless dicta.

D. A Pot of Gold at the End of the Rainbow

At the time of the writing of this Postscript, the district court had not yet decided the Grijalva case. The chances that the changes to the Medicare appeals process mandated in Grijalva will stand as written are slim. Is it a defeat? Some would argue that the question must be answered in the affirmative. Others would protest, contesting that the Grijalva plaintiffs were in fact more successful than they ever could have imagined. The main goals of the members of the Grijalva class action were to improve the appeals process and the overall quality of health care provided to Medicare beneficiaries.278 This has arguably been accomplished through the passing of the Balanced Budget Act of 1997, the new regulations promulgated by the HHS,279 and increased public awareness of their rights under the Medicare program.280 While not meeting the strict mandates of the original Grijalva decision, the new regulations are a marked improvement over the archaic and ineffective ones they replaced.281 In addition, the saga of the Grijalva rulings has helped bring the plight of Medicare beneficiaries to the forefront of the national stage. Medicare has become an important issue in the up-

277. McKee, supra note 271.
279. See McKee, supra note 271 (discussing that lawyers for the Justice Department argued that the regulations promulgated by the Balanced Budget Act "more than address the changes requested by the court last year").
280. A number of Medicare advocates may not agree with this position. See id. "'The people who are the sickest and the oldest and the most unsophisticated about demanding their rights are those who fall by the wayside.' ... 'The people who are hit the hardest are those with chronic conditions who need to be in nursing homes.'" Id.
281. See Supreme Court Boots Grijalva Case on Enrollee Appeals to Lower Court, MANAGED CARE Wk., May 10, 1999, available in LEXIS, News Library, Curnws File (stating that the Department of Health and Human Services argued in its brief to the Supreme Court that the Medicare+Choice rules were superior to those ordered by the court). But see Brief: Balanced Budget Act Does Not Address All Parts of Decision in Grijalva, MEALEY'S MAN. CARE LIAB. REP., Apr. 28, 1999, available in LEXIS, News Library, Curnws File.
coming presidential election, as well as an overriding concern in Congress.

The Grijalva case began in a district court in Arizona and it seems that it will most likely end there. However, along the way important changes in the administration of the Medicare appeals process have been accomplished. Even if the district court folds to the mandate of the Supreme Court to find that Medicare HMOs are not state actors, there can be no doubt the day has been won by Gregoria Grijalva. She had the courage to bring the trials and travails of her own desperate medical condition to the highest levels of the federal government. With or without a new constitutional right to due process, the case of Grijalva v. Shalala has made significant strides in the battle to improve the access to, and the quality of, the health care provided by Medicare HMOs to our nation’s elderly.

Christopher G. Gegwich*


283. See Are Unrealistic Expectations Confusing Policy Debate on Medicare HMOs?, MEDICINE & HEALTH, Sept. 27, 1999, available in LEXIS, News Library, Curnws File. But see Editorial, Medicare Reforms Held Captive, BALTIMORE SUN, Nov. 11, 1999, at 30A (“There won’t be any big changes in the current congressional session on Medicare or other aspects of this nation’s struggling health-care system.”).

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