

GRIJALVA

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THE WHITE HOUSE
WASHINGTON

February 4, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed, Chris Jennings, Elena Kagan, Dan Marcus (Counsel's Office)

SUBJECT: Grijalva v. Shalala

John Podesta held a meeting last night with staff from the DPC, Counsel's office, OLA, OVP, OMB, and HHS to discuss whether the Solicitor General and HHS should petition the Supreme Court for a writ of certiorari in Grijalva v Shalala. The cert petition, which is due on Wednesday, would seek to vacate a decision (1) holding that Medicare HMOs are "state actors" and, as such, required to provide enrollees with constitutional due process and (2) requiring the Secretary of HHS to ensure that all Medicare HMOs comply with specific notice and hearing requirements when seeking to deny or reduce medical benefits.

You previously noted (on a copy of a New York Times article attached to this memo) that this is a "tricky issue," and your comment, if anything, understates the difficulty and political sensitivity of the decision. HHS objects to the administrative burdens that the district court's injunction imposes and worries that these onerous requirements -- as well as the fear of being subject to other constitutional standards -- will drive some HMOs from the Medicare program. Many Congressional Democrats and health advocates, however, believe that contesting the ruling below will undermine our effort to enact patients' rights legislation and perhaps threaten federal enforcement of Medicaid requirements.

Background

In Grijalva, a nationwide class of individuals enrolled in Medicare HMOs alleged that the HMOs were failing to provide the notice and appeal rights guaranteed by the Due Process Clause of the Constitution. The district court (Judge Alfredo Marquez) agreed that Medicare HMOs were state actors and, as such, required to provide constitutional due process; he also found that the notice and appeal procedures then in existence failed to meet constitutional requirements. The judge issued an injunction specifying precise notice, hearing, and appeal procedures, including a requirement that review of an HMO's decision to deny, terminate, or reduce services take place prior to implementing that decision. The injunction also commanded the Secretary to terminate contracts with any Medicare HMO failing to comply with these requirements. The District Court stayed this injunction pending completion of the appeals process, so the injunction has not yet gone into effect.

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While the Secretary's appeal of the District Court's decision was pending, Congress (in the Balanced Budget Act) overhauled the Medicare HMO program and the Secretary issued a new set of regulations governing Medicare HMOs. Although the new statutory and regulatory scheme provided Medicare enrollees with far greater protections than the original scheme, a panel of the Ninth Circuit upheld the District Court's decision. The Ninth Circuit panel agreed with the District Court that Medicare HMOs were state actors, required to provide constitutional due process, and that the procedural rules in effect at the time of the District Court's decision failed to meet constitutional standards. The panel declined to consider whether the new procedural rules met constitutional requirements and thus rendered the injunction unnecessary, noting that the Secretary could petition the District Court for a ruling on this issue. Concerned about the basic state action issue, the Secretary chose instead to seek a rehearing en banc (which the full Ninth Circuit denied) and now seeks a writ of certiorari.

The Solicitor General's draft cert petition (which we can give you if you want it) notes first that the principal legal issue in Grijalva (whether Medicare HMOs are state actors) is very similar to an issue now before the Court in American Mutual Insurance Co. v. Sullivan (whether workers' compensation insurers are state actors); hence, the SG says, the Court should hold the petition in Grijalva pending the Court's decision in Sullivan. Although this point could be made very simply, the SG's draft uses it as a launching pad to argue the merits of the state action issue; the petition argues for almost 10 pages that Medicare HMOs are not state actors. The SG apparently believes that this extended discussion is desirable to ensure that the Supreme Court appreciates the importance of this case (and therefore holds the petition for Sullivan) and to influence the Court's writing of the Sullivan opinion (so that the decision there effectively forces the district court to lift the injunction).

The draft petition argues next that the new statutory and regulatory scheme governing Medicare HMOs -- which, as noted, provides greater protections than the original regulatory scheme, although some lesser protections than the injunction -- effectively moots the legal challenge adjudicated by the lower courts in this case. The SG thus asks that after holding the petition for Sullivan, the Court vacate the judgment below and remand the case for consideration of any challenge to the new statute and regulations in light of the Sullivan decision.

Discussion and Options

HHS believes that the District Court's injunction imposes a burdensome set of notice and hearing requirements, inconsistent with the Department's current policies and unnecessary to protect Medicare enrollees. HHS notes especially the obligation on health plans under the injunction to give extensive notice to enrollees of changes in service and to continue providing services during the appeals process (effectively forcing HMOs to eat the

cost of these services even if the HMO's initial decision was proper). HHS believes that these additional notice and hearing requirements will increase costs to Medicare HMOs and perhaps drive some out of the Medicare program; in addition, HHS worries that Medicare HMOs will incur other additional costs in the future if they continue to be viewed as state actors. Finally, HHS notes that the injunction imposes considerable administrative burdens on the Department itself, because the district court ordered it to monitor Medicare HMOs' compliance with the injunction and to terminate the contracts of non-complying HMOs.

But this position -- and these arguments -- place the Administration in an awkward position when it comes to pushing Congress to enact a Patients' Bill of Rights. Although the patient protections at issue are different, the Department is making the same kind of arguments against the injunction that private health plans routinely make against the Bill of Rights: that the added protections are excessively burdensome and would raise medical costs without improving the quality of patient care. Of course, the requirements in the one case were imposed by a court, whereas in the other they would be imposed by Congress. But this difference is unlikely to make much of a difference to our critics. In insisting on Supreme Court review of the judgment below, we would be giving credence to the health plans' view of regulation, while making ourselves vulnerable to the charge of hypocrisy.

Perhaps more important, many advocates and some Hill Democrats are worried that our arguments on state action will undermine the Medicaid entitlement. If Medicare HMOs are not state actors, then Medicaid HMOs probably are not either. Although it is possible to make distinctions between the Medicare and Medicaid programs with respect to state action, even HHS admits that these distinctions are strained and may not be convincing. What is more, the enforcement of Medicaid guarantees depends on whether participants in the system (such as HMOs) are state actors in a way that the enforcement of Medicare guarantees does not. Whereas the Medicare statute has built-in enforcement mechanisms that are unaffected by the state action issue, the Medicaid statute has no such mechanisms: federal enforcement relies largely on Section 1983 suits, which can only be brought against state actors. We fought hard, in the Medicaid block grant debate of 1995, to maintain this right of action for Medicaid violations, and we should be reluctant to start down a road that could make it less effective.

We are now considering three options. The first option is to file the cert petition drafted by the SG's office. The second option is to file a stripped-down version of the cert petition, simply making the point that Grijalva and Sullivan are related and asking the Supreme Court to hold the former for the latter. Because this kind of petition would not explicitly argue that Medicare HMOs are private actors or that the district court erred in issuing its injunction, it would inflame advocates less and insulate us somewhat from the charge of hypocrisy. As noted above, however, it might also be less effective in getting the Court to dispose of both this case and Sullivan in the way that stands the best chance of overturning the injunction. The third option is to decline to file any cert petition and instead return to the district court to argue that it should lift (or modify) its injunction in light of the

new statute and regulation. Under this approach, we would say nothing now about the state action issue -- although if the Supreme Court later decides Sullivan in a way that is relevant, we could ask the District Court to reconsider its injunction in light of the decision. This approach best protects our position on the Patients' Bill of Rights and poses the least threat to the Medicaid entitlement, but it is probably the least effective way of helping HHS to escape from the district court's injunction.

Secretary Shalala favors the first option, but she recognizes that this is a difficult decision. We are almost sure that Shalala would prefer the second option to the third, although she has not yet considered this issue. The Solicitor General believes that the first option best protects the government's broad interest in entering into contracts with private parties, but our sense is that the SG is largely taking its direction in this case from HHS. We have not yet discussed with the SG whether he would prefer the second or third options and cannot guess how he would come out on this issue. The DPC and Counsel's Office believe strongly that we should not choose the first option. All of us think that either the second or third options would be acceptable, with Bruce and Dan leaning slightly to the second and Chris and Elena slightly to the third. We expect that John will talk to you about this matter after you have had a chance to read this memo.

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Rulings on Medicare Rights Split White House

By ROBERT PEAR

WASHINGTON, Jan. 21 — A bitter dispute has broken out within the Clinton Administration over the legal rights of Medicare beneficiaries, with some officials trying to limit those rights even as President Clinton urges Congress to establish new protections for millions of other patients with private health insurance.

At issue are Federal court rulings that upheld the rights of six million Medicare beneficiaries in health maintenance organizations.

A Federal district judge in Tucson, Ariz., and the United States Court of Appeals for the Ninth Circuit, in San Francisco, said such patients have a constitutional right to receive written notices and hearings on any denial of medical services, because the H.M.O.'s were acting on behalf of the Government.

Medicare officials are urging Donna E. Shalala, the Secretary of Health and Human Services, to appeal the decision to the Supreme Court. But other Administration officials, who work on legislative affairs and domestic policy, strenuously oppose any appeal, saying the Administration will look ridiculous and will outrage consumer groups and Democrats in Congress.

The arguments are set forth in confidential memorandums that provide a rare insight into the legal and political considerations that shape the Government's decisions on litigation before the High Court. They seem to parallel the arguments made for and against a "patient's bill of rights" like the one proposed by Mr. Clinton.

Medicare officials argue that the lower-court orders intrude on their ability to set Medicare policy, and go much further than necessary to protect elderly patients. "The appeals process required by the district court could impose significant administrative and financial burdens on health plans," raising costs by \$4.70 a person per month, or a total of \$343 million a year, said a memorandum by Medicare officials.

Under the lower-court orders, H.M.O.'s must provide a written notice whenever a service requested by a patient or a doctor is denied, or a course of treatment is reduced or terminated.

"Under this standard, beneficiaries could be inundated with written notices whenever a perceived reduction occurs," the Medicare officials said. "Such a situation would be confusing and even stressful to beneficiaries."

In short, Medicare officials do not like being second-guessed by the courts, and they resent judicial supervision just as much as H.M.O. executives resent regulation.

But a memorandum written by other officials of the Department of Health and Human Services emphasizes the political risks of an appeal

A rare insight into the considerations that shape decisions on litigation.

to the Supreme Court.

"The department's position could be seen as inconsistent with the Administration's stated policy of expanding consumer protections for health plan enrollees," it says. "As a result, a petition could weaken the department's and the Administration's ability to pass legislation that creates additional protections, such as in the patient's bill of rights."

Nancy-Ann Min DeParle, the administrator of the Health Care Financing Administration, which runs Medicare, came down against the lower-court decisions. She told Dr. Shalala that the Administration "should seek relief from the Supreme Court," even though Ms. DeParle acknowledged that there were legal and political risks in this approach.

By contrast, other Administration officials said the rights of Medicare H.M.O. patients should meet constitutional standards for "due process of law" because the stakes were so high: if an H.M.O. denies coverage of a service, the patient may suffer irreparable harm or die.

Further, these officials said in confidential memorandums, if the Ad-

ministration succeeds in its effort to overturn the court decisions won by Medicare beneficiaries, it could undermine the rights of poor people in Medicaid, who have increasingly been required to get their care through H.M.O.'s.

Moreover, these officials said, "health plans may be exaggerating the financial and administrative burdens" imposed by the lower-court orders.

The case, a nationwide class action, was filed in 1993 by elderly people who said they had been denied medically necessary services. The plaintiffs won a ruling from the Federal District Court in Tucson in October 1996. Dr. Shalala appealed, saying the judge, Alfredo C. Marquez, had usurped her authority.

Last August the appellate court in San Francisco rejected the Administration's argument. Judge Charles E. Wiggins, a former Republican Congressman from California, said Medicare beneficiaries are entitled to due process because the H.M.O. decisions amount to "Government action."

H.M.O.'s are private corporations, but when they deny services to Medicare beneficiaries they are acting on behalf of the Government, the court said.

The Administration has issued rules for Medicare H.M.O.'s, but the order by Judge Marquez provides greater protection to beneficiaries. The judge's order sets tighter deadlines for H.M.O.'s to rule on appeals, and it guarantees that patients can receive urgently needed services while they pursue appeals.

Vicki Gottlich, a lawyer at the National Senior Citizens Law Center, said the court order also "goes much further than current Federal rules in requiring H.M.O.'s to explain what additional evidence you need to support your claim, and how to get that evidence."

A report on the case by Government lawyers says "the worst possible scenario" is that Dr. Shalala will appeal to the Supreme Court and the Justices will decline to accept the case for review.

Lower courts would probably view such action as "a judgment by the Supreme Court that our arguments were unpersuasive," the report said.

The New York Times

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