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Recognizing and Reinvigorating Medical Necessity

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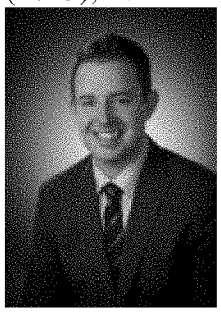
Janet L. Dolgin, *Unhealthy Determinations: Controlling Medical Necessity*, 22 **Va. J. Soc. Pol'y & L.** 435 (2015), available at SSRN.



Zack Buck

In the fight to control health care costs, the determination of whether something is "medical necessary" is of paramount importance. A clear vision of medical necessity would allow payers, regulators, and doctors to arrive at universal and understood standards regarding clinical appropriateness and appropriate reimbursement. But, even in the midst of health care reform, its importance has been lost. In *Unhealthy Determinations: Controlling Medical Necessity*, Janet Dolgin makes a contribution to the scholarship that examines the perplexing topic of medical necessity by robustly arguing for its recognition and restructuring. In the piece, Dolgin focuses on the history of the doctrine, particularly on the idea that the doctrine more likely reflects the characteristics of the American health care system and the will of any given decision-maker, than it presents an actual useable clinical definition.

The quest for understanding medical necessity depends on two separate queries—one that focuses on the *who*: which actor it is within the modern American health care regime that is the decision-maker, and, secondly, of course, the *what*: what the standard will look like in a given clinical scenario. Indeed, medical necessity can be characterized as a rationing tool employed by the insurance industry or as a flexible standard used by physicians to justify expensive and unnecessary medical care. Accordingly, one would have expected defining medical necessity to have been an object of attention—for insurance companies, who want to constrict it, doctors, who want to expand it, and federal administrators, who want to control it—in the effort to reform health care under the Affordable Care Act (ACA). But instead, according to Dolgin, the ACA leaves many of the rules that existed before its passage governing medical necessity in place.

Given multiple interested parties (including patients), the main thesis of Dolgin's piece focuses on how the doctrine of medical necessity has been historically defined and dominated by the private insurance industry. Presenting obvious conflicts of interest, Dolgin argues that the industry allows cost-cutting incentives and the profit motive to trump both medical expertise of the doctors requesting the services, and the patients' interests who would benefit from the services. Evincing a desire to vest providers with greater control over medical necessity, Dolgin pushes for more transparency and public input over a process that presently produces inconsistent and "amorphous" standards lacking in precedential power.

Dolgin's analysis focuses on what she characterizes as the damaging effects of the Employee Retirement Income Security Act (ERISA) regime, which protects insurance companies that provide employer-sponsored health plans, arguing that these companies may make medical necessity determinations in an uneven and indefensible manner without legal consequence. She astutely highlights that, even though it could have been an

effective tool, the ACA fails to define what is medically necessary, punting on an important ultimate question—and as a result, reaffirms the private insurance company as the most powerful party in American health care delivery. She does not quibble with the reliance on a so-called "medical necessity" standard or criterion, but is concerned about which party owns the ability to decide what that standard is. Finally, Dolgin's piece is strongly supportive of the independent autonomy of doctors, arguing that "physicians' medical decisions for their patients, assuming they do not contravene the terms of a patient's plan, should only rarely be denied by payers." She references other countries' health care regimes—particularly those in Canada, Germany, and Israel—that feature additional government control and public negotiation as programs to which the U.S. should aspire.

In short, Dolgin's piece is a strong rebuke of the private insurance industry, the ERISA regime, and in some ways, the ACA. Interestingly, she uses the story of medical necessity as an effective tool. As is the case in many health policy issues, the cost-containment problem in American health care, and the inability of the industry to agree on an understandable medical necessity standard, may have many causes. Dolgin rightly takes on the private, for-profit insurance companies as the chief concern in the medical necessity battles. However, the solution of rewarding physicians with power in determining what procedures are medically necessary may run the risk of overcompensating, bringing a new set of problems to American health care. Indeed, historically, American health care may owe its cost problems to *not enough* cost control by decision-makers other than physicians who are financially benefitted by increased care. Additionally, new tools imposed by the ACA—particularly the medical loss ratio (MLR) requirements that require a percentage of insurance premiums to be spent on actual care by insurance companies—are intended to blunt the private insurance companies' incentive to limit care in order to pad profits.

Of course, Dolgin may argue that the answer to standard setting doesn't then lie with an industry that is financially benefitted by *limiting* care—care that is truly needed for the health of the patient. Indeed, her piece pushes for a reexamination that features an increased public role in determining what type of health system Americans want. And with that argument, it is hard to argue.

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