OLR RESEARCH REPORT

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DEFINING MEDICAL NECESSITY

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You asked if any second circuit court cases rule on the definition of medical necessity; what definition insurers agreed to in the national settlements with providers; and, if the legislature were to codify a definition, if it would be controlling instead of the settlement definition.

SUMMARY

The Second Circuit Court of Appeals has decided numerous cases in which medical necessity is mentioned. We found only one that described what the term means in the absence of a definition in the plan document, saying "unless the contrary is specified, the term "medical necessity" must refer to what is medically necessary *for a particular patient,* and hence entails an individual assessment rather than a general determination of what works in the ordinary case."

Class action settlements between major national insurance companies and physicians include a definition of medical necessity, which is included in this report. The definition is applicable to only those insurers that are party to a settlement; thus many insurance companies are not required to use it. Each settlement includes an expiration date after which the companies are no longer bound to use the agreed upon definition.

Whether a state-enacted medical necessity definition has a controlling effect over parties subject to a medical necessity definition contained in a settlement that was approved by a federal court depends on whether there is a conflict between the two definitions. If there is a conflict

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between the definitions and, as in this case, the settlement was arrived at based on allegations of a federal law violation, then the federally-approved settlement definition controls pursuant to the U.S. Constitution's Supremacy Clause. In this instance, however, we are told that the settlements expressly permit a state-enacted term to control if it is more stringent than the settlement terms (*See*, public hearing testimony of Michael Katz, on behalf of the Connecticut Medical Society, to the Insurance and Real Estate Committee on February 22, 2007). Therefore, if a state-enacted definition is more expensive than the settlement's definition, the state law will control. But if the settlement's definition is more expansive, it will control with respect to the parties subject to the settlement.

Note that last year's raised bill HB 5460, An Act Concerning Medically Necessary Health Care Services in Managed Care Contracts, included a definition of medically necessary, which is included in this report. After a public hearing on the bill, the Insurance and Real Estate Committee took no further action on it. We have enclosed copies of the written testimony submitted at the public hearing.

SECOND CIRCUIT CASES

We performed an on-line search for Second Circuit Court of Appeals decisions that discuss the meaning of "medical necessity" or "medically necessary." We found numerous cases that, when deciding issues (e.g., whether a health care company or plan administrator violated the federal Employee Retirement Income Security Act (ERISA) or acted in an arbitrary or capricious manner in denying coverage), briefly mentioned medical necessity or its definition contained in the particular plans' documents. The court typically did not discuss the content or appropriateness of the definition.

One case went slightly further in its discussion of "medical necessity," *Mario v. P & C Food Markets, Inc.,* 313 F.3d 758, (C.A.2 N.Y., 2002) (copy enclosed). An employee sued his employer alleging that the employer unlawfully denied him health insurance coverage for gender reassignment surgeries when it determined that they were not medically necessary. In its discussion, the court points out that, "as a matter of general insurance law, the insured has the burden of proving that a benefit is covered, while the insurer has the burden of proving that an exclusion applies." Further, the court said that:

> unless the contrary is specified, the term "medical necessity" must refer to what is medically necessary *for a particular patient,* and hence entails an individual assessment rather than

> a general determination of what works in the ordinary case. But where, as here, the plan administrator presents sufficient evidence to show that a treatment is not medically necessary in the *usual* case, it is up to the patient and his or her physician to show that *this* individual patient is different from the usual in ways that make the treatment medically necessary for *him* or *her.*

NATIONAL SETTLEMENTS

Aetna, CIGNA, Health Net, Prudential, Anthem/WellPoint, and Humana entered into settlement agreements with over 900,000 physicians and state and county medical societies in the class action lawsuits consolidated as *In re Managed Care Litigation* in the U.S. District Court for the Southern District of Florida. The settlements were approved at various times between 2003 and 2006. (Other defendants-PacifiCare, United, and Coventry-did not enter into settlement agreements with the physicians.)

The lawsuits alleged that since 1990, these companies engaged in a conspiracy to improperly deny, delay, or reduce payment to physicians by engaging in several types of allegedly improper conduct, including failing to pay for "medically necessary" services in accordance with member plan documents. Under the terms of the settlement agreements, each company has agreed to accept a definition of medical necessity. The definition is generally the same for each company, as follows:

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

The Connecticut State Medical Society provided the above definition in flyers summarizing the settlements prepared by the American Medical Association (AMA) to the Insurance and Real Estate Committee at a December 1, 2006 committee meeting with physicians and managed care organizations, as required by Public Act 06-178. The flyers reflect that each company agreed to the same definition, except CIGNA, whose agreed upon definition omits the word "preventing" in the third line. Also, Health Net and Anthem/WellPoint agreed to the definition specifically for clinical conditions and mental health care, including treatment for psychiatric illness and substance abuse. The agreements with Aetna, CIGNA, and Humana did not limit the use of the term, based on the AMA's flyers.

The settlements have expiration dates that vary by company. At some point in the future, therefore, the companies will no longer be bound to follow the definition contained in the settlements.

PROPOSED STATUTORY DEFINITION

Raised bill HB 5460 (2006), An Act Concerning Medically Necessary Health Care Services in Managed Care Contracts, included the following definition of medically necessary:

> As used in a managed care contract, the term "medically necessary" means any health care service or procedure that a prudent practitioner of the healing arts, as defined in section 20-1, would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (1) in accordance with generally accepted standards of care, (2) clinically appropriate in terms of type, frequency, extent, site and duration, (3) not primarily for the convenience of the patient, and (4) within the scope of practice of such practitioner.

The committee's public hearing on HB 5460 was March 2, 2006. The Attorney General, State Healthcare Advocate, Connecticut Chiropractic Association, and Connecticut Nurses Association submitted written testimony in favor of the bill, while Anthem Blue Cross and Blue Shield, the Connecticut Association of Health Plans, and CBIA opposed the bill. The Connecticut State Medical Society supported codifying a definition of medical necessity through its testimony on another bill (HB 5189, An Act Concerning Standards in Contracts Between Physicians and Health Insurers). Copies of the testimony are included. The committee took no further action on HB 5460.

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