



## MEDICAL NECESSITY

A Symposium on Policy Issues  
Implementation Challenges  
and Tough Choices

**POLICY BRIEF**

April 28, 1995 • Washington DC

ABOUT THE AGENCY FOR HEALTH CARE  
POLICY AND RESEARCH

The Agency for Health Care Policy and Research (AHCPR) was established in December 1989 under Public Law 101-239 (Omnibus Budget Reconciliation Act of 1989). AHCPR, a part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHCPR's broad programs of research, clinical guideline development, and technology assessment bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

ABOUT THE NATIONAL INSTITUTE FOR  
HEALTH CARE MANAGEMENT

The National Institute for Health Care Management (NIHCM), established in 1993 by leading managed care companies, supports fact-based research and dissemination of effective and innovative practices in health care, especially those involving management, financing, and delivery. The Institute is also a clearinghouse for studies on health management and provides a forum for learning and building upon existing managed care expertise. These activities make it a valuable resource for government policy makers, health industry leaders, the media, and the general public.

## INTRODUCTION

Publicly-funded health programs and private plans insure medical services and treatments based on contracts, government regulations and/or laws. Nearly all of the benefit descriptions for these programs and plans only include coverage for care that is *medically necessary*.

A problem that has long concerned public- and private-sector benefits administrators is that there is no consensus about what constitutes medically necessary care—and what may be unneeded, duplicative or even harmful care for patients.

In setting the stage for a day-long symposium on medical necessity, co-sponsored by the Agency for Health Care Policy and Research and the National Institute for Health Care Management, one author observed that the term medical necessity "is rarely defined, largely unexamined, generally misunderstood and idiosyncratically applied in medical and insurance practice. It covers a wide area of ambiguity."\* This ambiguity has led to disagreements between and among the numerous parties involved, including patients, physicians, hospitals and health plans.

The issues surrounding medical necessity have been heightened by the debate over health care reform. At the heart of the issue is: Who gets what coverage and at what price? As public programs face pressures from Congress and state legislatures to cut their budgets, and as private payers seek medical services at lower cost with higher quality, disagreements over how to define and apply the term medical necessity are likely to increase.

Who should make the decisions about what is medically necessary? What standards should be used? How should they be applied? And how should conflicts be resolved in a world of limited resources and increasing demands?

These and other issues were debated at a symposium sponsored jointly by the Agency for Health Care Policy and Research (AHCPR) and the National Institute for Health Care Management (NIHCM).

Both groups—one a government agency and the other a private, nonprofit organization—promote research and analysis of issues relating to the delivery of health care.

"Medical Necessity: A Symposium on Issues, Implementation Challenges and Tough Choices," was held April 28, 1995 in Washington, DC. It was moderated by John Iglehart, editor of Health Affairs.

The symposium brought together experts from a range of professional and consumer organizations, insurance companies, practice settings, state and federal agencies and policy research institutes. The goal was to advance the medical necessity debate, to define areas for future research and to help government agencies better understand how medical necessity standards are applied by private health plans.

The symposium was divided into six panel sessions, each covering a key issue relating to medical necessity: plan design, legal issues, consumers' concerns, legislative developments, new technologies and cost-effectiveness. Original papers were presented at each session, followed by comments from a panel of experts and a question-and-answer period.

This is a summary of the discussions held at the conference. An edited version of the proceedings is available from both AHCPR and NIHCM.

*"Medical necessity is on the cutting edge of many of the health care issues that we face today. It will become more important as health care plans compete and seek to fine-tune their products and prices."*

Clifton Gaus, Sc.D., Administrator,  
Agency for Health Care Policy and  
Research

*"We will seek insights from all participants on how to bring quality health care to people at a price they can afford by more accurately defining medical necessity."*

Rogers Coleman, M.D., Chief Executive  
Officer, Blue Cross and Blue Shield of  
Texas and Board Member, National  
Institute for Health Care Management

\*Linda Bergthold, Ph.D., Vice President, Lewin-VHI, from a paper commissioned by AHCPR and NIHCM

How does medical necessity language affect health care delivery and health plan decision making?

*Presenters: John Lawrence Colley, M.D., Vice President for Medical Policy, Trigon Blue Cross Blue Shield, Virginia*

*Owen Hunt, J.D., Associate Counsel, Legal Department, Trigon Blue Cross Blue Shield*

*Reactors: Kathleen Buto, M.P.A., Associate Administrator for Policy, Health Care Financing Administration*

*Douglas Wood, M.D., Vice Chairman, Department of Medicine, Mayo Clinic*

*Raymond Werntz, J.D., Vice President for Compensation and Benefits, Whitman Corporation*

*"Given the complexities of the issue, a lot of people making decisions (about coverage in the marketplace) is a far better process than a small group of smart people deciding."*

John Lawrence Colley, M.D., Vice President for Medical Policy of Trigon Blue Cross and Blue Shield, Virginia

*"Medical necessity is the intent of those not directly involved in patient care to change medical practice. That can have a very significant impact on the physician-patient relationship."*

Douglas L. Wood, M.D., Vice Chairman for Medicine, Mayo Clinic

*"We in Medicare think about medical necessity very differently. We have to consider the appropriate level of care in deciding which services are necessary."*

Kathleen Buto, M.P.A., Associate Administrator for Policy, Health Care Financing Administration

*"The medical necessity debate is driven by the perceived need of payers to make payments for health care efficiently, predictably, rationally and humanely. We are spending more time on efficiently and predictably than we are on rationally and humanely."*

Raymond B. Werntz, J.D., Vice President for Compensation and Benefits, Whitman Corporation

Working together in integrated health systems, providers and health care plans are in a position to improve the way medical necessity decisions are made. As incentives for treatment change and as plans become financially responsible for the care of patients, they are likely to direct members to proven and cost-effective treatments and away from ones with questionable benefits.

At issue is who decides which medical services are necessary and what processes are used to make these decisions. Medical research could be hindered by limits on health plans' ability and willingness to cover certain types of care. Some critics charge the controversy surrounding medical necessity arises from a society focusing too much on cost and not enough on the health of people. The focus of health care, they argue, should be healing, not cost-effectiveness. Others say that if costs were controlled, more people could afford health care and thus more healing could actually take place.

The use of practice guidelines for both clinical decision making and payer coverage can resolve some of the uncertainties concerning medical necessity. Practice protocols and standards are already being established by managed care systems and other health plans. They are, however, used more for developing provider consensus about good principles of care than resolving individual coverage claims.

Historically, medical necessity was used to protect patients from quackery and other services not recognized by the medical community. More recently, the focus of medical necessity has turned to providing a tool to balance the cost and quality of patient care that is proven and effective. With increasingly constrained resources, large employers, government payers and others are demanding value for money.

Current definitions of medical necessity are ambiguous and subject to varying interpretations. Health plans need clearly defined criteria for making decisions concerning the medical necessity of a procedure or treatment. Both criteria and well-developed decision-making processes can help assure that coverage decisions are not attacked as arbitrary.

## LEGAL PERSPECTIVE

How have the courts approached medical necessity?

*Presenter: William Sage, M.D., J.D., Associate, O'Melveny and Myers*

*Reactors: Lyle Swallow, J.D., Associate Vice President for Legal Services, HealthNet*

*Gerard Anderson, Ph.D., Director, Center for Hospital Finance and Management, Johns Hopkins University*

*Elizabeth Webr, J.D., Research Scientist, George Washington University Center on Health Policy*

Courts have been defining medical necessity by default for years. Earlier cases often dealt with coverage of fringe therapies or medical care not delivered in the traditional way. With the development of medical technologies in the 1960s, coverage disputes began to arise that dealt with new and expensive treatments coming from mainstream medicine. These cases presented a more difficult challenge for health plans and, ultimately, the courts. The increased reliance on the courts to resolve coverage issues raises questions concerning their lack of technical background with which to make complex medical decisions.

Lawsuits over medical necessity often pit providers against payers, and payers against patients. In such cases, the relationship becomes one of conflict rather than cooperation. Americans take naturally to an adversarial relationship. The movement to managed care, which presupposes a tension between the delivery of care and cost, may exacerbate this tendency towards conflict.

Under managed care, more plaintiffs are likely to bring a greater number and variety of suits, in part as an outlet for dissatisfaction with certain features of the system. It is expected that there will be more suits challenging coverage decisions relating to restrictions on providers, delays in receiving care and denials for authorization of care. This increased litigation will highlight the importance of coverage decision-making procedures within managed care plans.

Courts tend to make fact-specific decisions that are not generalizable. Because of this, court decisions should not be interpreted as a broad statement of law.

In fact, courts rarely attempt to decide law relating to coverage decisions. This is why many people believe that the courts are the wrong place to review these cases of medical necessity.

A better approach to resolving disputes about medical necessity is to hear them in a quasi-legal forum before they reach the judicial system. The forum would consist of a panel of neutral experts on the science and the decision on medical matters would be binding. That would let the courts review the process for deciding medical necessity, which is more appropriate for the legal system than adjudicating substantive medical issues. It is not fair to ask judges and juries to make medical decisions.

To analyze patterns of who usually wins in court and under what circumstances, Gerard Anderson of Johns Hopkins University and Mark Hall of Wake Forest University studied a comprehensive list of medical necessity law cases filed between 1960 and 1995. Their research showed that patients won about 60 percent of the time and insurers 40 percent. Patients were less likely to win if the contract gave the insurer discretion in deciding medical necessity, if the exclusion was explicit and if the case was heard in a federal court. Patients were more likely to prevail if they were 65 years or older or if a death or serious injury occurred.

For insurers, judicial decisions involving medical necessity cases represent a moving target. Insurance companies and health plans may make a coverage decision in response to one court ruling, only to be criticized by another court for not doing enough or not doing something else.

*"Americans take naturally to an adversarial way of decision making. Before we back ourselves into an adversarial system, we should ask ourselves if that is what we really want."*

William M. Sage, M.D., J.D., Associate, O'Melveny and Myers

*"Expecting judges and juries to decide medical necessity issues is wrong. The adversarial approach is the wrong model. We have to go someplace else to resolve issues and decide definitions."*

Lyle S. Swallow, J.D., Associate Vice President for Legal Services, HealthNet

*"The courts are structured to decide individual cases. If we want to decide on an aggregate basis, we have to take decisions out of the courts."*

Gerard Anderson, Ph.D., Director, Center for Hospital Finance and Management, Johns Hopkins University

---

## CONSUMERS' PERSPECTIVE

How can we empower consumers in decisions about medical necessity?

*Presenter: Shoshanna Sofaer, Dr.P.H., Associate Chair for Research, Department of Health Care Services, George Washington University*

*Reactors: Kathleen Cota, R.N., J.D., Director, Minnesota Department of Human Services*

*Richard H. Christenson, M.D., Corporate Medical Director, United Wisconsin Services, Inc.*

*Laurence Lavin, J.D., Director, National Health Law Program*

*"Medical necessity is the small print in which what was promised is taken away."*

Shoshanna Sofaer, Dr.P.H., Associate Chair for Research, Department of Health Care Sciences, George Washington University

*"Unlimited demands are driven by the concept of hope. We tend to idolatryze the concept in the United States.*

*Preserving hope for an individual is not always honest, productive for society or cost-effective."*

Richard Christenson, M.D., Corporate Medical Director, United Wisconsin Services, Inc.

Judgments about coverage involve physicians, health plan administrators and other experts. What role, then, do consumers play, with their more limited technical expertise?

Consumers traditionally play two distinct roles in health care. First, when they make a decision to join a health plan, they act in their role as economic activists.

Second, when they get sick, they act in a patient role. In this role, they are not worried about what premiums they pay, but rather what care they are going to get.

Patients are believed to—or at least sometimes appear to—want unlimited health care services, and for some, proof of medical necessity is immaterial. Behind this quest for care at any cost—even when it is not beneficial or is potentially harmful—is an expectation of receiving all possible treatments because they purchased that right through premium payments. Such an expectation, of course, is neither universally achievable nor cost-effective.

In spite of these perceived consumer demands, some experts are concerned that current economic incentives may actually favor the underuse of medical services rather than their overuse. There is a related concern that providers do not tell consumers about all the treatment options, especially when some of those options are not covered by their plan. As a result, there is a growing feeling that consumers can no longer believe their physician is always acting in their best interest. This feeling holds true for participants of both fee-for-service and managed care plans.

One of the impediments to strong consumer involvement in making medical decisions is that many consumers do not understand the concept of medical necessity and how it may limit services that are covered by their insurance or health care plan. Having access to more independent and credible sources of information about health care plans could help them make well-balanced choices. However, quality information that is specifically developed for consumers is still limited, particularly as it relates to treatment options and the potential risks and benefits of those treatments.

Another stumbling block is that employers have traditionally acted unilaterally to purchase health insurance on behalf of their employees, usually in the spirit of corporate paternalism. This relationship is changing, however, and employers are increasingly involving employees not only in selecting health plans but also helping design the benefits the company includes in the plans, and in consumer satisfaction surveys.

One change that will help consumers and health plans alike is the development of a formal appeals process for coverage decisions. Some managed care plans have an in-house appeals process where almost all coverage issues are solved on a one-to-one basis. In the long run, consumers are better served by this approach.

## LEGISLATIVE PERSPECTIVE

What are the legislative perspectives on medical necessity?

*Presenters: Susan Foote, J.D., Partner, Dorsey and Whitney*

*Karen Hein, M.D., Executive Officer, Institute of Medicine, National Academy of Sciences*

*Reactors: Chadran Cheriell, Ph.D., Director, Oregon Office of Health Policy*

*Linda Bergthold, Ph.D., Vice President, Lewin-VHI*

The health care reform debate that took place in the 103rd Congress—especially as it related to structuring provisions about medical necessity—was really a debate about of the role of government. A national health board that would be given authority to develop criteria and decide coverage was the choice of those who see the government as a problem solver. Others were suspicious of any government-backed solution. In the middle were those favoring government interventions that supported market-based incentives—for example, developing a government-defined process by which plans would make their own coverage decisions.

Even though there was no final consensus about health care reform, much was accomplished during the debate in setting the groundwork for subsequent discussions. Legislation that specified a benefits package was successfully drafted and passed through several committees. In addition, a foundation was laid for a national board that makes coverage decisions for existing and emerging medical procedures. Left unresolved was whether the national board should operate as a federal regulatory agency or independent federal agency.

Much also can be learned from the Oregon experience, where the state government set up a process that ranks health care services from the most to least beneficial and then decides the total benefits package based on available resources. Economic forces—not political forces—were the ones that eventually shaped the program. Ultimately, decision makers looked to medical experts and the community-at-large to develop the program, rather than have a central board be the final arbiter on what is medically necessary.

According to legislative analysts who participated in the health care reform debate, perhaps the centralized, political process is not ready to move forward on this issue. One short-term solution is to move the debate to the marketplace where health plans and other participants could come to some consensus about coverage.

*"The legislative process is a political process. That's the nature of Congress. I am skeptical that any {government} bureaucratic process would be any less political than the legislative one."*

Susan Bartlett Foote, J.D., Partner, Dorsey and Whitney, and previously Senior Legislative Assistant to former Sen. Dave Durenburger (R-Minn.)

*"This debate is very central to what will happen, not just what did happen. It's an example of how we tried in Congress to resolve a societal ambivalence, something that society had really not yet come to grips with."*

Karen Hein, M.D., Executive Officer, Institute of Medicine, National Academy of Sciences and former Staff Assistant, Senate Committee on Finance

*"The role of the federal government is to set standards and provide information while encouraging private health plans to be flexible on medical necessity. Society needs a way to define medical necessity that is not imposed by the federal government."*

Linda Bergthold, Ph.D.,  
Vice President, Lewin-VHI

## NEW TECHNOLOGY PERSPECTIVE

**When and how should investigational treatments be a covered benefit?**

*Presenters: Earl Steinberg, M.D., Vice President, Health Technology Associates*

*Sean Tunis, M.D., Health Program Manager, Office of Technology Assessment, U.S. Congress*

*David Shaprio, M.D., J.D., Assistant Clinical Professor of Medicine, University of California, San Francisco*

*Reactors: Clifton Gaus, Sc.D., Administrator, Agency for Health Care Policy and Research*

*Nelda Wray, M.D., M.P.H., Director, Center for Quality Evaluation, Baylor College of Medicine, and a Robert Wood Johnson Congressional Fellow in the office of Sen. Robert Dole (R-Kan.)*

*"A wide range of policies currently deal, one way or another, with coverage for experimental technologies. HCFA has begun to provide experimental coverage on a provisional basis, meaning that there is some restriction on it and there is some quid pro quo."*

Earl Steinberg, M.D., Vice President,  
Health Technology Associates

*"Some national body may be needed to decide when an experimental technology is promising enough for insurers to cover patients enrolled in clinical trials."*

Sean Tunis, M.D., Health Program  
Manager, Office of Technology  
Assessment, U.S. Congress

*"There is no political will for a centralized way to define medical necessity in a way that can ensure {appropriate} coverage of experimental technologies. Such decisions will likely be played out locally."*

Clifton Gaus, Sc.D., Administrator,  
Agency for Health Care Policy and  
Research

*"The pertinent ethical question is not whether I want access to research, but whether the advancement of medical knowledge is a common good. If it is a common good, we should all pay for it."*

Nelda P. Wray, M.D., M.P.H., Director of  
the Center for Quality Evaluation at  
Baylor College of Medicine, and a Robert  
Wood Johnson Congressional Fellow in  
the office of Sen. Robert Dole (R-Kan.)

Experimental technologies are typically defined as ones still under investigation or not in widespread use. Such definitions are believed to be far too stringent and unsatisfactory. Some technologies are under investigation after their benefits have been well-established, and others that have been proven safe and efficacious are not widely used. An alternative definition for experimental technologies is those whose benefits and risks are not yet fully known.

There are several issues associated with making an experimental technology a covered benefit. The public is fascinated by the promise of new medical technology to diagnose and/or treat medical conditions. By providing health plan coverage of experi-

mental technologies, Americans can have access to promising new procedures that they otherwise might not have. Covering experimental technologies also would promote their early use and encourage innovation.

At the same time, there are concerns about patient safety involved in utilizing an unproven technique and the cost of health care—a cost driven up in part by new technology. One question often raised is: How much data should be available before a new procedure is covered?

Currently, experimental treatments are covered on an ad hoc basis, if at all. Medicare has traditionally not covered such technologies, but is now beginning to provide coverage on a provisional basis. To provide a more standardized way of thinking about coverage of experimental treatments, one proposal presented by technology assessment experts is to cover the cost of standard care when the device or services clearly substitute for an approved one and the experimental technology is being evaluated in a clinical study. Another approach is to cover technologies used for life-threatening and severely disabling diseases where no adequate alternative therapy is available and where there is some evidence suggesting that there might be substantial clinical benefit to using the new technology.

A better science base needs to be developed before new technologies become widely diffused. For example, there are relatively few studies on the effects of new technologies on children, pregnant women and other special groups. Similarly, ineffective and harmful procedures that are already being covered need to be aggressively reviewed, using the same criteria developed for new technologies.

Looking ahead, some national body may be needed to decide when experimental technologies are promising enough for insurers to cover, or at least to decide under what circumstances insurers should cover patients enrolled in clinical trials. In a public-private partnership, the government could convene and facilitate a process that would protect both public and private health plans that provide coverage for select emerging technologies.

## COST-EFFECTIVENESS PERSPECTIVE

How should health plans and public programs treat cost-effectiveness in medical necessity determinations?

*Presenter: David Eddy, M.D., Ph.D., Professor of Health Policy and Management, Duke University and Senior Advisor for Health Policy and Management, Southern California Kaiser Permanente*

*Reactors: Judy Wagner, Ph.D., Senior Associate, Office of Technology Assessment, U.S. Congress*

*Robert Valdez, Ph.D., Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services*

*David Gollaber, Ph.D., President and Chief Executive Officer, California Health Care Institute*

The language that has been used to define what comprises medically necessary benefits has lost much of its usefulness for health plans. It is too vague and is subject to too many interpretations. Health plans need new language that clearly and concisely describes what criteria are used in coverage decisions.

To advance public discussion of this issue, five criteria for coverage were developed by David Eddy of Duke University and Southern California Kaiser Permanente as well as a group of medical directors and legal counsel from the National Institute for Health Care Management who participated in a workshop in Boulder, Colorado in 1994. The workshop participants established these criteria to help eliminate ambiguity in current language and articulate exactly what is covered in a health plan's contract. Health care plans would be required to cover interventions listed in the criteria, but would be free to cover others as well.

Under the criteria, health plans would be required to cover medical interventions if each of the following conditions were met:

- The intervention is used to treat a condition;
- Sufficient evidence exists to draw conclusions about its health outcomes;
- The evidence demonstrates that the intervention can be expected to produce its intended effects;
- The expected benefits outweigh expected harmful results; and
- The intervention is the most cost-effective method available to address the medical condition.

By design, these criteria do not mention medical necessity, medical appropriateness, investigative therapies or other terms that are usually used in coverage determination. According to the developers of the criteria, the most important is the last—the one dealing with cost-effectiveness. The cost-effectiveness criterion provides a sound basis for the rationing of health care services that currently is done in an arbitrary, inconsistent and sometimes harmful way.

The proposed criteria, however, may raise as many questions as they resolve. Is the marketplace ready to accept cost-effectiveness as an explicit criterion for coverage? Is the technology of cost-effectiveness analysis sufficiently well developed to serve as a science-based guide to coverage decisions? Is the public ready to put a dollar value on human life? These are among the issues that must be addressed as health plans struggle to make coverage decisions about both existing and emerging medical interventions.

*"Unfortunately, right now the methods we are using to ration are arbitrary, inconsistent, unsuccessful, and harmful. That is because until now we have forbidden ourselves from considering costs explicitly, and if you cannot consider costs, there is no way to find the proper balance between quality and cost."*

David Eddy, M.D., Ph.D., Professor of Health Policy and Management, Duke University and Senior Advisor for Health Policy and Management, Southern California Kaiser Permanente

*"I'm not sure consumers will enter a plan when coverage decisions will be governed by cost. Are we ready to place an explicit value on life or additional years of life? That is a noble but dangerous concept."*

Judith Wagner, Ph.D., Senior Associate, Office of Technology Assessment, U.S. Congress

*"I'm skeptical that cost-effectiveness data could be translated into better decisions. Data are not neutral in a political context or where vested economic and clinical interests play key roles."*

David Gollaber, Ph.D., President and Chief Executive Officer, California Health Care Institute

*"We may abandon the medical necessity terminology, but we will still have to take cost considerations into account. We have to be flexible in recognizing ambiguity in medicine and health care."*

Robert Valdez, Ph.D., Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services

---

## A FINAL PERSPECTIVE

What lessons have been learned for future actions?

*Presenters: John Iglehart, Editor, Health Affairs and Conference Moderator*

*Clifton Gaus, Sc.D., Administrator, Agency for Health Care Policy and Research*

*Rogers Coleman, M.D., Chief Executive Officer, Blue Cross Blue Shield of Texas and Board Member, National Institute for Health Care Management*

*"We talk about the cost of coverage in almost a pejorative way. There is a growing number of folks who have no coverage because we spend so much on the covered population. I hope we can all leave with a little sensitivity that while we explore concerns about explicit rationing, our system implicitly rations all the time."*

Rogers Coleman, M.D., Chief Executive Officer, Blue Cross Blue Shield of Texas and Board Member, National Institute for Health Care Management

What does the future hold for resolving the many questions surrounding the medical necessity issue? Perhaps the question should be: Do we need new medical necessity language to make health plan coverage decisions?

After all the arguments, there are compelling reasons to develop new language and new criteria for making health care coverage decisions. The health care system has moved away from the traditional

insurance model for which medical necessity policies were devised and toward a system of coordinated models of care. What is needed is a new way of thinking about covered benefits that reflects the economic incentives in today's marketplace.

While there are numerous medical, ethical, economic and personal issues related to the concept of medical necessity that remain unresolved, leaders in the government and the private sector are collaboratively discussing these concerns in a far more thoughtful way than in the past. Better organized and financed private and public sector partnerships are needed to address these issues. As a result, new terms, new concepts and a more equitable approach to coverage are likely to emerge.

## APPENDICES

## APPENDIX A • AGENDA

7:30-8:30 a.m.

### REGISTRATION/CONTINENTAL BREAKFAST

8:30-8:45 a.m.

### WELCOME/CONTEXT SETTING

Clifton R. Gaus, Sc.D., Administrator, Agency for Health Care Policy and Research

Rogers K. Coleman, M.D., CEO, Blue Cross and Blue Shield of Texas and Board Member, National Institute for Health Care Management

8:45-9:00 a.m.

### OVERVIEW

Conference Moderator: John K. Iglehart, National Correspondent, *The New England Journal of Medicine* and Editor, *Health Affairs*

9:00-10:00 a.m.

### SESSION ONE: HEALTH PLAN PERSPECTIVE

**"At a crossroads: medical necessity decisions and the delivery of health care"**

John Lawrence Colley, M.D., Vice President, Medical Policy, Trigon Blue Cross Blue Shield

Owen Hunt, J.D., Associate Counsel, Legal Department, Trigon Blue Cross Blue Shield

How medical necessity decisions by health plans reflect benefits design, medical decision making and fiduciary responsibilities

#### *Reactors*

Kathleen A. Buto, M.P.A., Associate Administrator for Policy, Health Care Financing Administration

Douglas L. Wood, M.D., Vice-Chair, Department of Internal Medicine, Mayo Clinic

Raymond B. Wertz, J.D., Vice President, Compensation and Benefits, Whitman Corporation

10:00-11:00 a.m.

### SESSION TWO: LEGAL PERSPECTIVE

**"Courts, coverage and managed care: do we really want an adversarial health care system?"**

William M. Sage, M.D., J.D., Associate, O'Melveny & Myers

Legal basis for current state of court decisions on medical necessity and recommendations for improving dispute resolution and appeals processes

#### *Reactors*

Lyle S. Swallow, J.D., Associate Vice President, Legal Services, Health Net

Gerard F. Anderson, Ph.D., Director, Center for Hospital Finance & Management, Johns Hopkins Medical Institutions

Elizabeth Wehr, J.D., Research Scientist, Center on Health Policy, George Washington University

11:00-11:15 a.m.

### BREAK

11:15 a.m.-12:15 p.m.

### SESSION THREE: CONSUMER PERSPECTIVE

**"How can we empower consumers in decisions about medical necessity?"**

Shoshanna Sofaer, Dr.P.H., Associate Chair for Research, Department of Health Care Sciences, George Washington University Medical Center

Issues in promoting consumer involvement in medical necessity decision making and in protecting vulnerable populations

#### *Reactors*

Kathleen Cota R.N., J.D., Director of Benefit Care Services, Minnesota Department of Human Services

Richard H. Christenson, M.D., Corporate Medical Director, United Wisconsin Services, Inc.

Laurence Lavin, J.D., Director, National Health Law Program

12:15-1:15 p.m.

LUNCH

1:15-2:30 p.m.

SESSION FOUR: LEGISLATIVE PERSPECTIVE

**"Legislative perspectives on medical necessity"**

Susan Bartlett Foote, J.D., Partner, Dorsey & Whitney; formerly senior health policy analyst, Office of Senator Durenburger

Karen Hein, M.D., Executive Officer, Institute of Medicine, formerly senior staff member, Senate Finance Committee

Discussion of how federal and state policy makers have dealt with medical necessity language

*Reactors*

Chad Cheriell, Ph.D., Director, Oregon Office of Health Policy

Linda Bergthold, Ph.D., Vice President, Lewin-VHI

2:30-3:30 p.m.

SESSION FIVE:

**"When and how should investigational treatments be a covered benefit?"**

Earl P. Steinberg, M.D., M.P.P., Vice President, Health Technology Associates, Inc.

Sean Tunis, M.D., M.Sc., Director of Health Programs, Congressional Office of Technology Assessment

David W. Shapiro M.D., J.D., Assistant Clinical Professor, University of California, San Francisco

Whether and when should investigational treatments be a covered benefit? What types of experimental trials or types of services should be covered?

*Reactors*

Clifton R. Gaus, Sc.D., Administrator, Agency for Health Care Policy and Research

Nelda P. Wray, M.D., M.P.H. Robert Wood Johnson Fellow, Office of Sen. Robert Dole; Chief of General Medicine, Baylor College

3:30-3:45 p.m.

BREAK

3:45 - 4:45 p.m.

SESSION SIX:

**"How should health plans and public programs treat cost effectiveness in medical necessity determinations?"**

David M. Eddy, M.D., Ph.D., Duke University and Senior Advisor for Health Policy and Management, Southern California Kaiser Permanente

Discussion of issues raised including cost-effectiveness in benefits coverage decisions

*Reactors*

Judith Wagner, Ph.D., Senior Associate, Health Programs, Congressional Office of Technology Assessment

Robert O. Valdez, Ph.D., Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services

David Gollaher, Ph.D., President and CEO, California Health Care Institute

4:45-5:30 p.m.

WRAP-UP SESSION:

**"Lessons learned and future actions"**

John K. Iglehart, Conference Moderator

Clifton R. Gaus, Sc.D., Administrator, Agency for Health Care Policy and Research

Rogers K. Coleman, M.D., CEO, Blue Cross and Blue Shield of Texas and Board Member, National Institute for Health Care Management

Summary of the major issues and research questions and discussion of their implications for health plans, communities, consumers, practitioners, government policy makers and health services researchers

5:30-6:30 p.m.

COCKTAILS

6:30-8:00 p.m.

DINNER

APPENDIX B • ORGANIZATIONS REPRESENTED  
IN WASHINGTON DC AT THE CONFERENCE

Aetna Health Plans  
Agency for Health Care Policy and Research  
American Academy of Pediatrics  
American Hospital Association  
Arkansas Blue Cross Blue Shield  
Baylor University College of Medicine  
Blue Cross Blue Shield of Georgia  
Blue Cross Blue Shield of Texas  
Blue Cross of California  
Blue Cross of Western Pennsylvania  
Boston University School of Public Health  
California Health Care Institute  
Cedars-Sinai Medical Center  
CIGNA HealthCare  
Columbia University Medical College  
Congressional Office of Technology Assessment  
Dalhousie Law School  
Davis, Wright, Tremaine  
Dean Medical Center  
Dorsey & Whitney  
Duke University  
George Washington University  
Georgetown University  
Government Accounting Office  
Group Health Association of America  
Group Health Cooperative of Puget Sound  
Health Care Financing Administration  
Health Net  
Health Partners  
Health Resources and Services Administration  
Health Technology Associates, Inc.  
Hogan & Hartson  
Humana, Inc.  
Institute for Health Policy Solutions  
National Academy of Sciences  
Johns Hopkins Medical Institutions  
Katten, Muchin & Zavis  
Lewin-VHI, Inc.  
Maine Medical Assessment  
Managed Risk Medical Insurance Program  
Mayo Clinic  
Medtronic, Inc.  
MetraHealth  
Midwest Business Group on Health  
Minnesota Department of Human Services  
National Association of Insurance Commissioners  
National Health Law Program  
Nationwide Insurance  
National Institute for Health Care Management  
O'Melveny & Myers  
Office of Senator Robert Dole  
Office of Personnel Management  
PacifiCare of California, Inc.  
RAND  
State of Hawaii Department of Health  
State of Oregon Office of Health Policy  
Technology Evaluation Center  
The New England Journal of Medicine  
The Permanente Medical Group  
Trigon Blue Cross Blue Shield  
U.S. Department of Health & Human Services  
United Wisconsin Services, Inc.  
University of California  
Urban Institute  
Wake Forest University  
Washington Business Group on Health  
Washington Health Care Authority  
Washington Health Services  
Whitman Corporation  
XEROX Corporation  
Yale Medical School

AHCPR • NIHCM



NIHCM



NIHCM  
1818 N STREET, NW  
SUITE 300  
WASHINGTON, DC 20036

AHCPR  
2101 E. JEFFERSON STREET  
ROCKVILLE, MD 20852