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A Response to Rules of Medical Necessity

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ABSTRACT: Professors Monahan and Schwarcz's recent Article in the Iowa Law Review, Rules of Medical Necessity, *is a must-read for multiple audiences. In this short Response, I informally describe health insurance, and—using that perspective—describe and comment on why* Rules of Medical Necessity *is a piece of work that not only deserves attention from experts in the field, but is also one that casual readers should choose first when attempting to understand how health insurance works in theory and practice.*

INTRODUCTION

When I was asked by the *Iowa Law Review* to write a Response to Amy Monahan and Daniel Schwarcz's fabulous Article, *Rules of Medical Necessity* ("RMN"),[1] I agreed without hesitation. As someone who writes frequently about private health insurance and health benefits, for me to say that *RMN* is quality work would be an embarrassing understatement: It is fantastic and groundbreaking work. And that is entirely consistent with what Monahan and Schwarcz routinely produce, both when writing together and when writing separately. I would go so far as to say that, *solely* by reading selected works that

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1. *See generally* Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. 423 (2022) (analyzing the evolution of the medical necessity promise).

these two have produced over the last fifteen years, one could get a complete and lucid picture of the state of health insurance in the United States.[2]

In this short Response, I will do three things: Part I will offer a brief, informal account of insurance generally and health insurance specifically, to help set the stage for *RMN*. Part II will summarize and comment on, in part, the work *RMN* does. I will conclude by offering some brief closing thoughts about this Response and *RMN*.

I. THINKING ABOUT PRIVATE HEALTH INSURANCE

Private insurance is a funny thing.[3] It is so prevalent in modern America and yet some of its core realities are often underappreciated by those using, commenting on, or regulating it. I will begin with two inescapable such truths about insurance: (1) that it is a risk contract; and (2) that it involves mutual advantage.

Risk contract. Reality number one is that private insurance is a risk contract.[4] A risk contract is when one party (the insured) wishes to transfer risk and pays money to the other party (the insurer) to bear it.[5] For the contract to make sense, it must define the covered loss and the payout in the event of the covered loss. That, after all, is the core deal; i.e., what the insured is "buying" with her premium and what the insurer is "selling" in return for the premium.

Mutual advantage. Reality number two is that private insurance exists *because* it offers mutual advantage to the parties. Presumably, the insurer entered the deal because it preferred (1) having the premium and the risk to

2. By way of example and not limitation, I commend to the reader's attention Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777 (2006) (considering the benefits and shortcomings of health savings accounts); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125 (2011) (examining the risk that the Affordable Care Act will incentivize employers to disparately treat low-risk and high-risk employees); Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935 (2013) (examining how the Affordable Care Act treats small-group insurance and considering potential reforms); Daniel Schwarz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263 (2011) (analyzing homeowners insurance policies across insurance carriers); Amy B. Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139 (2012) (examining the role of the federal and state governments in determining the meaning of "essential health benefits"); Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394 (2014) (analyzing flaws in the transparency of the insurance regulatory system); Amy B. Monahan, *The Regulatory Failure to Define Essential Health Benefits*, 44 AM. J.L. & MED. 529, 530 (2018) (analyzing the consequences of undefined "essential health benefits" in the Affordable Care Act); and Anya E.R. Prince & Daniel Schwarcz, *Proxy Discrimination in the Age of Artificial Intelligence and Big Data*, 105 IOWA L. REV. 1257 (2020) (analyzing proxy discrimination by artificial intelligence).

3. One may object that literally nothing about health insurance, or about how I am going to explain it, is funny. One would be right. I am using the term "funny thing" in a colloquial way, namely, to note how a certain phenomenon has ironic qualities. I include this footnote to ensure that all readers know I am 100% committed to being pedantic.

4. *See, e.g.*, Brendan S. Maher, *The Private Option*, 2020 MICH. ST. L. REV. 1043, 1053 (2020) (explaining the health insurance bargain regarding risk).

5. 44 C.J.S. INSURANCE § 421 (2022).

(2) not carrying the risk and not having the premium. Likewise for the insured: She prefers (1) not having the risk and the premium to (2) carrying the risk and keeping the premium. The accepted reason that insurance makes both parties better off is risk-aversion.[6] In simple terms, the insured prefers little losses (the premium payments) to big ones, while the insurer is indifferent to the size of the losses and cares only about the expected value of the insurance deal: That is, the insurer expects that, on average, its insurance policies will yield more revenue (in terms of premiums plus investment returns) than losses (in terms of payouts and administrative costs). If legal rules make it such that insurance is no longer mutually advantageous, then in the long run people either won't sell it or won't buy it, and any set of social benefits one hopes to secure via the use of private insurance will evaporate.

Health insurance. The above applies to all types of insurance, including health insurance. But health insurance involves an additional twist. Like all insurance policies, health insurance is a risk contract with a core deal. However, its core deal is different—and more complicated—than the core deal in many other types of insurance policies. Let us consider two non-health insurance examples first.

Consider life insurance. Whatever poets and playwrights may have said about the impossibility of valuing a human life, a life insurance policy does exactly that, and it does so precisely. It is a very simple contract. If you die during the term of the policy, the insurance company pays your beneficiaries a fixed amount.[7] The loss condition—your death—is easily ascertainable, and the payout amount was fixed by contract in advance. Certainly, there are complications. Suicide—for the reason you might think—is explicitly not covered.[8] Regulation exists to ensure that opportunistic sellers do not prey on vulnerable populations by selling policies using unfair practices or improper inducements.[9] But the core deal is fairly simple and transparent.

Now consider a somewhat more complicated insurance deal: homeowners insurance. Homeowners insurance is a risk contract that covers certain types of damage to the policyholder's home and possessions.[10] Unlike life insurance, frequent challenges can arise with respect to the scope of coverage and the payout. Regarding scope, some things are generally covered, (such as fire damage),[11] while other things are generally not covered, (such

6. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 959–60 (1963).

7. 1 FRANKLIN L. BEST, JR., LIFE & HEALTH INSURANCE LAW § 3:1 (2d ed. 2022).

8. 46 C.J.S. INSURANCE § 1434 (explaining suicide exclusions).

9. *See, e.g.*, TEX. INS. CODE ANN. § 541.052 (West 2022) (false and misleading statements banned); *id.* at § 541.056 (improper inducements banned).

10. Steven Plitt, Daniel Maldonado, Joshua D. Rogers & Jordan R. Plitt, 1 COUCH ON INS. § 1:56 (3d ed. 2022) (describing homeowners' insurance).

11. *See* 34 AM. JUR. 3D PROOF OF FACTS § 291 (noting coverage of fire damage in homeowners policies). Fire loss coverage is frequently limited by an intentional loss exclusion (such as arson). *Id.* That is functionally analogous to the suicide exclusion in life insurance policies.

as flood damage),[12] and still other things are *sometimes* covered, such as plumbing damage.[13] Determining whether a particular loss is attributable to a covered cause is much harder in the homeowners setting than in the life insurance setting. Also harder is determining the payout. Often—but not always—homeowners policies promise to provide the homeowner with the "replacement cost" of the damaged thing.[14] Figuring out the replacement cost of a damaged home or lost or damaged possessions can be a challenge—even for disinterested arbiters—and that is before digging into the specific idiosyncrasies of any particular policy. In any event, the point is that the core deal is more complicated and opaque than that of life insurance.

Now consider health insurance. What core deal does it consist of? It is a risk contract that covers the cost of treatment for illnesses suffered by the insured.[15] Figuring out whether someone is ill seems easy enough at first glance—e.g., when someone has a broken leg. However, illness assessment is vastly more complicated than figuring out if someone is dead and somewhat more complicated than figuring out if a house is damaged. In part, that is because some conditions are mental—and thus have no telltale physical symptoms—while other conditions are latent and cannot be discovered without costly testing. The latter is sometimes true in the homeowner case, but insureds generally care more about latent health problems than latent house problems, because sometimes no amount of money can fix a latent health problem that has gone untreated. That, in part, is why people get routine check-ups for their bodies but not for their houses. Moreover, even once it is clear that something is "wrong" with a person (as compared to a fully healthy person)—e.g., a leg doesn't work, a person cannot get to sleep at night many days in a row, a mass is discovered—only a highly-trained observer (a doctor) can diagnose the problem with the level of detail required to know what the possible "fixes" (treatments) are.[16] That final part is the most complicated of the entire deal still, because what it means to *successfully* "fix" a human being is no simple matter.

Before thinking about how a contract may specify what it means to successfully "fix" an insured, let us pause to consider what we think successful medical care should generally look like, before considering the insurance complication. First, the doctor must be able to distinguish between those

12. *See, e.g.*, Bradley v. Allstate Ins. Co., 620 F.3d 509, 515 (5th Cir. 2010) ("Like many homeowners policies, the Bradleys' homeowners policy specifically excluded flood damage."); Leonard v. Nationwide Mut. Ins. Co., 438 F. Supp. 2d 684, 691 (S.D. Miss. 2006) (acknowledging that standard homeowners policies do not cover flood damage).

13. *See, e.g.*, Peterson v. State Farm Lloyds, 242 F. Supp. 3d 557, 560 (W.D. Tex. 2017) (involving policy where plumbing damage is excluded).

14. *See generally* Johnny Parker, *Replacement Cost Coverage: A Legal Primer*, 34 WAKE FOREST L. REV. 295 (1999) (discussing the legal implications that result from insurance companies' replacement cost policies).

15. *See, e.g.*, Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 461 (2010) (describing health insurance deal).

16. *See* Maher, *supra* note 4, at 1061 (explaining the necessary role of physicians in insured care).

treatments that are worthless—or harmful—and those treatments that do *something* positive: He must be able to distinguish between "waste" and "clinical effectiveness."[17] The former, after all, won't fix anything.

Second, the doctor should be able to distinguish between treatment options that do lesser and greater amounts of good: For example, he should know that Treatment A is better than nothing because it causes a fifty percent improvement in functionality of the damaged joint, whereas Treatment B is better than Treatment A because it causes a ninety percent improvement in functionality. The latter is a comparatively better fix than the former.

Third, the doctor should be able to articulate the difference between treatments where it is not clear which treatment is "better" because, for example, Treatment A improves functionality by eighty percent but has no risk of side effects, whereas Treatment B improves functionality by ninety percent but has a mild risk of side effects. Which of those treatments is a better "fix" presumptively depends on the view and choice of the patient, assuming the doctor has adequately explained to him the options.

Finally, the doctor—or another provider the doctor identifies—should be able to perform the treatments, whether through surgery, therapy, monitoring a pharmaceutical regime, etc.

Back now to health insurance. Because health insurance is a risk contract whose core deal is paying for treatments that will "fix" an insured's illness, insureds are going to begin with the expectation that insured care looks something like the ideal provision of medical care we considered above: i.e., a doctor recommending and competently performing only the most clinically effective treatments, including by explaining how—when medical science so justifies—a number of different treatments, given their efficacy and side effect profiles, could be a reasonably effective "fix" depending on the patient's preferences.[18] Health insurance policies that offer a core deal meaningfully different from that are presumably going to have a hard time attracting customers in the long run. Conversely, policies that promise care without some conceptual limitation will consume infinite resources and not be offered by any insurer who hopes to stay solvent.

Roughly a marriage of those two notions—of the insured-side and insurer-side expectation—is what health insurance promises. Specifically, the fulcrum of all health insurance promises in the United States is that the insured pays premiums in return for "medically necessary" care should the insured fall ill.[19] That concise term of art—"medically necessary" and its synonymous variant "medical necessity"—is useful in both describing and conveying to a lay person the fundamental thing (and fundamental limit) one is buying when purchasing health insurance. It does not, however, lessen the complicated underlying reality of the insurance contract that embodies that

17. *See id.* at 1063–64.

18. *Cf.* Maher & Stris, *supra* note 15, at 461–62 (discussing insureds' expectations); Maher, *supra* note 4, at 1060–61 (same).

19. Maher, *supra* note 4, at 1060–61 (noting and explaining prevalence of "medical necessity" in private and public insurance).

deal. Compared to other forms of insurance—such as life insurance and homeowners insurance[20]—health insurance is more complicated and opaque.

II. THINKING ABOUT *RULES OF MEDICAL NECESSITY*

Health law professors ("JDs") frequently interact with doctors ("MDs"), businesspeople ("MBAs"), and health policy wonks ("PhDs") at "The State of American Health Care" type conferences.[21] These interactions, in addition to being highly entertaining, often include exchanges along the following lines. The MDs, MBAs, and PhDs will argue over what set of treatments work (or do not work) and are justified (or not) in terms of dollars spent. The JDs will listen carefully and then ask: (1) precisely what the contract embodying the health insurance promise will say; and (2) what legal rules will govern: (a) how the contract should be interpreted; (b) in what forum; and (c) by whom. The MDs, MBAs, and PhDs will dutifully nod, having been advised in the past by their own legal colleagues about the importance of such things, but otherwise convey with their body language that they could not possibly think of a less interesting subject, and occasionally even voice the thought that they "hope such things do not matter as much as you lawyers tell us they do."

Rules of Medical Necessity explains in great detail, with penetrating insight and with empirical evidence, precisely how and why those types of things very much matter in the world of health insurance—and indeed with respect to the *most* fundamental part of the health insurance promise, namely, medical necessity.[22] Trillions of dollars have funneled through that concept. Meta-anecdotes aside, *Rules of Medical Necessity* is constructed straightforwardly, and for convenience sake I'll summarize some of what it says below, before offering some interspersed thoughts on its insights.

A. *PART II OF* RULES OF MEDICAL NECESSITY

RMN begins (in Part II) by explaining the well-known difference between "rules" and "standards," and how medical necessity was originally embodied as a "standard."[23] A rule is a bright-line approach with easily ascertainable boundaries; a standard is a flexible approach with malleable boundaries.[24]

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20. Professor Schwarcz has thoughtfully written about homeowners insurance and may challenge the implication that homeowners policies are "simpler" than health insurance policies. I stress that I am not suggesting homeowners policies are simple; they are most certainly not and are frequently litigated. Instead, I am saying only that—for all its challenges and complications—homeowners insurance is not quite as conceptually aggravating as health insurance. To use an analogy: However tall Shaquille O'Neal is, Yao Ming is even taller.

21. Some law professors also have PhDs and a few do not even have JDs. Not all medical providers are MDs, not all businesspeople have MBAs, and health policy wonks often have degrees in addition to PhDs. But the tale tells much more smoothly by referring to the players as having singular graduate degrees.

22. *See generally* Monahan & Schwarcz, *supra* note 1 (exploring how the "medical necessity" promise in health insurance contracts has changed from its inception to today).

23. *Id.* at 429–31.

24. *See id.* at 429–30.

The former is more predictable and uniformly applied, but likely to be "over- and under-inclusive."[25] The latter is more likely to be Goldilocks-inclusive, but harder to predict in advance and more likely to be disuniform in its application.[26] Medical necessity has most often been a "standard," because, among other things, the difficult and dynamic nature of medical practice was more readily amenable to a standard-like approach.[27]

Insurers soon recognized, however, that using medical necessity as a pure standard was leading to either unnecessary or grossly inefficient care.[28] When insurers responded by contesting coverage—often with respect to high-dollar treatments involving major health conditions like cancer—ferocious court, regulatory, and public relations battles resulted.[29] Patient advocates complained of insurance coverage vanishing when it was needed most, while insurer advocates complained that the provision of unnecessary care would bankrupt them and the system.[30] Insurers—in addition to furiously lobbying public authorities for favorable rules and regulations—internally responded by pursuing a number of approaches to constrain care expenditures, such as utilization review.[31] They also began thinking about how they might "rulify" medical necessity, that is, by attempting to spell out in specific detail which treatments were covered and which were not.[32] The rise of evidence-based medicine—and the rise of the Internet, which theoretically increased the speed by which medical research could be spread—gave insurance companies reasons to believe that at least *some* types of medical need could benefit from ex-ante specification of what would be covered and what would not be.[33] And so ends Part II.

Before moving on to Part III, I should emphasize that I found Monahan and Schwarcz's Part II explanation of medical-necessity-as-a-standard-and-what-that-has-wrought to be a wonderfully concise, readable, and unquestionably accurate description of that very important subject; so clear, in fact, that a non-lawyer could read that Part of the Article and walk away with a firm understanding of health insurance and its challenges pre-2000. If only something similar were true for so many other law review articles.

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25. *See id.* at 430 (internal citation omitted).

26. *See id.* at 430.

27. *See id.* at 432.

28. *See id.* at 433. The standard explanation for this is that doctors financially benefit from more care and patients prefer to be safe than sorry, opting for both the most care and the most costly care, absent some financial or contractual constraint on their care choice.

29. *See id.* at 433–34.

30. *Cf.* Leslie Pickering Francis, *Legitimate Expectations, Unreasonable Beliefs, and Legally Mandated Coverage of Experimental Therapy*, 1 IND. HEALTH L. REV. 215, 215, 221–26 (2004) (contrasting patient and insurer views on covering experimental therapies and detailing disputes in 1980s and 1990s over certain costly cancer treatments).

31. *See* Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1652–53 (1992) (describing introduction of "utilization review" as cost control mechanism); *see also* Monahan & Schwarcz, *supra* note 1, at 433–35.

32. Monahan & Schwarcz, *supra* note 1, at 436.

33. *See id.* at 436–37.

B. *PART III OF* RULES OF MEDICAL NECESSITY

While—as *RMN* recognizes—others may have theorized or noted that some rulification could occur or was occurring in the health insurance setting, aside from some work looking at coverage approaches in very specific settings, no one prior to Monahan and Schwarcz has made any methodical effort to assess the degree to which health insurance was transitioning from standards to rules.

In Part III, they do precisely that. They review caselaw and an enormous number of publicly available health insurance policies to determine: (1) how insurers incorporate medical necessity rules into their promises; (2) how "binding" these rules are on insurance personnel making coverage determinations; and (3) how these rules are created and updated.[34]

To oversimplify, the chief way insurers "rulify" medical necessity is through use of written materials that are commonly called "clinical guidelines," "medical criteria," or some like term.[35] These lengthy documents—i.e., these "rules of medical necessity"—spell out in extensive and precise detail exactly what type of treatment is authorized for what type of condition, and what circumstantial variances justify (or do not justify) other treatments.[36] The manner and fashion in which these rules of medical necessity are generated is only weakly regulated. The degree to which insurers use these documents varies in both manner and scope; in some cases, the "medical criteria" document is explicitly incorporated and in others not, and in some cases only several categories of care, rather than all of them, are tied to a "clinical guidelines" document.[37] As Monahan and Schwarcz correctly point out, however, the overall effect these documents have on coverage determinations is one of rulification; the only question is how much.[38]

Although—as *RMN* acknowledges—insurers' use of clinical guidelines has been known for some time, the specifics by and degree to which insurers have in fact harnessed clinical guidelines as part of the rulification effort across the entire industry was—notwithstanding its obvious importance—unknown.[39] *RMN* fills that gap. A full appreciation of the scope of the work's empirical findings demands that one read Part III of the Article. The TLDR[40] version is that: (1) rulification, via some form of use of "rules of medical necessity" documents, is occurring writ large; and (2) it is for now mostly occurring as a partial matter, i.e., with respect to some categories of care.[41]

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34. *See id.* at 438–58.

35. *See id.* at 428, 440. "Clinical guidelines" is a term not specifically mentioned by Monahan & Schwarcz but one I have personally come across.

36. *See id.* at 440.

37. *See id.* at 439–47.

38. *See id.* at 449–50.

39. *Id.* at 445–46.

40. For those behind the times: TLDR is a Generation Z acronym for "too long didn't read." It is used to introduce a summary of a longer work.

41. *See* Monahan & Schwarcz, *supra* note 1, at 438–58.

For that alone, the work deserves acclaim. *RMN* could have ended there, and it would have been a major contribution.

Before moving onto Part IV, however, I should like to note a personal observation. In my travels as an academic and (retired) litigator, I have been exposed to more health care policies and plans—and their relevant coverage language—than is considered conducive to balanced living. That fact, and my desire to hold forth on the general subject, probably says a great deal about why I rarely receive dinner party invitations. But here it allows me to share that Monahan and Schwarcz's formal findings correspond quite strongly with my own experience; namely, that rulification is most certainly occurring, albeit mostly (for now) as a partial matter.

C. *PART IV OF* RULES OF MEDICAL NECESSITY

As Monahan and Schwarcz correctly acknowledge throughout their Article, there are theoretical reasons why rulification might *benefit* insureds (and the system generally), compared to a standards-dominated coverage world.[42] So, they are not blind to those possibilities. In Part IV, however, they explain, in considerable detail and with persuasive force, how the way in which rulification is occurring across the health insurance industry may weaken and undermine the statutory, regulatory, and interpretive doctrines that have long been held to protect insureds against insurer opportunism.[43]

For example, one legal mechanism long thought to constrain unjust denials was to subject coverage determinations to external review; i.e., review of the denial by an impartial medical expert.[44] State and federal law now, in most cases, requires exactly that.[45] As Monahan and Schwarcz point out, however, the problem is that most positive law on the subject has attempted to cabin the power of the external reviewer.[46] External reviewers are supposed to exercise purely medical judgment, and, most often, are forbidden or limited in their ability to make determinations that are contrary to the explicit terms of the policy.[47] Explicit incorporation of "medical criteria" documents into the contract thus meaningfully constrains external review, because it expands the territory upon which external reviewers cannot encroach.[48]

External review was the approach of people who hoped to increase the chances that insureds were treated fairly without the additional cost and

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42. *See, e.g.*, *id.* at 437–38.

43. *See id.* at 458–81.

44. *See, e.g.*, John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2324–26 (2008) (explaining appeal of external review).

45. *See* Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 670–72 (2014) (discussing external review requirements).

46. *See* Monahan & Schwarcz, *supra* note 1, at 462–68.

47. *Id.* at 467. A potentially cynical explanation for that restriction is that those in favor of external review did not wish to be accused of authorizing "rewriting the contract," which, in certain American political circles, is considered to be a mortal sin.

48. *See id.*

volatility of coverage litigation.[49] Coverage litigation, particularly over health insurance denials with respect to the major treatment of serious conditions, was and is particularly worrisome to insurers. They argued, not implausibly, that for juries or even judges to rule against very sick or dying patients was a difficult emotional task, and that in many cases, emotionalism might result in forcing the insurance company to pay exorbitant sums for treatments either unlikely to work or that were quite clearly excluded from the health insurance promise ex-ante. Nor would that set of outcomes only hurt the insurance company; it would generally drive up premiums for everyone, making insurance less available for the people that needed it most.[50] Making external review widely available was hoped to reduce the frequency of coverage litigation and its potentially extreme results, while also protecting insureds.[51] That said, even with the now near-ubiquity of external review, coverage litigation is still thought to be the major force constraining insurer opportunism.

It is thus not surprising that Monahan and Schwarcz consider with some care the manner in which rulification occurring through clinical guidelines affects coverage litigation.[52] They rightly distinguish between coverage litigation brought in the group plan context (which is governed by the Affordable Care Act ("ACA") and ERISA)[53] and coverage litigation in the individual policy context (which is governed by ACA and state law).[54] The law governing the group plan setting, in which judicial deference to coverage determinations is the rule, has greatly limited the power of insureds to successfully contest denials.[55] Under ERISA, judicial deference to administrators is appropriate when: (1) the plan provides the administrator with discretion; and (2) the administrator has exercised that discretion reasonably.[56] As the first condition is very often so, it is the second question that frequently resolves disputes.

Here, Monahan and Schwarcz argue that medical necessity rulification reduces the odds of insureds prevailing because many courts view the adoption of rules of medical necessity as reasonable exercises of discretion

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49. *See* Bronsteen et al., *supra* note 44, at 2324–26 and accompanying text.

50. *See, e.g.*, Hall & Anderson, *supra* note 31, at 1641 (referring to "expensive new procedures that if performed [and covered] on a widespread basis could leave more people uninsured and drive up costs for those who remain covered").

51. Maher, *supra* note 45, at 671–72 (describing rationale for external review of health claims).

52. *See* Monahan & Schwarcz, *supra* note 1, at 468–69.

53. *See id.* at 469–72.

54. *See id.* at 472–75.

55. Maher, *supra* note 45, at 658–59 (explaining how judicial deference under ERISA operates).

56. *See* Conkright v. Frommert, 559 U.S. 506, 512 (2010) (explaining ERISA's deferential standard, which was first announced in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). To say commentators have criticized what is often called *Firestone* deference—which was invented whole cloth by the courts—is to put it mildly. *See, e.g.*, John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 217–20 (criticizing deference).

and thus merely consider whether the rules were reasonably followed.[57] In the small number of cases where deference to an administrator's denial was overcome by an insured, sometimes the reason is because the plan had adopted a standards-based approach to coverage—i.e., a court had concluded that the insurer wrongfully denied payment for care that was generally accepted as clinically indicated—on the theory that generally accepted care is roughly what a medical necessity *standard* covers.[58] Had the plan more carefully described what it was covering (and not covering)—by using *rules* of medical necessity—a court presumably would not be able to rely on generally acceptable standards of care as the bar and thus be unable to find in favor of the insured.[59]

It is here where I offer some caution to generalist readers regarding Monahan and Schwarcz's account. Because there is no question that ERISA deference tilts the field against insureds, I wonder how much work rulification is doing here. Put differently, ERISA's deference standards are in practice so capacious that they contain all sorts of ways for insurers to prevail in cases where ex-ante observers would think that they should not.[60] In other words, I still suspect courts would rule against insureds overwhelmingly even absent rulification. To be sure, Monahan and Schwarcz do *not* suggest that rulification, whatever its perils, is the chief villain in the ERISA deference world—but I nonetheless want to take perhaps unnecessary pains to warn casual readers not to leave with the impression that if we address rulification, the problems with ERISA benefit determinations will be solved.

Monahan and Schwarcz close Part IV by explaining how rulification can be deployed to undermine common law doctrines or statutory commands intended to protect insureds.[61] Insurance disputes outside of ERISA are generally governed by state law, and mainly involve a number of doctrines that favor the insured.[62] But many of those doctrines can be limited or neutered by explicit use of medical necessity rules incorporated into the insurance contract.[63] Even statutorily mandated benefits—a clear example of the legislature wanting an insurance arrangement to cover something specific—can be manipulated through the use of rules of medical necessity, for the simple reason that many (but not all) mandated benefits laws articulate the mandate in broad language that does little to prevent covered insurers from

57. *See* Monahan & Schwarcz, *supra* note 1, at 469, 472.

58. *See id.* at 470–71.

59. *See id.* at 471–72.

60. *See, e.g.*, John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1316 (2007). Professor Langbein described ERISA's *Firestone* deference regime as "allow[ing] ERISA plan sponsors to impose self-serving terms that severely restrict the ability of a reviewing court to correct a wrongful benefit denial" and argued that "Unum's [years-long] program of bad faith benefit denials was all but invited" by ERISA's deference to conflicted decisionmakers. *Id.* The Unum scandal involved disability rather than health insurance, but the principles at issue are the same.

61. *See* Monahan & Schwarcz, *supra* note 1, at 475–81.

62. *See id.* at 475.

63. *See id.* at 476–79.

rulifying it in their own policies.[64] For example, certain mandates require that all care falling within a certain category (e.g., orthopedic care) be covered, but only to the extent that such care is medically necessary . . . without defining medical necessity. One can see the problem.

D. PART V OF RULES OF MEDICAL NECESSITY

Part V is the "solutions" portion of the Article.[65] It is this part of the Article about which I have the least to say. It is well-written, thoughtful, and takes great care to catalogue the positives and negatives of the reforms it considers. Those reforms are: "requiring the use of standard-based coverage terms after the initial claims determination, reforming existing state utilization review laws, mandating the use of specific rules of medical necessity, and improving the transparency of insurers' rules of medical necessity."[66] What the Article does not do is overclaim or oversell, which may leave readers looking for happy endings unsatisfied. Spoiler alert: there is no perfect solution, and Monahan and Schwarcz do not pretend otherwise. All the reforms they consider come with trade-offs, limitations, and political constraints. About that they are explicit, and one's preferred reform will likely correspond to one's priors and beliefs about what is politically possible.

These days, I have no idea what is politically possible, so I will set that aside. What I will say is that the first reform Monahan and Schwarcz propose—to use rulified medical necessity for initial coverage determinations but standards-based medical necessity for internal appeals and litigation[67]—has considerable theoretical merit as a middle-ground type approach. Rulification has the virtue of increasing predictability and efficiency, and the overwhelming majority of claims are resolved at the initial level.[68] A standards-based approach thereafter affords flexibility in the tougher cases, but also serves to discipline the creation of the rules in the first place. Merely because something is a rule does not mean action taken pursuant to it cannot satisfy a standard. Well-written, reasonably constructed rules are more likely to *win* even standards-based review, although of course not always. Admittedly, those who fear standards-based adjudication as merely an avenue for emotional opportunism by plaintiffs' lawyers that will drive up costs will be skeptical of requiring standards-based review at any level. But a system likely to result in well-crafted rules should reduce the amount of times the rule-writer loses under a standards-based review, and thus chill plaintiff opportunism and the potential systematic cost of using standards. That, combined with the numerous explicit and implicit constraints on the likelihood of runaway verdicts that were not present in past decades, should give the fair-minded less reason to fear standards in coverage disputes.

64. *See id.* at 481.
65. *See id.* at 481–93.
66. *Id.* at 482.
67. *See id.* at 482–85.
68. *Id.* at 482.

FINAL THOUGHTS

I would like to close with a few final thoughts. First, I have deliberately written this Response more informally than I could have, in part because this Response is *not* a traditional, long-form, printed law review article. Although others have questioned the entire enterprise of writing formal law review articles, I think that enterprise remains quite valuable—as Monahan and Schwarcz have shown. But informal and shorter expressions in reputable online forums such as this one might do meaningful work in communicating important ideas regarding a subject—such as, say, insurance proceduralism—that can sometimes be challenging for the non-specialist, casual reader, or congressional aide to digest.

Second, that said, let me state succinctly and plainly my view on *Rules of Medical Necessity*: It is a must-read work, an instant classic in the world of health insurance. Any student, commentator, scholar, or policymaker who cares about health insurance who does not read this Article with care is making a grave mistake.

Third, I want to connect *RMN* with Part I of this Response, where I informally consider the core features of insurance generally and health insurance specifically. Health insurance regulation is a hard problem. There are a lot of different ways to explain why it's a hard problem. In Part I of this Response, I offered one way.

To summarize: When people contract over risk—which is what insurance is—they do so by choice, which means some part of the deal must be appealing to both sides. In health insurance, the core component of the deal is the covered risk and the required payout. Within reason, the insured wants the covered risk to be as broad as possible and the required payout to be as generous as possible. The insurer wants the converse. In health insurance, however, the covered risk is illness, and the payout is money for medical care. *Defining* that particular covered risk and the corresponding payout in a way that benefits both parties and *also* matches society's sense of what is a fair deal is hard. Nor can the problem be dodged, because so many depend on private health insurance to finance care, and medical necessity is the chief fulcrum of coverage. Thus, to the extent using "rules" rather than "standards" in defining *the* key term in an ubiquitous and socially important deal (namely, medical necessity in health insurance arrangements) will undermine whether said deal is *fair*—well, then one should care *very* much about understanding how rules versus standards work in theory and practice. That is the subject with which *RMN* lucidly, expertly, and novelly grapples. My hope was that Part I of this Response would, by framing the challenge of health insurance from a slightly different (and more informal) vantage point, increase the chance that a passerby will carefully read *RMN* and appreciate the valuable work it does.