Members Brief

An informational brief prepared by the LSC staff for members and staff of the Ohio General Assembly

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Volume 134 Issue 34
March 16, 2022

Prior Authorization and the Practice of Medicine

Prior authorization – whereby a health plan issuer makes coverage of a requested health care service or drug dependent on the issuer's determining that the service or drug is medically necessary – is a common component of health plans today. But some opponents of the practice have argued that prior authorization is the unlawful practice of medicine. This brief provides an overview of relevant state, case, and federal law.

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Overview

Health plan issuers assert that prior authorization reduces waste by weeding out unnecessary services, keeping costs down, and preventing fraud. On the other hand, health services providers contend that prior authorization requirements are burdensome, and that decisions by unlicensed insurer staff often interfere with the providers' ability to adequately treat patients. Over time, interested parties have turned to legislation to address the issue.

Prior authorization overview

"Prior authorization" is the practice by health plan issuers of making coverage of a requested health care service or drug dependent upon the health plan issuer determining that the service or drug is in fact medically necessary. It is one of several utilization review procedures used by insurers to keep costs down and is sometimes referred to as "pre-certification."

Here is a broad overview of how prior authorization generally works: A health benefit plan adopts a prior authorization requirement regarding a certain procedure or the prescription of a specified drug. A doctor recommends a procedure (or prescribes a drug) for a patient covered by that plan. The plan reviews the request. If the plan determines that the procedure is medically necessary, the procedure is covered (assuming it was covered by the plan in the first place). If the plan determines that the procedure is *not* medically necessary, it is not covered. The doctor can then appeal this decision. After all appeals with the health plan issuer have been exhausted, the doctor can appeal to an external, third-party source. Note that the health benefit plan's decision to not cover does not prohibit the health care provider from providing the procedure; rather, it means that the health benefit plan will not pay for the procedure.

Much of the contention related to prior authorization revolves around a health plan issuer's assessment of "medical necessity." When a doctor prescribes a health service or medication, the doctor is finding that the procedure or drug is needed to treat the patient and meets the accepted standards of medicine. A physician is authorized by law to make such determinations as a part of the physician's license to practice medicine. Accordingly, some have argued that when an insurer reviews a requested service for medical necessity, this is equivalent or analogous to the initial recommendation and is therefore engaging in the practice of medicine. And as many of the employees of health plan issuers making prior authorization decisions are not licensed physicians, it is further argued that insurer employees conducting medical necessity reviews are engaging in the practice of medicine without a license.[1]

For legal purposes, the definition of "practice of medicine" is a matter of state law and varies slightly from state to state. Under Ohio law, the definition of "practice of medicine" includes:

- Examining or diagnosing for compensation of any kind; and
- Prescribing, advising, recommending, administering, or dispensing any sort of cure or treatment for a medical ailment.[2]

When a health plan issuer denies coverage of a requested drug or procedure due to lack of medical necessity, some argue that the health plan issuer is essentially saying a covered person will not be harmed if they do not receive the drug or procedure. As such, they might argue that the action falls under the category of medical "advising" and therefore could be considered the practice of medicine.[3]

State legislative initiatives

In response to this ambiguity, many interested parties and states have taken to addressing the situation via legislation. For example, model language espoused by the American

[1] R.C. 1751.72, 3923.041, 4731.34, and 5160.34; American Medical Association, *Prior authorization practice resources*, available on the Association's website, ama-assn.org; Healthcare.gov, *Medically Necessary*; Healthcare.gov, *Preauthorization*.

[2] R.C. 4731.34(A).

[3] See, for example, *Murphy v. Board of Med. Examiners*, 190 Ariz. 441, 443 – 4468 (1997).

Medical Association (AMA) includes provisions that would require all adverse prior authorization determinations (in other words, denials) be made by a physician who "possesses a current and valid nonrestricted license to practice medicine" and that is "of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request."[4]

The requirements vary from state to state on when, or even if, a medical professional is required to be involved in a prior authorization review of a claim. Some states require health plan issuer staff to be licensed physicians at all levels of the process, others require only staff reviewing appeals to be licensed, and others do not require staff to have a license at any level of review.

According to a 2021 survey conducted by the AMA, 29 states impose no requirements on health plan issuers that use prior authorization. Nine states require a licensed physician to review a prior authorization request at all levels. And six states require a licensed physician to conduct the review for appeals and external reviews.[5] Ohio is in this last category, requiring appeals of adverse determinations to be between the health care practitioner in question and a clinical peer.[6]

Prior authorization law in Ohio

Non-physicians in Ohio make prior authorizations for insurers. But does Ohio law ever definitively state that prior authorization is not the practice of medicine? Answering this question involves several factors. First, activities conducted by health insuring corporations are defined in the Revised Code as being "not the practice of medicine." Second, state oversight of many health benefit plans is preempted by the federal Employee Retirement Income Security Act (ERISA). And third, oversight of the practice of medicine usually falls to the State Medical Board of Ohio, whereas oversight of health plan issuers falls under the jurisdiction of the Superintendent of Insurance.

Health insuring corporations

Ohio's Health Insuring Corporation Law contains a provision that unequivocally states that any health insuring corporation holding a certificate of authority under that law is not to be considered to be practicing medicine. An Ohio Attorney General opinion relied heavily on this provision when responding to a query from the State Medical Board in 1999. During this time, the Medical Board had been receiving several complaints related to health insuring corporations and medical necessity determinations in utilization review procedures. Accordingly, the Medical Board asked the Attorney General if such practices by a health insuring corporation constituted the practice of medicine and if it does, does the Medical Board have jurisdiction over the activities?

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[4] AMA, *Model bill: Ensuring Transparency in Prior Authorization* (PDF), Section V, Personnel qualified to make adverse determinations. The document is available on the AMA's website, ama-assn.org.

[5] AMA, *2021 Prior Authorization State Law Chart* (PDF), which is available on the AMA's website, ama-assn.org.

[6] R.C. 1751.72 and 3923.041.

In short, the Attorney General responded that activities of a health insuring corporation, including the activities of its agents and employees, could *never* be considered the practice of medicine because of that provision. And accordingly, the Medical Board did not have any jurisdiction over health insuring corporation employees insofar as those employees were engaged on behalf of the health insuring corporation (activities outside the scope of their employment, however, could potentially fall under the Medical Board's jurisdiction).[7]

But this raises a question. This provision applies only to health insuring corporations – what about health plan issuers that are not health insuring corporations, such as sickness and accident insurers? There does not appear to be any similar provision in the Revised Code declaring that the activities of sickness and accident insurers are not the practice of medicine.

ERISA preemption

This, however, is where federal ERISA preemption comes into play. The vast majority of health insurance in Ohio and the rest of the United States is provided via employers; ERISA is the federal law governing employee benefit plans. ERISA states that it preempts state laws when it comes to the regulation of employee benefit plans. As such, the courts have held that the enforcement and interpretation of employee benefits plans are subject exclusively to federal law. "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive preemption provisions, which are intended to ensure that employee benefit plan regulation would be exclusively 'a federal concern.'"[8]

Why is this important? The prohibition against practicing medicine without a license is a state prohibition not duplicated in federal law. Thus, if a person were to allege that the insurer was practicing medicine without a license, the courts would likely judge the case under federal law.

This is essentially what happened in a 1989 case, *Varol v. Blue Cross & Blue Shield*. In this case a group of physicians alleged that dealing with Blue Cross and Blue Shield's unlicensed personnel in relation to prior authorization requirements violated the Michigan law requirement that health care corporations "offer benefits for the inpatient treatment of substance abuse [provided] by a licensed allopathic physician or a licensed osteopathic physician."[9] The federal court, however, never directly addressed this allegation. Instead, it decided that the claim was preempted by federal law and dismissed the case.[10]

Individual and small group health plans

So, if health insuring corporations are declared to be not practicing medicine by state law and employee benefit plans are preempted by federal law, what remains? Are there any health benefit plans for which the question of "is prior authorization engaging in the practice of medicine?" might be relevant? There are – individual and small group plans that are not offered

[7] R.C. 1751.08(D); 1999 Ohio Attorney General Opinion No. 44.

[8] 29 United States Code 1144; *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

[9] MCLS 550.1414a(1).

[10] *Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield*, 708 F.Supp. 826, 1989 U.S. Dist. LEXIS 2549 (1989).

by health insuring corporations. These plans are not employee benefit plans, are not subject to ERISA, and still might face this question.

In that case, only a court could say for certain. A review of the pertinent case law indicates that several courts outside Ohio have found that prior authorization is, at least in part, the practice of medicine. In *Pegram v. Herdrich*, a 2000 case where a health maintenance organization delayed treatment of appendicitis to the detriment of the patient, the U.S. Supreme Court asserted the following with regard to utilization review:

> [A] great many and possibly most coverage questions are not simple yes or no questions . . . . The more common coverage question is a when-and-how question . . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment . . . . The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.[11]

The U.S. Supreme Court in 2004 reinforced this perspective from *Pegram*, asserting that benefit determinations are "infused with medical judgments."[12]

Finally, is the 1997 case *Murphy v. Board of Medical Examiners*. In this case, a physician (Dr. Murphy) working for an insurer had rejected a prior authorization request for a surgery as being not medically necessary. In spite of this, the surgery was performed. After the surgery, Dr. Murphy's determination was found to be incorrect – the surgery had in fact been medically necessary. The Arizona medical board then issued a nondisciplinary, advisory letter to Dr. Murphy.

Dr. Murphy and his employer responded by suing the medical board in state court, alleging that the board had no authority to oversee the physician, as he was not engaging in the practice of medicine in his work for the insurer. The court, however, stated unequivocally that "[t]here is no other way to characterize Dr. Murphy's decision: it was a 'medical' decision" and ruled that Dr. Murphy's activities on behalf of the insurer were indeed subject to oversight by the Arizona board.[13]

Conclusion

In Ohio, for most health benefit plans, the question of "is prior authorization the practice of medicine?" is moot under state or federal law. Health insuring corporations are exempted by the Revised Code, and most sickness and accident insurance policies are covered by a federal law preemption. However, prior authorization or other utilization review policies implemented by individual and small group plans sold by sickness and accident insurers still might face the question because those laws do not apply them.

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[11] *Pegram v. Herdrich*, 530 U.S. 211 (2000).

[12] *Aetna Health Inc. v. Davila*, 542 U.S. 200, 219 (2004).

[13] *Murphy v Board of Med. Examiners*, 190 Ariz. 441, 443, 446 – 448 (1997).