Members Brief

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# 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 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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## Prior authorization overview

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

Prior authorization generally works as follows:

1. A health plan issuer adopts, under its health benefit plan, a prior authorization requirement regarding a certain medical service, medical procedure, or prescription drug potentially covered under the plan.
2. A doctor recommends the service or procedure, or prescribes the drug for a patient enrolled in that plan.

3. The health plan issuer reviews the request. If the health plan issuer determines that the service, procedure, or drug is medically necessary, it is covered. If the issuer determines that the service, procedure, or drug is *not* medically necessary, it is not covered.
4. The health care provider can then appeal this decision. After all appeals with the health plan issuer have been exhausted, the provider 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 service, procedure, or drug; rather, it means that the health benefit plan will not pay for the service, procedure, or drug under the health benefit plan. The patient could still self-pay or seek other payment sources.

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 care 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 matter.

## Medical necessity

Much of the contention related to prior authorization revolves around a health plan issuer's assessment of what is "medical necessity." When a health care provider recommends a health care service or procedure or prescribes a drug to a patient, the health care provider has determined that the service, procedure, or drug is needed to treat the patient under accepted standards of medicine. For example, a physician is authorized by law to make such determinations as a part of the physician's license to practice medicine.

Accordingly, some argue that when an insurer reviews a requested service, procedure, or drug for medical necessity, that review is equivalent to the initial recommendation of a health care provider and is therefore analogous to engaging in the practice of medicine. Similarly, some argue that under those circumstances, the health plan issuer is making a determination that a covered person will not be harmed if they do not receive the service, procedure, or drug is engaging in medical "advising," which could be considered the practice of medicine.[1] And, as artificial intelligence systems (AI) and many of the employees of health plan issuers making prior authorization decisions are not licensed health care providers, it is further argued that the AI systems and employees are engaging in the practice of medicine without a license.[2]

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

[1] See, for example, *Murphy v. Board of Med. Examiners*, 190 Ariz. 441, 446-447 (1997).

[2] R.C. 1751.72, 3923.041, 4731.34, and 5160.34; American Medical Association, Prior authorization practice resources and How AI is leading to more prior authorization denials; Healthcare.gov, Medically Necessary and Preauthorization; HealthAffairs, The AI Arms Race in Health Insurance Utilization Review.

- Prescribing, advising, recommending, administering, or dispensing any sort of cure or treatment for a medical ailment.[3]

## State legislative initiatives

In response to this ambiguity, many states and interested parties have taken to addressing the situation through legislation. For example, model language developed by the American Medical Association (AMA) would require all adverse prior authorization determinations to be made by a physician who "possesses a current and valid nonrestricted license to practice medicine" and 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 state to state on when, or if, a medical professional must be involved in a prior authorization review of a claim. Some states require health plan issuer staff at all levels of the prior authorization process to be licensed health care providers, others require only staff reviewing appeals to be licensed, and others do not require staff to have a license at any level of review.

Based on data from a 2024 survey conducted by the AMA, 24 states impose no requirement that health plan issuer staff making prior authorization determinations be licensed health care providers. Of the remaining states, 17 require a licensed health care provider (often requiring a licensed physician) or a clinical peer to review a prior authorization request at all levels. And nine states require a licensed health care provider to conduct the review for appeals and external reviews only.[5] Ohio is in this last category, requiring appeals of adverse determinations to be between the health care provider in question and a clinical peer.[6] Additionally, as of April 2026, nine states have enacted laws that regulate the use of AI in the prior authorization review process.[7]

## Prior authorization law in Ohio

Has Ohio law determined whether the act of making prior authorization determinations is engaging in the practice of medicine? Answering this question involves several factors.

- First, activities conducted by health insuring corporations (a type of health insurer regulated under Ohio law) 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).

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

[4] AMA, Model bill: Ensuring Transparency in Prior Authorization (PDF), Section 6, Personnel qualified to make adverse determinations.

[5] AMA, 2024 Prior Authorization State Law Chart (PDF).

[6] R.C. 1751.72 and 3923.041.

[7] KFF, Regulation of AI in Prior Authorization and Claims Review: A Look at Federal and State Consumer Protections.

- 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 unequivocally states that any health insuring corporation holding a certificate of authority is not considered to be practicing medicine.[8] An Ohio Attorney General opinion relied heavily on this provision when responding to a query from the State Medical Board in 1999. The Medical Board had received several complaints related to health insuring corporations making medical necessity determinations while conducting 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 so, does the Medical Board have jurisdiction over the activities?

In short, the Attorney General responded that activities of a health insuring corporation in conducting a prior authorization review procedure, including the activities of its agents and employees, does not constitute the practice of medicine because of the provision of the Health Insuring Corporation Law explicitly stating it does not. Accordingly, the Medical Board did not have 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).[9]

This provision of law applies to health insuring corporations only – 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 Ohio law 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. Most people in Ohio and the rest of the United States receive health insurance through employer-sponsored health plans. ERISA is the federal law governing employee benefit plans and it explicitly states that it preempts state laws when it comes to the regulation of these plans. Accordingly, courts have held that the enforcement and interpretation of employee benefit plans is subject exclusively to federal law. The U.S. Supreme Court reasoned that:

> 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.'[10]

[8] R.C. 1751.08(D).

[9] 1999 Ohio Attorney General, Opinion No. 99-044 (PDF).

[10] 29 United States Code 1144; *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

Why is this important? If a person were to allege that an insurer making prior authorization determinations under an employee health benefit plan was practicing medicine without a license, the courts would likely judge the case under federal law due to ERISA preemption. The prohibition against practicing medicine without a license under Ohio law is not duplicated in federal law, however.

This is essentially what happened in *Varol v. Blue Cross & Blue Shield*. In this 1989 case, a group of physicians alleged that dealing with Blue Cross and Blue Shield's unlicensed personnel in relation to prior authorization requirements violated a 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."[11] The federal court, however, never directly addressed this allegation. Instead, it decided that the claim was preempted by federal law and dismissed the case.[12]

## Individual and small group health plans

So, if health insuring corporations are not practicing medicine under state law and employee benefit plans are preempted by federal law, what remains? Are there any health benefit plans for which the question of whether making prior authorization determinations is engaging in the practice of medicine might be relevant? Yes – individual and small group plans that are not offered by health insuring corporations. These plans are not employee benefit plans, are not subject to ERISA, and still might face this question.

Only a court can say for certain whether a health insurer offering such a plan is engaging in the practice of medicine when making prior authorization determinations. A review of the case law indicates that several courts outside of Ohio have found that prior authorization determinations are, 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:

> [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.[13]

In 2004, the Court reinforced this perspective from *Pegram*, asserting that benefit determinations are "infused with medical judgments."[14]

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[11] Michigan Compiled Laws Annotated 550.1414a(1).

[12] *Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield*, 708 F.Supp. 826 (E.D. Mich. 1989).

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

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

## Conclusion

In Ohio, for most health benefit plans, the question of whether making a prior authorization determination constitutes engaging in the practice of medicine is moot under state or federal law. Ohio law deems actions by health insuring corporations as not engaging in the practice of medicine. And, regulation of most sickness and accident insurance policies is preempted by federal law, which does not contain an analogous provision exempting health insuring corporation actions from the practice of medicine. However, prior authorization or other utilization review policies implemented by individual and small group plans sold by sickness and accident insurers in Ohio still might face the question because those laws do not apply them.