REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

AN INITIAL EVALUATION OF PRECEDENT, NEED, SUPPORT AND DESIRABILITY OF INCLUDING OBSTETRICIAN/GYNECOLOGIST IN LEGISLATIVE DEFINITIONS OF PRIMARY CARE PROVIDER

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 24

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Kay Coles James
Secretary of Health and Human Resources

January 6, 1995

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to House Joint Resolution 52, agreed to by the 1994 General Assembly.

This report constitutes the response of the Secretary of Health and Human Resources to this resolution and recommends appropriate legislative and administrative actions related to the definition of primary care provider to include certain obstetricians/gynecologists.

Respectfully Submitted,

Kay Coles James
Secretary of Health and Human Resources

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EXECUTIVE SUMMARY

Research Approach and Conclusions

I. The major questions/issues related to the need of legislative intervention with regard to the inclusion of obstetrician/gynecologist (OB/Gyn) in the definition of "primary care provider" (PCP) are as follows:

- Is this an issue which requires legislation or is it one which is best left to consensus powers within the medical community? Is it best left to negotiation between consumers and providers of the various insurance packages (e.g., Preferred Provider Organizations)?

- Is such a definitional distinction necessary to the safety and welfare of consumers of medical services?

- Is the motivation practitioner oriented, consumer oriented or both?

- Do current trends provide sufficient rationale for inclusion of OB/Gyn practitioners among PCPs?

- Do supporting materials (i.e. study results etc.) provide sufficient evidence of need?

- Do OB/Gyn practitioners, in large part, support the "generalist" designation? Do they prefer to retain a "specialist" designation only? Do they prefer to acquire the former and maintain both (i.e., to be swingers?)

II. Resources and methods of exploration

Exploration has been made through library research and telephone interviews with individuals on the resource list.

III. Summary of Findings

The primary argument seems to rest in the contention that OB/Gyn practitioners currently serve as PCPs to a large number of women. In other words, women rely on OB/Gyn physicians for common ailments unrelated to either preventive or morbid gynecological matters. A furtherance of the argument seems to be that a large number of women would not receive certain general routine medical interventions (e.g., blood pressure readings) were it not for yearly routine visits to a gynecologist.

Current VA Code does not indicate the type of practitioners which can be designated as and serve as PCPs. This is a matter which is established by the medical community. Typically, Family Practice Physicians, Medical Internists, General Practitioners and Pediatricians are included as PCPs on panels for insurance purposes. In some cases, OB/Gyn practitioners may elect to be included as well. (It is interesting to note that OB/Gyn practitioners may serve on PCP panels as generalists, on OB/Gyn panels as specialists or both.)

There is no apparent convincing support for placing this matter before the legislature.

Although the American Medical Association recognizes this group as PCPs, support among OB/Gyn practitioners seems to range from desire to resistance. (Formal, confidential polling of the constituency would be appropriate.)

Research provides some limited support for the proposal and its underlying contentions.

To a major degree, both Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) currently exclude OB/Gyn practitioners from PCP lists. However, most also provide for yearly "well-woman" gynecological visits which do not require PCP referral. Women can by-pass the PCP for that purpose. Indeed, in some cases, women can choose both a PCP and a gynecologist.

With regard to obstetrics, almost all seem to place the OB/Gyn practitioner in the position of PCP during the gestation period. (Of course there are contract variations due to the individual desires of the consumer groups. However, from a consumer standpoint, sensitivity does seem to exist with regard to women's needs and desires.)

Before further consideration of the legislation of Joint Resolution No. 52 is taken, the following administrative actions are recommended:

1) OB/Gyns licensed in the Commonwealth should be surveyed in a confidential and independent manner so that a consensus can be determined with regard to this issue. Personal interest in providing PCP services should be explored. (Such inquiry should be extended to the total physician constituency if possible.)

2) Evidence which justifies this designation and which outweighs potentially adverse consequences to the health of women and fetuses should be gathered before this issue is pursued. (Current evidence is not convincing.)

3) More formal exploration of relevant practices and trends within the health care industry should be performed.

4) Further, a greater exchange of information and ideas should be facilitated between the provider community and purchasers and insurers of their services with an emphasis on determining the need for access. The Bureau of Insurance, Medical Society of Virginia, and other interested parties should be involved in this exchange. A conference involving affected parties may be beneficial.

Terminology

This report is driven by an issue involving a distinction between a "primary care provider/physician" (PCP) and a "specialist" in the provision of health care. A definitional understanding is therefore necessary to general understanding.

The American College of Obstetricians and Gynecologists (ACOG) defines a primary care physician as "a physician directly accessible to patients for their initial contact. This physician will see patients who have a specific or an undifferentiated complaint or patients who desire health maintenance through periodic health checkups. The primary care physician also provides continuity of care and is readily available to the patient when he or she has either a specific or nonspecific complaint. Such physicians perform initial evaluation and management within their expertise. The primary care physician advises when referral to another physician is indicated, coordinating subsequent and continuing care to assure the patient of appropriate comprehensive care."

This definition is typical of those used in the insurance industry to define PCPs. For insurance purposes, Medical Internists, Pediatricians, Family Practitioners, General Practitioners and, in some instances, Obstetricians and Gynecologists (OB/Gyns) are included in this definition.

Within the insurance industry, specialists are generally defined by default and consist of all practitioner groups not included in the PCP definition for a given plan and who are a part of a referral network. The State Corporation Commission's Rules Governing Health Maintenance Organizations defines a specialist as "a licensed health care provider to whom an enrollee may be referred by his primary care physician and who is certified or eligible for certification by the appropriate specialty board, where applicable, to provide health care services in a specialized area of health care."

Overview

House Joint Resolution No. 52 proposes that, through state legislation, obstetricians/gynecologists (OB/Gyns) be included in the definition of "primary care provider" (PCP) for purposes of third-party payer coverage. Rationale for such action rests in the contention that, in spite of the traditional "specialist" designation, OB/Gyns currently provide a substantial amount of general primary care services received by women.

The alleged motivation is to maximize the number of women receiving general primary care services as well as those services that are traditionally OB/Gyn specific (i.e. annual, preventative gynecological exams and prenatal care.) The underlying implication is that, in light of current trends in the health care industry, this designation is necessary if current levels of services to women are to be maintained and/or improved.

Proponents of the resolution contend that as emphasis on managed care evolves, the health of women may suffer unless they are given the option of choosing an OB/Gyn as PCP. It is alleged that "well-woman" gynecological visits are often the only medical services sought by women and that such visits provide a means for detection of general disorders as well as those directly related to the reproductive system. A commonly expressed fear is that women will avoid yearly gynecological exams if a PCP referral is required for OB/Gyn visits.

Costs associated with referral requirements and/or a reluctance on the part of PCP to refer routine gynecological matters are among concerns expressed or implied by advocates of the proposal.

This report is based on initial exploration of the proposal for legislative action set forth in House Joint Resolution No. 52. Information was gathered primarily through: 1) interviews with individuals currently and directly involved in the health insurance industry, key persons involved in the generation of the resolution and individuals with ancillary interest in issues inherent in or emanating from the resolution and 2) exploration of relevant materials (e.g., research studies and current statutes) related to the resolution. The changing nature of the health care industry and a concomitant lack of organized research on certain relevant issues dictate a fairly informal initial approach to exploration.

The following general questions were used in study development:

- Is this an issue which requires legislation or is it one which is best left to consensus powers within the medical community? Is it best left to negotiation between consumers and providers of the various insurance packages (e.g., PPOs?)

- Is such a definitional distinction necessary to the safety and welfare of consumers of medical services?

- Is the motivation practitioner oriented, consumer oriented or both?

- Do current trends provide sufficient rationale for inclusion of OB/Gyn practitioners among PCPs?

- Do supporting materials (i.e., study results etc.) provide sufficient evidence of need?

- Do OB/Gyn practitioners, in large part, support the "generalist" designation? Do they prefer to retain a "specialist" designation only? Do they prefer to acquire the former and maintain both (i.e., to be swingers?)

Precedent and Need

Legislation characteristically is generated by need where precedent may or may not exist. The intended result of legislation is to obtain an sustainable, long-term benefit to society. Both precedent and need are relevant in the determination of the efficacy of Resolution No. 52.

The Code of Virginia is currently silent on the issue set forth in the resolution. There is no statutory stipulation that particular physician groups shall be categorized as PCPs. These designations are typically determined through consensus in the medical community and not through legislative action.

As stated previously, Medical Internists, Family Practice Practitioners, General Practitioners, Pediatricians and, in some instances, OB/GYNs are regarded as PCPs in insurance programs which require such designations. Specific contract inclusions are determined through predetermined plan offerings as is generally the case with HMOs or through negotiations between service providers and individual consumer groups as is generally the case with PPOs.

At this time, proposed health care reform legislation at the federal level includes OB/Gyns among PCPs and a few states other than Virginia are exploring this issue (e.g., Maryland, New York and California). At this writing, verification of the specific disposition of the issue in these recent cases has not been sufficiently accomplished. (Queries have been made. However, sources are tenuous.)

A separate issue indirectly related to precedent involves the nature of OB/Gyn services. Such services are provided only to women, resulting in a prima facie case for including OB/Gyns among specialists. No other PCP or specialist group excludes individuals on the basis of gender. If OB/Gyns are PCPs in the true sense of definition and practice, a case could be made for the extension of PCP services of OB/Gyns to adult males and to children of both sexes.

The determination of need---another primary factor in determination of the efficacy of Resolution No. 52---requires exploration from a consumer standpoint. The primary issue is whether the current or an improved level of health care for women is dependent on a PCP designation for OB/Gyns. In order to evaluate this question, it is necessary to determine: 1) the current state of and relevant trends within the industry and 2) issues inherent in such a designation.

Materials presented in support of the resolution provide evidence that OB/Gyns currently provide certain PCP services to women. However, in large part, services included in the studies are those which one would typically expect in annual OB/Gyn examinations. Furthermore, the nature of illnesses treated by OB/Gyns is not sufficiently

addressed, making evaluation of the extent of PCP functions difficult to determine.

Even if one were to accept the contention that PCP services are substantially provided by OB/Gyns, the genuine issue is whether these services would cease to be provided in the absence of the requested PCP designation for OB/Gyns.

Exploration of the current state of the industry in the Commonwealth indicates that sensitivity exists with regard to the special needs of women in the area of OB/Gyn-related health care. Approximately 90 percent of the HMOs licensed in Virginia either include OB/Gyns on PCP panels (10 percent) or they include provisions which allow women to obtain OB/Gyn services for an annual Gyn examination without a PCP referral (80 percent.) (In one plan, women are provided the opportunity to choose both a PCP and an OB/Gyn so that patients can access either depending on the nature of a particular medical problem.) Furthermore, while specific and quantifiable information is not currently available, PPOs appear to be following a similar course----a trend which indicates sensitivity from the standpoint of employer/consumer groups as well as the insurance and medical communities.

With regard to obstetrical needs, managed care programs typically allow the OB/Gyn to serve, without penalty to the patient/participant, as the PCP during the gestation period.

Key Advantage, the HMO which serves state employees in the Commonwealth, provides OB/Gyns the option of serving on PCP panels. Further, women who choose a traditional PCPs (e.g., Medical Internist, General Practitioner) may visit an OB/Gyn for an annual gynecological ("well-woman") examination without referral and without penalty. Likewise, obstetrical needs are not hampered by PCP referral requirements.

Evidence indicates a sensitivity to the health care needs of women. For the most part, women can seek both general and OB/Gyn services without difficulty or additional costs that may be associated with referral requirements.

Even if special provisions were not made with regard to OB/Gyn visits, those who typically serve as PCPs are generally qualified to perform routine gyn examinations and to diagnose and refer extraordinary pathological conditions to OB/Gyns. Furthermore, findings in this limited investigation indicate that women are encouraged by PCPs to have routine gynecological examinations and that PCPs are willing to provide OB/Gyn referrals in cases where women prefer to continue an established patient/physician relationship for this purpose.

Response of the Medical Community

Since PCP designations are traditionally determined within the medical community, reaction of that group is relevant to the issue of PCP designation for OB/Gyns.

The medical community's reaction to the resolution is difficult to ascertain without benefit of a confidential inquiry capable of producing candid responses from individual members of group. However, initial informal inquiry into the reaction among the OB/Gyn constituency indicates a continuum ranging from desire to resistance. Furthermore, sources from HMOs which include OB/Gyns on PCP panels, indicate that many OB/Gyns, who initially choose the PCP option remove themselves from such panels after experiencing the obligations inherent in the PCP role.

Informal reaction from the medical community (OB/Gyn and other) indicates that there is an additional paradoxical concern for patient welfare. In general, individuals visiting OB/Gyns for OB/Gyn services are either in good health or are presenting with complaints that are not contagious (e.g., pregnancy or gynecological disorders.) PCPs are obligated to care for common maladies such as colds, other viral infections, bacterial infections, etc. Introduction of pathogens into offices and waiting areas may indeed adversely affect the health of women and unborn children.

While the American Medical Association may recognize OB/Gyns as PCPs, there are apparently some reservations among constituent members of the medical community.

Conclusions and Recommendations

Legislative action for the purpose of categorizing obstetricians and gynecologists as primary care physicians does not seem justified. There is no precedent in current state legislation which indicates need or appropriateness of such action. Traditionally, such designations have been determined by consensus within the medical community. Supporting evidence is not clear and convincing, and sustainable societal benefit is not apparent.

First, realities and trends within the industry do not support contentions that the medical health of women would suffer if PCP status is not extended to OB/Gyns. The trend among managed care programs demonstrates sensitivity to the special needs of women. In some instances, OB/Gyns are included on PCP panels. In those cases where they are not, there is generally a contractual provision which provides women the freedom to bypass the PCP, without referral, in order to visit an OB/Gyn for an annual gynecological examination. With regard to obstetrical care, most programs allow the OB/Gyn to serve as PCP during the period of gestation. On balance, contentions that the medical needs of women would be neglected if OB/Gyns are not included among the PCPs do not seem to be supported by this evidence.

Second, support within the medical community for this designation is questionable. Even among OB/Gyns, support and interest seem questionable. Indeed, in some instances where OB/Gyns have been included on PCP panels, individuals withdrew themselves from that option after discovering the full impact of that decision.

Third, there are consumer issues which bear serious consideration. PCPs are obligated to care for common maladies such as colds, other viral infections, bacterial infections, etc. Exposure to illness may have a detrimental affect on the health of women and their unborn children.

Given the lack of precedent for legislating such issues and given the current status of the rationale for such designation, efforts toward legislation do not seem appropriate. In general, the issue is one which is currently subject to negotiations among players in the health care industry, and trends indicate a sensitivity to the special medical care needs of women.

In general, this study indicates that this issue is one which may emanate in large part from concerns over practitioner well-being as well as consumer well-being. It is perhaps an issue that is best addressed by market forces.

Before further consideration of the legislation of Joint Resolution No. 52 is taken, the following administrative actions are recommended:

1) OB/Gyns licensed in the Commonwealth should be surveyed in a confidential and independent manner so that a consensus can be determined with regard to this issue. Personal interest in providing PCP services should be explored. (Such inquiry should be extended to the total physician constituency if possible.)

2) Evidence which justifies this designation and which outweighs potentially adverse consequences to the health of women and fetuses should be gathered before this issue is pursued. (Current evidence is not convincing.)

3) More formal exploration of relevant practices and trends within the health care industry should be performed.

4) Further, a greater exchange of information and ideas should be facilitated between the provider community and purchasers and insurers of their services with an emphasis on determining the need for access. The Bureau of Insurance, Medical Society of Virginia, and other interested parties should be involved in this exchange. A conference involving affected parties may be beneficial.

Selected Study Resources

Resource	Type of Information
Corporation Commission Bureau of Insurance Contact: Agatha Stokes (804) 371-9691	Statutes; HMO Regs.; info. on PPOs
State Personnel and Training Health Benefits Contact: Bill King (804) 225-2170	Info. on Key Advantage
Leo Dunn, M.D. (804) 828-7877	Perspective/Comments clarification of issue
Warren Koontz, M.D. (Executive Director, State Board of Medical Licensure---VA) (804) 288-3079	Perspective/Comments clarification of issue
Medical Society of Virginia (OB/Gyn group) 353-2721 Contact: Melanie Gebheart (804) 788-8006	Evidence of Practitioner/ Constituency support
American College of Obstetricians and Gynecologists (ACOG) (202) 638-5577	Additional information with regard to major studies cited in supporting materials
Shelah Leader, Ph.D. (author of supporting material-- "Provision of Primary-Preventive Health Care Services by Obstetrician- Gynecologists") (202) 966-4690	Elaboration/refinement of points
Bruce Keeney Virginia Optometric Association (804) 643-0309	List of HMOs licensed to practice in VA

Tony Grazeano State Personnel and Training 371-7931	Recommended source of PPO information
E.G. Miller (former director of Insurance Studies) VCU 828-1595	General information and resources
Bobby Cohn (Trigon Administrators) 673-5802	General information and resources
Joan Gardner (Trigon BC/BS) 354-7288	Information on current, relevant trends in managed care etc.
BC/BS (Provider Network Management) 354-7000 (general)	
Jackie Overton (Trigon BC/BS) 354-4513	PPO/managed care information
Mary Grosenick (Trigon BC/BS) 354-2321	PPO/managed care information
Mike Mullen, Deputy Director State Council for Higher Education (SCHEV) 587-1463	Report on medical education
Nancy Finch MCV Women's Health Advisory Council 644-7101	History of resolution and evidence of need

HMOs Licensed in VA

AETNA
(703) 903-7100

Capital Care, Inc.
(703) 761-5400

CIGNA
(410) 720-5800
(804) 273-1100

George Washington U.
(202) 416-0410

HMO VA, Inc.
(804) 354-3860

HealthKeepers, Inc.
(804) 354-3860

HealthPlus, Inc.
(301) 982-0098

Humana Group Health Plan, Inc.
(202) 364-2000

Kaiser Foundation
(301) 816-2424

MD-Individual Practice Association, Inc.
(301) 762-8205

Optima
(804) 552-7400

Optimum Choice, Inc.
(301) 762-8205

Peninsula Health Care, Inc.
(804) 875-5760

Physicians Health Plan, Inc.
(804) 354-3860

Principal Health Care
(301) 881-1033

Priority Health Plan, Inc.
(804) 463-4600

Prudential
(804) 323-0900

Sentara Health Plans
(804) 552-7220

Southern
(804) 747-3700

Appendix

LD2349320

HOUSE JOINT RESOLUTION NO. 52

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Rules
on March 3, 1994)

(Patron Prior to Substitute—Delegate Keating)

Requesting the Secretary of Health and Human Resources to recommend appropriate legislative and administrative actions related to the definition of primary care provider to include certain obstetricians/gynecologists.

WHEREAS, women constitute more than 50 percent of the population of the Commonwealth of Virginia; and

WHEREAS, women's health has received inadequate attention in medical research and in delivery of services; and

WHEREAS, 86 percent of all ambulatory care visits of women between 15 and 44 years of age are to obstetricians/gynecologists; and

WHEREAS, 97 percent of women ages 18 to 65 have had a physical examination by an obstetrician/gynecologist; and

WHEREAS, 78 percent of women now insured can see an obstetrician/gynecologist without referral; and

WHEREAS, 75 percent of all women object to a system which requires a referral in order to have access to an obstetrician/gynecologist; and

WHEREAS, the majority of women view their obstetrician/gynecologist as their primary or sole physician; and

WHEREAS, an obstetrician/gynecologist improves the access to health care for women by providing primary and preventive health care to the individual as a whole patient in addition to focusing on reproductive processes; and

WHEREAS, preventive and primary care provided by obstetricians/gynecologists should include instruction in breast self-examination, cervical cancer screening, health education, instruction in health promotion, hypertension and cardiovascular surveillance, osteoporosis counseling, sexually transmitted disease prevention, and identification of victims of domestic violence; and

WHEREAS, the most effective ways to improve health are prevention and detection of disease in its early stages when it is most treatable; and

WHEREAS, 60 percent of all office visits to obstetricians/gynecologists are for preventive care; and

WHEREAS, obstetricians/gynecologists refer their patients to other physicians less frequently than other primary care providers, thus avoiding costly and time-consuming referrals; and

WHEREAS, more than two-thirds of all visits to obstetricians/gynecologists are by established patients of the physician returning for care of a medical condition; and

WHEREAS, obstetricians/gynecologists manage the health of women beyond the reproductive system and are qualified on the basis of both education and experience to provide these services; and

WHEREAS, 80 percent of all births in the United States are attended by obstetricians/gynecologists; and

WHEREAS obstetricians/gynecologists provide both health care to women and an awareness of the relationship of disease and inherited disorders; and

WHEREAS, proposed federal legislation has identified obstetricians/gynecologists as primary care providers and has increased the distribution of primary care physicians from 50 percent to 55 percent; and

WHEREAS, obstetricians/gynecologists should be designated as primary care providers for women in state laws relating to the delivery of health care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to recommend appropriate legislative and administrative actions related to the definition of primary care provider to include certain

obstetricians/gynecologists. The Secretary shall complete her work in time to submit her findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates prepare a copy of this resolution for transmittal to the Governor so that he may be apprised of the sense of the General Assembly in this matter.

Official Use By Clerks

Agreed to By The House of Delegates		Agreed to By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate