REPORT OF THE JOINT SUBCOMMITTEE STUDYING

ACCESS TO OB/GYN SERVICES IN MANAGED CARE PLANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 49

COMMONWEALTH OF VIRGINIA
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1996

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Report of the
Joint Subcommittee Studying
Access to Ob/Gyn Services in Managed Care Plans

TO: The Honorable George F. Allen, Governor,
and
the General Assembly of Virginia

I. INTRODUCTION AND OVERVIEW

A. HJR-560'S SCOPE AND BACKGROUND.

HJR-560 approved by the 1995 Session of the Virginia General Assembly established a joint subcommittee to "study women's access to obstetrical and gynecological services, particularly in managed care plans." The subcommittee was directed to make recommendations on "how duplicative costs and administrative snarls can be avoided." The resolution *(Appendix A)* was patroned by Delegate Gladys Keating who also served as the subcommittee's chairman. The nine-member joint subcommittee consisted of: Delegates Joyce K. Crouch of Lynchburg, George H. Heilig, Jr. of Norfolk, Gladys B. Keating of Fairfax, Kenneth R. Plum of Fairfax, and Lacey E. Putney of Bedford, all appointed by the Speaker of the House of Delegates; and Senators Clarence A. Holland of Virginia Beach, Yvonne B. Miller of Norfolk, H. Russell Potts, Jr. of Winchester and W. Henry Maxwell of Newport News who served as vice-chairman, all appointed by the Senate Committee on Privileges and Elections.

A related study resolution (HJR-52) was passed by the 1994 Session, requesting the Secretary of Health and Human Resources ("the Secretary) to consider whether legislative or administrative action should be taken to require health insurers and other health care coverage plans to designate obstetricians/gynecologists as "primary care physicians," or "PCPs" within managed care plans. PCPs serve a "gatekeeper" role in health care coverage plans employing managed care structures, coordinating the medical care and treatment of designated patients.

The Secretary's report (House Document 24 of 1995) found that there was no consensus on the PCP designation issue within the medical community. The report also indicated that Ob/Gyns are included in some managed care plans' PCP panels, and that access to Ob/Gyns, without referral, for annual gynecological examinations was then permitted to some extent.

The Secretary concluded that no legislative or other action was warranted on the issue at that time, stating that the PCP issue was one "best addressed by market forces." The report went on to suggest, however, that (i) Ob/Gyns be surveyed on this general issue to obtain a consensus on the PCP issue and (ii) further study was indicated to determine the overall need for Ob/Gyn access.

B. PERTINENT LAW IN VIRGINIA AND IN OTHER STATES.

The study's overarching issue was PCP coordination of patient access to Ob/Gyns. Except to the extent Ob/Gyns are designated as PCPs within such plans (when such designation is permitted), they are specialists. As such, some managed care plans require that Ob/Gyn patient visits, examinations and treatments covered by such plans be coordinated by PCPs. Failure to do so may result in a patient paying more out-of-pocket than for a visit or treatment coordinated through her PCP.

Currently, Virginia law is silent on the access issue. The Code of Virginia's insurance title (38.2) contains no express provision governing the reimbursement of Ob/Gyns in managed care plans, generally, or patient self-referral to Ob/Gyns in particular. Thus, Ob/Gyn access is dictated by market forces, and, as discussed in the Secretary's 1995 report, the degree of access varies somewhat from plan to plan.

In some other states, however, Ob/Gyn access has been addressed. In **North Carolina**, for example, a 1995 bill directed HMOs, PPOs (preferred provider organizations) and other managed care-style plans to permit unrestricted "direct access" to in-network Ob/Gyns (*Appendix B*). The legislation, effective January 1, 1996, places no limitations on the number of self-referred visits and includes "the full scope of medically necessary services provided by the participating Ob/Gyn in the care of or related to the female reproductive system and breasts." Services covered include the services of nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with Ob/Gyns. Coverage is limited, however, to the benefits provided in the pertinent health care plan.

Maryland addressed this issue in its 1992 and 1994 Sessions (*Appendix C)*. Under Maryland law, managed care plans have two options: (i) permit covered individuals to designate Ob/Gyns as PCPs, or (ii) permit covered individuals one self-referred annual visit to in-network Ob/Gyns for routine gynecological care. **Louisiana** enacted legislation in its 1995 Session (*Appendix D)* authorizing PCP designation for Ob/Gyns, and also permitting direct access for one annual visit, with a second direct access visit permitted if medically indicated. Direct access is principally limited to in-network providers, and the managed care plan may require consultation between the provider and the patient's PCP.

A **Connecticut** law (*Appendix E)* enacted in 1995 is similar to the Maryland and Louisiana laws. It permits direct access to in-network Ob/Gyns for primary and preventive obstetric and gynecological services. There are no restrictions on the number of covered visits. The Connecticut law also permits an individual to designate an in-network Ob/Gyn as her PCP, and any other in-network physician as an additional PCP. The statute permits managed care plans to require Ob/Gyn consultation with PCPs to discuss proposed services and treatment plans.

A 1994 **New York** enactment *(Appendix F)* requires HMOs to permit direct access to an in-network "qualified provider" of primary and preventive obstetrical and gynecological services. Such access, however, is limited to two annual examinations, and to care related to any pregnancy. Further direct access is permitted for any additional services or treatment required as a result of the examinations or acute gynecological conditions. The HMO may, however, require the provider to discuss any proposed treatment plan or services with the individual's PCP.

Other states which have legislated in this area include the State of **Washington** which acted in its 1995 Session to require Ob/Gyns' designation as PCPs (*Appendix G).* Similar PCP-designation legislation passed the **Florida** Legislature in its 1995 Session (*Appendix H)*, and in **California** in 1994 (*Appendix I)*. A 1995 **Mississippi** bill (*Appendix J)* is silent on the PCP designation issue, while permitting direct access to in-network Ob/Gyns.

From these bills, a number of legislative models emerge. They are summarized in the chart below.

Model	**Illustrative States**	**Comments**
Market driven	**Virginia**	
Ob/Gyn designation as PCP	**Washington, Florida** (1995 enactments) **California** (1994 enactment)	
Unlimited Direct Access to in-network Ob/Gyns.	**North Carolina, Mississippi** (1995 enactments)	**NC** law includes collaborative treatment with nurse practitioners, physicians' assistants, nurse midwives. **MS** law not as broad as NC's, but does include

		any and all ob/gyn services covered under the plan.
Unlimited Direct Access to in-network provider for primary and preventive services; Can designate Ob / Gyn as PCP and designate an additional non-Ob / Gyn PCP.	**Connecticut** (1995 enactment)	Plan may require Ob/Gyn to consult with patient's PCP re: services and treatment plan.
Limited Direct Access to "qualified providers" of Ob / Gyn services.	**New York** (1994 enactment)	Statute addressed to HMOs only. Two visits for primary and preventive care authorized, and services required as a result of exams or acute gynecological condition..
Limited Direct Access or Ob / Gyn designation as PCP.	**Maryland** (1994, 1995 enactments.)	Provides managed care plan sponsor two options: (i) permit patients direct access to in-network Ob/Gyn for one annual visit providing routine gynecological care *or* (ii) permit Ob/Gyns to be designated as PCPs.
Limited Direct Access and PCP designation.	**Louisiana** (1995 enactment)	Permits direct access to in-network provider for one visit (possibly a follow-up) and authorizes designation of in-network Ob/Gyn as PCP

The key variables within these enactments are: (i) PCP designation, (ii) limited versus unlimited direct access, (iii) extent of service authorized where direct access permitted, (iv) whether consultation is required between PCP and Ob/Gyns, and (v) whether providers other than Ob/Gyns, e.g., nurse practitioners and other

providers of obstetrical and gynecological care are included in any direct access provision.

II. THE SUBCOMMITTEE'S WORK

The joint subcommittee used its first meeting to determine the study's focus. This was accomplished in large part by receiving testimony from the Ob/Gyn community on the access issue, and also by receiving testimony on the access issue from other providers, such as family physicians. Additionally, managed care plan representatives summarized their views concerning Ob/Gyn access within managed care structures.

The joint subcommittee's second meeting featured a public hearing and a work session. Speakers at the public hearing included Ob/Gyns, family practice physicians, managed care plans, women receiving their obstetrical and gynecological care through managed care plans and representative of the business community. The joint subcommittee used its work session to focus on information received at the public hearing, and on the access legislation enacted in other states.

In its final two meetings, the joint subcommittee focused on two legislative models--those of Maryland and North Carolina--and a resolution to continue the study in 1996.

A. VIEW OF THE OB/GYN COMMUNITY

Representatives of the Virginia Obstetrical and Gynecological Society told the subcommittee that managed care plan structures have, in their view, negatively affected the quality and availability of obstetrical and gynecological care afforded women covered under such plans--particularly in the area of gynecological care. In many such plans, women must be formally referred by their PCP (who are typically internists, family practice physicians, or general practitioners) to an Ob/Gyn before reimbursement for the latter's services will be approved. Since most plans do not permit Ob/Gyns to be designated as PCPs, women covered under these plans must coordinate their visits to an Ob/Gyn through a nonOb/Gyn PCP.

Ob/Gyn representatives also told the subcommittee that PCP coordination may delay treatment when PCPs require an office visit before authorizing a referral. This results in inconvenience to female patients and in duplicative medical expenses. Additionally, some PCPs prefer to treat certain gynecological conditions or to perform certain screening tests (e.g., pap smears), instead of referring patients to an Ob/Gyn for these services. One public hearing witness suggested that PCPs may be disinclined to refer because of PCP contract terms penalizing them for excess referrals. One Ob/gyn also told the subcommittee that

while some plans permit Ob/Gyn direct access for annual "wellness" examinations, virtually all follow-up treatments must typically be approved by the patient's PCP.

Ob/Gyn representatives said that a nonOb/Gyn PCP who treats a female patient's gynecological condition instead of referring her to an Ob/Gyn, may lack the education, training or experience necessary to fully assess the condition and its potential complications. An Ob/Gyn who testified at the subcommittee's public hearing said that several of her patients had gynecological conditions that were improperly diagnosed or treated by nonOb/Gyn PCPs. A summary of these cases is attached as *Appendix K*.

Ob/Gyns also spoke to the relationship of trust that is established between women and their Ob/Gyns. For many women in their reproductive years, Ob/Gyns are the only physicians many of them see regularly. Consequently, the interposition of PCP gatekeeping mechanisms, Ob/Gyns said, disrupts these relationships and may ultimately affect women's gynecological health. A representative of the Virginia League for Planned Parenthood supported that viewpoint, stating that particularly in the area of pregnancy prevention and sexually transmitted diseases, the continuity of relationships between women and their Ob/Gyns is central to diagnosis and treatment.

A September 1995 survey of Virginia's Ob/Gyns conducted by the Virginia Ob/Gyn Society and the Virginia section of the American College of Obstetrics and Gynecology showed that ninety percent of respondents' greatest concern for their patients was direct access, while only ten percent said their greatest concern was having primary care provider status. Ninety-nine percent of respondents said they would support legislation allowing direct access to Ob/Gyns in managed care plans. A report of the survey is attached as *Appendix L*.

Ob/Gyns, Ob/Gyn nurse practitioners, and Certified Nurse Midwives urged Virginia's adoption of legislation patterned after the North Carolina law permitting unrestricted access by women to in-network Ob/Gyn providers within their managed care plans.

B. VIEWPOINT OF MANAGED CARE PLAN REPRESENTATIVES.

The Virginia Association of HMOs ("the Association") took the lead in presenting the viewpoint of managed care plans on the access issue. Their view is that PCP coordination of women's health care, including oversight of referrals to specialist such as Ob/Gyns, is professionally appropriate while affording cost-moderating benefits. And, this system compares favorably to the conventional fee-for-service (FFS) plans in which patients select providers at will. According to the Association, between 1988 and 1993, HMO premiums increased forty percent less

than premiums for FFS plans, while providing more comprehensive benefits and lower out-of-pocket costs.

The Association also stated that HMOs provide women better access to preventive care than traditional FFS plans. According to a Health Care Financing Authority (HCFA) study of Medicare HMOs cited by the Association, almost 60 percent of HMO patients diagnosed with cervical cancer were diagnosed at the earliest stages as compared to thirty-nine percent of FFS patients. Moreover, a Center for Disease Control and Prevention report showed that the percentage of women age 50 and older receiving cancer screening, including mammograms, CBE and pap tests was higher in women in HMOs compared to FFS patients. The Association also stated that HMOs are much more likely to offer coverage for contraceptive and infertility services than conventional insured plans.

Managed care plans are currently providing limited direct access to Ob/Gyns in many managed care plans. The Association surveyed its HMO members in conjunction with this study to determine the extent of Ob/Gyn access. As of November 1995 there were twenty-five HMOs licensed by the State Corporation Commission's Bureau of Insurance. Of twenty-three plans responding to the survey, twenty-one indicated that self-referral to an in-network Ob/Gyn was allowed. Sixteen of the twenty-one limited such self-referrals to an annual well-woman visit, while five plans placed no limits on the number of self-referrals. The remaining two plans responding to the survey permitted Ob/Gyns to be designated as PCPs. A report of the survey is attached as *Appendix M*.

A representative of Trigon Blue Cross Blue Shield emphasized that the core assumption of managed care is that the quality of care is enhanced by each patient having a physician familiar with all aspects of their care. Trigon does not permit Ob/Gyns to be PCPs within its managed care groups. Its standard HMO and point of service products use pediatricians, internists, family practitioners and general practitioners as primary care physicians. Trigon's standard policies cover, without referral, one visit per year to an Ob/Gyn for screening and preventive services. Necessary follow-up may be authorized by telephone without the necessity of an office visit with the PCP.

Overall, representatives of the Virginia Association of HMOs, Trigon Blue Cross Blue Shield of Virginia, Kaiser Permanente, and Humana, maintained that Virginia's current market-driven approach to the Ob/Gyn Access issue is appropriate and desirable. And, they emphasized that PCPs are capable of coordinating women's care and making Ob/Gyn referrals as and when appropriate.

C. Viewpoint of Family Practitioners.

The Virginia Academy of Family Physicians presented the viewpoint of generalists most often called upon to serve PCPs in managed care plans. Academy representatives told the subcommittee that family practitioners are currently the most broadly trained physicians in the United States. In addition to their undergraduate and medical school education, family practice specialists must complete a three-year residency program and sit for a certification examination administered by the American Board of Family Practice.

The residency program provides training in a broad spectrum of obstetrical and gynecological conditions. Family practice residents are trained in providing prenatal care (including performing ultrasound studies to ensure fetal well-being) and performing routine vaginal deliveries. Additionally, residents learn to evaluate pap smears, perform endometrial biopsies to detect abnormalities of the uterus, and to perform fine-needle aspiration biopsies of breast lumps to diagnose breast cancer, and to perform numerous other procedures.

Family practice specialists also testified that their education and training prepares them to treat women for problems such as diabetes, hypertension, heart disease and a host of other medical problems. Family practitioners typically manage, without referral or consultation with a sub-specialist, over ninety percent of the medical problems they confront. In contrast, family practice representatives said, whenever a woman uses her Ob/Gyn for primary care, she will be referred to a specialist for whichever system is causing a medical problem. Thus, from a continuity of service and a cost point of view, the family practice physician is the specialty of choice for a primary care provider, they stated. An overview of family practice education and training is attached as *Appendix N*.

D. Viewpoint of the Business Community

Representatives of Virginia's business community, led by the Virginia Chamber of Commerce on behalf of Virginians for Health Care Solutions (a coalition of associations, businesses and health care companies), expressed their firm opposition to any statutory authorization for unlimited direct access or any requirement that managed care plans be required to designate Ob/Gyns as PCPs. The Chamber and the Commonwealth Coalition on Health emphasized that employers have chosen managed care because it delivers value in price and quality.

III. SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

The subcommittee concluded that managed care is modifying patients' use of specialists and sub-specialists such as Ob/Gyns who, in many cases, can be accessed

only after consultation with generalist PCPs. Access is a critical issue to Ob/Gyns as evident from the Virginia Ob/Gyn Society/ACOG survey which identified this as the most important issue to them in terms of patient care. The issue, however, is equally important to providers of managed care plans seeking to strike a balance between quality health care and creating an affordable, competitive product.

As a legislative study committee, the subcommittee was unable to determine in absolute terms whether the quality of women's obstetrical and gynecological care in Virginia has been significantly affected by managed care's PCP gatekeeping mechanisms. Nor was it possible to determine what effect pro-access legislation recently enacted in North Carolina, Connecticut and other states has had on the quality and cost of such care in those states. However, the testimony and documentation submitted to the subcommittee underscores the Ob/Gyn access issue's importance to the future of reimbursed health care delivery within the Commonwealth.

During joint subcommittee work sessions at both meetings, Ob/Gyn access legislation from other states, including Connecticut, New York, North Carolina and Maryland was discussed. At the December 12 meeting, joint subcommittee members concluded that legislative study of Ob/Gyn access in managed care plans should continue in 1996. Members present at the December 12 meeting further agreed that in conjunction with reviewing the draft of its final report, joint subcommittee members would examine three legislative drafts separately incorporating: (i) the North Carolina legislative model permitting unrestricted access *(Appendix O),* (ii) the Maryland model permitting one self referred Ob/Gyn visit, or Ob/Gyn PCP designation *(Appendix P),* and (iii) a proposal permitting unrestricted access under the Maryland model if an individual's PCP is not a Family Practitioner *(Appendix Q).*

The joint subcommittee held its final meeting on January 11. It received the written comments on the final report draft from subcommittee member, Senator Clarence A. Holland *(Appendix R).* It approved a proposed study resolution continuing the study of the HJR 560 issues in 1996 *(Appendix S)* and approved the joint subcommittee's final report.

Respectfully submitted,

The Honorable Gladys B. Keating, Chairman
The Honorable George H. Heilig, Jr.
The Honorable Kenneth R. Plum
The Honorable Joyce K. Crouch
The Honorable Lacey E. Putney
The Honorable Clarence A. Holland

The Honorable Yvonne B. Miller
The Honorable H. Russell Potts, Jr.
The Honorable W. Henry Maxwell

HOUSE JOINT RESOLUTION NO. 560

Establishing a joint subcommittee to study women's access to obstetrical and gynecological services, particularly in managed care plans.

Agreed to by the House of Delegates, February 4, 1995
Agreed to by the Senate, February 21, 1995

WHEREAS, existing law provides for regulation of third party payors by the Bureau of Insurance within the State Corporation Commission; and

WHEREAS, in the last several years, many third party health care plans have evolved toward managed care; and

WHEREAS, managed care is considered by most experts as one of the most important mechanisms for containing health care costs; however, every system has its flaws; and

WHEREAS, the specialty of obstetrics and gynecology is devoted to primary-preventive health care for women throughout their lifetimes; and

WHEREAS, some managed care plans list obstetrics and gynecology as primary care and others do not; and

WHEREAS, significant numbers of women view their obstetrician-gynecologist as their primary or only physician and, often, the only doctor they see regularly during their reproductive years; and

WHEREAS, the majority of women have visited their obstetrician-gynecologist during the past two years, with general medical examinations being the next most frequent and accounting for seven million visits each year; and

WHEREAS, women are opposed to restrictions on access to obstetrician- gynecologists and would prefer to access their obstetrician-gynecologists without the double expense of going through a "gatekeeper"; and

WHEREAS, 75 percent of those women who must be referred by another physician or "gatekeeper" before they may see their obstetrician-gynecologist would like to see this requirement eliminated; and

WHEREAS, the purpose of a "gatekeeper" is to avoid unnecessary self-referrals to specialists, and although some obstetrician-gynecologists are very specialized, the majority are primary care physicians; and

WHEREAS, over two-thirds of obstetrician-gynecology visits are made by established patients of the physician, returning for care of their condition; and

WHEREAS, in several states, laws have been approved which mandate that obstetricians and gynecologists be eligible primary care physicians if they meet the other plan criteria; and

WHEREAS, for women, it would be desirable to avoid bureaucratic delays in receiving care as well as double payments in order to access obstetrical and gynecology services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study women's access to obstetrical and gynecological services, particularly in managed care plans and to make recommendations on how duplicative costs and administrative snarls may be avoided. The joint subcommittee shall consist of nine members to be appointed as follows: five members of the House of Delegates appointed by the Speaker of the House; and four members of the Senate appointed by the Senate Committee on Privileges and Elections. In developing recommendations, the joint subcommittee is requested to confer with women, doctors, the Bureau of Insurance and various commercial insurers, and other insurers, preferred provider organizations, and health maintenance organizations.

The direct costs of this study shall not exceed $5,400.

The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

GENERAL ASSEMBLY OF NORTH CAROLINA
1995 SESSION
RATIFIED BILL

CHAPTER 63
HOUSE BILL 773

AN ACT TO PROVIDE FOR DIRECT ACCESS BY WOMEN TO OBSTETRICIAN-GYNECOLOGISTS.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-38. Direct access to obstetrician-gynecologists.**

(a) Each health benefit plan shall allow each female plan participant or beneficiary age 13 or older direct access within the health benefit plan, without prior referral, to the health care services of an obstetrician-gynecologist participating in the health benefit plan, within the benefits provided under that health benefit plan pertaining to obstetrician-gynecologist services.

For purposes of this section:

(1) 'Health benefit plan' means an HMO subscriber contract or any preferred provider, exclusive provider, or other managed care arrangement offered under a health benefit plan, as defined in G.S. 58-50-110(11).

(2) 'Health care services' means the full scope of medically necessary services provided by the participating obstetrician-gynecologist in the care of or related to the female reproductive system and breasts, and in performing annual screening, counseling, and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists, and includes services provided by nurse practitioners, physician's assistants, and certified nurse midwives in collaboration with the obstetrician-gynecologist in the care of the participant or beneficiary.

(3) 'Benefits' are those medical services or other items to which an individual is entitled under the terms of her contract with a health benefit plan, as approved by the Department of Insurance.

(b) Each health benefit plan shall inform female participants and beneficiaries in writing of the provisions of this section. The information shall be provided in benefit handbooks and materials and enrollment materials."

Sec. 2. This act becomes effective January 1, 1996, and applies to health benefit plans issued, renewed, or amended on or after that date. For purposes of this act, renewal is presumed to occur on each anniversary of the date when coverage was first effective on the person or persons covered by the plan.

In the General Assembly read three times and ratified this the 2nd day of May, 1995.

DENNIS A. WICKER

Dennis A. Wicker
President of the Senate

HAROLD J. BRUBAKER

Harold J. Brubaker
Speaker of the House of Representatives

Maryland

Editor's note. — Section 5, ch. 154, Acts 1992, provides, in part, that the act shall take effect July 1, 1992.

§ 19-705.4. Limitations on covered services and visits.

(a) *Limitations on covered services.* — Any limitation imposed by a health maintenance organization on the receipt of covered services provided to a member or subscriber by a physical therapist licensed under Title 13 of the Health Occupations Article may only be imposed per incident or per injury within a contract period.

(b) *Limitations on number of visits.* — This subsection may not be construed to prohibit a health maintenance organization from imposing any limitations on the number of visits permitted for a member or subscriber. (1994, ch. 604.)

Editor's note. — Section 2, ch. 604, Acts 1994, provides that the act shall take effect Oct. 1, 1994.

§ 19-706. Regulation; applicability of other laws.

(d) *Applicability of Article 48A, § 58A and Subtitles 9A and 11.* — The provisions of Article 48A, § 58A of the Code and Article 48A, Subtitles 9A and 11 shall apply to health maintenance organizations.

(g) *Applicability of Article 48A, § 230A.* — The provisions of Article 48A, § 230A of the Code shall apply to health maintenance organizations.

(h) *Applicability of Article 48A, §§ 354, 438A, and 490T.* — The provisions of Article 48A, §§ 354, 438A, and 490T of the Code shall apply to health maintenance organizations.

(i) *Applicability of Article 48A, § 490U.* — The provisions of Article 48A, § 490U of the Code shall apply to health maintenance organizations.

(j) *Applicability of Article 48A, Subtitle 55.* — The provisions of Article 48A, Subtitle 55 shall apply to health maintenance organizations.

(k) *Classification of obstetrician/gynecologist as primary care; annual visits.* — A health maintenance organization shall:

(1) Classify an obstetrician/gynecologist as a primary care physician; or

(2) Permit a woman to receive an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to first visit a primary care provider.

(1991, chs. 121, 267, 269; 1992, ch. 593, § 1; 1993, ch. 9, § 2; chs. 285, 392; 1994, ch. 3, § 1; chs. 492, 551; ch. 628, § 1.)

Effect of amendments.

Chapter 121, Acts 1991, effective July 1, 1991, added (g).

Chapter 267, Acts 1991, effective July 1, 1991, inserted "and § 58A" in (d).

Chapter 269, Acts 1991, effective July 1, 1991, inserted "§ 58A and" in (d).

Neither of the 1991 amendments to (d) referred to the other, and effect has been given to ch. 269 as the later one signed by the Governor.

Chapter 9, Acts 1993, effective July 1, 1994, added the subsection designated herein as (j).

Chapter 285, Acts 1993, effective Oct. 1, 1993, added (h).

Chapter 392, Acts 1993, effective Oct. 1,

Maryland

§ 490Z. Obstetrician and gynecological care.

Any insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits for issuance or delivery in the State to any group or individual on an expense-incurred basis, including a health maintenance organization, shall:

(1) Classify an obstetrician/gynecologist as a primary care physician; or

(2) Permit a woman to receive an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to first visit a primary care provider. (1994, ch. 492.)

Editor's note. — As enacted by ch. 492, Acts 1994, this section was designated as § 490W, but since a § 490W was previously added by ch. 113, Acts 1994, the provision added by ch. 492, Acts 1994, has been designated herein as § 490Z.

Section 2, ch. 492, Acts 1994, provides that the act shall take effect Oct. 1, 1994.

§ 490AA. Coverage for drugs not approved by the Food and Drug Administration.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Medical literature" means scientific studies published in a peer-reviewed national professional medical journal.

(3) "Off-label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

(4) "Standard reference compendia" means:

(i) The United States Pharmacopeia Drug Information;

(ii) The American Medical Association Drug Evaluations; or

(iii) The American Hospital Formulary Service Drug Information.

(b) *In general.* — (1) Each contract or policy of health insurance delivered or issued for delivery within the State to an employer or an individual on a group or individual basis that provides coverage for drugs may not exclude coverage of a drug for a particular indication on the ground that the drug has not been approved by the federal Food and Drug Administration for that indication if the drug is recognized for treatment of the indication in one of the standard reference compendia or in the medical literature.

(2) Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.

(c) *Authority to direct payment.* — The Secretary of Health and Mental Hygiene has the authority to direct a person that issues a contract or policy of health insurance to make payments required by this section.

(d) *Review panel for off-label uses of drugs.* — (1) The Secretary of Health and Mental Hygiene shall appoint a panel of medical experts to review off-label uses of drugs not included in any of the standard reference compendia or in the medical literature and to advise the Secretary whether a particular off-label use is medically appropriate.

(2) The panel shall consist of:

APPENDIX D

HLS 95-560 **REENGROSSED**

Regular Session, 1995

HOUSE BILL NO 318

BY REPRESENTATIVES FLOURNOY AND WILKERSON

INSURANCE/HEALTH-ACCID: Provides direct access to an obstetrician or gynecologist for certain services

1 AN ACT

2 To enact R.S. 22:215.17 and 2027(D) and R.S. 40:2206, relative to health
3 care services; to permit selection of an obstetrician or gynecologist
4 as a primary care physician; to provide women with direct access to
5 an obstetrician or gynecologist for certain services without penalty or
6 loss of benefits; and to provide for related matters.

7 Be it enacted by the Legislature of Louisiana:

8 Section 1. R.S. 22:215.17 and 2027(D) are hereby enacted to read
9 as follows:

10 <u>§215.17. Obstetrician or gynecological examination; coverage</u>

11 <u>A.(1) Every hospital, health, or medical expense insurance</u>
12 <u>policy, hospital or medical service contract, employee welfare benefit</u>
13 <u>plan, health and accident insurance policy, or any other insurance</u>
14 <u>contract of this type, including a group insurance plan, or any policy</u>
15 <u>of group, family group, blanket, or franchise health and accident</u>
16 <u>insurance, a self-insurance plan, health maintenance organization, and</u>
17 <u>preferred provider organization, which is delivered or issued for</u>
18 <u>delivery in this state shall not prevent any individual, who is an</u>
19 <u>insured, enrollee, or beneficiary of any such policy or benefit plan</u>

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1 from receiving direct access to an obstetrician or gynecologist or in-
2 network obstetrician or gynecologist for routine gynecological care.
3 For those enrollees in a plan that has made agreements with providers
4 for the provision of health care or related services, the provisions of
5 this Subsection may limit direct access to any in-network obstetrician
6 or gynecologist for routine gynecological care.
7 (2) Routine gynecological care as used in this Section shall
8 mean a minimum of two routine annual visits, provided that the
9 second visit shall be permitted based upon medical need only, and
10 follow-up treatment within sixty days following either visit if related
11 to a condition diagnosed or treated during the visits, and any care
12 related to a pregnancy. Nothing in this Section shall prevent a
13 policy, program, or plan from requiring that an obstetrician-
14 gynecologist treating a covered patient coordinate that care with the
15 patient's primary care physician, if applicable.
16 B. Any provision in a health insurance policy or benefit
17 program which is delivered, renewed, issued for delivery, or
18 otherwise contracted for in this state which is contrary to this Section
19 shall, to the extent of such conflict, be void.
20 * * *
21 §2027. Notice required for certain prepaid charge rate increases,
22 cancellation or nonrenewal of service agreements; other
23 requirements
24 * * *
25 D.(1)(a) Every health maintenance organization authorized
26 under this Part may include in its plan obstetricians or gynecologists

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1 as primary care physicians. In addition, the health maintenance
2 organization shall not limit direct access to an in-network obstetrician
3 or gynecologist for routine gynecological care. This selection shall be
4 permitted without penalty or denial of the benefits provided under the
5 health maintenance organization.
6 (b) Routine gynecological care as used in this Section shall
7 mean a minimum of two routine annual visits, provided that the
8 second visit shall be permitted based upon medical need only, and
9 follow-up treatment within sixty days following either visit if related
10 to a condition diagnosed or treated during the visits, and any care
11 related to a pregnancy. Nothing in this Section shall prevent a
12 policy, program, or plan from requiring that an obstetrician-
13 gynecologist treating a covered patient coordinate that care with the
14 patient's primary care physician, if applicable, or in conjunction with
15 other oversight procedures.
16 (2) Any provision in a health maintenance organization plan
17 which is delivered, renewed, issued for delivery, or otherwise
18 contracted for in this state which is contrary to this Section shall, to
19 the extent of such conflict, be void.
20 Section 2. R.S. 40:2206 is hereby enacted to read as follows:
21 §2206. Obstetrician or gynecological examination; coverage
22 A.(1) Every preferred provider organization authorized under
23 this Part shall not prevent any individual, who is a recipient of health
24 care or a beneficiary of any such preferred provider organization,
25 from selecting an empaneled obstetrician or gynecologist as a
26 provider for routine gynecological care. This selection shall be

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1 permitted without penalty or denial of the benefits provided under the
2 preferred provider organization.
3 (2) Routine gynecological care as used in this Section shall
4 mean a minimum of two routine annual visits, provided that the
5 second visit shall be permitted based upon medical need only, and
6 follow-up treatment within sixty days following either visit if related
7 to a condition diagnosed or treated during the visits, and any care
8 related to a pregnancy. Nothing in this Section shall prevent a
9 policy, program, or plan from requiring that an obstetrician-
10 gynecologist treating a covered patient coordinate that care with the
11 patient's primary care physician, if applicable.
12 B. Any provision in a preferred provider contract which is
13 delivered, renewed, issued for delivery, or otherwise contracted for
14 in this state which is contrary to this Section shall, to the extent of
15 such conflict, be void.
16 Section 3. This Act shall apply to any new policy, contract, program,
17 or plan issued on or after January 1, 1996. Any policy, contract, or plan in
18 effect prior to January 1, 1996, shall convert to conform to the provision of
19 this Act on or before the renewal date thereof but in no event later than
20 January 1, 1997.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument.

Flournoy, Wilkerson HB No. 318

Proposed law would require all health insurance policies, contracts, programs, and plans including self-insured plans, health maintenance

CODING: Words in ~~struck through~~ type are deletions from existing law; words underscored are additions.

organizations (HMO's) and preferred provider organizations (PPO's) to permit an insured, enrollee, or beneficiary to receive direct access to an obstetrician or gynecologist for routine gynecological care.

Proposed law would permit the plan to limit direct access to any in-network obstetrician or gynecologist if the plan has made agreements with providers of health care services.

Proposed law would define "routine gynecological care" as a minimum of two annual visits, provided that the second visit shall be permitted based upon medical need only, and any treatment required as a result of such visits, or any care related to a pregnancy.

Proposed law would permit the inclusion of obstetricians or gynecologists as primary care physicians under a benefit plan.

Proposed law would apply to any new policy, contract, program, or plan issued on or after January 1, 1996. Policies, contracts, programs, or plans in effect prior to January 1, 1996, would be required to convert to conform with the proposed law no later than January 1, 1997.

(Adds R.S. 22:215.17 and 2027(D) and R.S. 40:2206)

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Deletes the prohibition from limiting access to in-network physicians to permit the policy or benefit plan to limit access to an in-network obstetrician or gynecologist.

2. Adds a requirement that the second annual visit be based upon medical need only.

3. Deletes the requirement that an insured, enrollee, or beneficiary be permitted to select an obstetrician or gynecologist as a primary care physician under a benefit plan.

4. Adds a provision to permit the inclusion of obstetricians or gynecologists as primary care physicians under a benefit plan.

Substitute House Bill No. 5046

PUBLIC ACT NO. 95-199

AN ACT CONCERNING DIRECT ACCESS TO CERTAIN PHYSICIANS IN HEALTH MAINTENANCE ORGANIZATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (a) As used in this section, "carrier" means each insurer, health care center, hospital and medical service corporation, or other entity delivering, issuing for delivery, renewing or amending any individual health insurance policy in this state on or after October 1, 1995, providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10) and (11) of section 38a-469 of the general statutes.

(b) Each carrier shall permit a female enrollee direct access to a participating in-network obstetrician-gynecologist for any gynecological examination or care related to pregnancy and shall allow direct access to a participating in-network obstetrician-gynecologist for primary and preventive obstetric and gynecologic services required as a result of any gynecological examination or as a result of a gynecological condition. The plan may require the participating in-network obstetrician-gynecologist to discuss such services and any treatment plan with the female enrollee's primary care provider. Nothing in this section shall preclude access to an in-network nurse-midwife as licensed pursuant to sections 20-86c and 20-86g of the general statutes and in-network advanced practice nurses, as licensed pursuant to sections 20-93 and 20-94a of the general statutes for obstetrical and gynecological services within their scope of practice.

(c) Each carrier may allow a female enrollee to designate either a participating, in-network obstetrician-gynecologist or any other in-network physician designated by the carrier as a primary care provider, or both, and may offer the same choice to all female enrollees.

Sec. 2. (NEW) (a) As used in this section, "carrier" means each insurer, health care center, hospital and medical service corporation, or other entity delivering, issuing for delivery, renewing or amending any group health insurance policy in this state on or after October 1, 1995, providing

coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469 of the general statutes.

(b) Each carrier shall permit a female enrollee direct access to a participating in-network obstetrician-gynecologist for any gynecological examination or care related to pregnancy and shall allow direct access to a participating in-network obstetrician-gynecologist for primary and preventive obstetric and gynecologic services required as a result of any gynecological examination or as a result of a gynecological condition. The plan may require the participating in-network obstetrician-gynecologist to discuss such services and any treatment plan with the female enrollee's primary care provider. Nothing in this section shall preclude access to an in-network nurse-midwife as licensed pursuant to sections 20-86c and 20-86g of the general statutes and in-network advanced practice nurses, as licensed pursuant to sections 20-93 and 20-94a of the general statutes for obstetrical and gynecological services within their scope of practice.

(c) Each carrier may allow a female enrollee to designate either a participating, in-network obstetrician-gynecologist or any other in-network physician designated by the carrier as a primary care provider, or both, and may offer the same choice to all female enrollees.

Sec. 3. (NEW) No contract between a managed care company, other organization or insurer authorized to do business in this state and a medical provider practicing in this state for the provision of services may require that the medical provider indemnify the managed care company, other organization or insurer for any expenses and liabilities including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against a managed care company, other organization or insurer on the basis of its determination of medical necessity or appropriateness of health care services if the information provided by said medical provider used in making the determination was accurate and appropriate at the time it was given. As used in this section and section 4 of this act, "medical provider" means any person licensed pursuant to chapters 370 to 373,

inclusive, 375, 379, 380 or 383 of the general statutes.

Sec. 4. (NEW) Notwithstanding the provisions of section 3 of this act, every medical provider participating in a contract pursuant to section 3 of this act, shall be responsible for his professional actions and related liability.

Certified as correct by

____

Legislative Commissioner.

____

Clerk of the Senate.

____

Clerk of the House.

Approved _______________________________ , 1995.

____

Governor, State of Connecticut.

New York

7. Notwithstanding any inconsistent provisions of law, an agreement to arbitrate which complies with the provisions of this section shall be presumed valid.

(Added L.1986, c. 266, § 17.)

Historical and Statutory Notes

Effective Date. Section effective July 1, 1986, applicable to arbitration agreements entered into on or after such date, pursuant to L.1986, c. 266, § 44, as amended by L.1986, c. 267, § 1, set out as a note under CPLR 7550.

Separability of Provisions. See section 43 of L.1986, c. 266, set out as a note under CPLR 7550.

§ 4406–b. Primary and preventive obstetric and gynecologic care [Eff. Jan. 1, 1995.]

1. The health maintenance organization shall not limit a female enrollee's direct access to primary and preventive obstetric and gynecologic services from a qualified provider of such services of her choice from within the plan to less than two examinations annually for such services or to any care related to a pregnancy. In addition, the health maintenance organization shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the enrollee's primary care practitioner in accordance with the requirements of the health maintenance organization.

2. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization to advise each female enrollee, in writing, of the provisions of this section.

(Added L.1994, c. 645, § 1.)

Historical and Statutory Notes

Effective Date. Section effective Jan. 1, 1995, pursuant to L.1994, c. 645, § 2.

§ 4407. Health maintenance organizations; employer requirements

[See main volume for 1 and 2]

3. (a) If there is more than one health maintenance organization engaged in the provision of health services in the area in which the employees of the employer reside, and if:

(i) one or more of such organizations provides more than one-half of its comprehensive health services through physicians or other health professionals who are members of the staff of the organization or of a medical group (or groups) which contracts with the organization, and

(ii) one or more of such organizations provides its comprehensive health services through contracts with an individual practice association (or associations), individual physicians and other health professionals under contract directly with the organization, or a combination of an individual practice association (or associations), medical group (or groups), physicians who are members of the staff of the organization, and individual physicians and other health professionals under contract directly with the organization, then the employer shall, in accordance with regulations of the commissioner, be required to offer the option of enrollment in at least one organization described

WA

S-1489.2

SENATE BILL 5854

State of Washington 54th Legislature 1995 Regular Session

By Senators Haugen, Spanel, Wood, Prentice, Winsley, Rasmussen, Hale, Kohl, McCaslin, Fairley, Long, Loveland, Franklin, Roach, Moyer, Quigley, McAuliffe, Drew and Wojahn

Read first time 02/09/95. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to women's health care; adding a new section to
2 chapter 48.01 RCW; and creating a new section.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. Sec. 1. The legislature finds that:
5 (1) The specialty of obstetrics/gynecology is devoted to the
6 preventive health care of women throughout their lifetime;
7 (2) Significant numbers of women view their obstetrician/
8 gynecologist as their primary or only physician. For many women an
9 obstetrician/gynecologist is often the only physician they see
10 regularly during their reproductive years. According to a 1993 Gallup
11 poll, women are more likely to have had a physician examination within
12 the last two years from an obstetrician/gynecologist than from any
13 other type of physician, and a majority of these women consider their
14 obstetrician/gynecologist to be their primary care physician;
15 (3) A general medical examination was the second most frequently
16 cited purpose for patient visits to obstetricians/gynecologists in 1989
17 and 1990, accounting for seven million visits each year, according to
18 data gathered by the National Center for Health Statistics;

1 (4) Women are opposed to restrictions in accessing obstetricians/
2 gynecologists. Among women who have health coverage, a Gallup poll
3 reported that seventy-eight percent can currently access their
4 obstetrician/gynecologist without going through a gatekeeper. Seventy-
5 five percent of these women would object to requirements that they be
6 referred by another physician or gatekeeper before they may see their
7 obstetrician/gynecologist. Similarly seventy-four percent of those who
8 now have restricted access to obstetricians/gynecologists would approve
9 of a system that would eliminate the need for a referral;
10 (5) Obstetricians/gynecologists refer their patients less
11 frequently than other primary care physicians, avoiding costly and
12 time-consuming referrals to specialists; and
13 (6) More than two-thirds of all visits to obstetricians/
14 gynecologists were made by established patients of the physician
15 returning for care of their condition according to data gathered by the
16 National Center for Health Statistics. Only four and seven-tenths
17 percent of patient visits resulted from referrals from another
18 physician.

19 NEW SECTION. Sec. 2. A new section is added to chapter 48.01 RCW
20 to read as follows:
21 Health care services provided under a plan as defined in RCW
22 43.72.010 or by a provider network must include identification of
23 obstetricians and gynecologists who may be chosen as primary care
24 providers by enrollees. "Primary care provider" as used in this
25 section means that health care provider a person first consults and may
26 include a person who refers a patient to another provider.
27 Obstetricians and gynecologists under this section must be graduated
28 from a school approved and accredited by the medical care quality
29 assurance commission under chapter 18.71 RCW.

--- END ---

1 **

2 HOUSE SUMMARY

3 For purposes of statutes relating to workers' compensation managed care arrangements, includes
4 obstetrician/gynecologists within the definition of "primary care provider." Provides that female Medicaid
5 recipients under the MediPass program, and female subscribers to a health maintenance organization that
6 offers services through a managed care system, may choose an obstetrician/gynecologist as their primary care
7 physician.

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CODING: Words stricken are deletions; words underlined are additions.

By Senators Brown-Waite, Johnson, Gutman, and Myers

1 A bill to be entitled
2 An act relating to women's health care;
3 amending ss. 409.9122, 440.134, and 641.19,
4 F.S.; providing for designation of an
5 obstetrician/gynecologist as a primary care
6 physician; reenacting s. 641.495(3), F.S.,
7 relating to health maintenance organization
8 certificate requirements, to incorporate the
9 amendment to s. 641.19, F.S., in a reference;
10 providing an effective date.
11
12 WHEREAS, women of all ages have a unique relationship
13 with their obstetrician/gynecologist based on a lifetime of
14 receiving their primary-preventive health care from this
15 physician, and
16 WHEREAS, the obstetrician/gynecologist may be the only
17 physician seen by many women for a significant portion of
18 their lifetime, and
19 WHEREAS, women have the right to choose an
20 obstetrician/gynecologist as their primary care physician,
21 NOW, THEREFORE,
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Paragraph (b) of subsection (1) of section
26 409.9122, Florida Statutes, is amended to read:
27 409.9122 Mandatory Medicaid managed care enrollment.--
28 (1)
29 (b) The MediPass program may not be expanded unless
30 the agency certifies, for each county where MediPass is to be
31 started, that the necessary resources, including staff, are

CODING: Words stricken are deletions; words underlined are additions.

On the Gov's desk

available to adequately inform recipients of their choice of primary care providers and to enroll them with a provider and that the necessary resources, including staff, are available to adequately recruit providers, ensure access, monitor performance and patient satisfaction, and assess the quality of care provided. Each female recipient has the right to choose an obstetrician/gynecologist as her primary care physician.

Section 2. Paragraph (k) of subsection (1) of section 440.134, Florida Statutes, 1994 Supplement, is amended to read:

440.134 Workers' compensation managed care arrangement.--

(1) As used in this section, the term:

(k) "Primary care provider" means, except in the case of emergency treatment, the initial treating physician and, when appropriate, continuing treating physician, who may be a family practitioner, general practitioner, or internist physician, or obstetrician/gynecologist licensed under chapter 458; a family practitioner, general practitioner, or internist osteopath, or obstetrician/gynecologist licensed under chapter 459; a chiropractor licensed under chapter 460; a podiatrist licensed under chapter 461; an optometrist licensed under chapter 463; or a dentist licensed under chapter 466.

Section 3. Paragraph (e) of subsection (7) of section 641.19, Florida Statutes, is amended to read:

641.19 Definitions.--As used in this part, the term:

(7) "Health maintenance organization" means any organization authorized under this part which:

(e) If offering ~~an HMO offers~~ services through a managed care system, then the managed care system must be a

A-18

system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber must have the right to choose an obstetrician/gynecologist as her primary care physician.

Section 4. For the purpose of incorporating the amendment to section 641.19(7)(e) in a reference thereto, subsection (3) of section 641.495, Florida Statutes, is reenacted to read:

641.495 Requirements for issuance and maintenance of certificate.--

(3) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(7)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

Section 5. This act shall take effect July 1, 1995, and shall apply to all contracts issued or renewed on or after that date.

AB 2493 Health coverage: primary care providers: obstetr
BILL NUMBER: AB 2493 CHAPTERED 09/23/94

BILL TEXT

CHAPTER	759
FILED WITH SECRETARY OF STATE	SEPTEMBER 23, 1994
APPROVED BY GOVERNOR	SEPTEMBER 22, 1994
PASSED THE ASSEMBLY	AUGUST 31, 1994
PASSED THE SENATE	AUGUST 29, 1994
AMENDED IN SENATE	AUGUST 26, 1994
AMENDED IN SENATE	AUGUST 9, 1994
AMENDED IN ASSEMBLY	MARCH 24, 1994

INTRODUCED BY Assembly Member Speier
(Principal coauthor: Assembly Member Richter)
(Coauthors: Assembly Members Alpert, Bornstein, Bowen, Bronshvag, Valerie Brown, Cannella, Cortese, Eastin, Epple, Escutia, Karnette, Klehs, Lee, Martinez, Moore, O'Connell, and Solis)
(Coauthors: Senators Bergeson, Hughes, McCorquodale, Petris, Torres, and Watson)

JANUARY 11, 1994

An act to add Section 1367.69 to the Health and Safety Code, and to add Sections 10123.83 and 11512.295 to the Insurance Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2493, Speier. Health coverage: primary care providers: obstetrician-gynecologists.

Existing law provides for licensure and regulation of health care service plans by the Commissioner of Corporations. Under existing law, willful violation of these provisions is a misdemeanor. Existing law also provides for the regulation of policies for disability insurance and nonprofit hospital service plans by the Insurance Commissioner.

Existing law requires that health care service plan contracts, nonprofit hospital service plan contracts, and disability insurance policies provide coverage for certain services and treatments.

This bill would state the findings and declarations of the Legislature with regard to the necessity for obstetrician-gynecologists to be deemed primary care providers for the purposes of health coverage. On or after January 1, 1995, this bill would require that health care service plan contracts, nonprofit hospital service plan contracts, and disability insurance policies, that cover hospital, medical, or surgical expenses, issued, amended, delivered, or renewed in this state , include obstetrician-gynecologists as primary care physicians or providers, as defined, provided they meet certain eligibility criteria.

By revising the provisions pertaining to health care service plans, this bill would create a new crime, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated

by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

SECTION 1. The Legislature finds and declares all of the following:

(a) The specialty of obstetrics and gynecology is devoted to primary-preventive health care of women throughout their lifetime.

(b) Significant numbers of women view their obstetrician-gynecologist as their primary or only physician. For many women, an obstetrician-gynecologist is often the only physician they see regularly during their reproductive years. According to a 1993 Gallup poll, women are more likely to have had a physical examination within the last two years from an obstetrician-gynecologist than from any other type of doctor (72 percent versus 57 percent) and the majority of these women (52 percent) consider their obstetrician-gynecologist to be their primary care physician.

(c) A general medical examination was the second most frequently cited purpose for patient visits to obstetrician-gynecologists in 1989 and 1990, accounting for seven million visits each year, according to data gathered by the National Center for Health Statistics.

(c) Women are opposed to restrictions in accessing obstetrician-gynecologists. Among women who have health coverage, a Gallup poll reported that 78 percent can currently access their obstetrician-gynecologist without going through a "gatekeeper." Seventy-five percent of these women would object to requirements that they be referred by another physician or "gatekeeper" before they may see their obstetrician-gynecologist. Similarly, 74 percent of those who now have restricted access to obstetrician-gynecologists would approve of a system that would eliminate the need for a referral.

(e) Obstetrician-gynecologists refer their patients less frequently than other primary care physicians, thus avoiding costly and time consuming referrals to specialists. According to a 1991 study of physician referral rates, obstetrician-gynecologists had the lowest referral rate of 4 percent compared with the rates of 7.3 percent for general internists and 8.4 percent for general and family practitioners.

(f) More than two-thirds (69.5 percent) of all visits to obstetrician-gynecologists were made by established patients of the physician returning for care of their condition, according to data gathered by the National Center for Health Statistics. Only 4.7 percent of patient visits resulted from referrals from another physician.

SEC. 2. Section 1367.69 is added to the Health and Safety Code, to read:

1367.69. (a) On or after January 1, 1995, every health care service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as eligible primary care physicians, provided they meet the plan'

s eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

SEC. 3. Section 10123.83 is added to the Insurance Code, to read:

10123.83. (a) On or after January 1, 1995, every policy of disability insurance that covers hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed in this state shall include obstetrician-gynecologists as primary care providers provided they meet the insurer's written eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

SEC. 4. Section 11512.295 is added to the Insurance Code, immediately following Section 11512.29, to read:

11512.295. (a) On or after January 1, 1995, every nonprofit hospital service plan contract that provides hospital, medical, or surgical coverage, that is issued, amended, delivered, or renewed in this state, shall include obstetrician-gynecologists as primary care providers provided they meet the plan's written eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term "primary care physician" means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

Searching keywords: (statusch) (authorSpeier)

MISSISSIPPI LEGISLATURE
By: Senator(s) Hall

REGULAR SESSION 1995
To: Insurance

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1691

AN ACT TO REQUIRE THAT ANY HEALTH CARE SERVICE PLAN CONTRACT SHALL COVER DIRECT ACCESS BY FEMALE ENROLLEES TO IN-NETWORK OBSTETRICIAN-GYNECOLOGISTS FOR INITIAL AND PRIMARY CARE AND REFERRAL; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Any health care service plan contract that provides hospital, outpatient, medical, or surgical coverage that is issued, amended, delivered, or renewed in this state shall allow and cover as a reimbursable expense direct access by female enrollees to in-network obstetricians-gynecologists for initial and primary care, for maintaining the continuity of patient care, and for initiating referral for specialist care. This includes any and all obstetric-gynecologic services required as a result of these patient contracts.

SECTION 2. This act shall take affect and be in force from and after July 1, 1995.

1. D.C. - 42 year old state employee found breast lump. Required multiple phone calls from patient to PCP to get permission for an exam by me and a mammogram. Both the patient and her PCP were confused about the requirements of her plan. This added greatly to her stress about the breast lump and her fear of non-coverage if she has done "the wrong thing" and her PCP's office staff were not helpful.

2. T.S. - 62 year old housewife referred by PCP to me to evaluate post menopausal bleeding. On history and exam she had gross hematuria (blood in urine), not vaginal bleeding. Urine culture was negative and her previous general physical was negative by PCP. The PCP denied me the ability to refer to a urologist. The patient was forced to see him again and all he did was refer her to a urologist.

3. W.S. - 28 healthy year old hospital worker seen for a routine gyn exam found to have severe dysplasia on PAP. Her second visit was used to perform colposcopy and cervical biopsy which confirmed extensive severe dysplasia requiring surgery. The PCP insisted upon seeing the patient before allowing the out patient surgery, even though she had <u>no</u> medical problems.

4. H.M. - 58 year old hospital worker followed entirely by PCP internist for both general and gyn health (Internal medicine has no required Gyn training). She was referred to me to perform D&C for the hemorrhaging she had after he placed her on improper estrogen. (This is completely contraindicated when a patient has a uterus, such as this patient).

5. J. F. - 33 year old female with uncontrolled insulin dependent diabetes since age 29. She had both general and gyn care by her PCP internist. She never received pre-conception counseling about the increased risk of birth defects with uncontrolled diabetes at the time of conception. She delivered this week a baby with multiple deformities which died at birth.

6. J. M - 32 year old nurse who had already "used up" her two allowed gyn visits previously. She refused to see her PCP for pelvic pain (mild) and discharge for two months due to embarrassment. She waited until a "new year" allowed a visit to me. I diagnosed cervicitis, mild pelvic inflammatory disease and hope this will not affect future fertility.

7. 46 year old nurse who had already had he allotted gyn visits, began having severe hot flashes, inability to sleep leading to severe sleep deprivation syndrome. She suffered for four months because she wanted her gynecologist to evaluate and treat, not her PCP.

8. C. W. - 48 year old housewife followed long term by PCP for both general and gyn care. She was referred to me because of heavy, prolonged menses with acute severe anemia requiring

transfusion. Thyroid studies drawn at the time of surgery revealed hypothyroidism - patient had obvious Myvedema features which her long time PCP had missed.

My biggest concerns are these:

1. Patients want the doctor who is most familiar with, and specially trained, in their own gynecologic care to see them for not just 1 or 2 visits a year, but anytime a gynecologic problem occurs.

2. Internists are allowed to be PCP, even though most have had no gynecologic training outside of medical school. This is not adequate to see women at a time when they have a problem outside of their "allotted visits".

3. Women are the only group who are asked to radically change both how they interact with medical care system and with whom they normally interact. Their children will continue to interact with Pediatrics as normal. Their husband will continue to interact for their general health, and starting only after age 40, prostate checks with their PCP (only rarely do men see a urologist for general urologic health). However 75% of women have in the past seen their gynecologist for their annual exam, and all gyn problems since the age of 18, or before if they are sexually active. Managed care, HMO, and other plans are unfairly and unwisely restricting one segment of the population. I see a law similar to North Carolina's law as the only way to redress this problem.

In September of 1995 the Virginia Ob/Gyn Society and the Virginia section of ACOG surveyed physicians concerning managed care.

800 surveys were mailed
277 surveys returned (35% return rate)

80% of physicians responded they particiated in a HMO
15% were considered primary care providers
75% were considered specialists
84% of physicians responded they particiated in a PPO
14% were considered primary care providers
80% were considered specialists

57% would sign up as PCP in fee-for-service managed care plan
14% would sign up as PCP in a capitated fee HMO
32% would not sign up as PCP for either one

90% stated greatest concern for their patients was direct access
10% stated greatest concern for their patients was having primary care provider status

99% agreed they would support a bill allowing DIRECT access to Ob/Gyn services by patients

Recently several states have responded to women's concerns relating to direct access to ob/gyn's by passing legislation which allows this.

Maryland's law became effective October 1, 1994 Ob/gyn can be a primary care provider if allowed by insurance or HMO. If ob/gyn not PCP women can self refer for one annual visit.

California's law became effective January 1, 1995 and gives women option to select an ob/gyn as their primary care physician in all insurance plans. Ob/gyns which participate must provide initial and primary care, continuity of care, and referrals to specialists.

New York's law likewise became effective January 1, 1995 but applies only to HMO's. Women are allowed immediate access to ob/gyn provider of their choice for specific services.

Mississippi's law became effective July 1, 1995. This act requires that any health care service plans contract shall cover direct access by female enrollees to in-network obstetrician-gynecologist for initial and primary care and referral and for related purposes.

Connecticut's law becomes effective October 1, 1995 and allows female enrollees in managed care networks direct access to participating in-network ob/gyn without having to seek a referral from their primary care physician.

North Carolina's law becomes effective January 1. 1996 and states "Each health benefit plan shall allow each female plan participant or beneficiary age 13 or older direct access within the health benefit plan, without prior referral, to the health care services of an obstetrician-gynecologist participating in the health benefit plan, within the benefits provided under that health benefit plan pertaining to obstetrician- gynecologist services. Participants of plan must be notified of this provision.

Hopefully, the Commonwealth of Virginia can be added to the list of states which have enacted legislation allowing DIRECT access, without prior referral, to ob/gyn care for our managed care patients.

HWJ

Results of the OB Society/Virginia Section ACOG Survey **September 1995**

	#	%
Number of surveys mailed	800	100%
Number of surveys returned	277	35%
Questions 1. Are you currently participating in any managed care plans? HMOs? Yes No PPOs? Yes No	 221 31 233 29	 80% 11% 84% 10%
Are you considered: (Circle One) a. primary care provider in HMOs? PPOs? b. specialist in HMO? PPO?	 41 40 209 216	 15% 14% 75% 80%
2. Would you sign up to be a primary care provider in a: a. fee-for-service managed care plan b. capitated fee HMO c. Neither	 159 39 89	 57% 14% 32%
3. What is your greatest concern for your patient in terms of accessing ob/gyn care in an HMO plan? a. direct access of women to their ob/gyn for pregnancy and gynecological problems b. primary care provider status in order to care for all medical problems of patient	 249 26	 90% 10%
4. Some states have passed legislation to provide direct access to ob/gyn care without a referral from the gatekeeper. Would you support a bill allowing DIRECT access to your services by your managed care patients? Yes No	 275 2	 99% 1%

National Ambulatory Care Survey. 1989-1990
National Center for Health Statistics NCHS

400,000,000 female ambulatory visits 14.1% were to OB/Gyn
59,800,000 ambulatory care visits to Ob/gyn 86% between ages 15-44
52,800,000 first most sited reason for visit was prenatal care
7,000,000 second most sited reason for visit was general medical exam
75% office visits for family planning were to ob/gyn
69.5% office visits to ob/gyn were by established patients returning for care
4.7% office visits to ob/gyn were by referral from other physician

ACOG/GALLUP Survey. 1993

97% of women between ages 18-65 have had a physical examination by an ob/gyn (72% within the previous 2 years)(Other type of doctor 57%)

78% of insured women can see an Ob/Gyn directly without referral

75% of insured women disapprove of a system which requires a referral to get access to an Ob/Gyn

74% of insured women with restricted access would approve of system without need for referral

54% of women who see Ob/Gyn's consider them their primary care physician.

AMA Center for Health Policy Research 1991 - who makes referrals?

Primary Care Specialty	No. Referrals per Week	No. of visits per Week	Referrals as a % of Visits
General/Family Practice	11.2	144.4	8.4%
General Internal Medicine	7.3	98.1	7.3%
Pediatrics	7.2	133.5	6.0%
Ob/Gyn	4.0	112.2	4.0%

Legislative Provision	MARYLAND	CALIFORNIA	NEW YORK	MISSISSIPPI	CONNECTICUT	NORTH CAROLINA
Provides a females traditional right of access to an ob/gyn	X	X	X	X	X	X
No prior authorization is necessary for female to see an ob-gyn	X	X	X	X	X	X
Allows female to self-refer to an ob-gyn	X	X	X	X	X	X
Applies to all insurers	X	X		X	X	X
Guarantees unrestricted direct access to an ob-gyn, for the full range of reproductive and preventive health care services		X		X	X	X
Insurers have the option to allow ob-gyns to operate as gatekeepers	X			X	X	
Insurers are required to notify female of their right to self-refer for ob-gyn services			X			X
Guarantees limited direct access to an ob-gyn, for specific services/visits only	X		X			
Ob-gyns must meet individual insurance plan criteria for primary care status and comply with care coordination and referral policies		X	X			
Explicitly designates ob-gyn as primary care providers		X			X	
Allows a female to self-refer to the ob-gyn provider of her choice; eg. family physician, certified nurse-midwife, physician, nurse practitioner, or ob-gyn			X			
Ob-gyns are not allowed to operate as gatekeepers			X			
Applies to HMO only			X			
Insurers must allow ob-gyns to operate as gatekeepers		X				
Law provides a definition of a "primary care provider"		X				

FACTS

National Ambulatory Care Survey, HHS, CDC, NCHS 1989-1990

- 400 million female ambulatory care visits 14.1% were to Ob-Gyns
- 59.8 million ambulatory care visits to Ob-Gyn, 86% between ages 15-44

ACOG/Gallup Survey, 1993

- 97% of women between ages 18-65 have had a physical examination by an Ob/Gyn (72% within the previous 2 years)
- 78% of insured women can see an Ob-Gyn directly without referral
- 75% of women disapprove of a system which requires a referral to get access to an Ob-Gyn
- 52% of women who see Ob-Gyn's consider them their primary care physicians.

AMA Center for Health Policy Research 1991 - who makes referrals?

Primary Care Specialty	No. Referrals per Week	No. of Visits per Week	Referrals as a % of Visits
General/Family Practice	11.2	144.4	8.4%
General Internal Medicine	7.3	98.1	7.3%
Pediatrics	7.2	133.5	6.0%
Ob/Gyn	4.0	112.2	4.0%

NOV 2 7 1995

Virginia Association of Health Maintenance Organizations
118 North Eighth Street • Richmond, Virginia 23219
Telephone (804) 648-VHMO (8466) Fax (804) 648-8036

November 22, 1995

The Honorable Gladys B. Keating
5909 Parkridge Lane
Franconia, VA 22310

RE: HJR 560 Study Resolution

Dear Gladys:

It is my understanding that you and other members of the Joint Subcommittee had some questions concerning the Virginia Association of Health Maintenance Organization's survey of its members on policies covering access to OB-GYN services. Specifically, your questions, as summarized for me by Arlen Bolstad, and the Association's responses are as follows:

1. **What is the total number of HMOs licensed in the Commonwealth, the number represented by the Association, and the number of plans responding to the Association's survey?**

   As of November 1, 1995, there are 25 HMOs licensed by the Bureau of Insurance. (At the time of the survey there were 24 licensed plans.) See attached list. Of the 25 HMOs, 23 plans are members of the Association. All 23 plans have responded to the survey. The two plans that are not currently members of the Association are U.S. Healthcare and Chartered Health Plan of Virginia (currently a Medicaid only HMO).

2. **Of the plans responding to the survey, how many indicated that their policy allows OB-GYN specialists to serve as primary care physicians and how many allow for at least one annual visit to an in-network OB-GYN without a PCP referral?**

   Of the 23 plans responding to the survey, 6 indicated that OB-GYNs could serve as a woman's PCP in some capacity. Four of these 6 plans indicated that women could choose an OB-GYN as her PCP for OB-GYN related matters only. Only 2 of these 6 plans allowed OB-GYNs to contract as PCPs for all matters.

   Twenty one of the 23 plans indicated that self-referral to an in-network OB-GYN was allowed; of these 21 plans, 16 limited the number of self-referrals to the annual well-women visit, while five plans had no limits on the number of self-referred visits to an in-network OB-GYN. Only two of the 23 plans reported that a referral from a PCP was necessary for an annual OB-GYN visit; however, these two plans were the same plans that allowed a woman to choose an OB-GYN as her regular PCP.

To put this in perspective in terms of women covered in HMOs (instead of number of plans), the total number of Virginia women enrolled in HMOs is estimated to be 585,000 (approximately 54% of the 1,084,000 Virginians enrolled in HMOs). Based on the enrollment of the 21 plans that currently allow self-referrals to OB-GYNs, 85% of women enrolled in Virginia's HMOs can self-refer to OB-GYNs for at least the annual well-women check-up; while the remaining 16% are enrolled in plans that allow OB-GYNs to contract as PCPs.

I hope that this information responds to the questions raised by members of the Joint Subcommittee. As I have previously testified before the Joint Subcommittee, the Association believes the current practices of HMOs provide a number of different approaches to the market demand for access to OB-GYN services. However, if the Joint Subcommittee concludes that specific legislation is necessary, it is our strong recommendation that the Maryland statute be adopted.

Please let me know if the Association can provide you with any additional information that will assist the Joint Subcommittee in its deliberations. I look forward to seeing you on the 12th.

Sincerely,

May H. Fox
Executive Director

Attachment

cc: Joint Subcommittee Members
Arlen K. Bolstad, Esquire

Aetna Health Plans of the
Mid-Atlantic, Inc.
7799 Leesburg Pike
Suite 1100 South
Falls Church, VA 22043
(703) 903-7100

Capital Care, Inc.
550 12th Street, SW
Washington, DC 20065
(202) 479-8000

CIGNA HealthCare Mid-Atlantic, Inc.
9700 Patuxent Woods Drive
Columbia, MD 21046
(301) 720-5800

CIGNA HealthCare of Virginia, Inc.
4050 Innslake Drive
Glen Allen, VA 23060
(804) 273-1100

Chartered Health Plan, Inc.
820 First Street, NW
Suite LL100
Washington, DC 20002-4205

The George Washington University Health Plan, Inc.
1901 Pennsylvania Ave, NW
Suite 600
Washington, DC 20006
(202) 416-0410

HMO Virginia, Inc.
(d/b/a HMO Plus)
PO Box 26623
Richmond, VA 23251
(804) 354-3860

Humana Group Health Plan
4301 Connecticut Ave, NW
Washington, DC 20008
(202) 364-2000

Health First, Inc.
621 Lynnhaven Parkway
Suite 450
Virginia Beach, VA 23452
(804) 463-4600

HealthKeepers, Inc.
PO Box 26623
Richmond, VA 23261
(804) 354-3860

HealthPlus, Inc.
7601 Ora Glen Drive
Greenbelt, MD 20770
(301) 982-0098

Kaiser Foundation Health Plan of the Mid-Atlantic
2101 East Jefferson Street
PO Box 6611
Rockville, MD 20849
(301) 816-2424

MD-Individual Practice Association, Inc.
4 Taft Court
Rockville, MD 20850
(301) 762-8205

Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

Optimum Choice, Inc.
4 Taft Court
Rockville, MD 20850
(301) 762-8205

PARTNERS National Health Plans of NC, Inc.
2000 Frontis Plaza Blvd
Winston-Salem, NC 27103
(910) 760-4822

Peninsula Health Care, Inc.
606 Denbigh Blvd, Ste 500
Newport News, VA 23602
(804) 875-5760

Physicians Health Plan, Inc.
(d/b/a Physicians Care First)
PO Box 26623
Richmond, VA 23261
(804) 354-3860

Principal Health Care of the Mid-Atlantic, Inc.
1801 Rockville Pike, Ste 110
Rockville, MD 20852
(301) 881-1033

Priority Health Plan, Inc.
621 Lynnhaven Parkway
Suite 450
Virginia Beach, VA 23452
(804) 463-4600

Prudential Health Plan, Inc.
1000 Boulders Parkway
Richmond, VA 23225
(804) 323-0900

Qual Choice of Virginia
1807 Seminole Trail
Suite 201
Charlottesville, VA 22901
(804) 975-1212

Sentara Health Plans, Inc.
4417 Corporation Lane
Virginia Beach, VA 23462
(804) 552-7220

Southern Health Services
PO Box 85603
Richmond, VA 23285-5603
(804) 747-3700

U.S. Healthcare, Inc.
980 Jolly Road
PO Box 1109
Blue Bell, PA 19422
(215) 628-4800

Enrollment in HMOs Licensed in Virginia

Northern Virginia

Aetna
Capital Care
CIGNA
GWU
HealthPlus
Humana
MD IPA
Optimum Choice
Kaiser
Principal
Prudential
U.S. Healthcare

Blue Ridge

QualChoice
CIGNA

Central Virginia

Aetna
CIGNA
HMO Virginia
HealthPlus
HealthKeepers
MD IPA
Optimum Choice
U.S. Healthcare
Chartered
Prudential
QualChoice
Southern Health

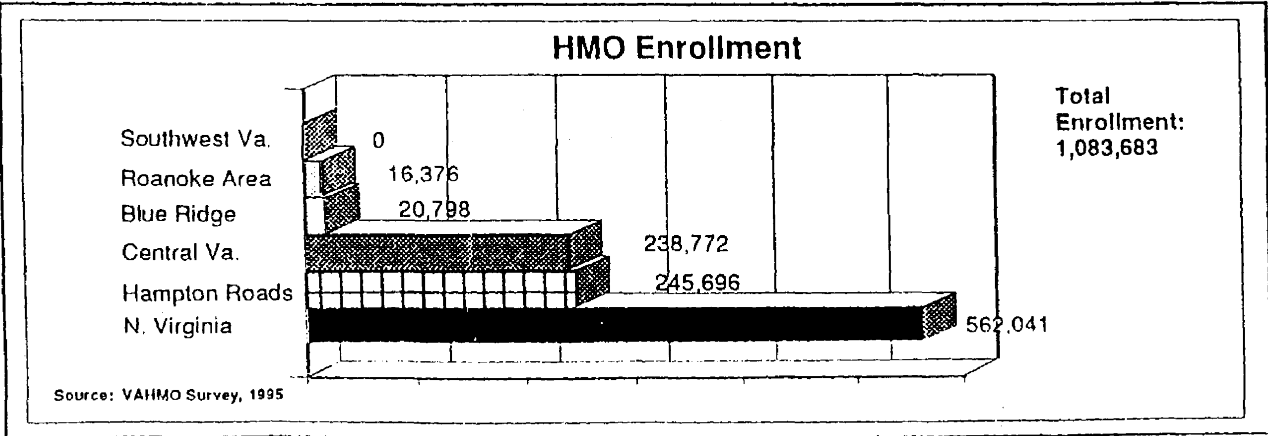
Roanoke Area

HealthKeepers
MD IPA
Optimum Choice
PARTNERS
QualChoice
Southern Health

Southwestern Virginia

Hampton Roads

CIGNA
Health First
HMO Virginia
HealthKeepers
Optimum Choice
Optima
Peninsula
Chartered
Priority
MD IPA
Sentara HP

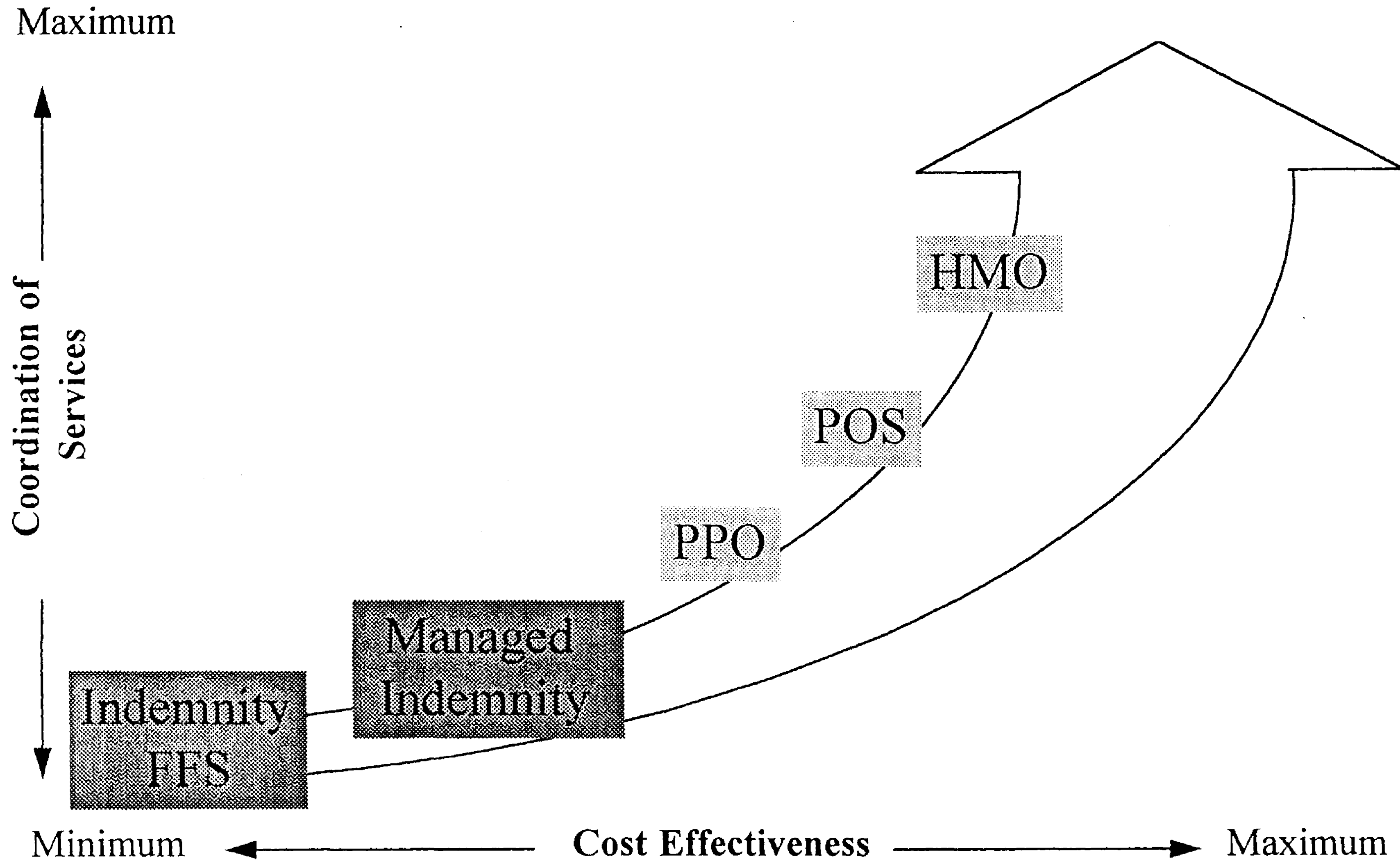


Source: VAHMO Survey, 1995

Presentation Before Joint Subcommittee HJR 560 Access to OB/GYNs

May H. Fox, Executive Director
Virginia Association of HMOs
September 22, 1995

Types of Health Care Plans



Source: Aetna Health Plans

INSURANCE DEFINITIONS

Fee-For-Service (FFS): a way of paying a health care provider - i.e. physician or hospital - by which providers set their own fees for the services they render and patients pay the fees for each and every service at the time it is rendered or when they are billed.

Health Maintenance Organization (HMO): a health care delivery system which is responsible for the organizing and provision of specified comprehensive services to an enrolled membership for a fixed, prepaid fee. The enrollees pay a set amount of premium or dues and the HMO provides agreed-on health care services. In most HMOs, the primary care physician coordinates and monitors the patients care.

Sc ~e: Virginians for Health Care Solutions

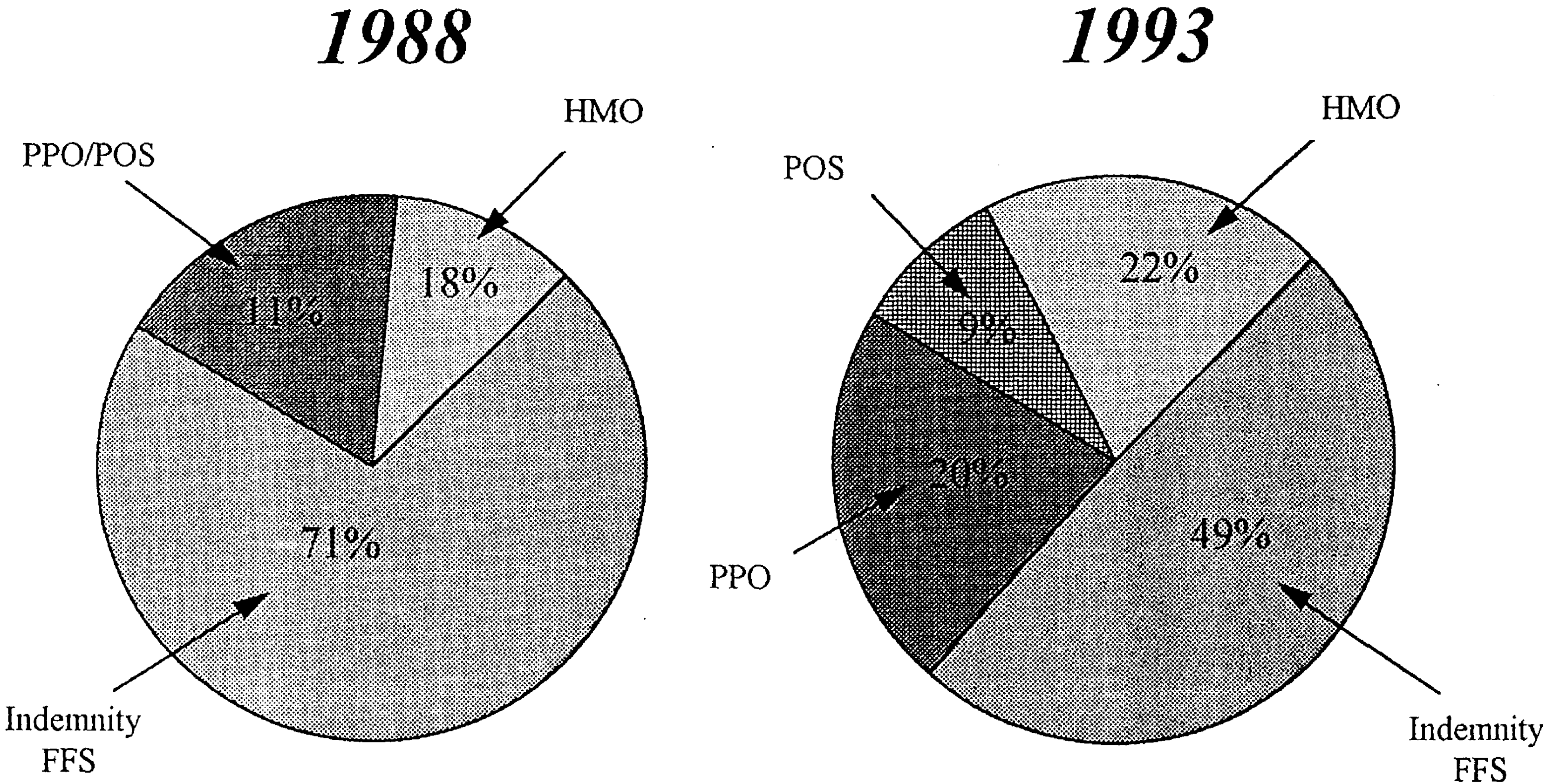
INSURANCE DEFINITIONS-Cont.

Preferred Provider Organization (PPO): a network of independent providers who agree to provide services at a predetermined and usually discounted price in return for prompt payment and increased volume of patients. Members of the PPO are encouraged to select the preferred providers by the use of lower contribution costs and usually more generous benefits. Members may choose to go outside of the network to receive care but, if so, they are responsible for a greater share of the co-insurance.

Point of Service (POS): a transition product which incorporates features of both HMOs and PPOs. Enrollees belong to an HMO but have the option to go outside the network of providers for an additional cost.

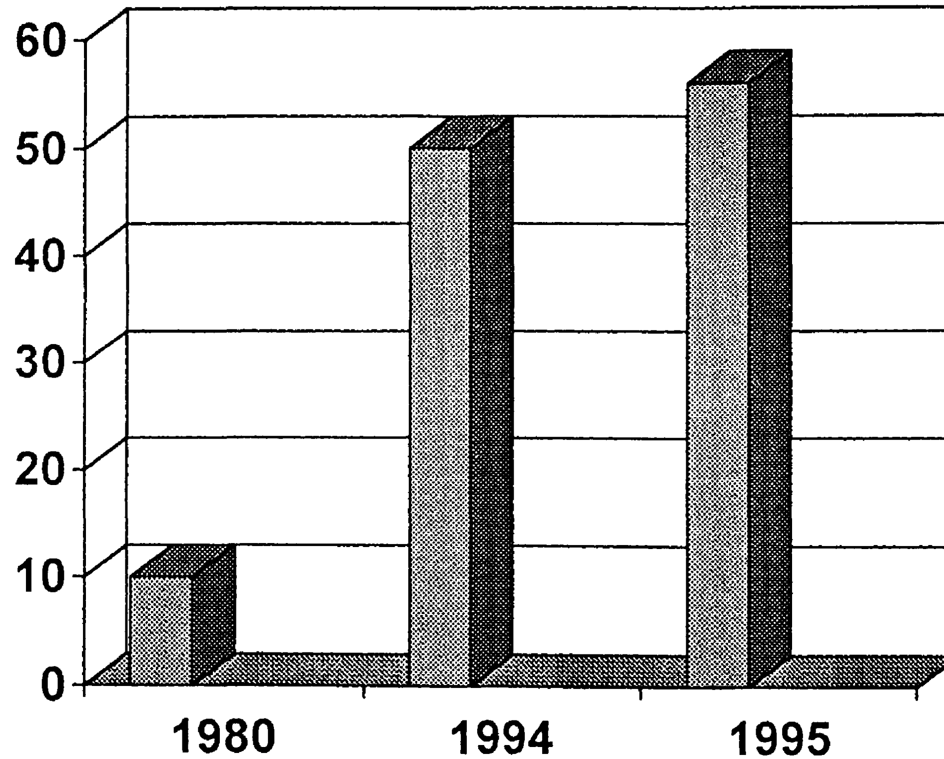
Source: Virginians for Health Care Solutions

Growth In Managed Care From 1988 To 1993



Source: KPMG Peat Marwick/Wayne State Univ., and Health Insurancce Association of America, 1993

Growth of HMO Enrollment from 1980 to 1995, United States



Growth in Millions

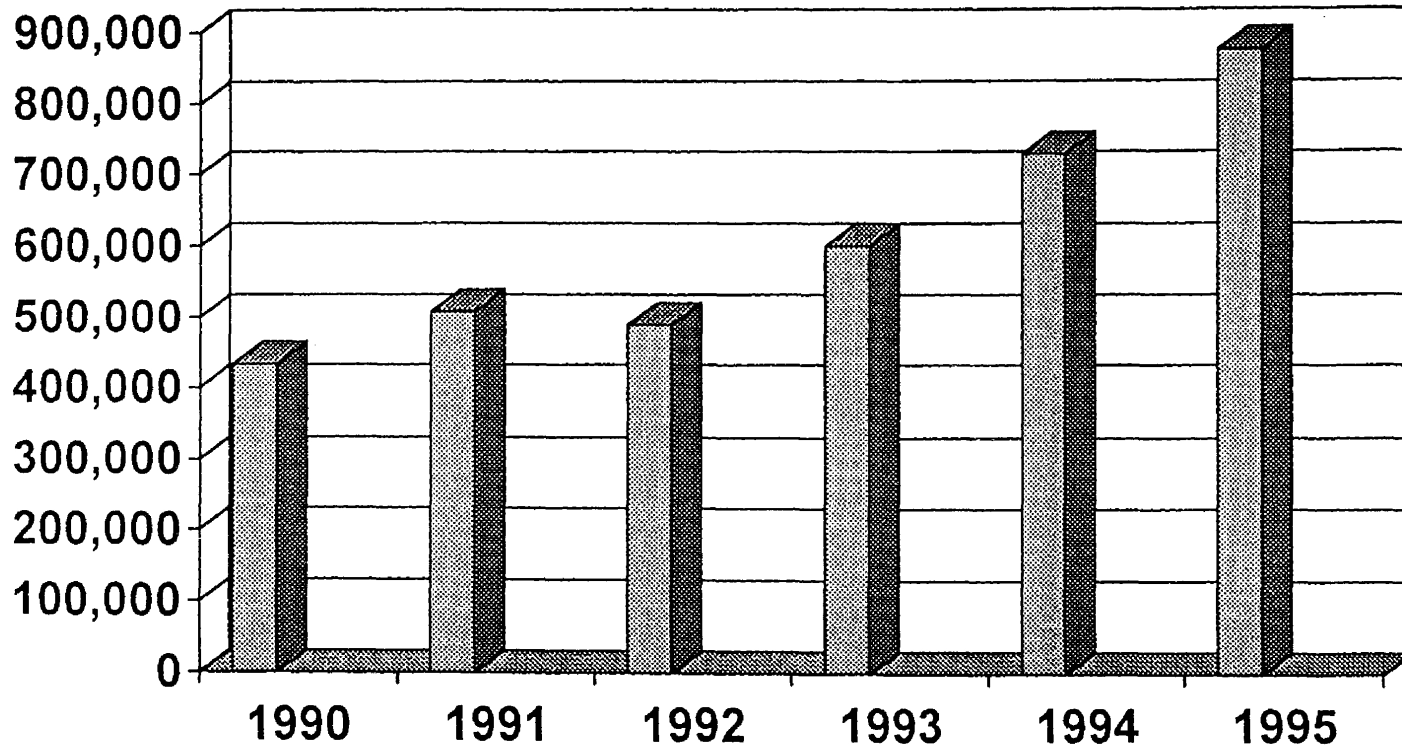
Source: Group Health Association of America

Trend in Monthly Premiums

Between 1988 and 1993 HMO premiums increased 40% less than premiums for FFS plans, while providing more comprehensive benefits and lower out-of-pocket costs than FFS plans.

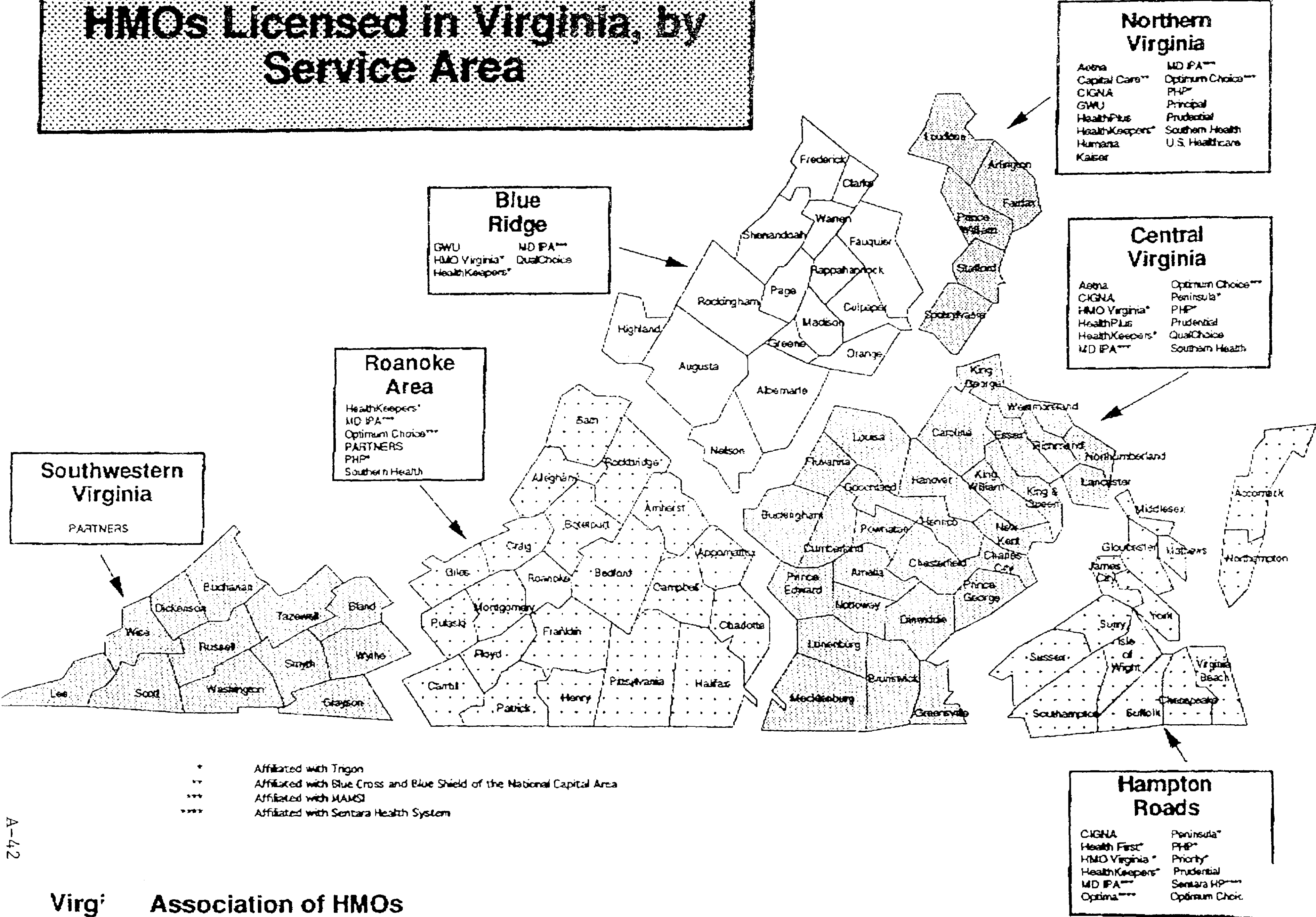
Source: KPMG Peat Marwick, December 1993

Growth in HMO Enrollment from 1990 to 1995, Virginia



Source: VAHMO

HMOs Licensed in Virginia, by Service Area



*	Affiliated with Trigon
**	Affiliated with Blue Cross and Blue Shield of the National Capital Area
***	Affiliated with MAMSI
****	Affiliated with Sentara Health System

Virg' Association of HMOs
August, 1995

Virginia HMOs By Type

IPA 19	**MIXED** 3
STAFF 1	**GROUP** 2

HMO MODEL TYPES

- ***STAFF:*** An organized prepaid health care system that delivers health services through a salaried physician group that is employed by the HMO.

- ***GROUP:*** An organized prepaid health care system that contracts with one independent group practice to provide health services.

- ***IPA:*** An organized prepaid health care system that contracts directly with physicians in independent practice, and/or with one or more multispecialty group practices (but predominantly organized around solo/single specialty practices) to provide health services.

So GHAA, 1995

% of Women Enrollees in HMOs
(as Compared to the Total Population)

Nationwide

Nationally, females make up 53.1% of HMO members, compared to 52.1% of the total population.

Virginia

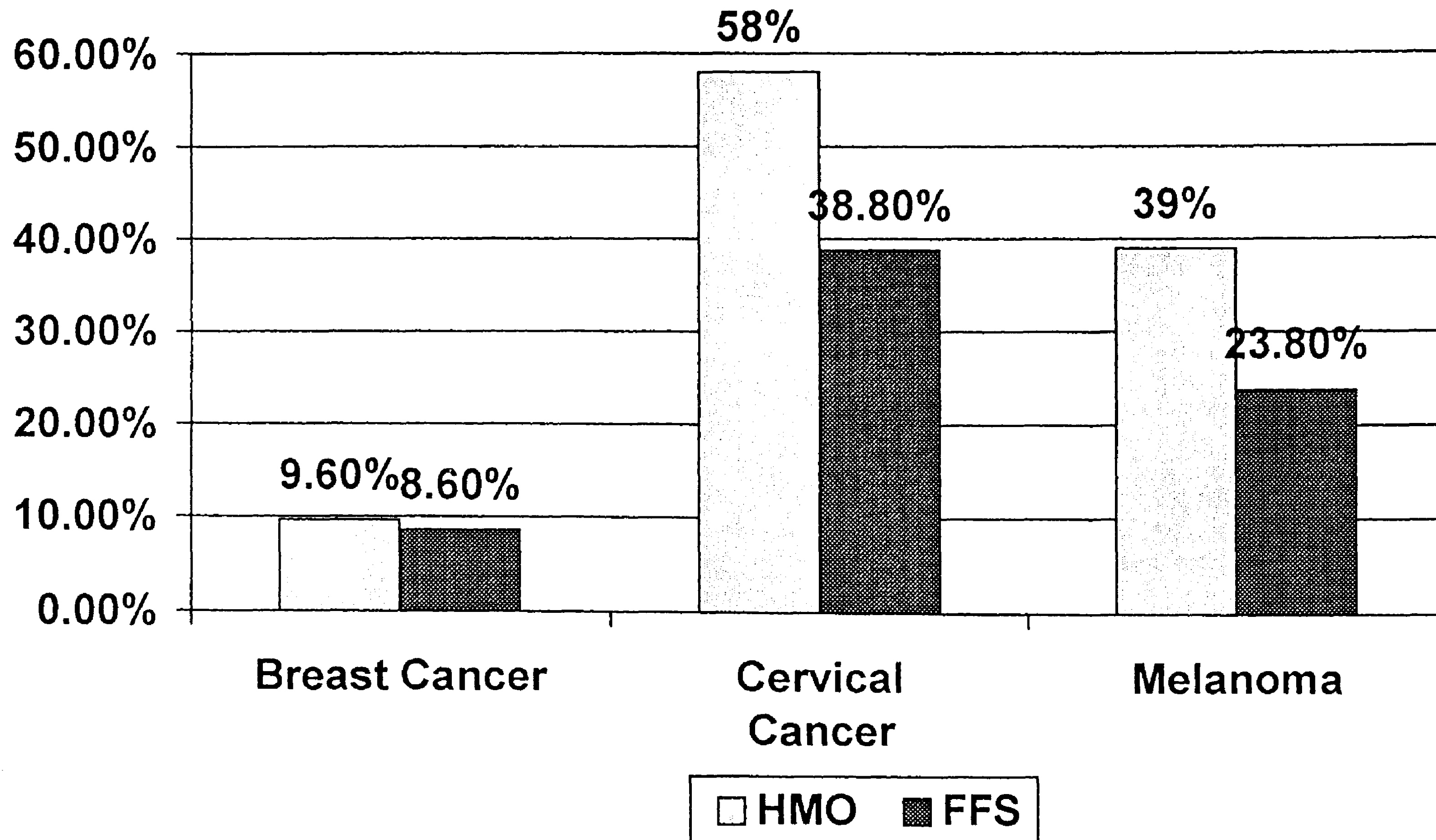
In Virginia, females composed 54.09% of HMO members, as compared to 50.9% of the Virginia population

HMOs Provide Women Better Access To Preventive Care Than Traditional FFS

- Almost 60% of HMO patients diagnosed with cervical cancer were diagnosed at the earliest stages as compared to 39% of fee-for-service patients
  - *Source: HCFA Study of Medicare HMOs reported in the American Journal of Public Health, October 1994*
- The percentage of women age 50 and older receiving cancer screening, including mammograms, CBE, and pap tests was higher in women in HMOs compared to fee-for-service patients.
  - *Source: Center for Disease Contral and Prevention, DHHS Advance Data, August 3, 1994*
- Ninety-one percent (91%) of HMO members are in plans which cover well-baby care, compared with 56% of persons in FFS plans
  - *Source: KPMG Peat Marwick, "Trends in Health Insurance," December, 1993*

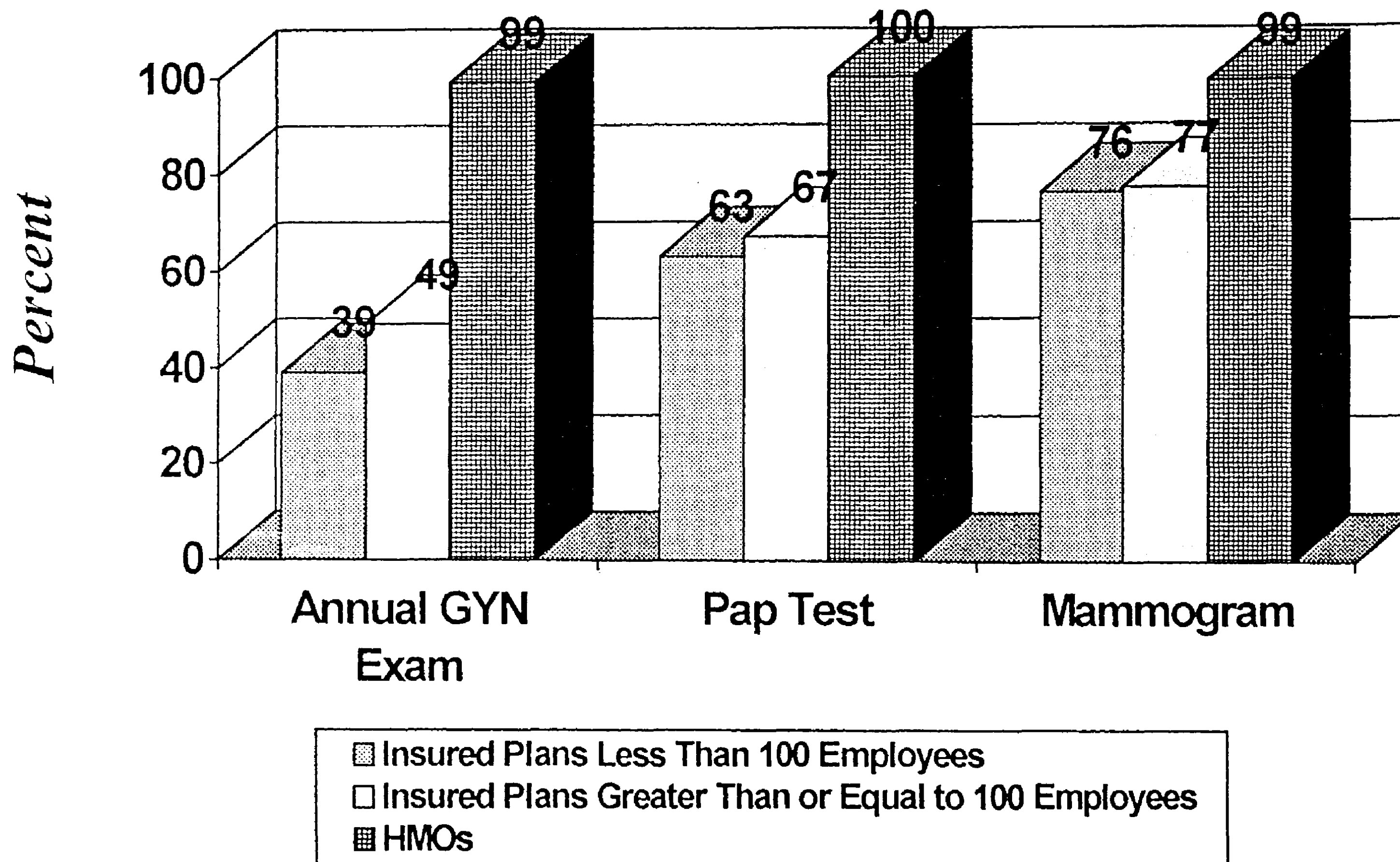
HMO Patients Are Diagnosed At Earlier Stages of Cancer Than FFS Patients

Percent Diagnosed at Earliest Stage



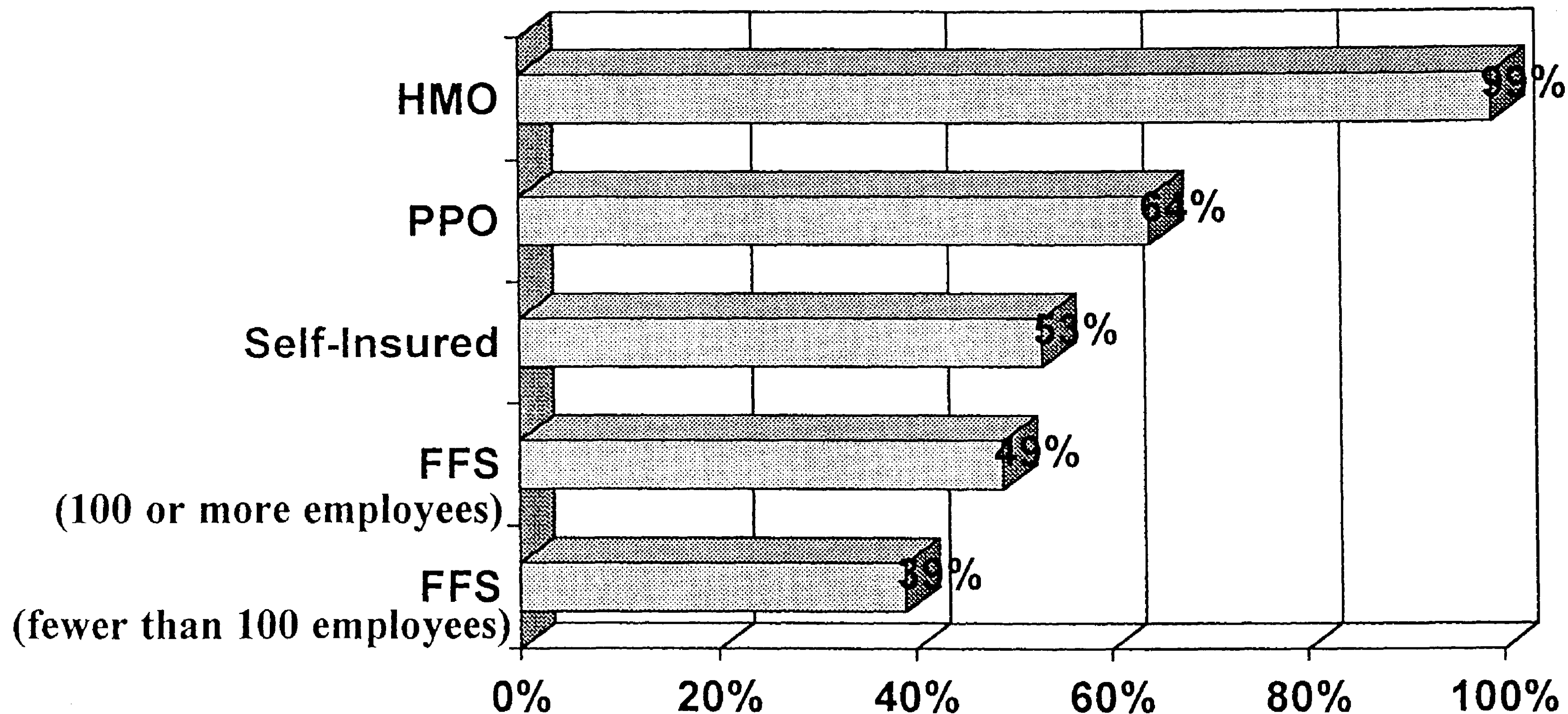
Source: American Journal of Public Health, October 1994

Coverage of Routine Gynecological Care, By Type of Plan



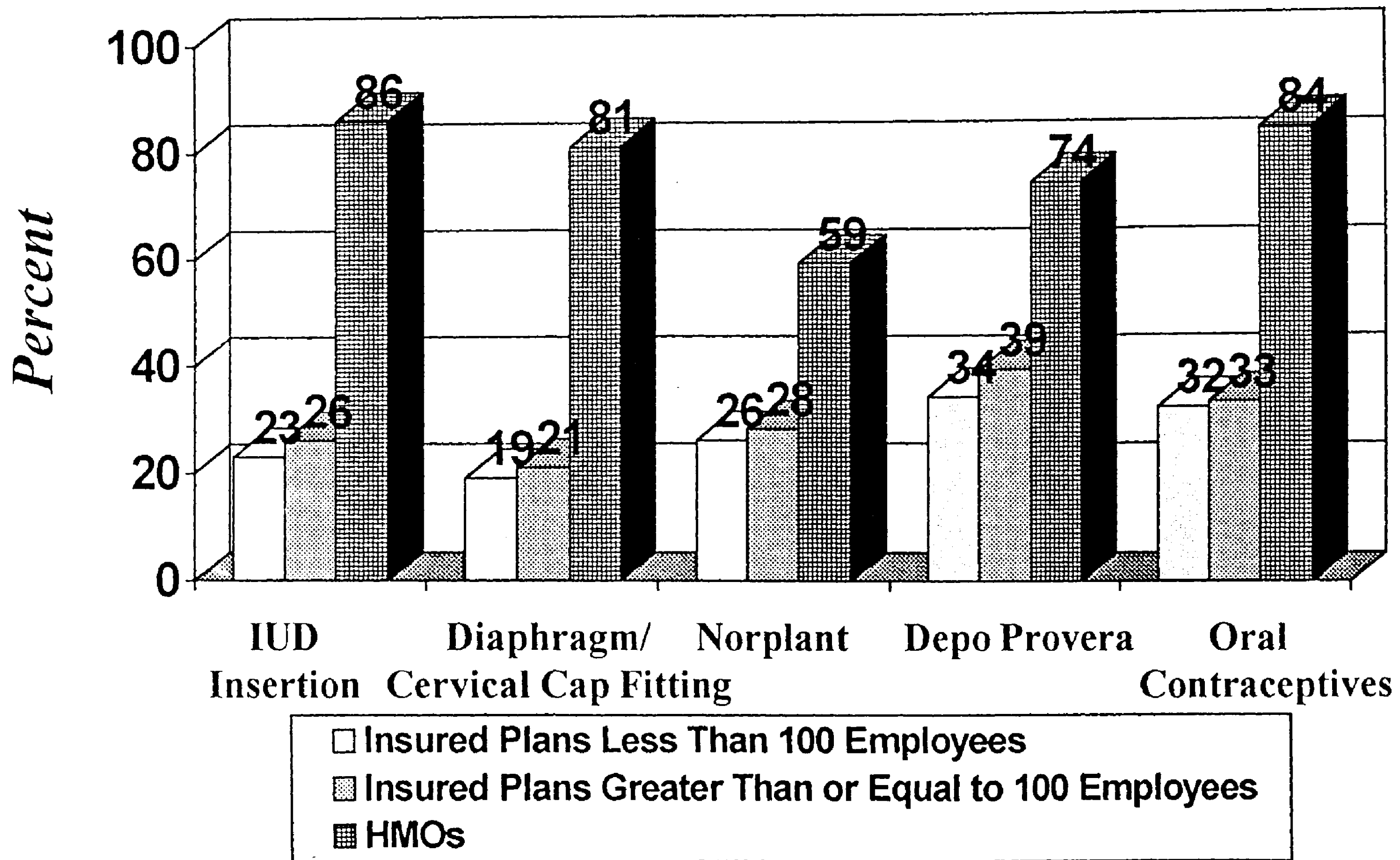
Sc ·: The Alan Guttmacher Institute, 1993

HMOs Are Much More Likely to Offer Annual Gynecological Exams Than Other Types of Health Plans



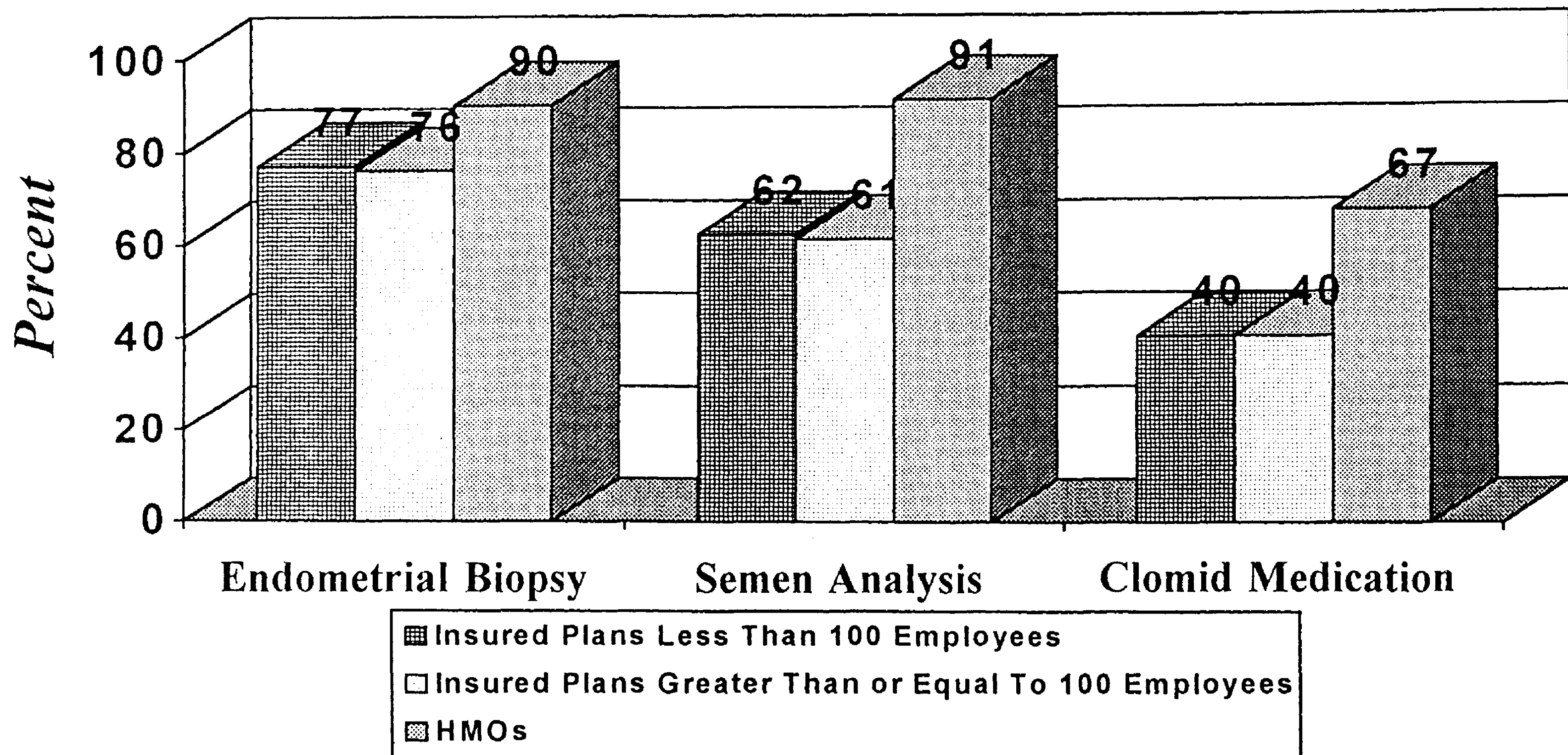
Source: The Alan Guttmacher Institute Study of Private-Sector Insurance Coverage of Reproductive Health Services, 1993

Coverage of Contraceptive Services By Type of Plan



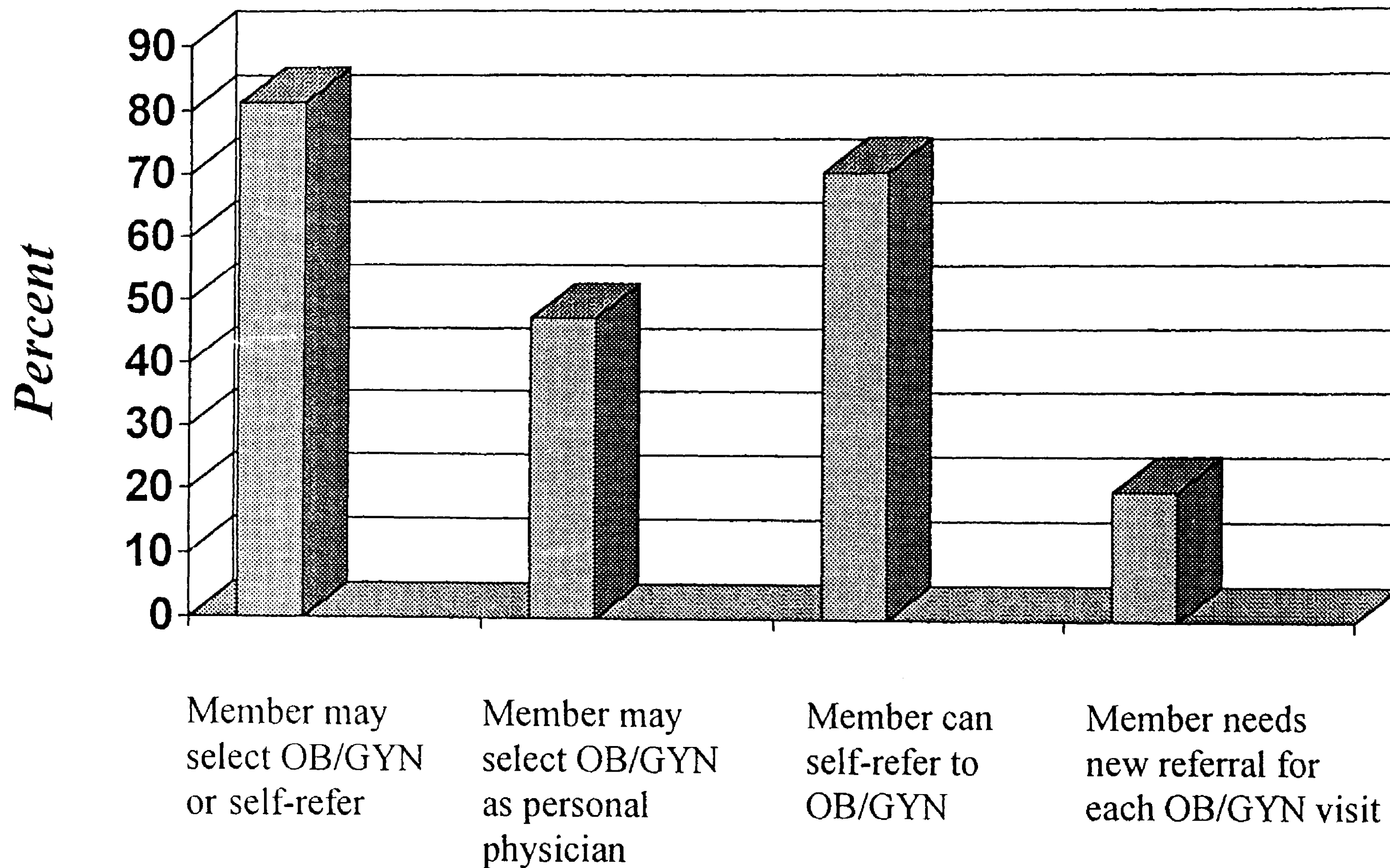
Source: The Alan Guttmacher Institute, 1993

Coverage of Selected Infertility Services, By Type of Plan



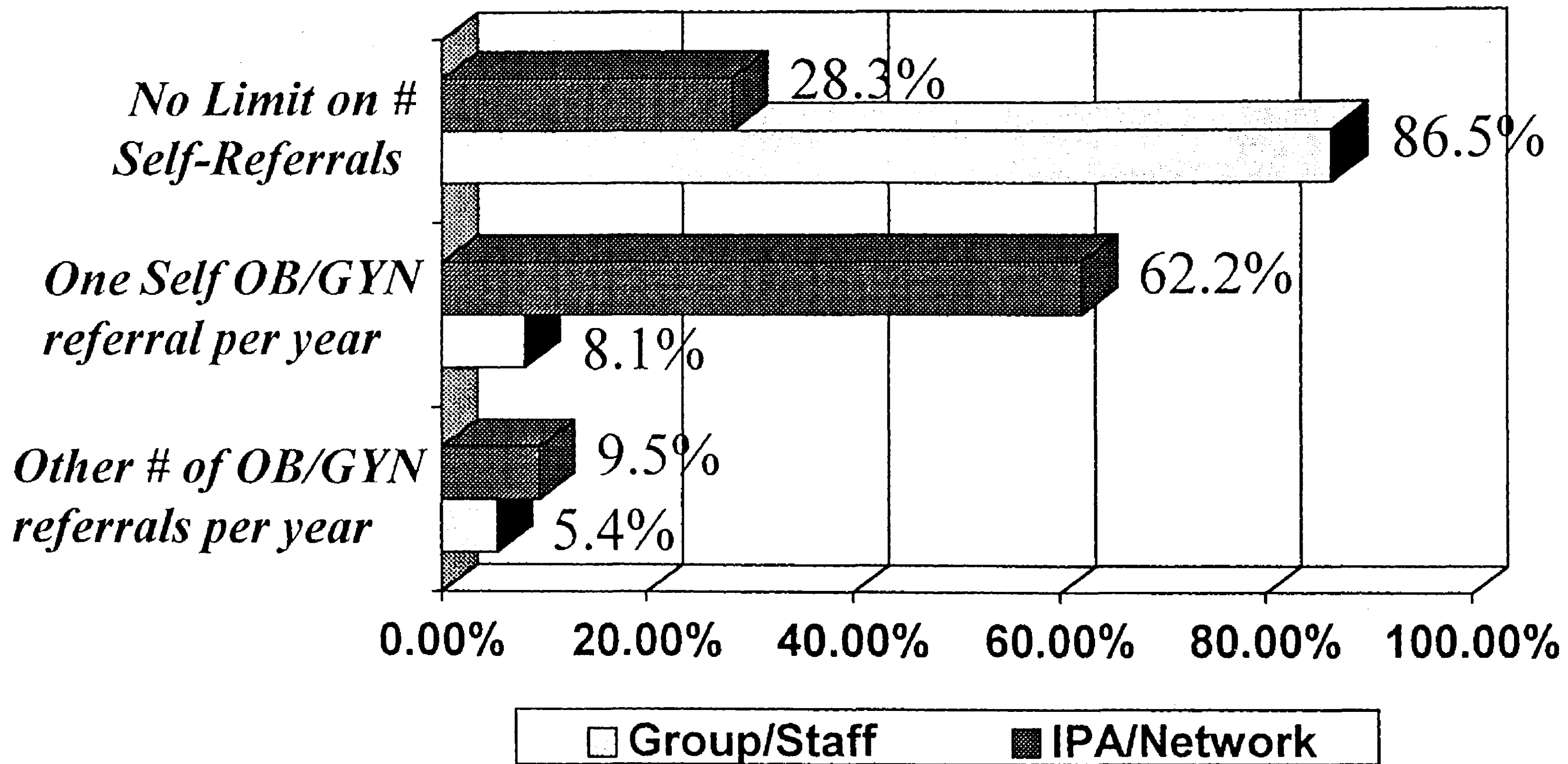
Source: The Alan Guttmacher Institute, 1993

Direct Access to OB/GYNs in HMOs, 1994



S : *GHAA/Kaiser Family Foundation, 1994*

Restrictions on OB/GYN Self-Referrals Differ by HMO Model Type



Source: GHAA/Kaiser Family Foundation Survey of Reproductive Health Benefits, 1994

VAHMO Survey on Access to OB/GYNs

- DO HMOs IN VIRGINIA ALLOW OB/GYN PHYSICIANS TO CONTRACT AS PCPs?

- DO HMOs IN VIRGINIA ALLOW SELF-REFERRALS TO OB/GYNs?

- UNDER WHAT CIRCUMSTANCES DO HMOs REQUIRE A REFERRAL FOR OB/GYN SERVICES?

DO HMOs IN VIRGINIA ALLOW OB/GYN PHYSICIANS TO CONTRACT AS PCPs?

- Of the 21 HMOs responding to the survey, 4 plans indicated that their plan design allows OB/GYNs to contract as PCPs.

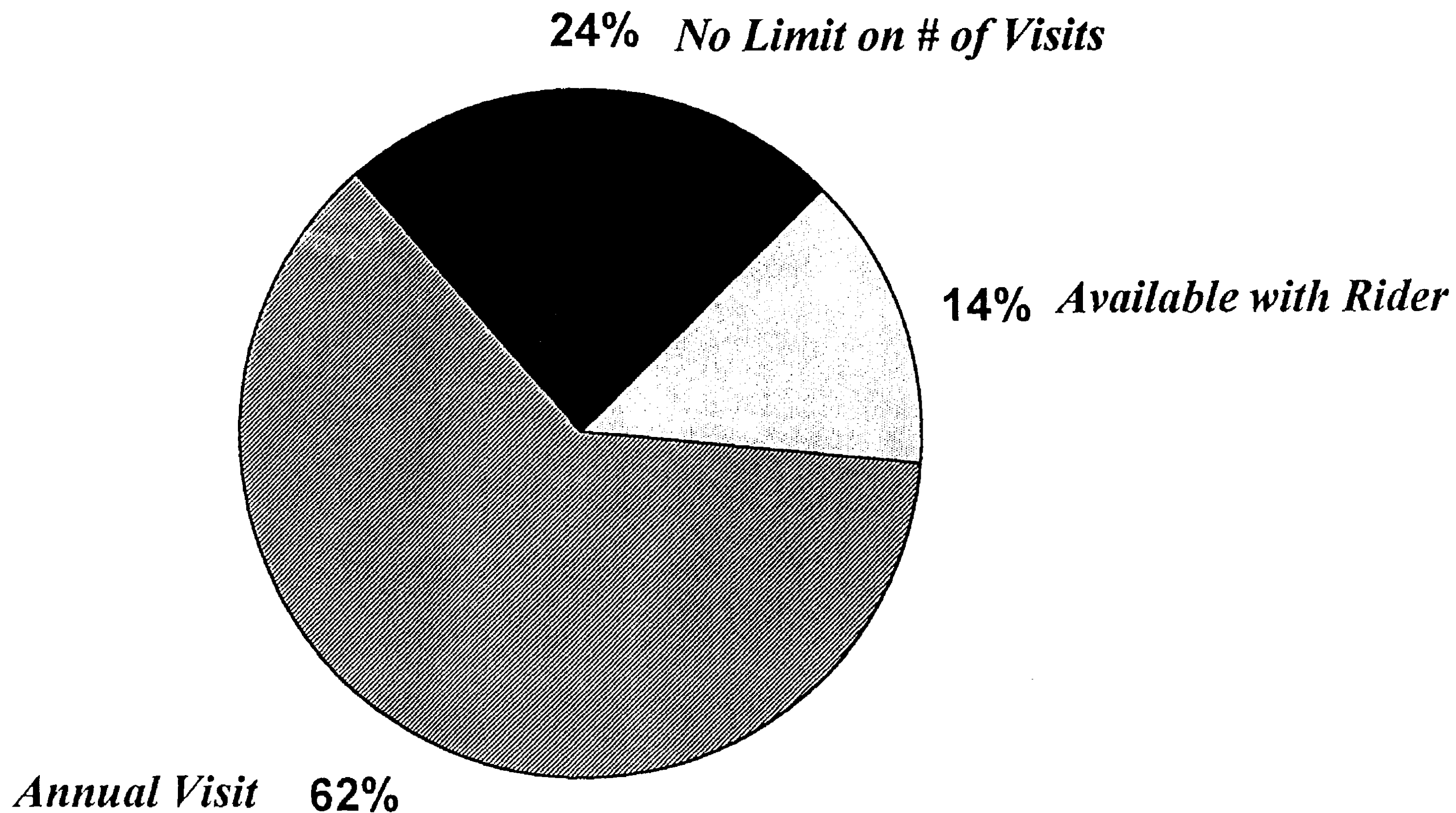
- The most frequently cited reason for OB/GYNs not participating as PCPs is the requirement for the provision of a full range of primary care services.

Do HMOs in Virginia Provide Direct Access to OB/GYNs?

- 92% of HMOs licensed in Virginia either offer enrollees choice of an OB/GYN as their primary care provider or allow them to self-refer to an OB/GYN.

- 86% of women enrolled in Virginia's HMOs may either choose an OB/GYN as their primary care physician or may self-refer to an OB/GYN.

Percent of Virginia Women Enrolled in HMOs With Access to OB/GYNs Without PCP Referral



Source: VAHMO Survey, 1995

VAFP TESTIMONY TO JOINT COMMISSION ON HEALTH CARE

JOINT SUBCOMMITTEE ON HJR 560

DECEMBER 12, 1995

Access to Obstetrical Care HJR 560

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Introduction Madame Chair and members of the committee, thank you for the opportunity to once again speak to you. My name is Jim Banks. I am a board certified Family Practitioner, a faculty member and the associate director of the family practice residency program in Roanoke. I actively include obstetrics and gynecology in my clinical practice, performing prenatal care, deliveries, D&C's for miscarriages, colposcopy for the evaluation of abnormal Pap smears and even electrosurgical conizations of the cervix for the treatment of precancers along with many other gynecological procedures. My role as a teacher of residents is to provide excellent training in the full scope of care encompassed by Family Practice, particularly in the areas of Obstetrics and Gynecology. I have had private practice experience, have worked in a health department, have done missionary work and prior to coming to Roanoke was the director of residency training at the University of Kentucky's FP residency.

Overview of Family Practice The specialty of Family Practice was founded in 1969 and is fully recognized as a medical specialty by the American Board of Medical Specialties (just like Internal Medicine, or Pediatrics or Obstetrics and Gynecology). To be a Family Practitioner, one must complete four years of college with a bachelors degree, four years of medical school obtaining an M.D. degree and then three years of an accredited residency in Family Practice. Upon completion of the residency training, the physician must sit for and successfully pass the specialty certification examination administered by the American Board of Family Practice. A family practitioner should not be confused with a "general practitioner". The term "general practitioner" typically implies a physician that has not successfully completed the rigorous and exacting training mentioned above and which I will detail more fully.

Virginia's Residencies Within the Commonwealth of Virginia, there are 10 Family Practice residency training programs. Eastern Virginia Medical School of the Medical College of Hampton Roads has two affiliated programs: one in Ghent and another in Portsmouth. Medical College of Virginia has five affiliated programs: one in Blackstone, one in Richmond (Chesterfield), one in Fairfax, one in Mechanicsville (Hanover), and one in Newport News (Riverside). There are three residency programs affiliated with the University of Virginia: one in Charlottesville, one in Roanoke and one in Lynchburg. Together, all ten residency programs produce 70 graduates a year.

Training Requirements: Let me now briefly detail the training requirements for Family Practice. All specialties have a set of specific requirements and guidelines for training that must be met in order for the residency to be accredited by the American Council on Graduate Medical Education (ACGME) Residency Review Committee (RRC) and the specific specialty board (see attached). No other specialty has as lengthy, detailed or specific requirements as Family Practice. All family practice residents must receive training in Behavioral Science, Counseling and Psychiatry; Community Medicine; Geriatrics; Disease Prevention and Health Promotion; Internal Medicine and all of its subspecialties (Gastroenterology, Rheumatology, Infectious

Disease, Cardiology, Hematology, Oncology, Allergy and Immunology, Pulmonary Medicine, Nephrology and Neurology); Pediatrics; Surgery; Obstetrics and Gynecology; Emergency Medicine; Sports Medicine; Dermatology; Diagnostic Imaging (Radiology); Practice Management; Nuclear Medicine; Physical Medicine and Rehabilitation: Clinical laboratory science; Anesthesia; Pharmacology; and finally, Professional liability and Risk Management. All this training occurs both in the hospital inpatient setting as well as in the ambulatory setting through longitudinal patient care experiences as well as specific intensive block rotation experiences in the various other medical and surgical specialties. In fact, each resident is required to maintain a panel of patients that they see in the family practice center and in essence have their own private practice throughout the three years of training. This panel of patients includes infants, children, adolescents, young adults, geriatric patients, nursing home and home bound patients and even pregnant patients that the resident cares for throughout her pregnancy, delivers the baby and then follows both mother and infant.

After completion of the three years of training, residency graduates sit for the certification examination administered by the American Board of Family Practice. Successful candidates are awarded diplomat status for a period of seven years. In order to remain board certified, the physician must sit for the re-certifcication examination every 6 or 7 years. The ABFP was the first (and for many years the only) specialty board to require recertification. Additionally, each diplomat must complete a minimum of 50 credit hours of approved continuing medical education each and every year. Even the American Academy of Family Physicians (the educational and political organization of the specialty) requires completion of an accredited residency program and yearly CME.

OB-GYN Training in Family Practice: Let me now focus on the training that family practice residents receive in Obstetrics and Gynecology. Every family practice resident must spend several months in an intense block rotation experience in Obstetrics with additional time spent in specific training in Gynecology. During this training, residents are closely supervised by board certified specialists in Obstetrics and Gynecology. The block rotation experiences are further supplemented by required longitudinal training through the care of patients in the family practice center under the supervision of board certified family practitioners. All residents are required to follow women through their pregnancy by providing prenatal care, management of labor and delivery and then providing ongoing care for the woman in the post-partum period and beyond. A large part of the routine office practice of family medicine involves seeing women and often this involves gynecological problems. All residents follow their own patients on a regular basis just as though they were physicians in private practice. Women are seen for family planning, contraceptive counseling, sexually transmitted disease screening, treatment, and prevention counseling, menstrual problems, menopausal issues, breast disease, and the whole gamut of problems specifically related to women. But unlike the limited specialty of Obstetrics and Gynecology, the family practitioner also sees women for problems such as diabetes, hypertension, thyroid

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disease, heart disease, strokes, asthma, depression, and a multitude of other medical problems. Residents are trained to perform routine vaginal deliveries (including the use of forceps and vacuum-assisted deliveries); perform limited ultrasound studies to assure fetal well being; to manage gestational diabetes and pregnancy induced hypertension, and to attend to the psychosocial aspects of pregnancy, childbirth, and raising a family. In addition, family practice residents are taught how to perform colposcopy to evaluate abnormal pap smears and to prevent cancer of the cervix; endometrial biopsies to detect abnormalities of the uterus and to prevent uterine cancer; simple office urometrics to evaluate and manage problems with incontinence; fine-needle aspiration biopsies of breast lumps to diagnose breast cancer without subjecting the patient to disfiguring surgery; as well as numerous other procedures. Throughout all this specialized training, however, the resident maintains their broad, comprehensive approach to patient care. Indeed, it is not at all unusual for the family practitioner to take care of a woman's back pain, hypertension, and thyroid disease during her annual examination for a Pap smear and breast exam while also addressing a host of psychosocial stressors and other behavioral problems that are impacting her health.

Family practitioners that include obstetrics in their practice in general do not perform cesarean sections or manage complicated problem pregnancies (although there are some who do). While the many family physicians do not include obstetrics in their practice, there is a significant increase interest among residents and young residency trained family physicians to include OB in their practices (nearly half of the current 36 residents in Roanoke are planning to include obstetrics in their practice after graduation). This will be especially beneficial for the more rural areas where an obstetrician may not have enough patients to maintain a practice but a family physician can because of the broad scope of the practice across both genders and all ages.

An obstetrician-gynecologist (OBG) can provide excellent care for many of the problems that face women, but they do not have the training to provide comprehensive care. A family practitioner typically manages, without referral or consultation with a sub-specialist, over 90% of the problems that present to their office. However, a women who uses an OBG for her primary care provider will be required to have at least one other physician to handle the non-gynecological problems that will arise. As is often the case, a woman who uses an OBG for primary care will be referred to a specialist for whichever specific system is causing the problem so it is not unusual for a woman to have a cardiologist for her high blood pressure and cholesterol problems, an endocrinologist for her diabetes, a rheumatologist for her arthritis and a surgeon for her breast lumps. Clearly, from a cost perspective, not to mention the benefits of a continuity relationship where physician and patient are well known to one another, family practice is the specialty of choice for primary care providers. Health insurance companies know this and are promoting family practice because of it. But because our culture has so long been specialty oriented and many women have good relationships with their OBG, most health insurance companies allow women to see their OBG at least once a year without a referral. I believe it is most prudent to allow market forces

rather than government mandates to make the determination of who is a primary care provider as well as what will be required for patients to see other specialists without a referral from a primary care provider.

Summary In summary, the Family Practitioner is the ultimate generalist, the penultimate primary care provider. Without question, the specialty of Family Practice provides the most broadly trained physicians in the United States. No other specialty can provide as comprehensive, continuous, and competent care.

VI. Specific Knowledge and Skills

A. Clinical

The program must provide educational experiences that enable residents to develop clinical competence in the overall field of sports medicine.

The curriculum must include but not be limited to the following content and skill areas:

1. Anatomy, physiology, and biomechanics of exercise
2. Basic nutritional principles and their application to exercise
3. Psychological aspects of exercise, performance, and competition
4. Guidelines for evaluation prior to participation in exercise and sport
5. Physical conditioning requirements for various activities
6. Special considerations related to age, gender, and disability
7. Pathology and pathophysiology of illness and injury as they relate to exercise
8. Effects of disease, eg, diabetes, cardiac conditions, arthritis, on exercise and the use of exercise in the care of medical problems
9. Prevention, evaluation, management, and rehabilitation of injuries
10. Understanding pharmacology and effects of therapeutic, performance-enhancing, and mood-altering drugs
11. Promotion of physical fitness and healthy lifestyles
12. Functioning as a team physician
13. Ethical principles as applied to exercise and sports
14. Medical-legal aspects of exercise and sports
15. Environmental effects on exercise
16. Growth and development related to exercise

B. Patient Education/Teaching

The program must provide the experiences necessary for the residents to develop and demonstrate competence in patient education regarding sports and exercise. They must have experience teaching others, eg, nurses, allied health personnel, medical students, residents, coaches, athletes, other professionals, and members of patients' families. There must also be relevant experience working in a community sports medicine network involving parents, coaches, certified athletic trainers, allied medical personnel, residents, and physicians.

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Program Requirements for Residency Education in Family Practice

I. Introduction

A. Duration of Training

Residencies in family practice must be at least 3 years in duration after graduation from medical school and must be planned so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured. The training must be specifically designed to meet the educational needs of medical school graduates intending to become family physicians.[1]

1. Applicants who have had previous graduate training may be considered for admission to family practice residencies. Credit for this other training may be given only in the amount that is compatible with the Program Requirements for Residency Education in Family Practice. Directors should consult with the American Board of Family Practice on each case prior to making a determination regarding the equivalence of such training.

B. Size of Program

To provide adequate peer interaction, a program should have a minimum of 12 residents at various levels of training. Residents accepted into the first year of training should be assured a position for the full 3 years, barring the development of grounds for dismissal. Except for periods of transition, the program should offer the same number of positions for each of the 3 years.

C. Program Design

All educational components of a residency program should be related to program goals.

1. The program design and/or structure must be approved by the Residency Review Committee (RRC) as part of the regular review process.
2. Participation by any institution providing more than 6 months of training in the program must be approved by the RRC.

D. Scope of Training

Family practice residency programs must provide experience and responsibility for the residents in those areas of medicine that will be of importance to their future practice. Because family practice programs are in part dependent on other specialties for the training of residents, the ability and commitment of the institution to fulfill these requirements must be ensured.

Specifically, the sponsoring institution must ensure the existence and availability of those basic educational and patient care resources necessary to provide the family practice resident with meaningful involvement and responsibility in the necessary clinical specialties.

The existence of other programs sponsored by the residency, eg, geriatric medicine, must not result in the dilution of experience available to the family practice residents.

Instruction in the other specialties must be conducted by faculty with expertise in these fields. The curricula and plans for such rotations or experiences must be developed by the family practice faculty in concert with appropriate other specialty faculty.

There must be agreement regarding the residents' need to maintain concurrent commitment to their patients in the Family Practice Center during these rotations. The program should implement a plan to ensure that the residents retain their identity and commitment to the principles and philosophic attitudes of family practice throughout the training program, particularly while they learn the appropriate skills, techniques, and procedures of other specialties.

Family practice residency programs should provide opportunity for the residents to learn, in both the hospital and ambulatory settings, those procedural skills that can reasonably be anticipated as part of their future practices. There must be a method of documenting the procedures that are performed and of evaluating the residents' competence. Such documentation should be maintained by the program.

E. Resident Workload and Impairment

It is the responsibility of the residents to render patient care in the pursuit of their education without additional remuneration based on productivity. This does not preclude them from earning income from patient care during off hours, provided this activity does not interfere with their education and performance as residents. In addition, such activity should not be in conflict with the policies of the program or the sponsoring institution.

The goal of the family practice training program is to produce fully competent physicians capable of providing high-quality care to their patients. To prevent impairment and promote physician well-being, residents should be trained to balance personal and professional responsibilities in a way that can be reflected throughout their careers.

The program must have mechanisms for monitoring resident stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support service to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

Both educational and patient care activities are best conducted when residents have appropriate amounts and levels of supervised responsibility and when their schedules allow them to make full utilization of their educational experiences without resultant counterproductive stress, fatigue, and depression.

There should be adequate resident staff to prevent excessive patient loads, excessive new admission workups, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation. The program must:

1. Permit residents to spend, on average, at least 1 day out of 7 away from the residency program.
2. Assign on-call duty no more frequently than every third night, on the average.
3. Ensure adequate backup if sudden and unexpected patient care needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

Formal written policies on these matters should be established and be available to the RRC, should they be requested.

II. Curriculum

A. Introduction

Every residency program must have the core or required curriculum as contained herein. However, on approval of the RRC, curriculum components may vary to reflect current regional practice patterns and patient care needs, and may be flexible enough to utilize the strengths of the program.

All major dimensions of the curriculum should be structured educational experiences for which written goals and objectives, a specific methodology for teaching, and a method of evaluation exist.[2] These goals must be distributed to residents and teaching staff. Family physicians should be utilized to the fullest extent as teachers, consistent with their experience, training, and current competence.

The organization of the curriculum should reflect the application of sound educational principles, recognizing that some elements of the curriculum are best learned in a longitudinal experience, whereas others are more efficiently learned in an intensive experience of shorter duration.

Although the content of a rotation is more important than the time assigned to it, it is necessary to establish guidelines for the allocation of time segments to provide an objective measure of the opportunity provided for residents to achieve the cognitive knowledge, psychomotor skills, attitudinal orientation, and practical experience required of a family physician in each of the curricular elements.

Ranges of time[3] are indicated for the various disciplines that the core curriculum comprises. This does not prohibit additional elective time in any of these areas.

B. Principles of Family Practice

The following curricular areas must be integral to each program. In addition, residents must be taught to demonstrate and clearly articulate the philosophy and concepts of family practice to patients.

1. Continuity of Care

   Continuity of care is an important concept in family practice and is expressed in the role and interrelationships that the system (eg, solo or group), the professional, the individual patient, the patient's family, the institution, and the community play in the maintenance of continuity of care.

   Residents should develop and maintain a continuing physician-patient relationship with a panel of patients throughout the 3-year period. This relationship must be in continuity during the resident's second and third years[4] and must include patient contacts in the family practice center, inpatient facility, domiciliary facility, and patients' homes. Family practice residents must be able to admit and care for their family practice center patients in the hospital with family practice faculty supervision as appropriate.

   Continuity of primary responsibility for patient care must be taught in a longitudinal way and include the following:

   a. Ambulatory care
   b. Inpatient care
   c. Home care
   d. Domiciliary care, eg, nursing, extended care facilities
   e. Referral and consultation
   f. Integrative function of the family physician
   g. Utilization of community resources

   Residents may spend time away from the family practice center in outside rotations designed to meet the needs of their training. The educational value of these rotations must be clearly documented. At these remote sites the same degree of constant on-site supervision is required as is required in the family practice center. The use of remote sites or rotations on clinical services must not interrupt continuity of care at the family practice center for longer than 2 months during the second and 2 months during the third year.

   Residents must return to the family practice center and provide continuity of care for their panels of patients for at least 2 months before leaving for any additional remote experience.

2. Family Oriented Comprehensive Care

   Family practice is a comprehensive specialty. The family physician assumes the responsibility for the total health care of the individual and family, taking into account the social, physiological, economic, cultural, and biological dimensions. Therefore, the programs must also emphasize the importance of comprehensive patient and family medical care. The residents must be given the opportunity to achieve high levels of competence in health maintenance; in disease and problem management; and in the development of knowledge, skills, and attitudes that reflect expertise in comprehensive patient management. Residents also must be trained in patient education.

   The responsibility to provide health care to families is a fundamental concept of the discipline of family medicine. The program must provide the opportunity for residents to acquire knowledge and experience in the provision of longitudinal health care to families. This should include assisting family members in coping with serious illness of other family members. Although the treatment of illness is a basic function of family physicians, another of

2. The RRC expects all programs to have written detailed plans for their curricula that should be available for review by the site visitor. Do not append them to the forms.

3. In identifying ranges it is recognized that certain programs will deviate from those ranges for excellent educational reasons. It is the responsibility of the program director to document and justify variations from the ranges herein stated. Concurrent time spent in the family practice center should not be included when calculating the duration of the specialty rotations for which a number of required hours is specified. Family practice center time may be included in the required rotations, which are specified in months.

4. When residents find it necessary to change programs, they and the program directors involved should consult with the American Board of Family Practice prior to implementing such arrangements.

Essentials

their major responsibilities is the maintenance of health among the family members.

Comprehensive care must be taught longitudinally in didactic and clinical settings during the entire period of residency training. The following elements must be included and should be understood within the concept of family care, ie, the impact on the family of the need for care of an individual within that family:

Individual
a. Health assessment
b. Health maintenance
c. Prevention
d. Acute and chronic illness or injury
e. Trauma
f. Rehabilitation
g. Behavioral counseling
h. Health education
i. Human sexuality

Family
a. Family structure
b. Family dynamics
c. Genetic counseling
d. Family development
e. Family planning
f. Child rearing and education
g. Aging
h. Death and dying
i. Epidemiology of illness in families
j. Role of family in illness management
k. Counseling and education
l. Nutrition

3. Primary Setting for Family Practice

While the residents' acquisition of knowledge, skills, and attitudes of family practice should take place during all curricular elements, the primary setting for this training is in the family practice center as the residents provide continuing, comprehensive care to their panels of patients.

In the first year of training an orientation period in the family practice center is needed to introduce the comprehensive approach to health care and to help the resident develop an identity as a family physician. Additionally, residents should be assigned to the family practice center for at least ½ day per week during the first year of training.

During the second year residents should spend from 2 to 4 half-days per week in the center. The amount of time in the center should be increased in the third year to 3 to 5 half-days per week. Intensive short duration assignments to the family practice center in the second and third years may be utilized for specific educational purposes, provided the overall curriculum is not thereby compromised.

C. Specialty Experience

1. Human Behavior and Psychiatry

Most of the family practice resident's knowledge and skills in this area should be acquired through a program in which psychiatry and behavioral science are integrated with family practice, internal medicine, pediatrics, and other disciplines throughout the resident's total educational experience.

The Family Practice Center should serve as the major site for residents to achieve the objectives of this portion of the curriculum. The human behavior curriculum should include the promotion of physician well-being and prevention of physician impairment.

There must be instruction in the following areas of human behavior:

a. Diagnosis and management of the psychological components of illness
b. Management of psychiatric disorders
c. Family dynamics
d. Physician/patient relationship
e. Patient counseling
f. Interviewing skills and other communicative skills
g. Normal psychosocial growth and variants
h. Stages of stress in the family life cycle
i. Substance abuse

There should be a formal didactic program that supplements the clinical experience in human behavior. Instruction should be provided by faculty who have training and experience necessary to apply modern behavioral and psychiatric principles to the care of an undifferentiated population.

There must be a psychiatry training component that encompasses recognition, diagnosis, and management of emotional and mental disorders. Elements of psychotherapy, psychopharmacology, psychiatric counseling, and a wide variety of mental illnesses must be included. Alcoholism and other substance abuse also must be specifically included in the curriculum. Intensive short-term experiences in facilities devoted to the care of chronically ill patients should be limited.

Qualified family physicians and psychiatrists should be involved in teaching this curricular component.

2. Community Medicine

Residents should have experiences that help them understand the role of private enterprise, voluntary organizations, and government in modern health care. In addition, residents should be taught the principles of the application of modern medical knowledge to the care of populations. There must be instruction in at least the following areas of community medicine:

a. Occupational medicine must include assessment of job-related illnesses and injuries, identification and management of job-related health risks, and fundamentals of disability assessment. Where possible, direct contact with organized industrial health programs is encouraged.
b. Community health resources must include contact with governmental, voluntary, and private agencies whose services can be utilized in the care of patients and their families.
c. Epidemiology of diseases must include the biologic and social causal relationships in common illnesses.
d. School health must include the study of school-related health problems, identification of common learning disabilities, adaptation to physical disabilities, and evaluation for organized sports and recreational activities.
e. Community health education must include examination of the methods available in the community for information transfer to the population, techniques of media utilization, and the physician's role in community health education.
f. Public health services must include the study of the public health resources available at the local, state, national, and international levels, and the means by which physicians can assist their patients through utilization of those resources.
g. Environmental health must include common problems such as toxic wastes, pure water supply, and air pollution, as well as the role of the physician in the community where these concerns exist.

3. Geriatrics

A significant portion of the practice of every family physician involves the care of the aged. Educational opportunities to address this element of the curriculum must be available throughout the resident's entire program. A structured multidisciplinary approach by faculty is essential to the teaching of this curricular

element through didactic conferences and clinical experience in the following settings: Family Practice Center, the hospital, nursing homes, retirement homes, voluntary agencies, the patient's home. Education in the care of the aged must include the preventive aspects of health care, the physiological and psychological changes of senescence, the social-cultural parameters, the nutritional and pathological (acute and chronic) entities of aging, and the proper utilization of all members of the health-care team. The residents must have sufficient training to be able to provide a functional assessment of elderly patients.

4. Disease Prevention/Health Promotion
Prevention of disease and disability, health promotion, health maintenance, and health screening are important aspects of family practice. Preventive medicine must include training in immunizations and in appropriate behaviors that protect individuals and families from illness or injury. Residents should be given the opportunity to acquire specific knowledge, skills, and attitudes that provide special competence in these areas. Residents should be instructed in the general principles of health promotion and appropriate intervention based on the needs of the individual patient and the community. This content should be presented in both didactic and clinical settings.

5. Internal Medicine
Internal medicine experience must provide the resident with the opportunity to acquire the knowledge and skills related to the diagnosis and management of nonsurgical diseases of adults. This experience should be utilized to enhance the resident's understanding of the pathophysiology of nonsurgical diagnostic and therapeutic techniques and to develop a disciplined, scientific approach to the practice of medicine.
The organization of the curriculum in internal medicine in large part will depend on the organization of the delivery of patient care services in the teaching environment. The experience must include both inpatient and outpatient experiences and progress from general to specific areas of content. Faculty should include family physicians, general internists, and subspecialists. The total duration of internal medicine training should be 8 to 12 months, including structured experiences in cardiology and critical care units (ICU/CCU), as well as education in endocrinology, pulmonary diseases, hematology and oncology, gastroenterology, infectious diseases, rheumatology, nephrology, allergy and immunology, and neurology. Where it exists, a family practice inpatient service may be utilized to fulfill a portion of this requirement.

6. Pediatrics
There must be a structured educational experience in pediatrics of 4 to 5 months, which involves ambulatory and inpatient experiences. This must include the newborn nursery, as well as experience in resuscitation, stabilization, and preparation for transport of the distressed neonate. The resident should have the opportunity to develop an understanding of the prenatal period, the growth and development of the newborn through adolescence, and emotional problems of children and their management. In addition, the resident should be taught to recognize and manage behavioral, medical, and surgical problems of children and adolescents in home, ambulatory, and hospital settings.

7. Surgery
The program must provide instruction in the diagnosis and management of surgical emergencies and the appropriate and timely referral of such emergencies for specialized care. The resident should also be taught to recognize conditions that are preferably managed on an elective basis.
The resident must be taught to appreciate the varieties of surgical treatments and the potential risks associated with them to be able to give proper advice, explanation, and emotional support to the patients and their families.
The resident must receive training in pre- and postoperative care, basic surgical principles, asepsis, handling of tissue, and technical skills to assist the surgeon in the operating room. The program should provide the opportunity for residents to develop technical proficiency in those specific surgical procedures that family physicians may be called on to perform. If the residents expect to include surgery as a major aspect of their practice, additional training must be obtained.
The requirement in surgery includes both general surgery and subspecialty experience. The residents must be required to participate in a structured experience in general surgery of 2 to 3 months' duration, including operating-room experience. Outpatient experiences in general surgery are encouraged in order for the resident to achieve competency in the diagnosis and management of a wide variety of common ambulatory general surgical problems.
The required experiences in surgical subspecialties may be in an intense short time format or in a longitudinal format. Between 140 and 200 hours of orthopedics are required, exclusive of time in the Family Practice Center, and 40 to 80 hours in each of the subspecialties of ophthalmology, otolaryngology, and urology are required. It is expected that experiences in the surgical subspecialties will be primarily in outpatient settings. This is in addition to learning from consultations.

8. Obstetrics and Gynecology
The resident must be provided with instruction in the biological and psychological impact of pregnancy, delivery, and care of the newborn on a woman and her family. The resident should be taught technical skills in the provision of antepartum and postpartum care and the normal delivery process as well as in the complications of pregnancy and their management. The resident should be taught certain operative skills in obstetrical and gynecological procedures. To acquire such skills, the family practice resident must spend at least 3 months in a structured educational experience, of which at least 2 months must be in obstetrics and at least 1 month must be in gynecology. The resident must assume the responsibility for provision of antenatal, natal, and postnatal care on a continuing basis to a number of patients sufficient to meet the required objectives. Whenever possible these patients should be derived from the residents' panel of patients in the family practice center.
A program must be able to make arrangements for additional Ob/Gyn training on an elective basis within the 36-month curriculum. This should include high-risk obstetrics and the opportunity for residents to develop technical proficiency in those surgical procedures that family physicians may be called on to perform.

9. Emergency Medicine
There must be a structured educational experience of 1 to 3 months' duration in the delivery of emergency medicine care with competent and full-time on-site supervision. The initial month should be a block rotation rather than a longitudinal format.
There must be sufficient quality and types of facilities, equipment, and support personnel and a broad range of patient problems to provide the residents with adequate experience in initial management of serious emergencies.
The emergency medicine portion of the curriculum should utilize both didactic and clinical experiences. Specific modern lifesaving skills must be taught to all residents, eg, advanced cardiac life support, airway insertion, chest tube insertion, hemostasis.

10. Sports Medicine
Sports medicine must include basic physical assessment for participation as well as evaluation and management of common injuries.
11. Dermatology
The curriculum must include a required educational experience in dermatology of 60 to 120 hours. Most of this experience should be in an outpatient setting with a qualified physician teacher of dermatology and should be supplementary to the learning that results from consultations.
12. Diagnostic Imaging
The program must provide the residents with ample opportunity to learn the appropriate application of techniques and specialty consultations in the diagnostic imaging of organs and body systems. Instruction should include the limitations and risks attendant on these techniques. The format of the instruction should be adapted to the resources available, but must include radiographic film and diagnostic imaging interpretation pertinent to family practice.
13. Practice Management
There must be 60 hours of instruction in practice management taught in both didactic and practical settings. Emphasis should be on providing the resident with the tools to be successful in practice while optimizing patient care.
The Family Practice Center should be considered one of the primary sites for teaching practice management.
14. Other Curricular Elements
Other areas of training should include:
a. Nuclear medicine
b. Physical medicine and rehabilitation
c. Clinical laboratory science
d. Use of drugs and their interaction
e. Administration of anesthetics
f. Professional liability/risk management
15. Electives
Electives that are well constructed, purposeful, and effective learning experiences are an essential part of a family practice residency program. Electives should not utilize more than 6 months of the total curriculum, but there must be a minimum of 3 months available to each resident for electives. The choice of electives by the resident must be made with the advice and consent of the program director. Most electives will be concerned with subspecialized areas of the major primary specialties and may be obtained in various ways. However, a structured educational experience in rural and/or inner-city health care should be available to residents if such experience adds a dimension to the educational program that is not otherwise present.
Electives are intended primarily to enrich the residents' training with experiences relevant to their future practice plans or interests as family physicians. After proper counseling by the program director and/or faculty, residents may use electives in part to remove identified deficiencies in knowledge or skills. No more than half of the total elective time may be used for remedial purposes.
16. Research and Scholarly Activity
Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.
a. Participation by Teaching Staff
While not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity. This activity should include:
1. Active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
2. Active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publication in their journals.
3. Participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings.
4. Offering of guidance and technical support (eg, research design, statistical analysis) for residents involved in research and support for resident participation in scholarly activities.
b. Resident Research and Scholarly Activity
The participation of each resident in an active research program should be encouraged as an essential part of the preparation for a lifetime of self-education after the completion of formal training. Generally, this activity should be concurrent with other assignments, provided the responsibilities of the resident are adjusted in a way to permit a reasonable time for research activity. This experience should give the residents an awareness of the basic principles of study design, performance, analysis, and reporting, as well as an awareness of the relevance of research to patient care.
17. Conferences
There should be an overall conference schedule that covers the broad range of topics essential to family practice.
The conferences, seminars, or workshops for the family practice residents should be designed to augment their clinical experiences and should be held at least twice a week. These must be conducted by persons knowledgeable in the topics under discussion. Residents should also have the opportunity to present cases. Faculty, staff, and residents should participate, but conferences designed solely for the medical staff are inadequate as a substitute for a complete conference schedule in graduate training.
There also should be regularly scheduled conferences for faculty and residents during which critical review of medical literature takes place. Reasonable attendance requirements must exist, and faculty and resident attendance should be monitored by the program director.

III. Program Personnel

The program director and teaching staff are responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.

A. Program Director

There must be a single program director responsible for the program. Continuity of leadership over a period of years is important to the stability of a residency program. Frequent changes in leadership or long periods of temporary leadership usually have an adverse effect on an educational program and will be cause for serious concern. The RRC must be notified promptly of any change in the leadership of the program.
1. Qualifications of the Director
The director must have demonstrated ability as a teacher, clinician, and administrator. The director must be capable of admini tering the program in an effective manner and be actively

involved in the care of patients. This individual must devote sufficient time to the residency program to provide continuity of leadership and to fulfill the administrative and teaching responsibilities inherent in achieving the educational goals of the program.

Prior to assuming this position the program director must have had a minimum of 2 years' full-time professional activity in family practice and should have had teaching experience in a family practice residency program.[5] The director must be currently certified by the American Board of Family Practice or have suitable equivalent qualifications and must be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.) The RRC will determine the acceptability of alternate qualifications. The director also must hold an appointment in good standing to the medical staff of an institution participating in the program.

2. Responsibilities of Director

In addition to those responsibilities described in other sections of these requirements, the program director is responsible for the selection and supervision of the teaching staff and other program personnel at each institution participating in the program. She or he also has responsibility for selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.

The director is also responsible for the implementation of fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances.

B. Family Practice Faculty

A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.

The faculty must contain teachers with the diversified interests and expertise necessary to meet the training responsibilities of the program. One measure of the quality of a faculty is whether there is evidence of participation in research and other scholarly activities. The number of physician faculty must be sufficient to ensure that there is always an appropriate number who, without other obligations, supervise the residents in the family practice center whenever the residents are seeing patients. There must be at least one full-time equivalent family physician faculty member for each six residents in the program. Where part-time faculty are utilized, there must be evidence of sufficient continuity of teaching and supervision.

The family physician faculty should have a specific time commitment to patient care to enable them to maintain their clinical skills and serve as role models for the residents. Family physician faculty must have admitting and attending privileges in the hospital(s) where the majority of Family Practice Center patients are hospitalized.

Physicians in the other specialties who are part of the faculty of the program must devote sufficient time to teaching and supervising the family practice residents to ensure that the program's goals for their specialty areas are accomplished.

C. Consultant Faculty

Consultations by recognized specialists in their fields should be utilized. Consultations should occur in a location that allows residents to participate in the consultation as an educational experience.

5. This does not apply to program directors who were appointed before July 1, 1983.

D. Other Special Faculty

Additional faculty will be needed to provide input into areas such as behavioral science, the social services, nutrition, oral pathology, and pharmacy. If faculty in these disciplines are not readily available from current staff or faculty, resources in the community may be utilized.

E. Qualifications of Faculty

All of the key faculty members in the program must demonstrate suitable qualifications for their specialty areas, eg, Board certification or equivalent for physician faculty, appropriate credentials for the nonphysician faculty. There must be an explicit system to develop and maintain academic and clinical skills of the faculty and to foster their continual professional growth and development.

F. Supervision

It is the responsibility of the program director and faculty to ensure that residents are appropriately supervised. Institutional and program policies and procedures must ensure that all residents are adequately supervised in carrying out their patient care responsibilities. Supervising policies of the residency should be consistent with those of the institution. These policies must be in writing and be distributed to all members of the program staff.

Faculty on-call schedules must be structured to ensure that supervision is readily available to residents on duty. An appropriately qualified member of the program's faculty must be in attendance on site when the needed services or procedures exceed the capability of the most senior supervising resident or when qualified senior residents are unavailable for supervision of more junior residents.

G. Support Staff

There must be appropriate numbers and types of support staff to meet the needs of health care and resident education.

IV. Patient Population

Patients who provide a broad spectrum of problems and represent varied income levels and ages and both sexes should be attended in the hospital, in the Family Practice Center, at home, and in institutions for long-term care or rehabilitation. There must be an institutional patient care evaluation program to foster continuing improvement of ambulatory and inpatient care provided by the institution and medical staff.

A. Inpatients

A sufficient number of inpatients must be available to provide a broad spectrum of problems in any given discipline. The disease spectrum available for resident education must be that common to the general community. The program must offer a structured educational experience that allows residents the opportunity to attain expertise in emergency initial care of unusual or life-threatening problems.

B. Ambulatory Patients

A stable patient population of sufficient number and variety is necessary to ensure comprehensiveness and continuity of experiences for the residents. The major part of the patient visits in the Family Practice Center should be from family units for which a resident is responsible. A patient population seeking only episodic care does not meet this requirement.

There must be a sufficient volume of patients in the family practice center to provide adequate experience for the residents in the program. While the total number of patients to be seen by each resident is not specified, the following minimum numbers of patients should be seen by residents as they progress through their training: one to two patients per hour for first-year residents; two to three patients per hour for second-year residents; and three to four patients per hour for third-year residents.

V. Facilities

A program must provide the facilities required for the education of residents in sufficiently close proximity to the primary hospital to allow for the efficient functioning of the training program.

Multiple teaching facilities may be used as long as there is no compromise of the quality of the educational program and no significant reduction in attendance of residents at teaching sessions or reduction of camaraderie and exchange of information among residents and/or faculty.

A. Primary and Affiliated Hospital

1. Number of Beds

   It is essential that the participating hospitals, primary and affiliated, be of sufficient size and have an adequate number of occupied teaching beds to ensure a sufficient patient load and variety of problems for the education of the number of residents and other learners on the services. Experience has demonstrated that facilities that have fewer than 135 occupied beds often are not able to provide adequate physical, human, and educational resources for training in family medicine.[6]

2. Medical Staff

   Qualified medical staff must be available in sufficient number to ensure adequate patient care and consultation in family practice, internal medicine, surgery, pediatrics, obstetrics/gynecology, pathology, psychiatry, radiology, otolaryngology, urology, neurology, cardiology, dermatology, orthopedics, ophthalmology, anesthesia, and emergency medicine.

   The medical staff should be organized so that family physician members may participate in appropriate hospital governance activities on a basis equivalent to that of those in other specialties. Where a hospital is departmentalized, there should be a clinical department of family practice.

3. Use of Multiple Hospitals

   Multiple hospitals may be used if the primary facility is unable to provide all of the required experiences. Such additional hospitals must not be at such a distance from the primary teaching sites that they require excessive travel time or otherwise fragment the educational experience.

B. Family Practice Center

1. Functional Status

   A family practice center must be in operation for the training of family practice residents (whether or not in a temporary location) on the date the program begins. If more than one center is used, the additional centers must meet the same criteria as the primary center. Experiences available in the multiple centers should be comparable.

2. Design

   The center must be a clearly identifiable unit that includes a separate entry, waiting room, and appointment system. The design of the Family Practice Center must ensure adequate patient flow to provide appropriate patient care, accessibility, and teaching opportunities. The Family Practice Center should have provisions for handicapped persons.

3. Size

   Two examining rooms per physician working in the center at one time (counting both residents and physician faculty who have patient care responsibilities) should be available. In cases where the Family Practice Center is utilized for training other learners, eg, fellows, nurses, medical students, and physician assistants, sufficient additional space must be available so that the efficiency of the residents is not compromised.

   Other functional areas must include a business office, a record room, an office library, patient care rooms, a conference room, a basic laboratory appropriate to office practice, a resident work area, and faculty/staff offices.

   The Family Practice Center should provide space for the physician to conduct individual and small-group counseling.

4. Diagnostic Laboratory and Imaging Services

   There must be provision for diagnostic laboratory and imaging services so that there is prompt and convenient access by patients and residents for patient care and education.

5. Location

   The location of the Family Practice Center in relation to the hospital(s) should be such that it allows conservation of the residents' time in order to utilize efficiently the educational opportunities and provide necessary patient care at both sites.

6. Equipment

   The Family Practice Center must contain all equipment necessary to meet the basic needs of an efficient family practice office and an acceptable educational program for family practice residents.

7. Record System

   Patients' ambulatory medical records must be maintained so that easy and prompt accessibility is ensured at all times.

   The record system must provide for patient care audit and chart review and must be capable of prompt documentation of all facets of family care, including care rendered in the Family Practice Center, hospital, home, via telephone, and that provided in other institutions.

   The medical record system must be designed for the retrievability of data pertinent to patient care and the monitoring of the residents' experiences.

8. Scheduling of Appointments

   Appointments must be scheduled in the Family Practice Center by regular employees of the center who are cognizant of the importance of the appointment system in the delivery of continuing care and in ensuring patient access to a requested physician.

9. Hours of Operation

   The Family Practice Center must be an exclusive facility available for patient services during weekday hours commensurate with community medical practices to provide continuing comprehensive care and a place where patients may expect to obtain services.

   When the Family Practice Center is closed, there must be provision for patients to have access to their personal physician or a designated substitute physician.

10. Source of Income

    The fiscal operation of the Family Practice Center must reflect a balance between service and education that does not adversely affect the educational objectives. There should be a plan to ensure long-range fiscal stability of the program.

C. Ambulatory Units Other Than Family Practice Centers

Ambulatory units other than Family Practice Centers are those sites that provide experiences that differ from those offered in the Family Practice Center and that enhance the educational program.

D. Library

1. Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions.
2. Library services should include the electronic retrieval of information from medical databases.

6. Requirements concerning number of hospital beds may be regarded more appropriately in terms of those available for use in training residents, whether in the primary hospital alone or in the primary plus affiliated hospitals combined. Number of beds must be perceived in context of the total number, types, and locations, as well as medical staff available for quality care and teaching.

3. There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

VI. Evaluation

A. Evaluation of Residents

There must be adequate, ongoing evaluation of the knowledge, competency, and performance of the residents. Entry evaluation assessment, interim testing, and periodic reassessment, as well as other modalities for evaluation, should be utilized.

Written evaluation of each resident's, knowledge, skills, professional growth, and performance, using appropriate criteria and procedures, must be accomplished at least semiannually. These evaluations must be communicated to the resident in a timely manner.

Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

The program must maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel.

The program director and faculty are responsible for provision of a written final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

A system for documentation of residents' experiences must be utilized to monitor the educational experience and to provide documentation for future hospital privileges.

B. Evaluation of Faculty

All teaching faculty must be evaluated on an ongoing basis. Documentation of faculty evaluation should include teaching ability, clinical knowledge, attitudes, scholarly contributions, interpersonal skills, and communication abilities.

C. Evaluation of Patient Care

The program must consider high-quality patient care as one of its primary objectives and evaluate the care that is provided. There must be a current and retrospective audit to provide necessary feedback for continuing improvement of ambulatory and inpatient care.

D. Evaluation of the Program

The family practice residency must incorporate all elements of the Program Requirements. The educational effectiveness of a program must be evaluated in a systematic manner. To implement this, the program should engage in self-evaluation within the context of the educational goals and objectives, the needs of the residents, teaching responsibilities of the faculty, the availability of administrative and financial support, and adequate health-care resources within the community. This evaluation should include an examination of the balance among education, research, and service and of the extent to which the educational goals have been met by residents. Written evaluations by residents should be utilized in this process. Continuing medical education should occupy a prominent place in the program, and residents should be encouraged to develop learning patterns to continue their education.

The teaching staff must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.

E. Evaluation of the Graduate

It is the responsibility of all programs to maintain contact with their graduates to obtain information about practice effectiveness, relevance of training to practice demands, personal satisfaction with role, practical responsibilities, evidence of participation in continuing medical education, and board certification.

VII. Information Items

A. Evaluation by the RRC

The program will be evaluated by the RRC at regular intervals. It is the responsibility of the program director to submit accurate and complete information as requested by the RRC on the program information forms or in special communication from the committee. The RRC will judge the degree of compliance with the Program Requirements and with the Institutional Requirements.

One measure of the quality of a residency program is the performance of its graduates on the certifying examination of the American Board of Family Practice. In its evaluation of residency programs the RRC will take into consideration the information provided by the board regarding resident performance on the certifying examinations over a period of several years.

The degree of resident attrition and the presence of a critical mass of residents also are factors that will be considered by the RRC in the overall evaluation of the program.

B. Notification of Change

The RRC must be notified promptly of major changes in the program, including a change in leadership. Prior approval of the RRC is required for the following: (1) the addition or deletion of a major participating hospital, (2) the utilization of a new and/or additional family practice center or the alteration of an existing center in any way that might make the facility less suitable, and (3) major changes in the program format. On review of a proposal for major change in a program, the RRC may determine that a site visit is necessary before a decision can be made.

C. Board Certification

Family practice residents who plan to seek certification by the American Board of Family Practice should communicate with the executive secretary of the board.

ACGME: June 1992 Effective: July 1995

Program Requirements for Residency Education in Family Practice Geriatric Medicine and Family Practice Sports Medicine

The following generic requirements pertain to programs in Family Practice Geriatric Medicine and Family Practice Sports Medicine. Each program must comply with the requirements listed below as well as with the specialty content found in the Program Requirements for the respective area.

These programs must exist in conjunction with and be an integrated part of an Accreditation Council for Graduate Medical Education (ACGME)-accredited family practice residency program. Their existence should not compromise the integrity of the core program.

Residents who are appointed to programs in geriatric medicine must have satisfactorily completed an ACGME-accredited residency in family practice or internal medicine. Residents appointed to the

Essentials

SUMMARY

Accident and sickness insurance; access to obstetrician-gynecologists. Requires health insurers (including HMOs) providing obstetrical and gynecological services under their policies or plans to permit females (age 13 and older) to have direct access to obstetrician-gynecologists, without the necessity of prior referral.

SENATE BILL NO. __________ HOUSE BILL NO. __________

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2, a section numbered 38.2-3407.10, relating to accident and sickness insurance; access to obstetrician-gynecologists.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered as follows:

§38.2-3407.10 Access to Obstetrician-Gynecologists.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policies, contracts or plans, including any certificate or evidence of coverage issued in connection with such policies, contracts or plans, include coverage for obstetrical or gynecological services, shall permit any female of age 13 or older covered thereunder direct access, without prior referral, to the health care services of an obstetrician-gynecologist (i) authorized to provide services under such policy, contract or plan and (ii) selected by such female.

B. For the purpose of this section, "health care services" means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system and immunization for disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists, and includes services provided by nurse practitioners,

1 physician's assistants, and certified nurse midwives in collaboration with the obstetrician-
2 gynecologist providing care to an individual covered under any such policy, contract or plan.
3 C. Each insurer, corporation or health maintenance organization subject to the
4 provisions of this section shall inform females covered under any such policy, contract, or
5 plan, of the provisions of this section.
6 D. The provisions of this section shall not apply to short-term travel, or accident-only
7 policies, or to short-term nonrenewable policies of not more than six months' duration.
8 § 38.2-4214. Application of certain provisions of law.
9 No provision of this title except this chapter and, insofar as they are not inconsistent
10 with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-
11 225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500
12 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through
13 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-
14 1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317
15 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through
16 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through
17 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-
18 3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-
19 3514.1, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-
20 3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§
21 38.2-5300 et seq.) of this title shall apply to the operation of a plan.
22 § 38.2-4319. Statutory construction and relationship to other laws.
23 A. No provisions of this title except this chapter and, insofar as they are not
24 inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218
25 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-
26 413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of
27 this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter

13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through
2 | 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-
3 3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3525,
4 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health
5 maintenance organization granted a license under this chapter. This chapter shall not apply to
6 an insurer or health services plan licensed and regulated in conformance with the insurance
7 laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its
8 health maintenance organization.

9 B. Solicitation of enrollees by a licensed health maintenance organization or by its
10 representatives shall not be construed to violate any provisions of law relating to solicitation or
11 advertising by health professionals.

12 C. A licensed health maintenance organization shall not be deemed to be engaged in
13 the unlawful practice of medicine. All health care providers associated with a health
1 maintenance organization shall be subject to all provisions of law.

15 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a
16 health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not
17 be required to offer coverage to or accept applications from an employee who does not reside
18 within the health maintenance organization's service area.

19 #

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DRAFT

SUMMARY

Accident and sickness insurance; access to Ob/Gyn providers. Requires insurers, HMOs and nonstock corporations providing health care coverage plans to integrate one of the following options in health care coverage plans providing coverage of obstetrical and gynecological services through managed care structures: (i) permit individuals to designate an in-network obstetrician/gynecologist as a primary care physician, or (ii) permit individuals to receive an annual examination by an in-network obstetrician/gynecologist for routine gynecological care without a referral from the individual's primary care provider.

SENATE BILL NO. __________ HOUSE BILL NO. __________

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia, and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2, a section numbered 38.2-3407.10, relating to accident and sickness insurance; access to Ob/Gyn services.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2, a section numbered 38.2-3407.10 as follows:

§ 38.2-3407.10. Access to obstetrical and gynecological services.

A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis through a preferred provider organization, each corporation providing individual or group accident and sickness subscription contracts through a preferred provider organization, and each health maintenance organization providing a health care plan for health care services that provides coverage for gynecological and obstetrical services under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, shall (i) permit individuals covered under any such policy, contract, or plan to designate an in-network obstetrician/gynecologist as a primary care physician, or (ii) permit individuals covered under any such policy, contract, or plan to receive an annual examination by an in-network obstetrician/gynecologist for routine gynecological care without a referral from the individual's primary care provider.

B. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance

1 laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

3 B. Solicitation of enrollees by a licensed health maintenance organization or by its
4 representatives shall not be construed to violate any provisions of law relating to solicitation or
5 advertising by health professionals.

6 C. A licensed health maintenance organization shall not be deemed to be engaged in
7 the unlawful practice of medicine. All health care providers associated with a health
8 maintenance organization shall be subject to all provisions of law.

9 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a
10 health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not
11 be required to offer coverage to or accept applications from an employee who does not reside
12 within the health maintenance organization's service area.

13 #

Accident and sickness insurance; access to ob/gyn providers; primary care providers. Requires insurers, HMOs and nonstock corporations providing health care coverage plans to integrate one of the following options in health care coverage plans providing coverage of obstetrical and gynecological services through managed care structures: (i) permit individuals to designate an in-network obstetrician/gynecologist as a primary care physician or (ii) permit individuals to receive an annual examination by an in-network obstetrician/gynecologist for routine gynecological care without a referral from the individual's primary care provider. If, however, an individual's primary care provider is neither an obstetrician/gynecologist nor a board-certified family practice specialist, then unlimited direct access to an in-network obstetrician/gynecologist shall be permitted.

SENATE BILL NO. __________ HOUSE BILL NO. __________

1 A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia, and to
2 amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section
3 numbered 38.2-3407.10, relating to accident and sickness insurance; access to ob/gyn
4 services.

5 **Be it enacted by the General Assembly of Virginia:**

6 **1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted,**
7 **and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title**
8 **38.2 a section numbered 38.2-3407.10 as follows:**

9 § 38.2-3407.10. Access to obstetrical and gynecological services.

10 A. Each insurer proposing to issue individual or group accident and sickness
insurance policies providing hospital, medical and surgical or major medical coverage on an
12 expense-incurred basis through a preferred provider organization, each corporation providing
13 individual or group accident and sickness subscription contracts through a preferred provider
14 organization, and each health maintenance organization providing a health care plan for
15 health care services that provides coverage for gynecological and obstetrical services under
16 any such policy, contract or plan delivered, issued for delivery or renewed in this
17 Commonwealth on and after July 1, 1996, shall (i) permit individuals covered under any such
18 policy, contract, or plan to designate an in-network obstetrician/gynecologist as a primary care
19 physician or (ii) permit individuals covered under any such policy, contract, or plan to receive
20 an annual examination by an in-network obstetrician/gynecologist for routine gynecological
21 care without a referral from the individual's primary care provider. If, however, such
22 individual's primary care provider is neither an obstetrician/gynecologist nor a board-certified
23 family practice specialist, then unlimited direct access to an in-network
24 obstetrician/gynecologist shall be permitted.

B. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health

maintenance organization granted a license under this chapter. This chapter shall not apply to
2 an insurer or health services plan licensed and regulated in conformance with the insurance
3 laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its
4 health maintenance organization.
5 B. Solicitation of enrollees by a licensed health maintenance organization or by its
6 representatives shall not be construed to violate any provisions of law relating to solicitation or
7 advertising by health professionals.
8 C. A licensed health maintenance organization shall not be deemed to be engaged in
9 the unlawful practice of medicine. All health care providers associated with a health
10 maintenance organization shall be subject to all provisions of law.
11 D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a
12 health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not
13 be required to offer coverage to or accept applications from an employee who does not reside
within the health maintenance organization's service area.
15 #
16

APPENDIX R

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January 10, 1996

The Honorable Gladys B. Keating, Chairman
Joint Subcommittee HJR 560
Division of Legislative Services
General Assembly Building
910 Capitol Street
Richmond, Virginia 23219

Dear Gladys:

Today I reviewed a copy of the draft report of HJR 560. Access to OB-GYN services is receiving a lot of attention nationwide, certainly, and Virginia is no exception. I am sorry I was not at the last meeting to help with a quorum. The discussion was apparently along the line of our telephone conversation prior to the meeting.

Over the 10 years I have practiced medicine in the new insurance arena, there has been a lot of changes with how the patients have responded as well as how physicians have reacted. Managed care -HMOs- have given the public and, especially, businesses another method of health care delivery at a more reasonable cost. These changes must present a different world for society to make decisions.

Since the insurance industry offers the older indemified policy to the newer policies, we have always added services to the insurance policies for the public. To my knowledge we have not told the insurance industry how to make their services available. None of the report shows that the quality of women's OB-GYN care in Virginia has been significantly affected by managed care's present mechanisms (see pg 9).

The most unobtrusive plan would be the Maryland plan and the North Carolina plan would destory HMO plans.

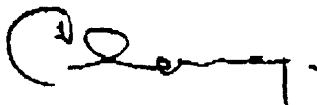
Actually, I would hope that the study of HJR 560 would be continued for one year before any legislation would be submitted. To date the evidence is that the market is responding with various options for woman's care

Sorry that I will not be with all of you to continue to

A member of the SENTARA MEDICAL GROUP

keep the Commonwealth's business on the right tract. Good luck.

Sincerely,



Clarence A. Holland, M.D.

96 - 0987320

DRAFT

SUMMARY

12/11/95 6:04 PM

Study: Continuing the joint subcommittee studying women's access to obstetrical and gynecological services in managed care plans. Continues the study of women's access to Ob/Gyn services within managed care plans. The proposed joint subcommittee would continue the work of the joint subcommittee established by the 1995 General Assembly in House Joint Resolution 560.

96 - 0987320 DRAFT 12/11/95 6:16 PM Arlen K. Bolstad

HOUSE JOINT RESOLUTION NO. __________

1 Continuing the joint subcommittee studying women's access to obstetrical and gynecological
2 services in managed care plans

3 WHEREAS, in House Joint Resolution 560, the 1995 Session of the Virginia General
4 Assembly established a joint subcommittee to study women's access to obstetrical and
5 gynecological services in managed care plans; and
6 WHEREAS, such joint subcommittee convened several meetings, including a public
7 hearing, in which women's access to Ob/Gyn providers and related issues were discussed by
8 the joint subcommittee members with Ob/Gyns, family practice specialists, HMO and PPO
9 representatives, Ob/Gyn patients, and other interested parties; and
10 WHEREAS, the joint subcommittee determined that the principal factual issue before it
11 was whether primary care physician (PCP) management of Ob/Gyn access is adversely
12 affecting the delivery of obstetrical and gynecological services within the Commonwealth; and
13 WHEREAS, the joint subcommittee determined that the principal policy issues before it
14 were whether the Commonwealth should, by legislation, require health care coverage plans
15 with managed care features to (i) permit women to designate in-network Ob/Gyns as their
16 PCPs, (ii) permit women to schedule appointments with in-network Ob/Gyns for gynecological
17 or obstetrical care without the necessity of PCP referral, or (iii) offer women some combination
18 of (i) and (ii) with or without limitations on the number of self-referred Ob/Gyn visits, or the
19 types of treatment or care authorized without PCP participation or approval.
20 WHEREAS, the joint subcommittee examined legislation adopted in other states,
21 including Maryland, Connecticut, New York and North Carolina, that establish a variety of
22 Ob/gyn direct access models; and

1 WHEREAS, the joint subcommittee believes that the Ob/Gyn access issue warrants
2 additional study before any final recommendations are made to the Governor and the General
3 Assembly; now, therefore, be it
4 RESOLVED by the House of Delegates, the Senate concurring, That the joint
5 subcommittee studying women's access to obstetrical and gynecological services in managed
6 care plans is continued. The current membership of the joint subcommittee shall continue to
7 serve. Any vacancies shall be filled by the Speaker of the House, or the Senate Committee
8 on Privileges and Elections, as appropriate.
9 The direct costs of this study shall not exceed $5,400.
10 The Division of Legislative Services shall provide staff support for the study. Technical
11 assistance shall be provided by the Bureau of Insurance of the State Corporation
12 Commission. In developing recommendations, the joint subcommittee is requested to confer
13 with women, doctors, various commercial insurers, sponsors of preferred provider
14 organizations, and health maintenance organizations. All agencies of the Commonwealth
15 shall provide assistance to the joint subcommittee, upon request.
16 The joint subcommittee shall complete its work in time to submit its findings and
17 recommendations to the Governor and the 1997 Session of the General Assembly as
18 provided in the procedures of the Division of Legislative Automated Systems for processing
19 legislative documents.
20 Implementation of this resolution is subject to subsequent approval and certification by
21 the Joint Rules Committee. The Committee may withhold expenditures or delay the period for
22 the conduct of the study.
23 #
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