SUBJECT: Patient access to obstetricians and gynecologists

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, G. Lewis, Olivo, Wise

0 nays

SENATE VOTE: On final passage, March 5 — voice vote

WITNESSES: (*On House companion, HB 180*)
For — Sheri Talley, Texas Academy of Family Practice Physicians; Sandra Gale, Coalition for Nurses in Advanced Practice; Terry Kuhlmann, Texas Association of Obstetricians and Gynecologists; Lydia Scarborough; Jeanette R. Essl; Hannah Riddering, Texas Chapter of the National Organization of Women; Wilhelmina Delco

Against — None

On — Will Davis, Texas Life Insurance Association/Texas Legal Reserve Officials Association

DIGEST: CSSB 54 would require health benefit plans to permit women to select obstetricians or gynecologists to provide relevant health care services. The selection would not affect the patient's ability to chose a primary care physician. A plan would have to permit direct access to the health care services of the designated obstetrician or gynecologist without a referral by the woman's primary care physician or prior authorization or precertification.

The bill would apply to health benefit plans that require enrollees to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper. Plans operating in violation of these provisions would be subject to administrative penalties under the Insurance Code.

A health benefit plan would be defined according to standard provisions, including individual and group insurance plans, health maintenance organizations (HMOs) and, to the extent allowed under federal law, certain employer welfare benefit plans. Health benefit plans that would not have to conform to the bill would include small employer plans under Chapter 26 of the Insurance Code and plans not providing pregnancy-related or well-woman care benefits.

Plans would have to include a sufficient numbers of properly credentialed obstetricians and gynecologists to ensure access to services, including one well-woman examination per year; care related to pregnancy; care for all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition within the scope of the obstetrician or gynecologist. A plan could not impose a copayment or deductible for direct access unless such a cost was imposed for access to other services provided.

A health benefit plan could require the designated obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. Failure to provide this information could not result in any penalty, financial or otherwise, on the physician or the patient if a good-faith effort had been made to supply the information.

A plan could not sanction or terminate primary care physicians as a result of female enrollees' access to participating obstetricians and gynecologists. A plan would have to provide timely notice in clear and accurate language of the choices and types of providers available under the plan pursuant to these provisions.

The bill would take effect September 1, 1997, and would apply to policies or contracts issued or renewed on or after January 1, 1998.

SUPPORTERS SAY:

CSSB 54 would allow women to obtain the obstetric and gynecologic (ob/gyn) health care services they need without the cost, inconvenience and delay of first obtaining a referral from another primary care physician. Most managed care plans require women to visit their primary care physician, such as a family doctor or internal medicine specialist, in order to receive a referral to an ob/gyn specialist, even though the health care problem may be chronic or potentially serious and require immediate and appropriate

medical response.

There also have been too many instances in which a primary care physician did not recognize a serious ob/gyn problem that could have been more appropriately and effectively treated if the woman had gone first to her ob/gyn specialist. Cancerous lumps, for example, have been mistaken for symptoms of sexually transmitted diseases, and abnormal uterine bleeding has been allowed to go untreated when immediate ob/gyn care would have more quickly resolved the problem.

CSSB 54 would maintain HMO cost containment practices while improving patient access to care by allowing direct access to ob/gyn care only for obstetrical or gynecological problems. The patient would not be allowed to designate the ob/gyn specialist as her primary care doctor. While ob/gyn doctors are well-educated and trained, they do not have sufficient expertise in diagnosing and treating conditions that could affect the whole body, and such a task should be left to the oversight and management of a true primary care physician, such as a family practice specialist. Even though some women's routine medical needs may be most frequently met by an ob/gyn doctor, women today die most often from cardiovascular disease and lung cancer, and a primary care doctor should be in charge of managing the whole patient and should have on hand her complete medical history.

CSSB 54 would also allow ob/gyn specialists to refer patients to other specialists for necessary treatment, but they would have to keep the primary care physician informed of the patient's condition and medical services to maintain necessary oversight of the patient's total health care condition and receipt of all medical services. Direct referrals by ob/gyn specialists to other specialists are important, especially in cases of suspected cancer when rapid medical response is critical to the patient's outcome. For example, women who are found by their ob/gyn to have a lump in their breast should not have to wait for a primary care physician's approval to seek further and necessary medical care. Referrals by ob/gyn specialists also would be limited to those conditions treated or diagnosed within the scope of an ob/gyn practice.

OPPONENTS SAY:

CSSB 54 should be amended to require patient referrals by ob/gyn specialists to other specialists be subject to a concomitant authorization of the patient's primary care physician. Without such authorization, the

primary care physician would lose oversight and control over the patient's utilization of medical services. Such oversight is necessary to ensure the patient receives services appropriate to her total health care condition, to preclude the delivery of any unnecessary or duplicative services and testing, and to contain patient care costs.

CSSB 54 also should be amended to allow women to declare an obstetrician or gynecologist as their primary care physician. For most women, ob/gyn health care services are their primary medical need, and a obstetrician or gynecologist may be the only doctor they require for most of their lives. Ob/gyn specialists are considered "primary care" doctors in a general sense of the term, and are sufficiently educated and trained to treat the whole person, not just body parts associated with the female gender.

OTHER OPPONENTS SAY:

SB 54 may be unnecessary. Most HMOs offer women at least one well-woman check per year with a network obstetrician or gynecologist of their choice. About half of the HMOs provide some type of direct access to ob/gyn care, and the current trend in HMO delivery is to improve women's access to ob/gyn care.

NOTES:

The committee substitute specified that the bill would not preclude a woman from selecting a family physician, internal medicine physician or other qualified physician to provide obstetric or gynecological care.