Direct Access for Women In Managed Care Plans

American women repeatedly have expressed the view that reproductive health care is basic care to which they should have "direct access"—that is, without first having to get permission either from a managed care plan or from a primary care provider within the plan. The managed care industry, along with state and federal policymakers, is responding in a variety of ways. But translating this principle into practice remains a significant challenge.

By Rachel Benson Gold

With the demise of national health care reform in 1993, attention largely has shifted from broad-based systemic reform toward limited, incremental approaches to discrete issues. In the intervening years, Congress and the states have taken a number of steps, addressing questions such as insurance "portability" and uninsured children. All the while, with managed care coming to dominate the health care landscape, concern has mounted over how well various managed care systems meet consumers' needs.

For all its rapidity, the transition to managed care has not always been smooth. And while many aspects of managed care have caused concern, how managed care plans address "women's health" has sparked some of the closest scrutiny. Indeed, the issue of so-called drive-through deliveries—strict plan limits on postpartum hospital stays—was one of the first managed care controversies to capture public—and political—attention. It resulted in the enactment of a 1996 federal law mandating coverage for a postpartum stay of at least 48 hours; similar laws are on the books in 33 states.

According to Kathryn Moore of the American College of Obstetricians and Gynecologists (ACOG), the drive-through delivery controversy was also significant in that it broke a logjam, catalyzing action on a variety of related issues. "It wasn't really until the drive-through delivery issue that lawmakers were receptive to a variety of other consumer issues," Moore says. "State legislatures, insurance commissioners and attorneys general realized that issues that seemed impossible to address suddenly seemed possible." One of the most important such issues for women is the question of direct access to reproductive health services without having to obtain prior approval from a network provider or the managed care plan.

Why Women Care

Most managed care plans are organized around the fundamental principle that enrollees select, or are assigned to, a primary care provider (PCP). In addition to providing basic health care, the PCP authorizes specialty care as needed. But most of women's health care—including reproductive health care in general and, most specifically, family planning—does not fit neatly into the primary vs. specialty care dichotomy. Indeed, American women—who often tend to view their gynecologist as their "primary" doctor—have consistently opposed prior authorization requirements for what is to them basic health care.

A 1993 survey conducted for ACOG found that three-quarters of insured women, regardless of their current insurance coverage, oppose requirements to obtain prior authorization for obstetrical and gynecological care. The same result was obtained in a poll conducted earlier this year for the National Partnership for Women & Families (formerly the Women's Legal Defense Fund).

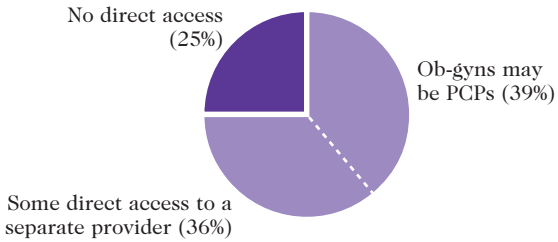
The putative purpose of the PCP/prior authorization system is to prevent unnecessary or excessive utilization of health care while ensuring that medical conditions are properly diagnosed and appropriate referrals made. But for many reproductive health care services, and especially for family planning, these rationales rarely apply. It is generally the woman, in accordance with her personal goals, rather than the provider making a medical determination, who identifies a need for family planning and decides whether to take action to avoid unintended pregnancy. Over-utilization is not an issue, and prior authorization may only delay or impede access to appropriate but time-sensitive care.

Prior authorization may also be difficult, if not impossible, in some cases, since definitions of appropriate care may be subject to the opinions and values of the PCP. A referral for a teenager seeking family planning may be withheld, for example, because the PCP considers her sexual activity inappropriate. Or, a referral for certain services could be withheld because the PCP has moral or religious objections to them.

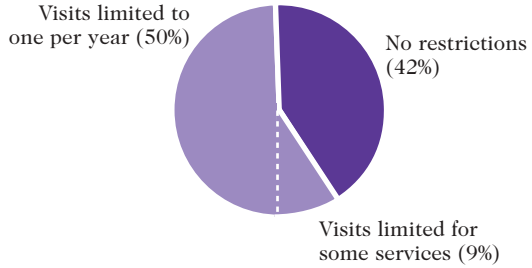
And, while coordinating a woman's total health care through the PCP is at the heart of managed care, this concept can pose serious confidentiality problems for some women who may not want their PCP—who may also care for their parents or other family members—to know that they need, or have obtained, family planning services. Fear that their PCP will find out may result in care delayed, or foregone entirely.

HMOs and Direct Access

By 1993, most HMOs were giving women at least some direct access...



...but limits on visits were common.



Voluntary Industry Moves

Not surprisingly, the managed care industry opposes the imposition of legal mandates. "Health plans have responded to consumer preferences for ease of access to women's health providers," asserts Felicia Bloom of the American Association of Health Plans. Direct access legislation is unnecessary, Bloom says, because "health plans currently provide appropriate access to specialty care and many health plans have…developed innovative products that have streamlined referral processes to facilitate appropriate and timely care."

Most plans have, in fact, addressed direct access issues. According to a 1993 study by The Alan Guttmacher Institute, three in four HMOs—comparable information is not available for other types of managed care systems—have taken steps to give women at least some direct access to reproductive health care, either by allowing women to have an obstetrician-gynecologist as a PCP or by giving them direct access to a separate provider of this care; much of that access is limited, however (see graph).

Joanne Hustead of the National Partnership argues that the failure of some plans to provide any direct access and the "one-size-fits-all restrictions" imposed by many of those that do, "simply don't take into account the realities of women's lives." Hustead acknowledges that "for some women, one visit per year may be enough," but says, "Many need to be monitored more closely. If a woman sees her provider of obstetrical and gynecological care for a routine annual visit and her Pap test is abnormal, she should not have to return to her PCP for a referral for a repeat Pap or other follow-up procedures."

When all the pieces of this complex puzzle are assembled, Hustead's bottom line is that mandates are needed. "Legislation would set a floor for all managed care plans," she says. "A woman wouldn't have to factor in whether a plan includes direct access, leaving her free to select a plan that most closely meets her needs or those of her family."

State Mandates

In fact, states—which traditionally have had the lead role in regulating health insurance—have been adopting such mandates; 32 states require at least some direct access for women's health care. However, all of these mandates provide for improved access within a managed care plan's network of participating providers; none requires plans to permit women to see providers not affiliated with the plan. In addition, these mandates only ease access to services already covered by the plan; none requires coverage of additional care.

One way to obtain direct access to women's health care is to allow a woman to designate an obstetrician-gynecologist as her PCP. Sixteen states require plans to afford women this option (see table). In this case, prior authorization would not be required for care, such as contraceptive services, provided by the obstetrician-gynecologist. However, women selecting a provider other than an obstetrician-gynecologist as a PCP would not necessarily have direct access for reproductive health care.

The other route—which some states take in addition to the PCP route—is to permit women direct access to women's health care from providers other than their PCPs. In this case, the woman is able to obtain at least some services from this non-PCP provider without having to obtain permission from either her PCP or her managed care plan. Twenty-seven states have followed this path, although they have addressed the issue differently. In these states, the key issues are the *providers* to whom the woman has direct access and the *services* that may be obtained.

While all 27 states mandate direct access to an obstetrician-gynecologist, 13 states give women more choices by mandating direct access (for the same services) to a broader range of providers, often including physician assistants, certified nurse midwives and nurse practitioners specializing in women's health. This option meets the needs of many women who prefer to receive gynecological or obstetrical services from mid-level practitioners.

Service limitations are common, however. Some states limit direct access to a woman's annual examination, a

Direct Access to Women's Health Services: State Mandates

State	Ob-gyns May Be PCPs	Other Direct Access: To Whom and For What			Consumer Protections	
		Direct Access to Non-PCP Ob-gyns...*	...and also to Non-physician Ob-gyn Providers	PCP Informed of Care	Notice to Enrollees About Direct Access Required	Additional Fees For Direct Access Prohibited
Alabama	YES	ANNUAL VISIT PLUS				
Alaska						
Arizona						
Arkansas		ANNUAL VISIT PLUS				
California	YES	ANNUAL VISIT PLUS[1]		OPTIONAL		
Colorado	YES[2]	ANNUAL VISIT PLUS[2]	YES			YES
Connecticut		ANNUAL VISIT PLUS	YES	OPTIONAL		
Delaware	YES	ANNUAL VISIT PLUS		REQUIRED	YES	YES
Florida	YES					
Georgia		ANNUAL VISIT PLUS			YES	
Hawaii						
Idaho	YES	ANNUAL VISIT PLUS				YES
Illinois		ANNUAL VISIT PLUS				
Indiana	YES					
Iowa						
Kansas						
Kentucky						
Louisiana		ANNUAL VISIT PLUS		OPTIONAL		
Maine	YES	ANNUAL VISIT ONLY[1]	YES	OPTIONAL		
Maryland	YES	ANNUAL VISIT ONLY		REQUIRED		
Massachusetts						
Michigan						
Minnesota		ANNUAL VISIT PLUS				YES
Mississippi	YES					
Missouri		ANNUAL VISIT ONLY		REQUIRED		
Montana	YES	ANNUAL VISIT PLUS	YES	OPTIONAL	YES	YES
Nebraska	YES					
Nevada		ANNUAL VISIT ONLY[3]	YES[3]			
New Hampshire						
New Jersey	YES[4]					
New Mexico	YES	ANNUAL VISIT PLUS[1]	YES	OPTIONAL	YES	YES
New York		ANNUAL VISIT PLUS[1]	YES	REQUIRED[5]	YES	
North Carolina		ANNUAL VISIT PLUS	YES		YES	
North Dakota						
Ohio						
Oklahoma						
Oregon	YES	ANNUAL VISIT PLUS	YES			
Pennsylvania						
Rhode Island		ANNUAL VISIT ONLY				
South Carolina						
South Dakota						
Tennessee						
Texas		ANNUAL VISIT PLUS[1]		OPTIONAL	YES	YES
Utah	YES	ANNUAL VISIT ONLY			YES	YES
Vermont		ANNUAL VISIT PLUS	YES	REQUIRED		
Virginia		ANNUAL VISIT PLUS	YES		YES	
Washington		ANNUAL VISIT PLUS[1]	YES		YES	YES
West Virginia		ANNUAL VISIT PLUS	YES		YES	YES
Wisconsin						
Wyoming						

*"Annual visit only" means women are permitted direct access for one annual visit. "Annual visit plus" means women are permitted direct access to a range of services in addition to an annual visit; the range of services beyond an annual visit varies widely from state to state. 1. Also includes direct access to family physician or other qualified physician. 2. In lieu of direct access, insurers may implement an expedited referral procedure. 3. Provider(s) to whom direct access is permitted is unspecified. 4. Certified nurse midwives, physician assistants and nurse practitioners specializing in women's health may also be PCPs. 5. For follow-up care and care related to an acute gynecological condition only.

restriction that may make the direct access afforded enrollees of only limited utility for a woman seeking family planning or other services that do not fit into a neat timetable. Most states, however, provide direct access for a somewhat broader range of services, although the range varies widely from state to state. Most states include follow-up and maternity care as direct access services. Some states also include a second exam over the course of a year or acute gynecological care.

A striking number of the direct access policies explicitly permit or even mandate plans to require that the separate woman's health provider inform the woman's PCP of any care that is obtained. Such provisions preclude confidential care, often a key concern of women seeking contraceptive services. In fact, it is often this desire for confidentiality that led the woman to seek care from a separate provider in the first place.

Nonetheless, many state laws do include a variety of consumer protections in their direct access provisions. For example, 11 states now require plans to give women timely notification of their direct access option, and 10 states prohibit plans from requiring additional out-of-pocket expenditures from women exercising their direct access option. Other types of consumer protections added by states include requiring insurance commissioners to take the steps necessary to enforce direct access provisions and requiring plans to include an adequate number of providers in their networks.

Action on the Federal Level

Congress, so far at least, has been more reluctant to act on these issues than have the state legislatures. Although three major congressional proposals for large-scale regulation of the managed care industry are pending, only one—sponsored by Rep. John Dingell (D-MI) and Sen. Tom Daschle (D-SD)—includes a direct access provision. In addition, Reps. Nita Lowey (D-NY), Rick Lazio (R-NY) and Larry Combest (R-TX) have introduced freestanding legislation designed to give managed care enrollees direct access to obstetrician-gynecologists and other providers practicing in collaboration with them.

On a separate track, the push for direct access has received important recent encouragement from the Consumer Bill of Rights and Responsibilities developed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The report calls for managed care plans to offer direct access to women's health care provided by a range of providers, specifically including gynecologists, certified nurse midwives and other qualified health care providers. According to the commission's deputy director, Richard Sorian, direct access is assured for "the provision of covered care necessary to provide routine and preventative women's health care services."

While this report already is being translated into formal legislative proposals at both the federal and state levels—and is likely to spur even more voluntary private-sector moves—its most immediate impact appears to be on the insurance programs directly controlled by the federal government. President Clinton moved quickly to implement the panel's recommendations in the health insurance programs he directly controls. In an executive memorandum on February 20, the president instructed the Office of Personnel Management (OPM), which administers insurance coverage for federal employees and their dependents, to come into compliance. Within weeks, OPM informed insurance carriers that they should provide direct access to "at least one annual routine gynecological examination"—interestingly, a far narrower right than that spelled out by the president's commission.

Ironically, the impact of the commission's report is likely to be far less immediate for the massive Medicaid program, which is the single largest source of public funding for family planning in the United States. Although President Clinton instructed the Department of Health and Human Services, the federal agency that administers the program, to comply with the commission's recommendations, the agency has concluded that while its existing authority is sufficient to implement several of the panel's recommendations, it lacks the statutory authority to require all state Medicaid programs to provide direct access to obstetrical and gynecological services. While many state programs have voluntarily adopted direct access policies, federal legislation would be needed to ensure that all programs do so. All of which throws this ball back into Congress's court as well.

The research on which this article is based was supported in part by the U.S. Department of Health and Human Services (DHHS) under grant no. FPR000057. The conclusions and opinions expressed in this article do not necessarily represent the views of DHHS.