Women's Access to Care:

A State-Level Analysis of Key Health Policies

Alabama Alaska Arizona Arkansas California Colorado Connecticut Delaware District of Columbia Florida Georgia Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Maryland Massachusetts Louisiana Michigan Minnesota Missouri Montana Nevada New Hampshire New Jersey New Mexico New York North Carolina North Dakota Oklahoma Oregon Pennsylvania Rhode Island South Carolina Washington South Dakota Texas Utah Vermont Virginia West Virginia Wisconsin Wyoming Alabama Alaska Arizona Ohio Arkansas California Colorado Delaware District of Columbia Florida Georgia Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Maine Massachusetts Michigan Mississippi Montana Arizona Arkansas California Colorado Connecticut Delaware District of Columbia Florida Georgia Hawaii Idaho Illinois Alabama Alaska Arizona Ohio Arkansas California Colorado Delaware District of Columbia Florida Georgia Hawaii Idaho Illinois Nevada New Hampshire New Jersey Ohio

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NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

THE HENRY J. KAISER FAMILY FOUNDATION

The National Women's Law Center is a Washington-based non-profit organization working to expand opportunities and eliminate barriers for women and their families, with a major emphasis on women's health, education and employment opportunities and family economic security.

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EXECUTIVE SUMMARY

Too often, access to health care services is an acute problem for women. Nearly one-quarter of women report that there was a time in the last year when they needed to see a doctor but did not, and nearly one in five is uninsured. While all health care system policies affect women, many important decisions affecting women's access to health care are made by state policymakers. Insurance regulation, Medicaid policy, and financing of public health services are policy issues under state jurisdiction. Although not traditionally considered to be women's health issues, regulations and legislation on these policies are of critical importance to women's access to health care services and to their health. This report details a broad range of state policies that can influence women's access to care and coverage, with a special focus on private insurance, Medicaid, reproductive health, and other public health services.

This report finds that overall, states have tackled a wide range of access issues of significance to women, ranging from preventive screening mandates to managed care consumer protections, to mental health parity to Medicaid eligibility expansions. While the sheer number of initiatives indicates a great deal of activity on access to health care, states have tended to address access using a piecemeal approach. In general, states have not established overarching priorities to expand women's access to care in a comprehensive manner. For instance, states have legislated extensively in the area of mandates for women who have private health coverage-about a third of the policies reviewed in this report are related to specific access issues for women with private insurance–but the activity has been uneven. Nearly twice as many states mandate that insurance plans cover mammograms than Pap smears, despite the proven benefits and low cost of regular cervical cancer screening. Similarly, states have legislated on many issues in response to public and media attention, such as infertility treatment or outpatient mastectomies. However, broader systemic considerations and improvements have been much harder to achieve. As a result, millions of women are still unable to afford coverage and without secure access to care.

Medicaid, the state-federal health insurance program for low-income people, has become a particularly important safety-net for women. Through expansions in eligibility and scope of services covered (with a particular emphasis on important services for women, such as prenatal care and family planning during reproductive years and income protections for the spouses of older beneficiaries), Medicaid has made progress in improving access to care for low-income women. It remains the most important financing program for long-term care, particularly nursing home care, which is a critical benefit for women, given that three-quarters of nursing home residents are elderly women. However, the economic downturn and budget shortfalls that the federal government and most states are facing have the potential to jeopardize much of the progress that Medicaid has accomplished and could have a disproportionately heavy effect on low-income women. Many states are considering making cutbacks in eligibility or benefits. Others are considering reducing payments to health care providers, which can have the unintended but very real consequence of reducing provider participation in Medicaid and thus availability of care.

Access to reproductive health care continues to be shaped by political, moral and religious debates. While progress has been made in expanding access to family planning services for low-income women through special Medicaid expansion programs and comprehensive contraceptive parity mandates for privately insured women, state legislatures continue to focus significant attention on abortion restrictions. Abortion is the most regulated health care service for women; the report details seven abortion-related policies. Reproductive health initiatives that promise positive public health benefits-such as requiring insurers to cover contraception or hospitals to inform women who are survivors of rape or incest about emergency contraception-have made important inroads, but continue to have limited acceptance at the state level. To date, about half of the states have contraceptive coverage mandates, although half include provisions that allow providers, plans, or employers to refuse participation if they have moral or religious objections to contraception.

Clearly there is still much room for states to adopt policies that expand access to key health services for women. Trends in Medicaid access for women have generally been positive, but it is unclear if the gains can be maintained given states' current budget crises. In addition, many working poor and childless women still are not eligible for coverage regardless of how poor they are or how much they need health care services. Certain individual access issues for women with private insurance, particularly for some preventive services, have been tackled with enthusiasm, but there is no evidence of large-scale action on two of the most serious and most costly issues–lack of health insurance and rapidly rising health care costs–that affect women's ability to obtain the care they need.

KEY FINDINGS

PRIVATE INSURANCE COVERAGE

States play a large role in improving access to services for the approximately 63.5 million women who are covered by private health insurance. Key areas where states have taken action to expand access to services for women with private insurance include mandates for screening tests and some reproductive health care services, parity for mental health services, and patient protections under managed care. These mandates, however, have limitations and do not apply to health insurance plans that are funded and administered by employers. An estimated 50% of workers are in these types of plans.

- **Most states mandate that insurers cover some screening tests important to women's health, but certain tests are much more widely mandated than others.** For instance, 49 states and the District of Columbia have mammography mandates, and cervical cancer screening mandates are in place in half the states and the District of Columbia. Fewer states have colorectal cancer and bone density screening mandates, and only three states have chlamydia screening mandates. Maryland is the only state that has all five screening mandates important to women's health and Utah is the only state that has no mandates.

- **Some states have taken major steps in increasing access to reproductive health care for women by mandating insurance coverage for key services.** Half the states have adopted contraceptive coverage mandates, which require insurers to cover contraceptives to the same extent as other prescription medications, although 14 states include an exemption for employers and/or insurers with moral or religious objections to contraception. Fifteen states have some type of infertility treatment mandate, however, five of them have clauses that limit the scope of the mandate. Nineteen states have post-mastectomy length-of-stay coverage mandates, and 37 states and the District of Columbia have post-mastectomy reconstructive breast surgery mandates, which is also federally mandated.

- **About two-thirds of states have addressed mental health parity in an attempt to increase access to mental health services.** Access to mental health care is particularly important for women, who are twice as likely as men to suffer from certain mental health conditions. Nearly one in five women will have an episode of major depression in her lifetime. Eight states have laws mandating full parity in the coverage of mental health services and 25 states have limited mental health parity laws.

- **States have also addressed access concerns for the 75% of women with private health insurance who are in managed care plans.** The majority of states now allow women to see an OB/GYN without a referral or as their primary care provider. Thirty-five states place restrictions on health plans' ability to require pregnant women or people with serious illnesses to change doctors before their treatment is completed. The majority of states and the District of Columbia have some type of external review process for addressing disputed managed care claims. Finally, thirteen states require managed care plans to cover experimental care for some people in clinical trials; insurers in two additional states provide this coverage on a voluntary basis.

MEDICAID

Medicaid, the nation's health insurance program for low-income people, is a crucial path to access to health care services for low-income women. Medicaid covers more than 8 million low-income women; nearly 70% of adult Medicaid beneficiaries are women. Each state operates its own program within broad federal guidelines, setting policies that influence beneficiaries' access to health services, including income eligibility levels, scope of benefits, mandatory managed care enrollment and expansions for family planning and other services.

- **Most states have made significant expansions in Medicaid eligibility.** Women comprise the majority of adult Medicaid recipients and nearly one in five women ages 18 to 64 living below 200% of the federal poverty level are enrolled in Medicaid. Historically, to qualify for Medicaid, a women must be either pregnant, disabled, 65 or older, or a parent of dependent child. In recent years, eligibility has been broadened through a combination of federal and state changes, allowing Medicaid to assist more low-income people. For example, most states increased income eligibility thresholds to cover more parents of dependent children using the Family Coverage Option created by the 1996 welfare reform law. Nine additional states have expanded Medicaid coverage to parents using a federal waiver. States have also promoted access to prenatal care coverage through Medicaid: 39 states and the District of Columbia have gone beyond the federal eligibility minimum of 133% of the federal poverty level for pregnant women. Few states, however, have extended Medicaid eligibility to low-income women without dependent children. Historically, adults without children could not qualify for Medicaid regardless of how poor they were. Now, states have the option of applying for a waiver from the federal government to expand coverage to low-income adults without children, but only eight states have done so. Three states provide health coverage to adults without children through separate state-funded programs.

- **States have taken steps to expand Medicaid coverage and income protections for low-income seniors and people with disabilities.** Medicaid is an important source of coverage for low-income seniors (who disproportionately tend to be women) and people with disabilities. Medicaid can assist seniors and people with disabilities by both making Medicare more affordable by paying Medicare cost-sharing and deductibles or by covering costs of long-term care and prescription drugs (Medicaid-covered services). One-third of states extend full Medicaid coverage to seniors and people with disabilities with incomes up to 100% of the federal poverty level. Most states have chosen to establish program eligibility at the level of State Supplemental Payments, which are use to augment federal Supplemental Security Income payments. In addition, 33 states and the District of Columbia have an optional medically needy eligibility category for seniors and adults with disabilities, which covers their acute and long-term care costs. Half the states have implemented Medicaid expansions for working adults with disabilities, under new options created by federal law. In addition to eligibility expansions, states also have Medicaid income limits to protect older adults with spouses in nursing homes from impoverishing themselves and programs to help low-income individuals afford prescription drugs.

- **Most states mandate enrollment in managed care for Medicaid beneficiaries.** To control costs, most states have adopted some type of managed care arrangement for Medicaid beneficiaries. Managed care enrollment is mandatory for beneficiaries in 35 states and the District of Columbia, eight states have voluntary managed care enrollment, and three states allow voluntary enrollment in some areas and mandate it in other areas. This has important implications for many of the services that women receive, particularly family planning services. To foster continuity and access to a full range of services, under the federal "free access" provision, states must allow women enrolled in Medicaid managed care plans to obtain family planning services from any participating Medicaid provider. However, states that operate their Medicaid managed care programs under federal 1115 waivers or as voluntary programs, may waive the free access provision. In total, eight states have chosen to waive this option for women.

- **States have used Medicaid to expand access to certain reproductive health care services while others remain limited.** Medicaid's emphasis on pregnant women and low-income women of reproductive age in general make it an important payer for reproductive health care. Sixteen states have obtained "family planning waivers" from the federal government that allow them to provide only family planning services to low-income women who are otherwise ineligible for Medicaid. These family planning waivers allow states to explicitly include a variety of services, including coverage for over the counter contraceptives, STD testing and treatment, and emergency contraception; however, few states have included coverage for all of these services. The majority of states also participate in a federal waiver program that allows them to extend Medicaid eligibility to uninsured women who need treatment for breast or cervical cancer. Medicaid coverage for abortions, though, is quite restricted. The federal "Hyde Amendment" prohibits use of federal funds for coverage of abortions unless the pregnancy is the result of rape or incest or the abortion is "necessary to save the life of the woman;" however, 23 states have opted to use their own state funds to cover other "medically necessary" abortions, which are defined as abortions that protect the health of the woman.

REPRODUCTIVE HEALTH SERVICES

State policies affect women's access to a range of reproductive health care services. For example, state regulations on abortions affect waiting periods, parental consent/notification, clinic access, and how late in the pregnancy women can obtain abortions. States also can promote new methods of contraception, such as emergency contraception. Another avenue where states have been involved is in allowance of refusal clauses. These policies limit access to services including infertility treatments, abortion, and contraception by permitting providers, plans, or employers to refuse provision, coverage, or referrals to services for which they have a moral or religious objection.

- **Many regulations limit access to abortion services at the state level.** The majority of states have banned abortions past the point of viability; most provide exceptions for the life and health of the woman. In addition, 31 states have banned the so-called "partial birth," abortion procedure, but the Supreme Court found a Nebraska law, which is very similar to other state "partial birth" ban bills, to be unconstitutional because the definition of the banned procedure was not precise and it does not make an exception if the health of the woman is at risk. Sixteen states have clinic access laws that help protect a woman's safety and facilitate her visit to an abortion provider, but many more states have laws that place additional regulations on abortion providers and clinics. The majority of states also have parental consent or notification laws for minors seeking an abortion: 23 states require parental consent and 21 states require parental notification before a female minor may have an abortion. Finally, 21 states have a mandatory waiting period before a woman may obtain an abortion.

- **States are just beginning to explore more avenues for access to emergency contraception.** Emergency contraception, also known as the morning after pill, is a higher dose of contraceptive pills that when taken within days of having unprotected sexual intercourse, greatly reduces the chance of pregnancy. Just over half the states cover emergency contraception as a family planning service under their Medicaid programs. Four states allow pharmacists to dispense emergency contraception without requiring the woman to contact or visit a physician first. Six states require emergency room staff to administer emergency contraception to sexual assault victims upon request; one state, Illinois, requires hospitals to develop and implement protocols to ensure that rape victims receive medically accurate information about emergency contraception.

- **The majority of states allow refusal clauses for individuals or institutions, plans, or employers to refuse to provide certain reproductive health services.** Refusal clauses, often called conscience clauses, allow health care providers to opt out of coverage for certain services, based on moral or religious objections. Most states allow exemptions for individual health care providers who refuse to perform or participate in abortions. Twenty-one states allow any health facility and 20 states allow hospitals to refuse to perform or participate in abortions. About half the states allow exemptions for individual health care providers and half allow exemptions for health care entities from providing family planning services. Five of the 15 states that mandate treatment for infertility permit exemptions for religious entities.

OTHER WOMEN'S HEALTH-RELATED SERVICES

Ensuring that state policies facilitate women's access to vital health services requires attention to a wide range of policy areas and issues that go beyond basic coverage or health care services. States can facilitate access to health-related services that address specific issues that threaten women's health and well being, such as violence or HIV/AIDS, or create infrastructures such as Offices of Women's Health to assist women with a broad range of health-related issues.

- **Few states have moved to create statewide Offices of Women's Health.** A total of 13 states have Offices of Women's Health that develop agendas on women's health issues; provide policy guidance to the governor's office, state legislature, and the state department of health; serve as a clearinghouse and resource for information on women's health for the public; and fund direct health care services.

- **Few states require special training and service protocols for health care providers and law enforcement personnel that serve victims of violence; most states do have laws prohibiting discrimination against victims of violence seeking health insurance.** Nine states require domestic violence protocols for health care providers to assist women, three states require that providers screen women for domestic violence and 11 states require provider training on domestic violence issues. The overwhelming majority of states have domestic violence anti-discrimination laws, most commonly for health insurance, but also for life, disability, and property/casualty insurance as well. These laws prohibit insurers from denying coverage based on a woman's history of domestic violence. In addition, seven states require training of health care providers and 14 states require training of police and/or prosecutors, to better assist survivors of sexual assault.

- **As the incidence of AIDS continues to increase among women, particularly minority women, states play an important role in the fight against HIV/AIDS.** Women now account for 30% of new HIV infections in the United States. To prevent vertical transmission of HIV, the majority of states have implemented the Centers for Disease Control and Prevention's 1995 guidelines for HIV testing of pregnant women, which call for voluntary testing for all pregnant women. Eleven states require providers to offer HIV tests to pregnant women and seven states automatically test unless a woman refuses. In addition, all 50 states assist HIV-positive individuals with the cost of AIDS medications through the ADAP program.

- **Rising pharmaceutical costs in the absence of a Medicare prescription drug benefit and the limits on Medicaid drug benefits have led many states to establish their own drug assistance programs.** Thirty-one states and the District of Columbia have state-sponsored pharmacy assistance programs targeted to seniors and people with disabilities who have limited incomes. In addition, 16 states operate discount or cooperative pharmacy programs that require eligible Medicare beneficiaries to pay an enrollment fee or copayment to receive reduced cost pharmaceuticals.

I. INTRODUCTION

Access to health services is crucial for women. They have ongoing reproductive health needs, suffer from more chronic conditions and are more likely to be poor-which means they are less likely to have private insurance and more likely to suffer from poor health than men.[1] National health concerns, especially rising health care costs, from prescription medications to premiums and out-of-pocket expenses, also have a disproportionate impact on women–even those with health insurance-because of their lower economic status.

Too often, however, access to health care services is an acute problem for women. The effects of limited access are tangible. Nearly one-quarter of women report that there was a time in the last year when they needed to see a doctor but did not.[2] Almost 40% of women in fair or poor health did not fill a prescription in the last year because they could not afford it, and half had to delay or forgo care because they encountered problems with insurance companies approving treatment.[3] Access problems are even more acute for the nearly one in five women who are uninsured who are less likely to see a doctor regularly and more likely to delay getting care for existing problems than their insured counterparts.[4] Low-income and minority women are also more likely to lack access to basic health care services, including preventive and prenatal care.[5]

Though it is not widely recognized, state policies can have tremendous influence on women's ability to receive care. Health insurers are regulated at the state level. States also are the arbiters of their Medicaid programs, a critical health care safety net for millions of low-income women of all ages. States also have opportunities to strengthen their public health infrastructure to better meet the needs of seniors, people with disabilities, or low-income people, all of whom are disproportionately women. Because of these key roles in ensuring access, this report examines state-level policies that affect women's access to care.

State policies can compel insurers to cover specific services, promoting their use and reducing their cost to women, or to provide access to specific types of physicians without a referral, again reducing cost as well as the burden of an additional doctor's appointment. To help ensure that women get the services they need when they need them, states can require managed care plans to provide external reviews of coverage denials. States can use the Medicaid program to help uninsured women get family planning services and breast and cervical cancer screening and treatment, extend Medicaid coverage to previously uncovered populations, and help seniors on Medicare afford their co-pays and prescription medications.

However, this influence cuts both ways. States can allow providers to opt out of performing certain reproductive health services, thereby diminishing the supply of providers and the availability of care. States can regulate services, such as abortion, with the intention of reducing, not increasing, access. States can set qualifying income levels for Medicaid so low that many low-income women are left without coverage or scale back the scope of services for those who are eligible. In the current fiscal climate with states facing severe budget shortfalls, many of these services and programs may be curtailed or eliminated.

This report details more than 50 key state policies that have impact on women's access to important health care services in the areas of private health insurance, Medicaid, reproductive health care and other women's health-related services. This report is intended to show the range of state activities that affect access to care. This report can serve as a resource for policymakers, members of the media, researchers and women's health advocates to assist them in comparing state efforts to expand women's access and to identify creative strategies, and pinpoint areas where there are gaps to fill.

II. PRIVATE INSURANCE COVERAGE

Nationally, approximately 63.5 million women (61% of women ages 18 to 64) are covered by health insurance they receive through their employer or their spouse's employer.[6] State policies can serve the privately insured by ensuring that private plans cover certain services. Many of these coverage mandates involve health care services that are particularly important to women, but historically have not been covered by insurers, including screening tests for diseases that predominantly affect women, prescription contraceptives and infertility treatment. To increase access to these services, some states have adopted policies requiring that insurance companies cover them.

However, these coverage mandates have limitations. While many states mandate that insurers cover specific services, some states only mandate that insurers *offer* to cover particular services. These "mandated offer" provisions require insurers to offer to sell coverage for the service, but do not require employers or individuals to purchase the coverage. And although the business of health insurance is primarily regulated by the states, several federal laws contain requirements that apply to private health insurers. Among these is the Employee Retirement Income Security Act (ERISA), which was enacted in 1974 to protect workers from the loss of benefits provided through the workplace.[7] Health insurance plans that are administered and funded directly by employers, known as "self-funded" plans, are regulated by ERISA and as a result, some aspects of these plans do not fall under state law. Approximately 50% of workers are in self-funded plans.[8] One consequence of this law is that states cannot mandate that self-funded plans provide specific benefits, which means that up to half of all people covered by employer-sponsored health plans may fail to benefit from state insurance mandates.

In addition, the majority of people in the U.S. and approximately three out of four women are covered by private managed care plans.[9] Managed care seeks to balance quality and cost by creating networks of health care providers and facilities that agree to accept negotiated, often discounted, fees; coordinating care through primary care physicians; and monitoring the appropriateness and medical necessity of care. Some of these policies have raised concerns at the state and national levels about the quality of care provided by managed care plans, so states have adopted policies that specifically regulate managed care practices.

To illustrate the role that states play in expanding access to services for women with private health insurance, this chapter examines private insurance mandates for screening tests, reproductive health care services, mental health services and managed care services.

SCREENING COVERAGE MANDATES

This section details trends in mandated screening coverage for five diseases that predominantly affect women or are a major cause of death in women: breast cancer, cervical cancer, colorectal cancer, osteoporosis and chlamydia. Screening tests result in people being diagnosed earlier, having a better chance of recovery because these diseases are highly responsive to early medical intervention, and ultimately reduce the cost of health care.[10] While states have made major efforts to require insurers to cover screening tests for breast and cervical cancers, there has not been nearly as much effort to encourage screening for the other diseases. Specifically, only three states mandate coverage for screening for chlamydia, the most common bacterial sexually transmitted disease affecting women. There is also great variation between the states as to which guidelines they follow for determining screening requirements. Generally, the screening mandates apply to group health insurance plans and managed care plans. A few states have screening mandates that apply to individual and disability plans.

Breast Cancer Screening Coverage Mandates

Breast cancer is the second leading cause of cancer-related death among women (following lung cancer).[11] Each year, over 200,000 new cases of breast cancer in women are diagnosed in the U.S.[12] A mammogram is an x-ray procedure that can detect early breast changes in women who have no signs of breast cancer.[13] A number of studies have shown that early detection of breast cancer allows treatment that may reduce the risk of cancer spreading to other parts of the body.[14] While there is currently debate over when women should start having mammograms and how frequently they should have them, the National Cancer Institute and most doctors agree that mammograms are an important screening tool. Every state except Utah has some type of mammography mandate. All but five states with mandates specify the age at which screening coverage is to begin; the majority of states mandate coverage for a mammogram every two years for women ages 40 to 49 and annually for women age 50 and over. Guidelines issued by the U.S. Preventive Services Task Force recommend a mammogram every 1-2 years for women ages 50 to 69, but say that there is "insufficient evidence to recommend for or against routine mammography" for women ages 40 to 49.[15] The American Cancer Society (ACS) recommends annual screening for all women age 40 and older.[16]

TABLE II-1 BREAST CANCER SCREENING COVERAGE MANDATES

- 49 states and the District of Columbia have some type of breast cancer screening mandate.
  - 28 states mandate coverage of annual mammograms for women age 50 and over; 27 of these states mandate biennial mammograms for women ages 40 to 49.
  - 16 states require insurers to cover annual mammograms for women age 40 and over; 1, Mississippi, starts at age 35.
  - 3 states require insurers to offer to sell mammography coverage, but do not require employers to purchase the coverage.
  - 3 states require coverage if the mammogram is recommended by a physician.

TABLE II-1
Breast Cancer Screening Coverage Mandates

State	Screening Mandate (Annual)	Age Annual Screening Begins	Biennial Screening (Ages 40-49)
United States Total	**49 + DC**		**27**
Alabama	●	50	●
Alaska	●	50	●
Arizona	●	50	●
Arkansas	⊙	50	●
California	●	50	●
Colorado	●	50	●
Connecticut	●	40	
Delaware	●	50	●
District of Columbia	●	no age requirement	
Florida	●	50	●
Georgia	●	50	●
Hawaii	●	40	
Idaho	●	50	●
Illinois	●	40	
Indiana	●	40	
Iowa	●	50	●
Kansas	○**	ACS	
Kentucky	●	50	●
Louisiana	●	50	●
Maine	●	40	
Maryland	●	50	●
Massachusetts	●	40	
Michigan	⊙	40	
Minnesota	○~	~	
Mississippi	⊙	35	
Missouri	●	50	●
Montana	●	50	●
Nebraska	●	50	●
Nevada	●	40	
New Hampshire	●	50	●
New Jersey	●	40	
New Mexico	●	50	●
New York	●	50	●
North Carolina	●	50	●
North Dakota	●	40	
Ohio	●	50	●
Oklahoma	●	40	
Oregon	●	40	
Pennsylvania	●	40	
Rhode Island	●	ACS	
South Carolina	●	40	
South Dakota	●	50	●
Tennessee	●	50	●
Texas	●	no age requirement	
Utah			
Vermont	●	50	~
Virginia	●	50	●
Washington	○~	~	
West Virginia	●	50	●
Wisconsin	●	50	●
Wyoming	●	no age requirement	

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to sell coverage, but employers are not required to purchase.
- ** When reimbursement is provided for laboratory and X-ray services, reimbursement for breast cancer screenings will not be denied.
- ~ Covered only when a physician recommends screening; no age requirement.
- ACS American Cancer Society guidelines (annual screening for women 40+)

Source: National Conference of State Legislatures, "Breast and Cervical Cancer Screenings," April 8, 2002, [Online] http://www.hpts.org/HPTS97/home.nsf.
Data current as of April 2002

Cervical Cancer Screening Coverage Mandates

Annually, approximately 13,000 new cases of cervical cancer are diagnosed and more than 4,000 women die of the disease in the U.S.[17] Cervical cancer is the twelfth most common newly diagnosed cancer in women in the U.S.[18] During the last several decades, the incidence of cervical cancer and deaths from the disease have declined steadily in the U.S. due to an increase in the use of Pap smears, which enable the disease to be diagnosed at its earliest stages, when it is easily treatable.[19] A Pap smear is a swab of cervical tissue that is examined for evidence of abnormal cell growth. New technologies are improving the accuracy of cervical cancer screening, although they may be more expensive and some insurers have limited routine coverage.[20] Most states that mandate coverage for cervical cancer screening require it on an annual basis.

TABLE II-2 CERVICAL CANCER SCREENING COVERAGE MANDATES

- 25 states and the District of Columbia have some type of cervical cancer screening mandate.
  - 21 states and the District of Columbia mandate coverage for annual cervical cancer screenings.
  - 4 states have limited policies requiring cervical cancer screening; either a physician must recommend the screening or screening must be provided if other laboratory services are covered.

TABLE II-2
Cervical Cancer Screening Coverage Mandates

State	Annual Screening Mandate	Type of Screening
United States Total	**25 + DC**	
Alabama		
Alaska	●	Pap smear
Arizona		
Arkansas		
California	●	Pap smear or other FDA-approved screening
Colorado		
Connecticut		
Delaware	●	Pap smear
District of Columbia	●	cytologic screening test
Florida		
Georgia	●	CAP
Hawaii		
Idaho		
Illinois	●	cervical smear or Pap smear
Indiana		
Iowa		
Kansas	○*	Pap smear
Kentucky		
Louisiana	●	Pap smear
Maine	○	pelvic exam~
Maryland	●+	USPSTF
Massachusetts	●	cytologic screening test
Michigan		
Minnesota	○**	Pap smear
Mississippi		
Missouri	●	ACS
Montana		
Nebraska		
Nevada	●	cytologic screening test
New Hampshire		
New Jersey	○◆	Pap smear
New Mexico	●***	cytologic screening test
New York	●	pelvic exam and Pap smear
North Carolina	●	Pap smear
North Dakota		
Ohio	●	cytologic screening test
Oklahoma		
Oregon	●	pelvic exam and Pap smear
Pennsylvania	●	ACOG
Rhode Island	●	ACS
South Carolina	●	Pap smear
South Dakota		
Tennessee		
Texas		
Utah		
Vermont		
Virginia	●	cytologic screening test and Pap smear
Washington		
West Virginia	●	Pap smear
Wisconsin		
Wyoming	●****	pelvic exam and Pap smear

Notes:

●	State has the policy
○	State has a limited policy
*	When reimbursement is provided for laboratory and X-ray services, reimbursement for cervical cancer screenings will not be denied.
**	Covered only when a physician recommends the screening
***	Frequency determined by health care provider
****	Frequency unspecified
~	Covers annual gynecological examinations, including routine pelvic examinations, but does not specify cervical cancer screening.
+	According to Maryland regulation, insurers in the small group market are required to cover preventive services as recommended in the USPSTF's Guide to Clinical Preventive Services, which includes coverage for cervical cancer screening tests.
◆	Individual plans every 2 years; group plans must cover Pap smears to the same extent as any other medical condition under the policy.
ACOG	American College of Obstetricians and Gynecologists
CAP	College of American Pathologists
ACS	American Cancer Society
USPSTF	United States Preventive Services Task Force

Source: National Conference of State Legislatures, "Breast and Cervical Cancer Screenings," April 8, 2002, [Online] http://www.hpts.org/HPTS97/home.nsf.
Data current as of April 2002

Colorectal Cancer Screening Coverage Mandates

Almost 150,000 people in the U.S. are diagnosed with colorectal cancer each year.[21] Cancers of the colon and rectum are the third leading cause of cancer-related death among women.[22] Although death rates for colorectal cancer are decreasing, a substantial number of cases are detected at later stages. As a result, 50% of people with colorectal cancer die within five years of diagnosis.[23] The National Cancer Institute and most health advocates recommend that beginning at age 50, women and men consult with their physicians as to which of the five colorectal cancer screening options recommended by the American Cancer Society is most appropriate for them.[24] Colorectal cancer screening coverage mandates routinely apply to individual health plans as well as group health plans.[25]

FIGURE II-1 AMERICAN CANCER SOCIETY COLORECTAL CANCER SCREENING RECOMMENDATIONS

According to the American Cancer Society, both women and men should receive one of the following five screening options beginning at age 50:

- Flexible Sigmoidoscopy (every 5 years)
- Colonoscopy (every 10 years)
- Fecal Occult Blood Test (yearly)
- Double-contrast barium enema (every 5 years)
- Combination Fecal Occult Blood Test and Flexible Sigmoidoscopy

  (The combination of Fecal Occult Blood Test and flexible sigmoidoscopy is preferred over any single test.)

Source: American Cancer Society, "How is Colorectal Cancer Found?" (Atlanta: American Cancer Society, 2001) [Online]; http://www.cancer.org, accessed June 4, 2002.

TABLE II-3 COLORECTAL CANCER SCREENING COVERAGE MANDATES

- 14 states mandate coverage of colorectal cancer screening in at least one of the recommended forms, though the age at which covered screenings begin and the frequency of covered exams vary by state.

TABLE II-3
Colorectal Cancer Screening Coverage Mandates

State	Screening Mandate	Age Screening Begins*	Frequency
United States Total	**14**		
Alabama			
Alaska			
Arizona			
Arkansas			
California			
Colorado			
Connecticut	●	ACS	ACS
Delaware	●	ACS	ACS
District of Columbia			
Florida			
Georgia			
Hawaii			
Idaho			
Illinois	●	50	FOB every 3 years
Indiana	●	50	ACS
Iowa			
Kansas			
Kentucky			
Louisiana			
Maine			
Maryland	●	50	ACS
Massachusetts			
Michigan			
Minnesota			
Mississippi			
Missouri	●	ACS	ACS
Montana			
Nebraska			
Nevada			
New Hampshire			
New Jersey	●	40	varies with exam
New Mexico			
New York			
North Carolina	●	50	ACS
North Dakota			
Ohio			
Oklahoma	●	50	According to "standard accepted published medical practice guidelines"
Oregon			
Pennsylvania			
Rhode Island	●	ACS	ACS
South Carolina			
South Dakota			
Tennessee			
Texas	●	50	varies with exam
Utah			
Vermont			
Virginia	●	ACS	ACS
Washington			
West Virginia	●	50	varies with exam
Wisconsin			
Wyoming	●	no age restrictions	not specified

Notes: ● State has the policy
* Every state except Texas and Wyoming has special provisions for high-risk persons.
FOB Fecal occult blood test
ACS American Cancer Society guidelines

Source: National Conference of State Legislatures Health Policy Tracking Service, "Colorectal Cancer Screening, 2001," unpublished data collected for this report (December 31, 2001). **Data current as of December 2001**

Osteoporosis Screening Coverage Mandates

Osteoporosis is characterized by low bone mass and structural deterioration of bone tissue that result in bone fractures that can be debilitating in older adults. It is estimated that 10 million people in the U.S. have osteoporosis, and another 18 million men and women are at risk for the disease due to low bone density.[26] Older women especially tend to be at an increased risk for the disease because they have less bone tissue and lose bone more rapidly than do men, making them four times as likely as men to have osteoporosis.[27]

Osteoporosis is often asymptomatic. The only way to determine bone density and fracture risk for osteoporosis is through bone density testing, although there is debate about who would benefit from this procedure. Medicare currently covers bone density testing for beneficiaries using all technologies approved by the U.S. Food and Drug Administration (FDA) as described below.

FIGURE II-2 MEDICARE-ELIGIBLE HIGH-RISK GROUPS FOR BONE DENSITY TESTING

Medicare covers bone density testing using all FDA-approved technologies for the following five categories of high-risk individuals:

- Estrogen-deficient women at clinical risk of osteoporosis and who are considering treatment
- Individuals with vertebral abnormalities
- Individuals receiving long-term glucocorticoid (steroid) therapy
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess the response to or efficacy of approved osteoporosis drug therapies

TABLE II-4 OSTEOPOROSIS SCREENING COVERAGE MANDATES

- 11 states have some type of osteoporosis screening coverage mandate.
  - 7 states require private insurers to cover bone density screening for all five high-risk groups (see box above).
  - 2 states require coverage for some of the risk groups.
  - 2 states requires private insurers to sell coverage of bone density screening, but do not require employers to purchase this coverage.

TABLE II-4
Osteoporosis Screening Coverage Mandates

State	Screening Mandate
United States Total	**11**
Alabama	
Alaska	
Arizona	
Arkansas	
California	○ (no high-risk groups or coverage for bone-density test specified)
Colorado	
Connecticut	
Delaware	
District of Columbia	
Florida	●*
Georgia	⊙
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	●*
Kentucky	⊙
Louisiana	○**
Maine	
Maryland	●*
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	●*
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	●*
North Dakota	
Ohio	
Oklahoma	●*
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	●*
Utah	
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to sell coverage, but employers are not required to purchase.
- * Applies to all 5 high-risk groups (Please see box on pg. 18 for descriptions of high risk groups.)
- ** Applies to 3 of 5 high-risk groups

Source: National Conference of State Legislatures, "Osteoporosis Screening," April 8, 2002, [Online] http://www.hpts.org/HPTS97/home.nsf; with additional analysis by the National Women's Law Center with Susan Davidson, consultant to the National Osteoporosis Foundation. **Data current as of April 2002**

Chlamydia Screening Coverage Mandates

Chlamydia is the most common bacterial sexually transmitted infection in the U.S., and the incidence of this infection is reported to be increasing in several areas across the country. Each year, approximately 3 million people are diagnosed with the disease.[28] Chlamydia is most prevalent in women ages 15 to 25.[29] The Centers for Disease Control and Prevention reports that females ages 15 to 19 represent 46% of infections and women ages 20 to 24 represent another 33% of all infections among women.[30] Untreated chlamydia can result in severe health problems for women, including pelvic inflammatory disease, which can lead to chronic pelvic pain, ectopic pregnancy, and infertility.[31] Routine testing of sexually active women is the most effective way to identify and treat women with chlamydia, since up to 75% of women with the infection are asymptomatic.[32]

In 2001, the Centers for Disease Control and Prevention recommended that sexually active women under the age of 25 be screened for chlamydia every six months.[33] However, one measure of chlamydia screening recently found that fewer than 20% of sexually active women ages 16 to 26 had been screened for chlamydia within the last year.[34] To date, only three states have addressed the issue of insurance coverage for chlamydia screening. These mandates are applicable to group and individual health insurance plans.

TABLE II-5 CHLAMYDIA SCREENING COVERAGE MANDATES

- 3 states have some type of chlamydia screening mandate.
  - 2 states mandate coverage of annual chlamydia screenings.
  - Tennessee requires private insurers to sell coverage of chlamydia screening, but does not require employers to purchase this coverage.

TABLE II-5
Chlamydia Screening Coverage Mandates

State	Annual Screening Mandate	Age Annual Screening Begins
United States Total	**3**	
Alabama		
Alaska		
Arizona		
Arkansas		
California		
Colorado		
Connecticut		
Delaware		
District of Columbia		
Florida		
Georgia	●	women under 29
Hawaii		
Idaho		
Illinois		
Indiana		
Iowa		
Kansas		
Kentucky		
Louisiana		
Maine		
Maryland	●	sexually active women under 20; women and men 20 and over with multiple risk factors
Massachusetts		
Michigan		
Minnesota		
Mississippi		
Missouri		
Montana		
Nebraska		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee	⊙	women under 29 with an annual Pap smear
Texas		
Utah		
Vermont		
Virginia		
Washington		
West Virginia		
Wisconsin		
Wyoming		

Notes: ● State has the policy
○ State has a limited policy
⊙ State requires insurers to sell coverage but employers are not required to purchase.

Source: National Conference of State Legislatures, Health Policy Tracking Service, "Chlamydia Screening, 2001," unpublished data collected for this report (December 31, 2001). **Data current as of December 2001**

NON-SCREENING REPRODUCTIVE HEALTH COVERAGE MANDATES

Women have many unique health care needs. In addition to specialized needs in terms of prevention and treatment, reproductive health affects women's physical, social and psychological well-being.[35] A woman's out-of-pocket health care costs are 68% greater than a man's during her childbearing years.[36] This difference is largely attributable to costs associated with reproductive health care services that traditionally have not been covered by insurance, including contraception.[37] In recent years, some states have moved to remedy this imbalance by requiring private insurers to cover some of these costs.

This section describes private insurance coverage mandates in four areas: contraception, infertility treatment, post-mastectomy hospital stays and post-mastectomy reconstructive breast surgery.

Contraceptive Coverage Mandates

Access to safe and reliable methods of contraception is a key reproductive health care need for women of childbearing age. In 1995, 93% of women between ages 18 to 44 who were sexually active and not attempting to conceive reported use of some type of contraception.[38]

While prescription drug coverage has become a standard part of employer-based insurance plans, prescription contraceptives are routinely excluded from coverage. States have taken the lead in working to increase access to prescription contraceptives and reduce women's health care costs by enacting statutory contraceptive coverage mandates.[39] These mandates require insurance plans that cover prescription drugs to cover prescription contraceptives approved by the FDA. Although opponents of contraceptive coverage mandates argue they increase the cost of insurance, it has been estimated that the failure to provide contraceptive coverage could cost an employer an additional 15% because of costs associated with unwanted pregnancies.[40] While the gap between coverage for oral contraceptives and other prescription contraceptives continues to exist, a recent study found that, in 2002, 78% of covered workers had coverage for oral contraceptives, up significantly from 64% the previous year.[41]

FIGURE II-3 FDA-APPROVED METHODS OF PRESCRIPTION CONTRACEPTION

- Oral contraceptives
- Barrier methods (diaphragms, cervical caps)
- Implant contraceptives (Norplant, IUDs)
- Injectables (Depo Provera, Lunelle)
- Contraceptive Patch (Ortho Evra)
- Vaginal ring (NuvaRing)

Sources: Gold, RB, et al, "Mainstreaming Contraceptive Services in Managed Care– Five States' Experiences," *Family Planning Perspectives* 30 (September/November 1998), pp. 204-211.

Association of Reproductive Health Professionals, "New Developments in Contraception," *Clinical Proceedings,* Feb. 1, 2001.

TABLE II-6 CONTRACEPTIVE COVERAGE MANDATES

- 25 states have some type of contraceptive coverage mandate.
  - 20 states require coverage of all FDA-approved contraceptive drugs and devices if the plan covers other prescription drugs.
  - 4 states have limited mandates that require insurers to offer at least one policy that covers contraceptives, or do not require insurers to cover all FDA-approved contraceptives.
  - Virginia requires insurers to sell plans with contraceptive coverage, but does not require employers to purchase this coverage.
- 15 states with contraceptive coverage mandates allow an exemption for employers and/or insurers with moral or religious objections to contraception.

TABLE II-6
Contraceptive Coverage Mandates

State	Contraceptive Coverage Mandate	Other Requirements, Inclusions and Exclusions
United States Total	**25**	
Alabama		
Alaska		
Arizona	●*	
Arkansas		
California	●*	Requires coverage of a "variety" of FDA-approved contraceptives; allows for coverage of alternative contraceptives if those available within plan are not medically appropriate; includes emergency contraception
Colorado	○	Requires coverage for family planning, including prescription contraceptives
Connecticut	●*	
Delaware	●*	
District of Columbia		
Florida		
Georgia	●	
Hawaii	●*	An enrollee whose employer objects to coverage of contraceptives may purchase such coverage directly from the insurer
Idaho	○	Requires coverage of some form of contraception in health benefit plan
Illinois		
Indiana		
Iowa	●	includes emergency contraception
Kansas		
Kentucky	○	includes emergency contraception
Louisiana		
Maine	●*	
Maryland	●*	
Massachusetts	●*	
Michigan		
Minnesota		
Mississippi		
Missouri	●*	
Montana		
Nebraska		
Nevada	●*	
New Hampshire	●	
New Jersey	○	Requires inclusion of at least one policy with contraceptive coverage
New Mexico	●*	
New York	●*	
North Carolina	●*	excludes emergency contraception
North Dakota		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island	●*	
South Carolina		
South Dakota		
Tennessee		
Texas	●*	
Utah		
Vermont	●	
Virginia	⊙	Requires that employees be offered plan with coverage of all FDA-approved contraceptives
Washington	●	includes emergency contraception
West Virginia		
Wisconsin		
Wyoming		

Notes: ● State has policy requiring comprehensive coverage of all FDA-approved contraceptives
○ State has a limited policy
⊙ State requires insurers to sell coverage but employers are not required to purchase.
* Law includes an exemption for insurers and/or employers who have a moral or religious objection to contraception.

Sources: National Women's Law Center, unpublished data collected for this report; Alan Guttmacher Institute, State Policies in Brief (New York: Alan Guttmacher Institute, February 2003). **Data current as of February 2003**

Infertility Treatment Coverage Mandates

Infertility is the inability of an individual or couple to achieve a pregnancy after trying to conceive for more than one year.[42] More than 6 million couples nationwide have trouble conceiving a child.[43] There are several assisted reproductive technologies (ARTs) available to treat infertility. Low-tech ARTs include the use of drugs to stimulate egg production in the ovaries and artificial insemination. High-tech ARTs include in vitro fertilization, zygote intrafallopian transfer and gamete intrafallopian transfer.[44] Approximately 50% of individuals who complete an infertility evaluation will respond to treatment with a successful pregnancy.[45]

Assisted reproductive technologies are costly. In vitro fertilization can cost $4,000 per treatment.[46] And while many insurance policies provide coverage for the diagnosis of infertility, many do not cover treatment.[47] As a result, a number of states have mandated insurers to cover infertility treatment. However, the mandating of infertility treatment benefits has been somewhat controversial given the expensive nature of the treatments and the limited population that may benefit from mandates.[48]

TABLE II-7 INFERTILITY TREATMENT COVERAGE MANDATES

- 15 states have some type of mandate regarding infertility treatment.
  - 10 states require private insurers to cover infertility treatment.
  - 3 states require private insurers to sell coverage for infertility treatment, but do not require employers to purchase this coverage.
  - New York and Louisiana require coverage for the treatment of other medical conditions that result in infertility, but do not require coverage for the treatment of infertility alone.
- 5 states allow exemptions for insurers and/or employers who have a moral or religious objection to infertility treatment.

TABLE II-7
Infertility Treatment Coverage Mandates

State	Coverage Mandates
United States Total	**15**
Alabama	
Alaska	
Arizona	
Arkansas	●
California	⊙*
Colorado	
Connecticut	⊙
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	●
Idaho	
Illinois	●*
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana	○+
Maine	
Maryland	●*
Massachusetts	●
Michigan	
Minnesota	
Mississippi	
Missouri	
Montana	●
Nebraska	
Nevada	
New Hampshire	
New Jersey	●*
New Mexico	
New York	○+
North Carolina	
North Dakota	
Ohio	●
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	●
South Carolina	
South Dakota	
Tennessee	
Texas	⊙*
Utah	
Vermont	
Virginia	
Washington	
West Virginia	●
Wisconsin	
Wyoming	

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to sell coverage but employers are not required to purchase.
- * Allows an exemption for insurers and/or employers who have a moral or religious objection to infertility treatment.
- + State forbids denial of coverage for treatment of medical conditions that result in infertility, but does not require coverage for treatment intended only to treat infertility.

Source: National Conference of State Legislatures, "Coverage for Infertility Treatments," April 8, 2002, [Online] www.hpts.org/HPTS97/home.nsf. **Data current as of April 2002**

Post-Mastectomy Coverage Mandates: Hospital Stays

Surgical treatments for breast cancer range from breast conserving surgeries such as lumpectomies and partial mastectomies to more aggressive treatments such as total mastectomies, modified radical mastectomies and radical mastectomies. Hospital recovery time for the various surgeries varies by procedure and patient. Several states have enacted laws that require insurance companies to allow physicians, in consultation with their patients, to determine how long a woman stays in the hospital following a mastectomy. These laws were adopted in response to concerns that insurance companies were denying coverage for hospitalization following mastectomy beyond a pre-determined length of stay in order to save costs.[49] As a result, states moved to mandate length-of-stays for mastectomy procedures.

TABLE II-8 POST-MASTECTOMY STAY COVERAGE MANDATES

- 19 states have post-mastectomy length-of-stay coverage mandates.
  - 10 states mandate insurance coverage of a minimum 48-hour hospital stay following a mastectomy.
  - 9 states mandate a physician-determined length of hospital stay following a mastectomy.

Post-Mastectomy Coverage Mandates: Reconstructive Breast Surgery

Breast reconstruction, surgery that rebuilds a woman's breast following a mastectomy, has become an increasingly common option for women.[50] However, insurance coverage of the procedure has been controversial. Some insurance plans deem breast reconstruction cosmetic surgery and exclude coverage of the procedure from health benefit plans.[51] A federal law, the Women's Health and Cancer Rights Act of 1998, and similar state laws require insurers to cover post-mastectomy reconstructive breast surgery.[52] The majority of states now have post-mastectomy reconstruction coverage mandates, many of which pre-date the federal law.

TABLE II-8 RECONSTRUCTIVE BREAST SURGERY MANDATES

- 36 states and the District of Columbia have some form of post-mastectomy reconstructive breast surgery mandate.
  - 34 states and the District of Columbia mandate insurance coverage of post-mastectomy breast reconstruction services.
  - Michigan mandates insurance coverage of medically necessary post-mastectomy breast reconstruction services.
  - Kentucky requires insurers to sell coverage of post-mastectomy reconstructive services, but does not require employers to purchase this coverage.
- 11 of the states mandating coverage of post-mastectomy breast reconstruction services require insurers to provide enrollees with notice about the reconstruction mandate.

TABLE II-8
Post-Mastectomy Stay and Reconstructive Breast Surgery Mandates

State	Post-Mastectomy Hospital Stays: Physician-Determined Length of Stay	Post-Mastectomy Hospital Stays: Minimum 48 hours Requirement	Reconstructive Breast Surgery: Coverage Mandate~	Reconstructive Breast Surgery: Notice of Coverage Required
United States Total	**9**	**10**	**36+DC**	**10+DC**
Alabama				
Alaska			●	
Arizona			●	
Arkansas		●	●#	
California	●		●	
Colorado				
Connecticut		●	●	
Delaware			●	●
District of Columbia			●	●
Florida	●		●	
Georgia	●			
Hawaii				
Idaho				
Illinois	●		●	●
Indiana			●	
Iowa				
Kansas			●	●
Kentucky			⊙	
Louisiana			●	●
Maine	●		●	●
Maryland			●	
Massachusetts				
Michigan			○ (only when medically necessary)#	
Minnesota			●	
Mississippi				
Missouri			●	
Montana	●		●	
Nebraska			●	●
Nevada			●	●
New Hampshire			●	
New Jersey		●*	●	
New Mexico		●		
New York	●		●	●
North Carolina	●		●	
North Dakota			●	
Ohio			+	
Oklahoma		●	●	
Oregon				
Pennsylvania	●		●	
Rhode Island		●	●	
South Carolina		●	●	
South Dakota				
Tennessee			●	
Texas		●	●	●
Utah			●	●
Vermont				
Virginia		●**	●	
Washington			●	
West Virginia		●	●	
Wisconsin			●#	
Wyoming				

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to sell coverage but does not require employers to purchase.
- * Insurers are required to provide a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours following a simple mastectomy.
- ** Insurers are required to provide coverage for inpatient care for a minimum of 48 hours following a radical or modified mastectomy and not less than 24 hours following a total or partial mastectomy.
- ~ Unless otherwise indicated, state mandates coverage of surgery on the healthy breast to restore symmetry.
- \+ The Ohio Dept. of Insurance issued a bulletin requiring insurers to comply with the federal Women's Health and Cancer Rights Act.
- # State does not mandate coverage of surgery on the healthy breast to restore symmetry.

Sources: National Conference of State Legislatures, "Minimum Inpatient Mastectomy Length of Stay and Breast Reconstructive Surgery," April 8, 2002, [Online] www.hpts.org/HPTS97/home.nsf. **Data current as of April 2002**

Information on notification requirements only, National Conference of State Legislatures Health Policy Tracking Service, "Addendum to Reconstructive Breast Surgery Requirements," unpublished data collected for this report (July 1, 2001). **Data current as of July 2001**

MENTAL HEALTH PARITY

Approximately one in five adults in the U.S. suffers from a mental disorder in any given year and one in five women will suffer an episode of major depression in her lifetime.[53] Women have a higher prevalence of certain mental illnesses, including eating disorders. Some 90% of eating disorder cases involve adolescent or young adult women, and eating disorders have among the highest death rates of any mental illness.[54] Anxiety disorders (panic disorder, phobias, obsessive-compulsive disorder) and mood disorders such as major depression are twice as common in women as men.[55]

According to the U.S. Surgeon General's report on mental health, less than one-third of adults with a diagnosable mental disorder receive treatment in any given year.[56] A major factor in limited access to mental health care is lack of insurance coverage for mental health services on the same basis as physical health services. Private health insurance plans usually provide less coverage for the treatment of mental illness through lower dollar coverage limits for mental health services, restrictions on the number of outpatient visits or hospital days, and higher cost-sharing in the form of co-payments, deductibles or coinsurance.

Mental Health Parity Laws

The federal Mental Health Parity Act of 1996 requires insurers that offer mental health coverage to treat mental and physical disorders equally in terms of lifetime and annual dollar spending limits.[57] The law, however, does not require private insurers to provide full parity (i.e., equal co-payments, deductibles) for mental health care services. States can go beyond federal law by passing laws requiring full parity for all mental health problems and/or mandating coverage of specific mental health conditions such as eating disorders or depression. Table II-9 describes state laws requiring private insurers to provide parity in mental health coverage as well as coverage of specific mental disorders that predominantly affect women.

TABLE II-9 MENTAL HEALTH PARITY LAWS

- 35 states have some type of mental health parity law.
  - 8 states have laws mandating full parity in the coverage of mental health services by private insurers.
  - 25 states have limited mental health parity laws. States may restrict the diagnoses covered to severe, biologically based mental illnesses; exempt small employers; exempt employers who can prove that the law caused their health insurance costs to rise by a certain percentage; apply the law only to state and local employees; and/or provide parity only for specific aspects of coverage, such as spending limits or out-of-pocket expenses.
  - 2 states require insurers to sell plans that provide parity for mental disorders, but do not require employers to purchase plans that provide parity.
- 19 states require coverage of eating disorders such as anorexia and bulimia in mental health parity mandates.
- 32 states require coverage for the treatment of depression in mental health parity mandates.
- 17 states exempt small employers (usually those with fewer than 20 or 50 employees) from mental health parity mandates.

TABLE II-9
Mental Health Parity Laws

State	Mental Health Parity Laws	Types of Disorders Covered by Parity Law	Limitations: Small Employer Exemption (Number of Employees)	Limitations: Cost Increase Cap (%)*	Limitations: Special Provisions Concerning State & Local Employees	Limitations: Parity Only for Specific Types of Coverage
United States Total	35		17	9	5	7
Alabama	⊙		20 or fewer			
Alaska						
Arizona	○	All	50 or fewer	1	full parity for state & local employees	lifetime and annual spending limits
Arkansas	○	All	50 or fewer	1.5	excludes state & local employees	
California	○	SMI, ED, D				
Colorado	○	SMI, D				
Connecticut	●	All				
Delaware	○	SMI, SA, ED, D				
District of Columbia						
Florida						
Georgia	⊙					
Hawaii	○	SMI	25 or fewer			
Idaho						
Illinois	○	SMI, D	50 or fewer			
Indiana	●	All	50 or fewer	4	includes additional parity for SA for state & local employees	
Iowa						
Kansas						
Kentucky	●	All	50 or fewer			
Louisiana	○	SMI, ED, D				
Maine	○	SMI, D	20 or fewer			
Maryland	●	All				
Massachusetts	○	SMI, D**	50 or fewer			
Michigan						
Minnesota	●	All				
Mississippi						
Missouri	○	SMI, ED, D				out-of-pocket expenses
Montana	○	SMI, D				
Nebraska	○	SMI, D	15 or fewer			
Nevada	○	SMI, D	25 or fewer			out-of-pocket expenses
New Hampshire	○	SMI, D				
New Jersey	○	SMI, D				
New Mexico	●	All		1.5 for < 50 employees & 2.5 for ≥ 50 employees		
New York						
North Carolina	○	All	50 or fewer	1	full parity for state & local employees	lifetime and annual spending limits
North Dakota						
Ohio						
Oklahoma	○	SMI, D	50 or fewer	2		
Oregon						
Pennsylvania						
Rhode Island	●	All				
South Carolina	○	SMI, ED, D		1 and 3.39~	full parity for state & local employees	lifetime and annual spending limits
South Dakota	○	SMI, D				
Tennessee	○	All	25 or fewer	1		lifetime and annual spending limits and out-of-pocket expenses
Texas	○	SMI, D	50 or fewer			
Utah	○	All	50 or fewer			out-of-pocket expenses
Vermont	●	All				
Virginia	○	SMI, D	25 or fewer			
Washington						
West Virginia	○	SMI, SA, ED, D		2 in general and 1 for employers with fewer than 25 employees		
Wisconsin						
Wyoming						

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to offer to sell coverage but does not require employers to purchase coverage.
- * Exempts employers who can prove that the law caused costs to increase by more than a certain percentage.
- ** Provides coverage for trauma counseling or other services for women who have been raped.
- ~ Exempts employers who can show a 1% cost increase by the end of the 3-year implementation period (1/1/02-12/31/04) or a 3.39% cost increase at any time during that 3-year period.

Disorders Covered:
- All Including, but not limted to, SMI, SA, ED, and D
- SMI Severe (biologically based) mental illnesses
- SA Substance abuse
- ED Eating disorders
- D Depression

Sources: National Mental Health Association (NMHA), "What Have States Done to Pass Parity?" (Washington, D.C.: NMHA, May 2002). NMHA, "Mandated Mental Health and Substance Abuse Benefits Chart," Draft (Washington, D.C.: NMHA, December 2001).

Information on the District of Columbia and West Virginia only, Erica Malik, NMHA, May 2002.

Information on coverage of eating disorders and depression only, correspondence with National Mental Health Association, January 2000-May 2002.
Data current as of May 2002

MANAGED CARE

The majority of Americans and approximately three out of four women in the U.S. are covered by private managed care plans.[58] Managed care plans use an array of techniques to limit health care costs that have drawn the attention of state legislatures because of concerns about their impact on the quality of health care. Because managed care plans often require consumers to obtain care from a network of providers or to obtain referrals from primary care physicians referred to as "gatekeepers" before accessing specialty care, there is some concern that consumers may be denied necessary health services or may face delays that result in poor care. These concerns have led states to mandate circumstances under which patients can access care directly from certain providers or continue to receive services from providers who have left their managed care networks. Another practice that has raised concern and is of particular importance to women is the denial of coverage for managed care patients enrolled in clinical trials. Finally, state laws that mandate external review of disputed managed care decisions can provide an important tool to address access issues commonly encountered by women.

This section of the report addresses state mandates that require managed care plans to provide the following services that are particularly important to women: direct access to obstetrician-gynecologists (OB/GYNs), the ability to designate an OB/GYN as a primary care provider, continuity of care provisions, provisions mandating coverage of certain clinical trials, and external review mechanisms.

Access to OB/GYNs

Requiring women to obtain a referral from a primary care provider to see an OB/GYN is increasingly viewed as an unnecessary obstacle to optimal health care for women. While OB/GYNs are specialists in women's health care, most women of reproductive age divide their health care needs between an OB/GYN and a primary care provider such as a family practitioner. Women who see an OB/GYN on a regular basis are more likely to receive important screening services such as pelvic exams and Pap smears, as well as counseling on sexually transmitted diseases and family planning.[59] In an effort to enhance women's ability to receive these services and in recognition that requiring a referral for a visit to an OB/GYN can be an overutilization of health care services and a burden on women, states have moved to allow women to access OB/GYNs directly or to designate their OB/GYN as their primary care provider.

TABLE II-10 OB/GYN DIRECT ACCESS AND PRIMARY CARE PHYSICIAN DESIGNATION

- 39 states and the District of Columbia mandate that women be given direct access to OB/GYNs without a primary care referral.
  - 14 of the 39 states that mandate direct access to OB/GYNs limit the number of direct visits allowed annually to one or two.
  - Kentucky allows direct access to OB/GYNs for Pap smears only.
  - 16 states require managed care plans to provide notice of the policy to enrollees.
  - 12 states that mandate direct access to OB/GYNs prohibit managed care plans from charging patients additional fees such as co-pays to gain direct access.
- 16 states and the District of Columbia require managed care plans to allow women to designate an OB/GYN as their primary care provider.

TABLE II-10
OB/GYN Direct Access and Primary Care Physician Designation

State	Direct Access to OB/GYN: Mandates Direct Access to OB/GYN	Direct Access to OB/GYN: Requires Notice to Enrollees	Direct Access to OB/GYN: Prohibits Co-Pay or Surcharge	Direct Access to OB/GYN: Required Minimum of Annual Visits Without Referral	OB/GYN as Primary Care Provider
United States Total	**39 + DC**	**16**	**12**	**14**	**16 + DC**
Alabama	●				●
Alaska					
Arizona					
Arkansas	●				
California	●				●
Colorado	●				
Connecticut	●				
Delaware	●	●	●	1	●
District of Columbia	●				●
Florida	●			1	●
Georgia	●	●			
Hawaii					
Idaho	●				●
Illinois	●	●			
Indiana					●
Iowa					
Kansas	●			1	
Kentucky	○				
Louisiana	●			2	
Maine	●			1	●
Maryland	●		●		●
Massachusetts	●		●	1	
Michigan	●	●			
Minnesota	●		●		
Mississippi	●				●
Missouri	●		●		
Montana	●	●	●		●
Nebraska					●
Nevada	●				
New Hampshire	●	●		1	
New Jersey					●
New Mexico	●	●	●		●
New York	●	●		2	
North Carolina	●	●			
North Dakota					
Ohio	●		●		
Oklahoma					
Oregon	●			1	●
Pennsylvania	●				
Rhode Island	●			1	
South Carolina	●	●		2	
South Dakota					
Tennessee	●			1	
Texas	●	●	●		
Utah	●	●	●		●
Vermont	●			2	
Virginia	●	●		1	
Washington	●	●	●		
West Virginia	●	●	●		●
Wisconsin	●	●			
Wyoming					

Notes: ● State has the policy
○ State has a limited policy (direct access limited to obtaining annual Pap smear)

Sources: The Henry J. Kaiser Family Foundation, "State Mandated Benefits: Direct Access to OB/Gyns, 2001," State Health Facts Online, [Online] http://www.statehealthfacts.kff.org, citing National Conference of State Legislatures, Health Policy Tracking Service. **Data current as of November 2001**

Information for Required Minimum of Annual Visits only, National Women's Law Center, unpublished data collected for this report. **Data current as of November 2001**

Information on OB/GYNs as Primary Care Provider only, The Henry J. Kaiser Family Foundation, "State Mandated Benefits: OB/Gyns as Primary Care Providers, 2001," State Health Facts Online, [Online] http://www.statehealthfacts.kff.org, citing National Conference of State Legislatures, Health Policy Tracking Service. **Data current as of November 2001**

Continuity of Care

Studies have shown that a consistent relationship between a patient and a health care provider facilitates access to preventive screenings and improves quality of care and health outcomes.[60] Continuity of care is particularly important for pregnant women and patients with chronic or terminal illnesses, as these populations have ongoing medical needs that require uninterrupted treatment. Continuity of care provisions are designed to protect patients from disruptions in care when their provider leaves or is terminated by a managed care network by requiring managed care plans to allow patients to continue to see the physician for a specified period of time.

TABLE II-11 MANAGED CARE CONTINUITY OF CARE COVERAGE MANDATES

- 35 states have continuity of care mandates. The length of time states require managed care plans to continue to pay for services ranges from 30 to 120 days.
  - 5 states with continuity of care mandates limit the mandate to services provided by the patient's primary care provider.
  - 25 states include specific language regarding continuing care for pregnant enrollees. Alaska, Delaware and New Jersey require coverage to continue through postpartum care if a woman's provider leaves the plan at any stage of her pregnancy; the remainder mandate coverage to continue if the woman is in her second or third trimester.
  - 14 states with continuity of care provisions mandate continuing coverage for patients when treatment has begun and uninterrupted care is medically necessary, including disability, life-threatening illness, acute or chronic conditions or pregnancy.

TABLE II-11
Managed Care Continuity of Care Provisions

State	Continuity of Care Provision	Days Care Must be Continued	Pregnancy-Related Coverage Requirements*	Required for Medically Necessary Treatment
United States Total	**35**		**25**	**14**
Alabama				
Alaska	●	90~	any stage of pregnancy	●
Arizona	●	30	3rd trimester	●
Arkansas	●	90		
California	●	90	2nd or 3rd trimester	●
Colorado	●	60		
Connecticut				
Delaware	●	120	any stage of pregnancy	●
District of Columbia				
Florida	●	60	3rd trimester	●
Georgia				
Hawaii				
Idaho				
Illinois	●	90	3rd trimester	
Indiana	○	60	3rd trimester	
Iowa	●	90	2nd or 3rd trimester	●
Kansas	●	90	3rd trimester	●
Kentucky	●	not specified	3rd trimester	●
Louisiana				
Maine	●	60	2nd or 3rd trimester	
Maryland	○	90		
Massachusetts	○	30	2nd or 3rd trimester	
Michigan	●	90	2nd or 3rd trimester	
Minnesota	●	120		●
Mississippi				
Missouri	●	90		●
Montana				
Nebraska				
Nevada				
New Hampshire	●	60		
New Jersey	●	120	any stage of pregnancy	●
New Mexico				
New York	●	90/60+	2nd or 3rd trimester	●
North Carolina	●	90	2nd or 3rd trimester	
North Dakota				
Ohio				
Oklahoma	●	90	3rd trimester	●
Oregon	●	120	2nd or 3rd trimester	
Pennsylvania	●	60	2nd or 3rd trimester	
Rhode Island	●	not specified		
South Carolina	●	90		
South Dakota	●	90	2nd or 3rd trimester	
Tennessee	●	120	2nd or 3rd trimester	
Texas	●	90	2nd or 3rd trimester	●
Utah				
Vermont	●	60	2nd or 3rd trimester	
Virginia	●	90	2nd or 3rd trimester	
Washington	○	60◆		
West Virginia	○	60		
Wisconsin	●	90	2nd or 3rd trimester	
Wyoming				

Notes:
- ● State has the policy
- ○ State has a limited policy
- * Coverage is required through postpartum care if enrollee has begun prenatal care and is in the stage indicated when the plan change occurs.
- ~ Or until the end of the plan year, whichever is longer. If the enrollee has a terminal condition, transitional care will be provided until the end of the medically necessary treatment for the condition, disease, illness or injury.
- \+ Current enrollees receive 90 days of continuing treatment; new enrollees receive 60 days.
- ◆ In-group coverage arrangements involving periods of open enrollment; transitional care will be provided until the end of the next open enrollment period.

Sources: National Conference of State Legislatures, "Continuity of Care," April 8, 2002, [Online] http://www.hpts.org. **Data current as of April 2002**
Information for Alaska (pregnancy only), Alaska Stat. § 21.07.030. **Data current as of May 2002**

Information for Massachusetts (pregnancy only), Mass. Gen. Laws Ann. ch. 1760 § 15. **Data current as of May 2002**

Coverage of Clinical Trials

Clinical trials help to determine whether new drugs, treatments or medical procedures are safe and effective for humans. These studies are conducted in four phases. During Phase I, research is conducted on a small group of volunteers (usually 20 to 80 people) to determine a product's safety, establish a safe dosage range and identify side effects. During Phase II, the product or treatment is given to a larger group of volunteers (approximately 100 to 300 people). During Phase III, the trial is expanded to an additional 1,000 to 3,000 people to confirm the effectiveness of the treatment, monitor side effects and compare results with other commonly used treatments. Phase IV occurs after the drug, treatment or procedure is marketed and investigators continue testing to determine effects on various populations and whether there are any side effects associated with long-term use.[61]

Because costs of clinical trials are often high and treatments are unproven, many insurers do not include coverage for clinical trials in their benefit plans. However, for many life-threatening illnesses such as serious cancers, clinical trials offer the only hope of a cure or extending survival time. Having an adequate number of people participate in clinical trials is also important to the overall advancement of medical research. For diseases such as multiple sclerosis, which has no cure and affects twice as many women as men, clinical trials are a crucial component of research into treatments that slow progression of the disease.[62] Women's participation in clinical trials is particularly important because their historical exclusion from trials has left gaps in knowledge about how various diseases, drugs and treatments affect women differently from men.[63]

TABLE II-12 MANAGED CARE CLINICAL TRIAL COVERAGE

- 13 states have a partial coverage mandate for clinical trials. The types of trials covered are limited to cancer trials and/or trials for life-threatening or permanently debilitating conditions.
  - 5 states that mandate coverage include participation in all four phases of clinical trials; 7 states mandate coverage only for Phases II through IV; 3 do not specify phase coverage.
- Insurers in 2 states, Michigan and New Jersey, have voluntarily agreed to cover participation in some types of clinical trials.
- Insurers in 12 states cover routine patient costs as part of clinical trials; 2 states, New Hampshire and North Carolina, limit coverage to medically necessary patient costs.

TABLE II-12
Managed Care Clinical Trial Coverage

State	Clinical Trial Coverage Mandate	Limits	Covers Routine Costs	Covers All Phases of Trials
United States Total	**15**	**13**	**14**	**5**
Alabama				
Alaska				
Arizona	○	limited to cancer trials	●	●
Arkansas				
California	○	limited to cancer trials	●	●
Colorado				
Connecticut	○	limited to cancer trials	●	not specified
Delaware	○	limited to life-threatening diseases	●	not specified
District of Columbia				
Florida				
Georgia	○	limited to children's cancer trials	●	
Hawaii				
Idaho				
Illinois	⊙		●	
Indiana				
Iowa				
Kansas				
Kentucky				
Louisiana	○	limited to cancer trials	●	
Maine	○	limited to life-threatening illness	●	not specified
Maryland	○	limited to life-threatening, degenerative or permanently disabling conditions	●	●
Massachusetts				
Michigan			**	**
Minnesota				
Mississippi				
Missouri				
Montana				
Nebraska				
Nevada				
New Hampshire	○	limited to cancer or other life-threatening condition	○ (medically necessary)	●
New Jersey			~	~
New Mexico	○	limited to cancer trials	●	●
New York				
North Carolina	○		○ (medically necessary)	
North Dakota				
Ohio				
Oklahoma				
Oregon				
Pennsylvania				
Rhode Island	○	limited to cancer trials		
South Carolina				
South Dakota				
Tennessee				
Texas				
Utah				
Vermont	○	limited to cancer trials	●	not specified
Virginia	○	limited to cancer trials	●	
Washington				
West Virginia				
Wisconsin				
Wyoming				

Notes:
- ● State has the policy
- ○ State has a limited policy
- ⊙ State requires insurers to sell coverage for routine patient care for Phase II-IV cancer trials, but employers are not required to purchase this coverage.
- ** Michigan insurers have voluntarily agreed to cover patient care costs for participation in Phase II or III cancer clinical trials performed in the state.
- ~ New Jersey insurers have voluntarily agreed to cover routine patient costs for all phases of cancer clinical trials sponsored by federal agencies.

Sources: National Conference of State Legislatures, "Mandated Benefits: Clinical Trial Coverage Requirements," April 8, 2002, [Online] http://www.hpts.org.
Data current as of April 2002

External Review Processes

Managed care plans usually have the final say on what services they will and will not cover for enrollees. Because of concerns that managed care plans' decision-making is weighted toward their own bottom lines, especially when for-profit plans are involved, states have intervened to add an external review process to examine disputed coverage decisions. The majority of states now allow an enrollee to appeal a disputed coverage decision to an independent panel of experts. Most states require enrollees to first exhaust their health plan's internal appeals process before seeking external review. However, some states limit reviewers to the insurer's definition of medical necessity.

TABLE II-13 MANAGED CARE EXTERNAL REVIEW

- 41 states and the District of Columbia have some type of external review process for disputed managed care claims.
  - 34 states and the District of Columbia have independent external reviews procedures.
  - 7 states have limited review procedures that require reviewers to apply the health plan's definition of medical necessity in the review.
  - 35 states with review processes and the District of Columbia require appeals to be filed within 180 days of the claim denial.
  - 11 states impose minimum claim thresholds of between $100 and $1,000 dollars.

✶ ✶ ✶

Key areas where states have taken action to expand access to services for women with private insurance include mandates for screening tests and some reproductive health care services, and efforts to ensure parity for mental health services and to address access concerns under managed care. The results of these expansions have been somewhat uneven, however, with nearly every state mandating coverage for mammograms, but only half for equally critical cervical cancer screenings and barely any states requiring coverage for chlamydia screening, despite its rise and threat to the health and fertility of young women. There is also wide variation in the standards that states use for the timing and frequency of screening services. For instance, among the standards in use by states to set parameters for cervical cancer screening are guidelines from the American College of Obstetricians and Gynecologists, the College of American Pathologists, and American Cancer Society and the United States Preventive Services Task Force. As a result of these variations, women may receive screening earlier or more frequently in some states than in others.

Only half the states have contraceptive coverage mandates, despite their potential to reduce unwanted pregnancies and women's out-of-pocket health care costs. Private insurance mandates are particularly important as health care costs and premiums continue to rise, further limiting women's ability to afford and obtain care.

The overall picture illustrates that efforts to expand access for women with private coverage have been largely piecemeal in nature and have not focused on making coverage more affordable or systemically identifying problematic areas of access.

TABLE II-13
Managed Care External Review

State	Mandated External Review	Filing Deadlines (Days After Claim Denial)	Claim Threshold ($)	Limitations
United States Total	**41 + DC**	**36**	**11**	
Alabama				
Alaska	○	180		external reviewer is bound by insurer's definition of medical necessity
Arizona	○	< 180		external reviewer is bound by insurer's definition of medical necessity
Arkansas				
California	●	180		
Colorado	●	< 180		
Connecticut	●	< 180		
Delaware	●	< 180		
District of Columbia	●	< 180		
Florida	●	> 180		
Georgia	●		500	
Hawaii	●	< 180		
Idaho				
Illinois	●	< 180		
Indiana	●	< 180		
Iowa	●	< 180		
Kansas	○	< 180		external reviewer is bound by insurer's definition of medical necessity
Kentucky	●	< 180	100	
Louisiana	●	< 180		
Maine	●	> 180		
Maryland	●	< 180		
Massachusetts	●	< 180		
Michigan	●	< 180		
Minnesota	●			
Mississippi				
Missouri	●			
Montana	●			
Nebraska				
Nevada				
New Hampshire	●	180	400	
New Jersey	●	< 180		
New Mexico	●	< 180		
New York	●	< 180		
North Carolina	●	< 180		
North Dakota				
Ohio	●	< 180	500*	
Oklahoma	●	< 180	1000	
Oregon	●	180		
Pennsylvania	○	< 180		external reviewer is bound by insurer's definition of medical necessity
Rhode Island	●	< 180		
South Carolina	●	< 180	500	
South Dakota				
Tennessee	○	< 180	500	external reviewer is bound by insurer's definition of medical necessity
Texas	●			
Utah	●	180		
Vermont	●	180 **	100**	
Virginia	●	< 180	300	
Washington	●			
West Virginia	○	< 180	1000	external reviewer is bound by insurer's definition of medical necessity
Wisconsin	○	< 180	250	external reviewer is bound by insurer's definition of medical necessity
Wyoming				

Notes: ● State has policy
○ State has a limited policy
* Threshold does not apply to expedited reviews and experimental procedure reviews.
** Filing deadline and claims threshold do not apply to review of mental health care denials.

Sources: Karin Pollitz and others, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2002). **Data current as of December 2001**

Information on North Carolina only, N.C. Gen. Stat. § 58-50-75. **Data current as of May 2002**

Information on Claims Threshold only, National Women's Law Center, unpublished data collected for this report. **Data current as of May 2002**

III. MEDICAID

Medicaid is the national health insurance program for low-income people. The program is jointly run by the federal and state governments; each state administers its own Medicaid program under federal guidelines and the federal government contributes a share of the program's costs.[64] Medicaid covers more than 40 million low-income people, making it one of the largest sources of funding for health care in the U.S. Eligibility is based on both meeting categorical and financial requirements.[65]

Women comprise nearly 70% of the Medicaid population over the age of 15.[66] While Medicaid provides health care coverage for a substantial number of low-income women, its income and categorical eligibility requirements are narrow, generally requiring adults to be pregnant, or low-income and parents of dependent children, or low-income and over age 65, or to have a disability. Because women are poorer than men and are more likely to care for children, they are twice as likely to qualify for Medicaid.[67] Nevertheless, many women, particularly those in low-wage jobs, do not qualify for Medicaid because of its narrow eligibility criteria, yet cannot afford private insurance premiums, leaving 19% of all women ages 18 to 64 and 34% of women living below the poverty level uninsured.[68]

States decide within federal guidelines what populations will be covered by Medicaid and which benefits beyond those mandated by the federal government will be provided. Certain populations such as low-income children and pregnant women and some seniors and people with disabilities must be covered by every state participating, as must certain services, including hospital and physician services, prenatal care, childhood vaccinations, family planning services and supplies, and nurse-midwife services.[69]

Despite restrictive eligibility criteria, Medicaid plays a critical role in securing access to care for its beneficiaries, with an emphasis on many services that are important to women. Medicaid covers about 8% of women ages 18 to 64, a total of more than 8.8 million women nationwide.[70] Medicaid is the largest insurer of single mothers, covering almost 40% of this population.[71] Medicaid is also the largest source of financing for publicly-funded family planning programs, providing approximately half of all public funding.[72] Nearly a quarter of women who use reversible methods of contraception obtain family planning services from a clinic or a private doctor reimbursed by Medicaid.[73] Furthermore, because of a federal mandate that states must cover pregnant women with incomes at or below 133% of the FPL, Medicaid finances one-third of all births in the U.S.[74]

Medicaid also plays an important role for seniors and qualified people with disabilities. Medicare lacks coverage for several important services, notably long-term care and prescription drugs, leaving many beneficiaries with large out-of-pocket costs.[75] Not only are women greater users of these services, but cost-sharing requirements have a greater effect on women than on men, as they are poorer, live longer, have more chronic health conditions, and make up the vast majority of Medicare beneficiaries over the age of 75.[76]

While the majority of Medicaid beneficiaries are children and adults in low-income families, nearly 70% of Medicaid spending goes to services for people with disabilities and people age 65 and older.[77]

In an effort to control deductibles and premiums as well as the cost of providing health care services and improve the continuity of care for the poor, most states now require all or some Medicaid beneficiaries to enroll in managed care. The majority of adult female Medicaid beneficiaries are now enrolled in managed care, which raises important questions about access to family planning and other services under managed care networks, particularly for women enrolled in faith-based plans. Medicaid has also been used to selectively cover services such as family planning or breast and cervical cancers for women without health coverage.

This chapter examines state Medicaid policies that influence low-income women's access to health services, including eligibility levels, mandatory Medicaid managed care programs, and expansions of Medicaid coverage for specific services.

MEDICAID ELIGIBILITY

Income is one of the most important criteria for Medicaid eligibility for qualifying populations, with most states establishing thresholds below 100% of the FPL. However, certain groups of people, designated by the federal government as "categorically needy" populations, must be covered by every state participating in the Medicaid program as follows:[78]

- Individuals who meet the income and resource eligibility requirements for their state's welfare program prior to the implementation of the 1996 welfare reform law;
- Pregnant women and children under age 6 in families with incomes at or below 133% FPL;
- Children under the age of 19 in families with incomes below 100% of the FPL;
- Certain groups of low-income seniors and people with disabilities.

States have several avenues for extending eligibility beyond these minimum federal requirements. Without federal permission, states can elect to raise income eligibility thresholds or disregard a portion of applicants' earnings or assets. In order to extend health benefits to more uninsured people or to categorically eligible populations at higher income levels, states may apply to the federal government for a variety of federal waivers from statutory and regulatory requirements. The basis of these expansions may be a particular health service or a particular population. For instance, states may use waivers to expand family planning services to populations not ordinarily covered under Medicaid, such as adults without children. Waivers have become an important tool which states can use to broaden Medicaid eligibility.

Parents of Dependent Children

Section 1931 Family Coverage

The welfare reform law of 1996 fundamentally changed Medicaid by delinking eligibility for Medicaid from eligibility for welfare cash assistance. However, in order to provide health coverage to people leaving the welfare rolls and entering the job market, Congress established the Transitional Medical Assistance (TMA) program. Individuals who obtained jobs and consequently were no longer eligible for cash assistance yet did not obtain employer-sponsored health insurance were permitted to retain Medicaid coverage for a limited period of time in the form of TMA. Furthermore, states were given new flexibility to extend Medicaid coverage to several groups of low-income parents who had not previously been eligible for Medicaid. States now have the opportunity to expand Medicaid coverage to the parents of low-income children through Section 1931 family coverage.[79]

Section 1931 of the Social Security Act requires states to cover families with incomes below the welfare qualifying income threshold that was in effect in July 1996 for their respective state.[80] States are allowed and encouraged to expand coverage to parents with higher incomes within limits set by the federal government. Most states and the District of Columbia have opted to expand Section 1931 coverage for either unemployed or employed parents of dependent children, although the income thresholds of the expansions vary and tend to be higher for working families. The majority of coverage expansions for unemployed parents cover those in families with incomes up to 50% of the FPL ($5,805 for a family of two in 2001), while the majority of coverage expansions for working parents cover those with incomes between 50% and 100% of the FPL ($11,610 for a family of two in 2001). States often disregard a portion of employed parents' earnings, hence expanding eligibility for these working parents. This is another example of the flexibility states can employ to expand Medicaid eligibility.

TABLE III-1 SECTION 1931 COVERAGE EXPANSIONS FOR PARENTS

- 41 states and the District of Columbia provide Medicaid coverage to low-income parents through Section 1931 family coverage.
  - 30 states extend Medicaid eligibility to unemployed parents in families with incomes up to 50% of the FPL; 13 states extend eligibility to employed parents in families with incomes up to 50% of the FPL.
  - 8 states extend eligibility to unemployed parents in families with incomes between 51% and 100% of the FPL; 22 states extend eligibility to employed parents in families with incomes between 51% and 100% of the FPL.
  - 2 states extend eligibility to unemployed parents in families with incomes between 101% and 199% of the FPL; 5 states extend eligibility to employed parents in families with incomes between 101% and 199% of the FPL.
  - One state, Washington, and the District of Columbia cover unemployed and employed parents in families with incomes at 200% of the FPL.

Section 1115 Waivers to Broaden Eligibility

Prior to the 1996 welfare reform law, states' primary option for expanding Medicaid eligibility to low-income parents was through a Section 1115 research and demonstration waiver.[81] States can apply to the federal Department of Health and Human Services for permission to alter their Medicaid program from the statutory requirements to test new approaches to delivering services or expand coverage to additional populations. The waivers have to meet rigorous regulatory review and have to be budget neutral. Under the terms of the 1115 waivers, states can provide expansion populations with a benefits package that is less generous than standard Medicaid benefits and require cost-sharing on the part of enrollees in the form of copayments or premiums.[82]

Nine states have gained federal permission to expand Medicaid coverage to parents using 1115 waiver authority. The income eligibility levels for 1115 waiver expansions tend to be higher than the levels set under Section 1931 family coverage. All of the nine states are covering populations at or above 100% of the FPL.

TABLE III-1 SECTION 1115 WAIVER COVER AGE EXPANSIONS FOR PARENTS

- 9 states provide Medicaid coverage to low-income parents through Section 1115 waivers.
  - 4 states offer eligibility to unemployed and employed parents in families with incomes between 100% and 133% of the FPL.
  - 3 states extend eligibility to unemployed and working parents in families with incomes between 185% and 200% of the FPL; 1 state, New Jersey, extends eligibility to unemployed parents up to 200% of the FPL, but offers coverage to working parents only between 25 and 37% of the FPL.
  - Minnesota offers the most generous coverage up to 275% of the FPL for employed and unemployed parents.

TABLE III-1
Section 1931 and 1115 Waiver Coverage Expansions for Parents

	Unemployed Parents		Employed Parents	
State	Income Eligibility Limit ($ per month)*	Income Eligibility Limit (% FPL)	Income Eligibility Limit ($ per month)	Income Eligibility Limit (% FPL)
Alabama	164	13	254	21
Alaska	1,118	73	1,208	79
Arizona ~	1,219	100	1,309	107
Arkansas	204	17	255	21
California	1,219	100	1,309	107
Colorado	421	35	511	42
Connecticut	1,829	100	1,919	100
Delaware	1,219	100	1,491	122
District of Columbia	2,438	200	2,438	200
Florida	303	25	806	66
Georgia	424	35	756	62
Hawaii ~	1,403	100	1,403	100
Idaho	317	26	407	33
Illinois	377	31	686	56
Indiana	288	24	378	31
Iowa	426	35	1,065	87
Kansas	403	33	493	40
Kentucky	526	43	909	75
Louisiana	174	14	264	22
Maine	1,829	150	1,919	157
Maryland	418	34	523	43
Massachusetts	1,621	133	1,621	133
Michigan	459	38	774	63
Minnesota ~	3,353	275	3,353	275
Mississippi	368	30	458	38
Missouri	1,219	77	1,309	77
Montana	478	39	836	69
Nebraska	535	44	669	55
Nevada	348	29	1,097	90
New Hampshire	600	49	750	62
New Jersey ~	2,438	200	2,438	25-37 #
New Mexico	389	32	704	58
New York ~	1,621	133	1,621	133
North Carolina	544	45	750	62
North Dakota	488	40	1,336	110
Ohio	1,219	100	1,219	100
Oklahoma	471	39	591	48
Oregon ~	1,219	100	1,219	100
Pennsylvania	403	33	677	56
Rhode Island ~	2,255	185	2,345	192
South Carolina	610	50	1,219	100
South Dakota	796	65	796	65
Tennessee	840	69	990	81
Texas	275	23	395	32
Utah	583	48	673	55
Vermont ~	2,255	185	2,345	192
Virginia	291	24	381	31
Washington	2,438	200	2,438	200
West Virginia	253	21	343	28
Wisconsin ~	2,255	185	2,255	185
Wyoming	590	48	790	65

Notes:
* Unless otherwise indicated, income eligibility is for Section 1931 Family Coverage.
~ Income eligibility levels are for state's Medicaid 1115 waiver.
FPL 100% of the federal poverty level (FPL) was $14,630 for a family of three in 2001.
\# In 2002, NJ stopped accepting new applications from working parents unless their incomes were below the state's income limit for welfare cash assistance. This effectively reduced the income limit for Medicaid eligibility to 25-37 percent of the FPL.

Source: Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Menlo Park: The Henry J. Kaiser Family Foundation, 2002), p. 40, Table 7. **Data current as of June 2001**

Information for Connecticut, Missouri, and New Jersey, Melanie Nathanson and Leighton Ku, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update* (Washington, D.C.: Center on Budget and Policy Priorities, 2003). **Data current as of March 2003**

Pregnant Women

Medicaid finances approximately one-third of all births in the U.S.[83] Medicaid coverage promotes access to prenatal care for beneficiaries, who are younger, poorer and in worse health than the general population, reducing their risk for problems such as low birthweight babies.[84] Medicaid must cover pregnant women at or below 133% of the FPL for pregnancy-related care and extends coverage through 60 days postpartum or through the last day of the month in which the 60 days expire.[85] To expand Medicaid coverage for pregnant women, states can expand income eligibility requirements and offer presumptive eligibility.

Eligibility Expansions

States have the option of expanding eligibility to pregnant women with incomes up to 185% of the FPL and beyond.[86] States may expand Medicaid coverage for pregnant women above the 185% threshold by disregarding a set amount of each applicant's income, such as the first $50.[87] Using this method, states have expanded coverage for pregnant women with incomes as high as 275% of the FPL.

Presumptive Eligibility

Another way states may expand coverage for pregnant women is to institute presumptive eligibility, which allows pregnant women who meet certain criteria to receive immediate, temporary Medicaid coverage while the application is processed.[88] This allows them to access prenatal health services as soon as they seek care.

TABLE III-2 MEDICAID COVERAGE EXPANSIONS FOR PREGNANT WOMEN

- 39 states and the District of Columbia have expanded Medicaid eligibility for pregnant women above the mandated 133% of the FPL.
  - 6 states cover pregnant women with incomes between 140% and 170% of the FPL.
  - 20 states and the District of Columbia cover pregnant women with incomes up to 185% of the FPL.
  - 13 states cover pregnant women at or above 200% of the FPL.
- 11 states cover pregnant women only up to the federally mandated 133% of the FPL.
- 30 states and the District of Columbia have presumptive eligibility for pregnant women.

Adults Without Dependent Children

Adults must be pregnant, parents of dependent children, over age 65, or have a disability to qualify for Medicaid.[89] Adults ages 19 to 64 who do not have children or with adult children are not typically eligible.[90] Only about 14% of women ages 18 to 64 who do not have dependent children are covered by Medicaid.[91] Of the 9.8 million low-income, uninsured childless adults, approximately 91% are ineligible for Medicaid coverage.[92] A handful of states have used 1115 waiver expansions to offer Medicaid benefits to childless adults. A smaller number of states finance coverage for adults without dependent children through separate state funds.

TABLE III-2 MEDICAID COVERAGE EXPANSIONS FOR ADULTS WITHOUT DEPENDENT CHILDREN

- 8 states have used 1115 waivers to expand Medicaid coverage to low-income childless adults. Eligibility levels range between 100% and 150% of the FPL.
- 3 states provide health coverage through separate state programs to childless adults with incomes ranging between 100% and 200% of the FPL.

TABLE III-2
Coverage Expansions for Pregnant Women and Childless Adults

State	Medicaid Coverage of Pregnant Women: Income Eligibility Limit^ (% FPL)	Medicaid Coverage of Pregnant Women: Presumptive Eligibility	Publicly Funded Coverage of Childless Adults: Income Eligibility Limit (% FPL)
United States Total		**30 + DC**	
Alabama	133		
Alaska	200		
Arizona	140		100*
Arkansas	200	●	
California	300#	●	
Colorado	133	●	
Connecticut	185		
Delaware	200	●	100*
District of Columbia	185	●	
Florida	185	●	
Georgia	235	●	
Hawaii	185		100*
Idaho	133	●	
Illinois	200	●	
Indiana	150		
Iowa	200	●	
Kansas	150	●	
Kentucky	185	●	
Louisiana	133	●	
Maine	200	●	
Maryland	250		
Massachusetts	200	●	133*
Michigan	185	●	
Minnesota	275		175**
Mississippi	185		
Missouri	185	●	
Montana	133	●	
Nebraska	185	●	
Nevada	133		
New Hampshire	185	●	
New Jersey	185	●	100**
New Mexico	185	●	
New York	200	●	100*
North Carolina	185	●	
North Dakota	133		
Ohio	150		
Oklahoma	185	●	
Oregon	170		100*
Pennsylvania	185	●	
Rhode Island	185		
South Carolina	185		
South Dakota	133		
Tennessee	185	●	100*
Texas	185	●	
Utah	133	●	
Vermont	200		150*
Virginia	133		
Washington	185		200**
West Virginia	150		
Wisconsin	185	●	
Wyoming	133	●	

Notes:
- ● State has the policy
- * 1115 Waiver
- ** Separate state program
- # California's Medicaid program extends eligibility to pregnant women through 200% of the FPL. The Access for Infants and Mothers (AIM) program extends eligiblity to pregnant women with incomes between 200% and 300% of the FPL.
- FPL 100% of the federal poverty level was $11,940 for a family of two in 2002.

Sources: **Information on Medicaid Coverage of Pregnant Women,** Emily Cornell, "Maternal and Child Health (MCH) Update: State Health Coverage for Low-Income Pregnant Women, Children, and Parents " National Governors' Association Report (June 9, 2003), Tables 2,8. **Data current as of October 2002**

Information on Publicly Funded Health Insurance Coverage of Childless Adults, "Expanding Coverage to Childless Adults," Families USA, unpublished data (January 2002). **Data current as of January 2002**

Seniors and People with Disabilities

Medicaid also plays an important role in the health care of low-income seniors and people with disabilities. While people age 65 and older and people with disabilities account for only 27% of Medicaid enrollment, they account for 71% of spending in the Medicaid program, with a large share of this attributed to long-term care.[93] Medicaid provides coverage to 5 million seniors and 8 million persons with disabilities.[94] Because women live longer and are more likely to require many of Medicaid's covered benefits, particularly professional long-term care services.[95] Women comprise nearly three-quarters of nursing home residents.[96] These services and Medicaid coverage of uncovered Medicare expenses are particularly important for women because the majority of low-income seniors are women.[97]

The extent of Medicaid assistance for the nation's poorest seniors and individuals with disabilities ranges in scope depending on their income and resources. (For a detailed discussion of Medicaid eligibility, please refer to the *Medicaid Resource Book*).[98] Those who qualify for Supplemental Security Income (SSI), a federal program that provides cash assistance to low-income individuals who are over 65 or blind or disabled, generally qualify for full Medicaid benefits. For example, a low-income Medicare beneficiary who also receives SSI is eligible for full Medicaid coverage. For a low-income Medicare beneficiary with an income that is greater than the SSI level, Medicaid assistance is limited to certain out-of-pocket Medicare costs such as premiums, deductibles, or copayments. Figure III-1 outlines the major federal guidelines for Medicaid eligibility for low-income Medicare beneficiaries. In addition, certain low-income people with disabilities who are not eligible for Medicare can also qualify for the full range of Medicaid benefits.[99]

FIGURE III-1 SELECT MEDICAID ELIGIBILITY PATHWAYS FOR MEDICARE BENEFICIARIES

	Family Income*	**Resource Test****	**Scope of Medicaid Coverage**
SSI Recipients	<$6,372 annually for individual; <$9,552 annually for family of two	100% SSI limit	Full Medicaid coverage
Qualified Medicare Beneficiaries (QMBs)	≤100% FPL	≤200% of SSI limit	All Medicare premiums and cost-sharing charges
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% FPL	≤200% of SSI limit	Medicare Part B monthly premium
Qualifying Individuals 1 (QI1s)	Between 120% and 135% FPL	≤200% of SSI limit	Medicare Part B monthly premium; benefit is subject to annual federal funding cap

* In 2001, the FPL was $11,610 for a family of two; 200% FPL was $23,220 for a family of two.

** In 2001, 100% of the annual Supplemental Security Income (SSI) resource level was $2,000 for individuals; $3,000 for couples.

Source: The Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, Washington, DC: The Henry J. Kaiser Family Foundation, pp. 33-40.

TABLE III-3
Coverage Expansions for Seniors and Adults With Disabilities

State	Coverage for SSP-Only Recipients (% FPL)	Expanded Eligibility for Medicare Benefs. (% FPL)	Medically Needy Income Limits (% FPL)	BBA or TWWIIA Expansion for Adults with Disabilities
United States Total				**26**
Alabama	74			
Alaska	137			●+
Arizona**	74			●◆
Arkansas	74		15	●◆
California	99	110	84	●+
Colorado	79			●◆
Connecticut	104		67~	●◆
Delaware	74			
District of Columbia	74	100	53	
Florida	74		25	●◆
Georgia	74		29	
Hawaii	75		51	
Idaho	81			
Illinois	74	100	40	
Indiana	74			●◆
Iowa	74		67	●+
Kansas	74		66	●◆
Kentucky	74		30	
Louisiana	74		13	
Maine	75	100	58	●+
Maryland	74		49	
Massachusetts	92	100	73	
Michigan	76	100	48	
Minnesota	85		67	●◆
Mississippi	74	142		●+
Missouri	74			●◆
Montana	74		71	
Nebraska	75	100	55	●+
Nevada	79			
New Hampshire	78		76	●◆
New Jersey	78	100	51	●◆
New Mexico	74			●+
New York	86		87	
North Carolina	74	100	34	
North Dakota	74	100	66	
Ohio	74			
Oklahoma	81	100		●◆
Oregon	74		58	●+
Pennsylvania	78	100	59	●◆
Rhode Island	83	100	87	
South Carolina	74	100		
South Dakota	76	100		
Tennessee	74		34	
Texas	74			●◆
Utah	74	100	53	●+
Vermont	82		95	●+
Virginia	74		30	
Washington	78		78	●◆
West Virginia	74		28	
Wisconsin	86		83	●+
Wyoming	75			

Notes:
- ● State has the policy
- ~ Higher income limits apply in some parts of the state; table shows lowest figure for the state.
- \+ Balanced Budget Act (BBA) of 1997 Option
- ◆ Ticket to Work and Work Incentives Improvement Act (TWWIIA) Option
- SSP State Supplemental Payment
- FPL 100% of the federal poverty level was $11,610 for a family of two in 2001.
- ** Arizona provides coverage up to 100% of the federal poverty level and allows a spend down to $279 monthly through a Section 1115 waiver

Sources: Families USA, *Could Your State Do More to Expand Medicaid to Seniors and Adults with Disabilities* (Washington, D.C.: Families USA, 2001). **Data current as of April 2001**

Information for Oklahoma (medically needy limit), Melanie Nathanson and Leighton Ku, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update* (Washington, D.C.: Center on Budget and Policy Priorities, 2003). **Data current as of March 2003**

Information on BBA/TWWIIA Expansions for Adults with Disabilities, Center for Workers with Disabilities, "Medicaid Buy-In Update" (American Public Health Association, Washington D.C. 2002), [Online] http://disabilities.aphsa.org/Resource%20Directory/MedicaidBuyIn.htm. **Data current as of April 2002**

Beyond these federal guidelines, states have several specific options for expanding Medicaid coverage to seniors and people with disabilities who are not eligible for SSI.

Coverage for Low-Income Seniors and People with Disabilities

Federal law generally mandates that Medicaid eligibility be extended to those who qualify for SSI (income thresholds for SSI are 74% of the FPL for individuals and 82% of the FPL for couples).[100] States must also provide partial Medicaid assistance, in the form of coverage for some Medicare expenses, to low-income seniors and people with disabilities with incomes up to and including 100% of the FPL. States have the option of providing full Medicaid coverage to Medicare beneficiaries with incomes up to 100% of the FPL.[101]

Coverage for SSP Beneficiaries

Most states augment federal SSI payments with State Supplemental Payments (SSP).[102] In some states, low-income seniors and people with disabilities who are ineligible for SSI may receive SSP if their income falls between the federal SSI limit and the state SSP limit.[103] These states may also expand Medicaid coverage to individuals who receive only SSP.[104]

"Medically Needy" Eligibility

Some individuals who are ineligible for Medicaid coverage based on SSI eligibility requirements may be eligible for Medicaid under a state's "medically needy" eligibility.[105] The "medically needy" category is intended to assist people with high medical expenses that consume a significant portion of their income, and cause them to "spend down" into poverty. States deduct medical expenses from a person's income, and if the remaining income is below the state's medically needy income limit, the person can qualify for Medicaid.

Medicaid Coverage for Working People with Disabilities

Both the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) give states the option of expanding Medicaid coverage to working adults with disabilities under the age of 65 with incomes above SSI qualifying levels.[106] Under the BBA, states can extend Medicaid coverage to people with disabilities under age 65 even if they have earnings above the Medicaid eligibility limit.[107] States have the flexibility to create their own income ceilings and can impose premiums or other cost-sharing charges.[108]

Under TWWIIA, states can set Medicaid income limits as high as they choose or eliminate income requirements completely.[109] States can charge premiums, and are required to charge the full premium to people with incomes exceeding $75,000.[110]

TABLE III-3 MEDICAID COVERAGE EXPANSIONS FOR SENIORS AND PEOPLE WITH DISABILITIES

- 23 states provide Medicaid coverage to seniors and people with disabilities who are eligible for State Supplemental Payments by extending eligibility beyond 74% of the FPL.
- 16 states and the District of Columbia extend full Medicaid coverage to seniors and people with disabilities with incomes up to or beyond 100% of the FPL.
- 33 states and the District of Columbia have a "medically needy" category for those with incomes ranging between 15% and 95% of the FPL.
- 11 states have implemented Medicaid expansions for adults with disabilities under the Balanced Budget Act and 15 states have expanded coverage under the Ticket to Work and Work Incentives Improvement Act.

MEDICAID MANAGED CARE

To control spending and improve access to services for beneficiaries, the majority of states have mandated that some or all of their Medicaid populations enroll in managed care plans. More than half of all people receiving services through the Medicaid program are now enrolled in managed care plans. In these programs, states contract with private managed care organizations (MCOs) to provide Medicaid-covered services to Medicaid beneficiaries. Beneficiaries are usually given a choice of several plans, but if they fail to choose one they are automatically enrolled in a plan. Beneficiaries in rural areas may not have a choice of plans.

There are three ways that states can mandate enrollment into Medicaid managed care programs. They can receive a Section 1115 or Section 1915(b) waiver from the federal requirement that gives enrollees freedom of choice to go to any provider that accepts Medicaid. In addition, Section 1932 of the Balanced Budget Act of 1997 allows states to mandate managed care enrollment without a waiver but with new statutory protections for enrollees.[111]

Low-income women and their children are the populations most likely to be covered by Medicaid managed care.[112] Eighty-two percent of non-elderly female Medicaid beneficiaries are enrolled in a managed care plan.[113] Access to family planning services is a special concern for low-income women of reproductive age enrolled in Medicaid managed care plans. Women who are required to enroll in a managed care plan may lose access to their previous reproductive health care provider if their doctor or clinic is not in their plan's network. Women may also enroll in or be automatically enrolled in a managed care plan that refuses to provide family planning services because it is owned by a religious entity that objects to these services (see Sections IV-3 through IV-5).[114] Medicaid's free access law helps protect against these barriers, but depending on a state's specific family planning structure (see Table III-5 for more information), many women are not covered under free access and may experience difficulties in accessing these reproductive health care services.

Managed Care Structure

The structure of states' Medicaid programs directly affects beneficiaries' access to services. Important structural differences include the way that states pay for care and if states mandate enrollment in managed care.

Capitation vs. Primary Care Case Management

States pay Medicaid managed care providers through either capitated MCOs or primary care case management (PCCM) systems. Under capitation, states pay MCOs a pre-negotiated, fixed fee for each enrollee's care. Under this system, beneficiaries are limited to providers in their MCO's network.[115] Under PCCM, each beneficiary is assigned to a primary care provider who is responsible for arranging and authorizing all the enrollee's covered services. These providers are paid on a fee-for-service basis for the direct services they provide and are paid a small monthly fee to manage the beneficiary's care.[116] Enrollees in this system are not limited to a network of providers, but must get approval from their primary care doctor to access additional services.

Mandatory Enrollment

Most states make enrollment in managed care mandatory for all or some Medicaid beneficiaries. Women of reproductive age are especially likely to be in the category of beneficiaries who are required to receive services through managed care plans.

TABLE III-4 STRUCTURE OF MEDICAID MANAGED CARE PROGRAMS AND COVERAGE OF FAMILY PLANNING SERVICES

- 30 states and the District of Columbia have capitated Medicaid managed care programs.
- 5 states utilize PCCM in their Medicaid programs.
- 11 states use both capitation and PCCM in different geographic areas.
- 35 states and the District of Columbia mandate enrollment in managed care for Medicaid beneficiaries.
- 8 states have voluntary Medicaid managed care enrollment; 3 states make enrollment mandatory in some areas but voluntary in others.
- 38 states and the District of Columbia include family planning services in their capitation rate; 3 states do not include family planning services in their capitation rate.
- 3 states exclude abortion services from their family planning capitation rate and 3 states exclude pharmacy services.

Family Planning Services

Although the federal government requires states to cover family planning services and supplies, federal Medicaid statutes do not define family planning.[117] According to the Centers for Medicare and Medicaid Services, a service must be "expected to achieve a family planning purpose" in order to receive an enhanced 90% federal family planning reimbursement rate.[118] States create their own definitions of family planning for their Medicaid managed care programs, which determines the scope of services covered. States generally cover gynecological exams, Pap smears, STD and HIV testing, FDA-approved forms of contraception and related counseling services, and contraceptive sterilization.[119] Preconception counseling and emergency contraception are considered family planning services in about half of the states, while infertility tests and treatment are rarely defined as family planning.[120] The U.S. Department of Health and Human Services has determined that abortion, while covered by Medicaid under limited circumstances, may not be defined as family planning.[121]

Two state policies are especially important in determining beneficiaries' access to family planning services under Medicaid managed care. The first is whether states include family planning services in the capitation rate. The second is how a state decides to inform enrollees of their right to receive family planning services from any provider.

TABLE III-4
Structure and Coverage of Managed Care Family Planning Services

State	Managed Care Structure	Mandatory or Voluntary Enrollment	Family Planning in Capitation Rate
	Managed Care Structure		
United States Total			**38 + DC**
Alabama	PCCM only	mandatory	N/A
Alaska	no managed care	no managed care	no managed care
Arizona	capitation only	mandatory	●
Arkansas	PCCM only	mandatory	N/A
California	capitation only	mandatory	●
Colorado	PCCM and capitation	mandatory	●
Connecticut	capitation only	mandatory	●
Delaware	capitation only	mandatory	●
District of Columbia	capitation only	mandatory	●
Florida	PCCM and capitation	mandatory	●
Georgia	PCCM and capitation^	voluntary	●
Hawaii	capitation only	mandatory	●
Idaho	PCCM only	voluntary	N/A
Illinois	capitation only	voluntary	●
Indiana	PCCM and capitation	mandatory	●
Iowa	PCCM and capitation^	mandatory	●
Kansas	capitation only	mandatory	
Kentucky	capitation only	mandatory	●
Louisiana	PCCM only	mandatory	N/A
Maine	PCCM and capitation^	voluntary	●
Maryland	capitation only	mandatory	●*
Massachusetts	PCCM and capitation	mandatory	●
Michigan	capitation only	voluntary	●
Minnesota	capitation only	mandatory	●
Mississippi	○	○	○
Missouri	capitation only	mandatory	●
Montana	capitation only	mandatory	●
Nebraska	capitation only	mandatory	●
Nevada	capitation only	varies	●
New Hampshire	capitation only	voluntary	●
New Jersey	capitation only	mandatory	●
New Mexico	○	○	○
New York	capitation only	varies	●***
North Carolina	PCCM and capitation^	varies	●
North Dakota	PCCM and capitation^	voluntary	●
Ohio	capitation only	mandatory	●
Oklahoma	capitation only	mandatory	●
Oregon	capitation only	mandatory	●
Pennsylvania	capitation only	mandatory	●
Rhode Island	capitation only	mandatory	●
South Carolina	capitation only	voluntary	
South Dakota	PCCM only	mandatory	N/A
Tennessee	capitation only	mandatory	●
Texas	PCCM and capitation^	mandatory	●
Utah	capitation only	mandatory	●***
Vermont	capitation only	mandatory	
Virginia	capitation only	mandatory	●*
Washington	capitation only	mandatory	●**
West Virginia	PCCM and capitation^	mandatory	●***
Wisconsin	capitation only	mandatory	●
Wyoming	○	○	○

Notes:
- ● State has policy
- ○ State did not respond/complete survey
- N/A State does not have capitation
- ^ Limited to certain counties
- * Abortion excluded from the capitation rate
- ** Abortion and sterilization excluded from the capitation rate
- *** Pharmacy services excluded from the capitation rate
- PCCM Primary Care Case Management

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 32. Table III-1. **Data current as of January 2000**

Family Planning in Medicaid Managed Care Capitation Rates

When family planning services are included within a plan's capitation rate, it can be difficult for states to calculate the federal funding owed them under the special 90% reimbursement rate for family planning services because all services under capitation are paid for in a lump sum per beneficiary. There is a risk that that states may miss out on the enhanced reimbursement for family planning services, and as Medicaid plays a significant role in state budgets, maximizing reimbursement is vital for states and can affect the level of services that women receive.

The Free Access Law

In order to ensure access to family planning services under Medicaid managed care, most women enrolled in Medicaid managed care are free to go out of plan to receive family planning services from any participating Medicaid provider. This "free access" law (also referred to as "freedom of choice") is an important safeguard for women, allowing them to continue with existing family planning providers and access to family planning services if they are enrolled in a plan that doesn't provide such services, such as some faith-based plans.[122] A study of well-established managed care programs in five states found that one in ten Medicaid managed care enrollees used a provider not affiliated with her plan for contraceptive services.[123]

Whether or not free access/freedom of choice is available under Medicaid depends on how states choose to operate their managed care programs. The 19 states that operate their Medicaid managed care programs under an 1115 waiver are allowed to waive the free access provision.[124] Five of these 19 states do not provide free access to family planning services. An additional 21 states and the District of Columbia operate their Medicaid managed care programs under a 1915(b) waiver.[125] With the exception of Maine, which has a small voluntary program, all these states have free access for family planning services. States operating Medicaid managed care plans under Section 1932 are not permitted to restrict freedom of choice for family planning services and must inform enrollees of their right to obtain services from any provider.[126] Figure III-2 outlines structural rules for state implementation of the free access provision.

FIGURE III-2 MEDICAID MANAGED CARE AND FREE ACCESS

Managed Care Structure	**Free Access Enforcement**	**State Actions***
1115 waiver	May waive free access provision	Of the 19 states with these waivers, 5 do not provide free access to family planning services.
1915 waiver	Must enforce free access	21 states + DC
Section 1932	Must enforce free access	12 states
Voluntary managed care programs	May waive free access provision	Of the 8 states with voluntary managed care programs, 2 do not provide free access to family planning services.

*Totals more than 50 states and the District of Columbia, because states may use different waiver provisions for different populations of beneficiaries.

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey,* 2001, p. 33.

TABLE III-5

State Approaches to Informing Beneficiaries About Family Planning Free Access

State	Responsibility for Informing Enrollees About Free Access			Medicaid Program Reviews Information or Provides Language	Method of Informing Enrollees
	Medicaid Program	Broker	Health Plan		
United States Total	**13**	**6**	**33 + DC**	**17**	
Alabama	N/A	N/A	N/A	N/A	N/A
Alaska	no managed care	no managed care	no managed care	no managed care	no managed care
Arizona	N/A	N/A	N/A	N/A	N/A
Arkansas	N/A	N/A	N/A	N/A	N/A
California			●		member handbook mailed within 7 days of enrollment
Colorado			●	●	member handbook
Connecticut			●		standard recipient notice
Delaware	●		●		notified at enrollment, plan newsletter & member handbook
District of Columbia			●		member handbook
Florida		●	●		broker counseling & member handbook
Georgia			●	●	plan marketing materials
Hawaii	N/A	N/A	N/A	N/A	N/A
Idaho	N/A	N/A	N/A	N/A	N/A
Illinois			●	●	member handbook
Indiana		●	●		member handbook & plan newsletter
Iowa			●	●	member handbook
Kansas			●		member booklet
Kentucky	N/A	N/A	N/A	N/A	N/A
Louisiana	N/A	N/A	N/A	N/A	N/A
Maine	N/A	N/A	N/A	N/A	N/A
Maryland	●		●	●	Medicaid brochure & plan informational materials
Massachusetts	●		●		new member packets
Michigan		●	●		enrollment agency & member handbook
Minnesota	●		●		Medicaid family planning brochure & plan informational materials
Mississippi	○	○	○	○	○
Missouri			●	●	member handbook
Montana		●	●	●	member handbook & enrollment broker interview
Nebraska		●	●		enrollment broker & member handbook
Nevada	●		●	●	member handbook
New Hampshire	●		●	●	plan welcome letter & enrollment information
New Jersey	●		●	●	Medicaid brochure, member handbook & list of family planning providers
New Mexico	○	○	○	○	○
New York	●		●	●	member handbook & state public education campaign
North Carolina	●		●	●	plan information & state Medicaid handbook
North Dakota			●	●	member handbook
Ohio			●		member handbook & periodic home visits
Oklahoma			●	●	member handbook
Oregon	○	○	○	○	○
Pennsylvania			●		member handbook
Rhode Island	N/A	N/A	N/A	N/A	N/A
South Carolina	●		●	●	plan information & state Medicaid handbook
South Dakota	N/A	N/A	N/A	N/A	N/A
Tennessee	N/A	N/A	N/A	N/A	N/A
Texas	●		●		member handbook, list of family planning providers & eligibility letter
Utah			●		plan orientation with new members
Vermont			●		○
Virginia	●				Medicaid enrollment brochure
Washington	●		●	●	member handbook
West Virginia		●	●		information mailed to enrollees
Wisconsin			●	●	member handbook
Wyoming	○	○	○	○	○

Notes: ● State has the policy
○ State did not respond/complete survey
N/A State is exempt from the free access requirement

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 39, Table III-2. **Data current as of January 2000**

The way that states inform enrollees about free access has implications for women's access to reproductive health care, as many women may not be aware of their full range of choices. Literacy and language barriers are also important considerations for the Medicaid population. Some states require oral as well as written notification, which helps ensure that women are aware of their family planning access options.

TABLE III-5 STATE APPROACHES TO INFORMING MEDICAID BENEFICIARIES ABOUT FREE ACCESS

- 33 states and the District of Columbia place responsibility for informing Medicaid beneficiaries about free access on health plans; 17 of these states review the information provided to enrollees or provides the health plans with language to use.
- 6 states place responsibility for informing Medicaid beneficiaries about free access on independent Medicaid enrollment brokers.
- 13 states assume responsibility for informing Medicaid beneficiaries about free access.

MEDICAID COVERAGE OF ADDITIONAL SERVICES OF IMPORTANCE TO WOMEN

In addition to expanding the populations eligible for Medicaid, states have acted to expand Medicaid coverage for specific services that have particular importance for women's health. Women with limited resources face challenges ranging from how to obtain family planning services to how to support a spouse in a nursing home without becoming impoverished. State policies to extend Medicaid coverage of abortion and family planning services, breast and cervical cancer treatment, and to help low-income individuals with the cost of prescription medications are important extensions of the Medicaid program.

Abortion

The Medicaid program requires coverage of all medically necessary services.[127] However, the federal Hyde Amendment, first passed in 1977, bans state use of federal Medicaid dollars to pay for abortions unless the pregnancy is the result of rape or incest, or the abortion is "necessary to save the life of the woman."[128] States can cover other medically necessary abortions–usually defined by the state as those to protect the physical or mental health of the woman–for Medicaid recipients with their own funds. Of the 19 states that do fund most or all "medically necessary" abortions, four states fund them on a voluntary basis and 15 fund them under the order of state courts.[129]

TABLE III-6 STATE MEDICAID FUNDING OF ABORTION

- 23 states use their own funds to cover abortions under Medicaid beyond the federal requirement

  -19 states provide additional funding for most or all "medically necessary" abortions for Medicaid recipients; 5 of theses states have decided to fund medical as well as surgical abortions.

  -4 states provide additional limited funding for abortions for Medicaid recipients in cases of severe fetal deformity or other limited health conditions impacting the woman.
- 27 states and the District of Columbia follow federal Medicaid abortion funding restrictions, which limit publicly funded abortions to rape, incest and those necessary to save the life of the woman.

TABLE III-6
State Medicaid Funding of Abortion

State	State Funding Beyond Federal Provision	Funding Limitations
United States Total	**23**	
Alabama		
Alaska	●	
Arizona	●	
Arkansas		
California	●+	
Colorado		
Connecticut	●	
Delaware		
District of Columbia		
Florida		
Georgia		
Hawaii	●	
Idaho		
Illinois	●+	
Indiana	●	
Iowa	○	Limited to life endangerment, fetal deformity, mental deficiency or congenital illness.
Kansas		
Kentucky		
Louisiana		
Maine		
Maryland	●	
Massachusetts	●	
Michigan		
Minnesota	●+	
Mississippi	○	Funding is available in some cases of fetal abnormality.
Missouri		
Montana	●	
Nebraska		
Nevada		
New Hampshire		
New Jersey	●	
New Mexico	●	
New York	●+	
North Carolina		
North Dakota		
Ohio		
Oklahoma		
Oregon	●	
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Texas	●*	
Utah		
Vermont	●	
Virginia	○	Limited to life or health endangerment, or gross and total fetal incapacitation, physical deformity or mental deficiency.
Washington	●+	
West Virginia	●	
Wisconsin	○	Limited to life endangerment, or to prevent grave, long-lasting physical health damage resulting from existing medical condition.
Wyoming		

Notes:
- ● State funds medically necessary abortions
- ○ State funds abortions on limited basis, but still beyond federal provision
- \+ Expressly includes medical abortion
- * Funding restriction ruled unconstitutional; restriction remains in effect pending appeal

Sources: National Conference of State Legislatures Health Policy Tracking Service unpublished data collected for this report (December 21, 2001); Alan Guttmacher Institute, State Policies in Brief (Washington, D.C.: Alan Guttmacher Institute, Feb. 2003).

Information on medical abortion funding, Danco Laboratories, *Reimbursement Facts* (Washington, D.C.: National Abortion Federation, undated) [Online]; http://www.earlyoptionpill.com/hcp_reimburse.php3. **Data current as of February 2003**

Section 1115 Family Planning Waivers

Many states have used Section 1115 waivers to extend coverage of family planning services to women who are not eligible for Medicaid. One way states have expanded access is by extending family planning services for a period of time beyond pregnancy and the 60-day postpartum period required by federal law.[130] The second way states have expanded coverage is by covering family planning services for a specific period of time for low-income women with incomes too high to qualify them for regular Medicaid coverage. One state, Delaware, expands coverage by providing two years of family planning services to women who become ineligible for Medicaid for any reason.

Family planning services provided under 1115 waivers vary by state and may also differ from the services provided under a state's regular Medicaid program. All states with family planning waivers cover prescription contraceptives and gynecological exams when conducted as a part of a family planning visit. Some states explicitly cover other services including testing and treatment for sexually transmitted diseases, including HIV, over-the-counter contraceptives, emergency contraception and contraceptive sterilization. Some programs also provide services for men.

TABLES III-7, III-8 SECTION 1115 FAMILY PLANNING WAIVERS AND SERVICES

- 16 states have approved section 1115 family planning waivers that allow them to extend family planning coverage to women who are not eligible for Medicaid.
- 4 states have pending 1115 family planning waivers to extend family planning services to women ineligible for Medicaid.
- In addition to prescription contraceptives, which all the states with Section 1115 family planning waivers cover, 8 states cover over-the-counter contraceptives and 3 states cover emergency contraception.
- 8 states cover STD testing and treatment and 3 states cover STD testing only; 8 states cover HIV testing.
- 13 states cover contraceptive sterilization; 3 of these states cover sterilization for men as well.
- 5 states cover additional health services such as transportation, home visits, interpreters and postpartum immunizations.

TABLE III-7
Section 1115 Family Planning Waivers

State	Approved Waiver	Eligibility Criteria	Length of Eligibility	Pending Waiver	Eligibility Criteria
United States Total	**16**			**4**	
Alabama	●	133% FPL	no time limit		
Alaska					
Arizona	●	postpartum loss of Medicaid if 140% FPL	2 years		
Arkansas	●	133% FPL	no time limit		
California	●	200% FPL (includes men)	1 year		
Colorado				●	150% FPL
Connecticut					
Delaware	●	loss of Medicaid for any reason	1 year, and 2nd year if 300% FPL		
District of Columbia					
Florida	●	postpartum loss of Medicaid*	2 years		
Georgia					
Hawaii					
Idaho					
Illinois					
Indiana					
Iowa					
Kansas					
Kentucky					
Louisiana					
Maine					
Maryland	●	postpartum loss of Medicaid if 185% FPL	5 years		
Massachusetts					
Michigan					
Minnesota					
Mississippi				●	185% FPL
Missouri	●	postpartum loss of Medicaid	2 years		
Montana					
Nebraska					
Nevada					
New Hampshire					
New Jersey					
New Mexico	●	185% FPL	2 years		
New York	●	200% FPL(includes men); postpartum loss of Medicaid if 185% FPL*	22 months		
North Carolina				●	185% FPL
North Dakota					
Ohio					
Oklahoma				●	185% FPL (includes men)
Oregon	●	185% FPL (includes men)	1 year		
Pennsylvania					
Rhode Island	●	postpartum loss of Medicaid if 250% FPL	2 years		
South Carolina	●	185% FPL	no time limit		
South Dakota					
Tennessee					
Texas					
Utah					
Vermont					
Virginia	●				
Washington	●	200% FPL (includes men)	no time limit		
West Virginia					
Wisconsin	●	185% FPL			
Wyoming		information not available			

Notes: ● State has approved or pending family planning waiver
* Extends Medicaid after any pregnancy-related service, not just delivery
FPL 100% of the federal poverty level (FPL) was $11,940 for a family of two in 2002.

Sources: Alan Guttmacher Institute, *State Policies in Brief* (Washington, D.C.: Alan Guttmacher Institute, Feb. 2003); The Henry J. Kaiser Family Foundation, *Section 1115 Medicaid Family Planning Waivers* (Menlo Park: The Henry J. Kaiser Family Foundation, October 2001). **Data current as of February 2003**

Information on Alabama and Washington eligibility, National Women's Law Center, unpublished data collected for this report, May 2002.

Information on Arkansas, California, New Mexico, Oregon, South Carolina eligibility, The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 56, Table IV-2.

Information on Washington and Oregon services for men, National Conference of State Legislatures unpublished data collected for this report (Nov. 2001).

TABLE III-8
Services Explicitly Included in Section 1115 Family Planning Waivers

State	Over-the-Counter Contraceptives	STD Testing/ Treatment	HIV Testing	Emergency Contraception	Sterilization	Other Health Care Services
United States Total	**8**	**11**	**8**	**3**	**13**	**5**
Alabama			●		●	
Alaska						
Arizona	●	○*	●	●	●	
Arkansas		○			●	full medical exam, 3x/yr. follow-up visits
California	●	●	●	●	●**	physical exam
Colorado						
Connecticut						
Delaware	●	●	●		●	
District of Columbia						
Florida		●	●		●	transportation
Georgia						
Hawaii						
Idaho						
Illinois						
Indiana						
Iowa						
Kansas						
Kentucky						
Louisiana						
Maine						
Maryland		●	●		●	
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri		●			●	
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey						
New Mexico		●			●	
New York	●	●	●			
North Carolina						
North Dakota						
Ohio						
Oklahoma						
Oregon	●				●**	home visits, interpreters
Pennsylvania						
Rhode Island	●	○*	●		●	up to three follow-up family planning visits, postpartum rubella immunization
South Carolina	●				●	
South Dakota						
Tennessee						
Texas						
Utah						
Vermont						
Virginia						
Washington	●	●		●	●**	
West Virginia						
Wisconsin						
Wyoming						

Notes:
- ● State has policy
- ○ Covers STD testing only
- * Program makes referral for low/no cost treatment
- ** Program covers men also

Sources: National Conference of State Legislatures unpublished data collected for this report (Nov. 2001). **Data current as of November 2001**

The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), pp. 56, 59-61. **Data current as of January 2000**

Information on Washington STD treatment, Washington State Department of Social and Health Services, *Take Charge Program* (Olympia: Washington State Department of Social and Health Services, May 2002), [Online] http://wws2.wa.gov/dshs/maa/familyplan/TCclientservices.html. **Data current as of May 2002**

Breast and Cervical Cancer Treatment Coverage Expansions

Nationwide, every year, an estimated 13,000 women are diagnosed with cervical cancer and more than 200,000 women are diagnosed with breast cancer.[131] More than 43,700 women die from these two diseases annually.[132] Access to screening and treatment for these cancers is crucial because both can be detected in the earliest stages and respond well to early medical intervention.[133] However, women who are uninsured or underinsured may skip routine screening for these diseases.

To address this problem, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).[134] Under the program, the CDC was authorized to promote and pay for breast and cervical cancer screening and follow-up diagnostic services for uninsured or low-income women. The CDC formed a network of providers to implement the screening program. The law, however, did not authorize payment for the treatment of women diagnosed with breast or cervical cancer under this program. To fill this gap, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act of 2000. Under this law, states have the option to provide full Medicaid benefits for the duration of treatment to uninsured women under age 65 who are diagnosed with cervical or breast cancer through the NBCCEDP. States that exercise this option receive enhanced Medicaid matching funds from the federal government.[135] All states have opted to participate in this program, but have adopted different policies that affect who is covered (Figure III-3).

States must receive approval from the federal government to participate in the program and must specify which of three eligibility options they will cover.

FIGURE III-3 BREAST AND CERVICAL CANCER TREATMENT PROGRAM ELIGIBILITY OPTIONS

Eligibility Option	Scope of coverage	State participation
1	Any woman screened by a provider in the NBCCEDP network	Mandatory
2	Any woman screened by a provider who receives some CDC funds to support screening services	Optional
3	Any woman screened by a provider the state decides to consider as part of screening network	Optional

Source: Centers for Medicare and Medicaid Services, *Breast and Cervical Cancer Prevention and Treatment Activity Map* [Online] cms.hhs.gov/bccpt/bccptmap.asp, accessed February 26, 2003.

Each state that chooses to participate must cover Option 1, also known as "the basic option." Under Option 1, any woman screened by a provider in the CDC screening network is eligible for treatment. Under Option 2, any woman screened by a non-CDC network provider who receives some CDC funds to support screening services is eligible for treatment. Under Option 3, any woman screened by a provider the state decides to consider part of the CDC screening network is eligible for treatment.[136]

States may also offer presumptive eligibility to applicants who appear to be eligible for the program, which allows women to enroll on a temporary basis and receive services while their Medicaid applications are processed, allowing them timely care.[137]

TABLE III-9 MEDICAID BREAST AND CERVICAL CANCER TREATMENT COVERAGE EXPANSIONS

- 50 states and the District of Columbia have chosen to participate in the federal program to expand Medicaid coverage for the treatment of breast and cervical cancers in low-income women.
  - 49 states and the District of Columbia have approved plans.
  - 1 state has enacted legislation that indicates a plan will be submitted.
- 25 states have selected Option 1 only;
  - 12 have selected Options 1 and 2;
  - 4 have selected Options 1 and 3,
  - 7 have selected all three options.
- 22 states have presumptive eligibility for the program.

TABLE III-9
Breast and Cervical Cancer Treatment Coverage Expansions

State	Participating in Federal Program	Screening Option	Presumptive Eligibility
United States Total	**50 + DC**		**22**
Alabama	●	1	
Alaska	●	1, 2	
Arizona	●	1	
Arkansas	●	1, 2, 3	
California	●	1, 3	●
Colorado	●	1	●
Connecticut	●	1	●
Delaware	●	1, 2	●
District of Columbia	●	*	*
Florida	●	1	
Georgia	●	1, 2, 3	●
Hawaii	●	1	
Idaho	●	1	●
Illinois	●	1, 2	
Indiana	●	1	
Iowa	●	1, 3	●
Kansas	●	1	
Kentucky	●	1, 2	
Louisiana	●	1, 2	
Maine	●	1	
Maryland	●	1, 2	
Massachusetts	●#	*	*
Michigan	●	1, 2, 3	
Minnesota	●	1	●
Mississippi	●	1, 2, 3	●
Missouri	●	1	●
Montana	●	1	
Nebraska	●	1, 3	●
Nevada	●	1, 2	●
New Hampshire	●	1, 2	●
New Jersey	●	1, 2	●
New Mexico	●	1	●
New York	●	1, 2	●
North Carolina	●	1	
North Dakota	●	1, 2	
Ohio	●	1	
Oklahoma	○		
Oregon	●	1	●
Pennsylvania	●	1	
Rhode Island	●	1, 2, 3	●
South Carolina	●	1	
South Dakota	●	1	
Tennessee	●	1, 2, 3	●
Texas	●	1	●
Utah	●	1, 2, 3	
Vermont	●	1	
Virginia	●	1	
Washington	●	1, 2	
West Virginia	●	1, 3	●
Wisconsin	●	1	●
Wyoming	●	1	

Notes:
- ● State has policy
- ○ State does not have an approved plan, but has enacted legislation that indicates plan will be submitted.
- * Additional information on the state's screening option/presumptive eligibility was not available.
- # Funding for Massachusetts' program was cut before the program started running.

Sources: Centers for Medicare and Medicaid Services, "Breast and Cervical Cancer Prevention and Treatment Activity Map," [Online] http://cms.hhs.gov/bccpt/bccptmap.asp. **Data current as of December 2002**

Information on states that do not have a plan but have enacted legislation, National Conference of State Legislatures, "State Legislation Relating to the Breast and Cervical Cancer Prevention and Treatment Act of 2000," [Online] http://www.ncsl.org/programs/health/cancerch.htm. **Data current as of July 2002**

Spousal Impoverishment Protection Policies

Medicaid is the largest payer of long-term care services,[138] and women constitute the majority of long-term care recipients.[139] Of the 1.5 million seniors living in nursing homes, approximately 75% are women.[140] Medicaid pays for 46% of the $87.8 billion spent on nursing home care, which accounts for three-fourths of all long-term care spending.[141]

Eligibility for Medicaid coverage of nursing home care is based on need. In the past, seniors were required to spend down their resources to qualify for assistance. This often left their spouses (called "community spouses") the choice of living in poverty or divorcing their spouses to preserve their assets such as a house. To protect the community spouses, who are disproportionately women, "spousal impoverishment" protections were enacted.[142]

Federal law requires states to protect the assets and income of the community spouse by permitting them to keep a "resource allowance" and an "income allowance."[143] States set these levels within federal guidelines. For the income allowance, states must allow the community spouse to retain a portion of the institutionalized spouse's income according to the state's Minimum Monthly Maintenance Needs Allowance, which must be between $1,451.25 and $2,175.[144] For the resource allowance, states must allow the community spouse to retain annually the greater of a minimum of $17,400 and a maximum of $87,000 in assets; or half the couple's joint assets up to $87,000.[145]

TABLE III-10 INCOME AND RESOURCE ALLOWANCES FOR SPOUSES OF NURSING HOME RESIDENTS

- 15 states and the District of Columbia permit community spouses to retain the maximum $2,175 per month of the Minimum Monthly Maintenance Needs Allowance.
- 33 states permit the community spouse to retain the minimum Monthly Maintenance Needs Allowance.
- 2 states permit the community spouse to retain an amount between the minimum and the maximum.
- 18 states and the District of Columbia permit the community spouse to retain the maximum resource allowance.
- 24 states permit the community spouse to retain the minimum resource allowance.
- 8 states permit the community spouse to retain an amount between the minimum and maximum resource allowance.

TABLE III-10

Spousal Impoverishment Protections - Income and Resource Allowances for Spouses of Nursing Home Residents

State	Minimum Monthly Maintenance Needs Allowance ($)	Annual Community Spouse Resource Allowance ($)
United States Total	**17+DC***	26 + DC*
Alabama	1,451	87,000
Alaska	2,175	87,000
Arizona	1,451	17,400
Arkansas	1,451	17,400
California	2,175	87,000
Colorado	1,451	87,000
Connecticut	1,451	17,400
Delaware	1,451	25,000
District of Columbia	2,175	87,000
Florida	1,451	87,000
Georgia	2,175	87,000
Hawaii	2,175	87,000
Idaho	1,451	17,400
Illinois	2,175	87,000
Indiana	1,451	17,400
Iowa	2,175	87,000
Kansas	1,451	17,400
Kentucky	2,175	87,000
Louisiana	2,175	87,000
Maine	1,451	87,000
Maryland	1,451	17,400
Massachusetts	1,451	87,000
Michigan	1,451	17,400
Minnesota	1,451	24,607
Mississippi	2,175	87,000
Missouri	1,451	17,400
Montana	1,451	17,400
Nebraska	1,451	17,400
Nevada	1,451	17,400
New Hampshire	1,451	17,400
New Jersey	1,451	17,400
New Mexico	1,451	31,290
New York	2,175	74,820
North Carolina	1,451	17,400
North Dakota	2,175	87,000
Ohio	1,451	17,400
Oklahoma	2,175	25,000
Oregon	1,451	17,400
Pennsylvania	1,451	17,400
Rhode Island	1,451	17,400
South Carolina	1,662	66,480
South Dakota	1,451	20,000
Tennessee	1,451	17,400
Texas	2,175	17,400
Utah	2,175	17,400
Vermont	1,451	87,000
Virginia	1,451	17,400
Washington	1,451	87,000
West Virginia	1,451	17,400
Wisconsin	1,875	50,000
Wyoming	2,175	87,000

Note: * Number of states whose allowance exceeds the federal minimum of $1,451 for minimum montly maintenance needs allowance and $17,400 for resource allowance.

Source: Eric Carlson, "Long-Term Care Advocacy Appendices, Section 7.401, State-Specific Chart of Resource and Income Allowance, and Average Monthly Private Pay Rates," (Los Angeles: Lexis Publishing, 2001), 7-133 to 7-135. **Data current as of December 2001**

Prescription Drug Coverage

Coverage for prescription drugs under Medicaid is an optional benefit, but all 50 states and the District of Columbia provide this coverage in their Medicaid programs. States have flexibility to determine the scope of coverage of their Medicaid prescription drug programs and may place limits on prescription coverage, including copayments and limits on the number of refills or prescriptions allowed per month or per year.

Prescription drug coverage is one of the most widely utilized benefits in the Medicaid program, accounting for $16.6 billion of Medicaid expenditures in 2000.[146] However, many women on Medicaid still have problems affording prescription drugs. One-quarter of women who receive Medicaid report that they did not fill a prescription due to the cost.[147] The Medicaid program does not have a uniform prescription drug benefit, and as with other benefits, prescription drug coverage and policies vary by state. States may require some beneficiaries to make minimal copayments, but are prohibited from charging copayments to pregnant women, children or people in institutions or for emergency or family planning services, and may not deny services to people who cannot afford the copayment.[148] (Information about separate non-Medicaid state pharmaceutical assistance programs is contained in Table V-5).

TABLE III-11 STATE MEDICAID PRESCRIPTION DRUG COVERAGE

- 50 states and the District of Columbia provide prescription drug coverage under Medicaid.
- 15 states place limits on the number of prescriptions Medicaid recipients may receive per month or per year.
- 31 states and the District of Columbia require a copayment for prescriptions that ranges from $0.50 to $3.00 per prescription.

✶ ✶ ✶

Medicaid is an important source of health care access for low-income women. For women in their reproductive years, Medicaid's role as a financier of family planning and prenatal care services is critical. Trends in Medicaid access for women have generally been positive. Most states have expanded eligibility for the parents of children covered by Medicaid and for pregnant women. Access to family planning and screening and treatment for breast and cervical cancer have also been enhanced through the Medicaid program, although access to abortion is still extremely limited under the program. For seniors and women with disabilities, Medicaid provides critical assistance for prescription drugs, long-term care, and with Medicare cost-sharing.

The current economic downturn has put additional pressures on states to reduce spending. Many states are looking to Medicaid to cut costs. This could have serious repercussions for access to coverage and care for low-income women.

TABLE III-11
Prescription Drug Coverage

State	Prescription Drug Coverage	Copayment Required ($)	Limits on Number of Prescriptions
United States Total	**50 + DC**	**31 + DC**	**15**
Alabama	●	.50-3.00	
Alaska	●	2.00	
Arizona	●		
Arkansas	●	.50-3.00	3 per month
California	●	1.00	6 per month without prior authorization
Colorado	●	.50-2.00	
Connecticut	●		
Delaware	●		
District of Columbia	●	1.00	
Florida	●		4 per month brand; unlimited generic
Georgia	●	0.50	5 per month without prior authorization
Hawaii	●		
Idaho	●		
Illinois	●		varies by drug
Indiana	●	3.00	
Iowa	●	1.00	
Kansas	●	2.00	
Kentucky	●		
Louisiana	●	.50-3.00	Viagra only (6 per month)
Maine	●	.50-3.00	
Maryland	●	1.00	
Massachusetts	●	0.50	
Michigan	●	1.00	
Minnesota	●		
Mississippi	●	1.00	10 per month
Missouri	●	.50-2.00	
Montana	●	1.00-2.00	
Nebraska	●	1.00	
Nevada	●		6 per month
New Hampshire	●	.50-1.00	
New Jersey	●		
New Mexico	●		
New York	●	.50-2.00	43 per year
North Carolina	●	1.00	6 per month
North Dakota	●		
Ohio	●		
Oklahoma	●	1.00-2.00	3 per month; unlimited for recipients under age 21
Oregon	●		
Pennsylvania	●	1.00	
Rhode Island	●		
South Carolina	●	2.00	4 per month
South Dakota	●	2.00	
Tennessee	●		7 per month
Texas	●		3 per month; unlimited for recipients under age 21, nursing home residents
Utah	●	1.00 (5.00/month limit)	
Vermont	●	1.00-2.00	
Virginia	●	1.00	
Washington	●		
West Virginia	●	.50-2.00	10 per month without prior authorization
Wisconsin	●	.50-1.00	
Wyoming	●	2.00	

Notes: ● State has the policy

Source: Renee Schwalberg and others, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2001), Tables 1, 5, 7. **Data current as of mid-2000**

Information for Arizona, conversation with Branch McNeil, Deputy Director, Arizona Health Care Cost Containment System, July 3, 2001. **Data current as of mid-2000**

Information for Colorado, Ohio (copay only), Oklahoma, Texas, and Wisconsin, National Pharmaceutical Council, *Pharmaceutical Benefits Under State Medical Assistance Programs* (Reston, VA: NPC, 2000), 4-48, 4-51. **Data current as of mid-2000**

Information for Ohio (limits only), conversation with Robert Reid, Pharmacy Program Coordinator, Ohio Department of Job and Family Services, July 3, 2001. **Data current as of mid-2000**

Information for Tennessee, "Copay Implementation Rules," March 7, 2001, [Online] http://www.state.tn.us/tenncare/copayimp.html; Tennessee Department of Finance and Administration, Bureau of TennCare, "General Rules: 1200-13-1-.03: Amount, Duration, and Scope of Assistance," March 2002 (Revised), [Online] http://www.state.tn.us/sos/rules/1200/1200-13/1200-13-01.pdf. **Data current as of mid-2000**

IV. REPRODUCTIVE HEALTH SERVICES

Reproductive health services are an integral component of women's health care. Women's reproductive health care needs have received considerable attention from state policymakers. In addition to mandating that private insurers cover services that are important to women's health and expanding access to reproductive health services under Medicaid, states have adopted a host of other provisions to facilitate or limit access to a range of reproductive health care services, including abortion and emergency contraception.

This chapter examines state policies that affect women's access to reproductive health services, specifically abortion and emergency contraception, as well as the practice of allowing health care providers, hospitals and other health facilities, employers and insurers exemptions from providing certain reproductive health services because of moral or religious objections. With increasing numbers of religious plans merging with non-sectarian plans, these policies will influence the extent of reproductive services available to women. (Note: information on private insurance coverage and Medicaid coverage of various reproductive health services is contained in several sections and tables of Chapters II and III.)

ABORTION

Access to abortion remains controversial at the national and state levels. The 1973 *Roe v. Wade* Supreme Court decision that legalized abortion and subsequent court rulings on abortion give states considerable latitude in setting policies that affect women's access to abortion services. States may constitutionally restrict access to pre-viability abortions as long as restrictions do not place an "undue burden" on a woman's constitutional right to abortion or endanger her health or life. After the point of fetal viability, states have more leeway to restrict abortion, but must not endanger the life and health of the woman. As a result, some laws dealing with abortion are designed to enhance access to services, while others are explicitly designed to limit access.

Clinic Access Laws

More than 90% of abortions are performed in clinics or physicians' offices.[149] Many clinics that provide abortion services have been targeted by abortion protestors, who sometimes intimidate patients in an effort to dissuade them from having abortions. The federal Freedom of Access to Clinic Entrances (FACE) Act prohibits acts of physical or psychological intimidation that impede access to clinics and reproductive health services for women and the health care workers who provide services.[150] States can pass additional laws to prosecute acts of violence or intimidation against clinic staff, patients and facilities; several states have passed such clinic access laws, however, most of them are not as protective as the federal FACE Act.

Regulation of Abortion Providers

In recent years, a number of states have adopted laws and regulations specific to abortion clinics and providers. These statutes and regulations usually apply to zoning, building codes, record keeping and administration. Advocates of these measures contend they help protect the health and safety of women receiving abortions, since most abortion clinics and providers fall outside of hospital or inpatient clinic licensing and regulatory procedures. However, abortion rights advocates fear that such laws are a back-door method of discouraging the provision of abortion by increasing providers' costs through expensive renovations or administrative requirements.[151]

TABLE IV-I CLINIC ACCESS LAWS AND ABORTION PROVIDER REGULATIONS

- 15 states and the District of Columbia have clinic access laws.
  - 14 states and the District of Columbia have limited clinic access laws.
  - Washington has a comprehensive clinic access law that expands protections found in the federal FACE act, allowing individuals to go to court to halt activities forbidden by the law and to sue accused violators for damages.
- 36 states have laws that specifically regulate abortion providers and clinics; some of these laws are enjoined or not enforced.

TABLE IV-1
Clinic Access Laws and Abortion Provider Regulations

State	Clinic Access Laws	Abortion Provider Regulations**
United States Total	15 + DC	36
Alabama		●
Alaska		●
Arizona		●
Arkansas		●
California	○	●
Colorado	○	
Connecticut	○*	●
Delaware		
District of Columbia	○	
Florida		●
Georgia		●
Hawaii		●
Idaho		●
Illinois		●
Indiana		●
Iowa		
Kansas	○	
Kentucky		●
Louisiana		●
Maine	○	
Maryland	○	
Massachusetts	○	●
Michigan	○	●
Minnesota	○	●
Mississippi		●
Missouri		●
Montana		●
Nebraska		●
Nevada	○	
New Hampshire		
New Jersey		●
New Mexico		
New York	○	●
North Carolina	○	●
North Dakota		●
Ohio		●
Oklahoma		●
Oregon	○	
Pennsylvania		●
Rhode Island		●
South Carolina		●
South Dakota		●
Tennessee		●
Texas		●
Utah		●
Vermont		
Virginia		●
Washington	●	
West Virginia		
Wisconsin	○	●
Wyoming		

Notes:

Clinic Access Laws:

- ● State has law
- ○ State has limited law
- * Does not have explicit law pertaining to clinics, but legislative history of Conn. Gen. Stat. § 53-37b clearly indicates that it was intended to serve that purpose. Statements on Senate Floor Concerning S.B. 1046 (June 2, 1993), at http://www.cga.state.ct.us.

Abortion Provider Regulations:

- ● State has law
- ** Some of these laws may be enjoined or not enforced.

Sources: National Conference of State Legislatures Health Policy Tracking Service unpublished data collected for this report (May 2002). **Data current as of December 2001**

Information on Abortion Provider Regulations, Center for Reproductive Law And Policy, *Targeted Regulation of Abortion Providers: Avoiding the "TRAP"* (New York: Center for Reproductive Law and Policy, October 2001). **Data current as of October 2001**

Post-Viability Bans

The U.S. Supreme Court has held that states may constitutionally ban or restrict abortions after the point of fetal viability except where necessary to preserve a woman's life or health.[152] State post-viability bans set a gestational age after which a woman cannot have an abortion (usually between 19 and 25 weeks), and most include life and health exceptions. The majority of states have passed such bans, though four of these laws have been found unconstitutional or unenforceable by a state attorney general.

Bans on So-Called "Partial-Birth" Abortion Procedures

A number of states have sought to ban what abortion rights opponents call "partial-birth" abortion. These bans generally claim to prohibit the dilation and extraction procedure (D&X), which is used in a small percentage of second trimester abortions, but is similar to the more common second trimester procedure, dilation and evacuation (D&E). Abortion rights supporters, however, state that these bans often cover more than just the D&X procedure. In 2000, the Supreme Court ruled that the Nebraska state "partial birth" abortion ban was unconstitutional, as it could be interpreted to prohibit a pre-viability D&E, consequently imposing an undue burden on a woman's right to terminate before viability, and it lacked an exception for cases where the health of the woman was at risk. In 2003, both houses of Congress passed national so-called "partial-birth" abortion bans. It is expected that a bill will be signed into law and that court challenges will follow.

TABLE IV-2 POST-VIABILITY AND SO-CALLED "PARTIAL BIRTH" ABORTION BANS

- 40 states and the District of Columbia have post-viability abortion bans.
  - Post-viability bans in 4 states have been enjoined by a court or found unenforceable by an attorney general.
- 36 states and the District of Columbia provide exceptions to their post-viability abortion bans.
  - 29 states and the District of Columbia provide exceptions for the life and health of the woman.
  - 3 states provide exceptions for the life and health of the woman and fetal abnormalities.
  - 1 state, Arkansas, provides exceptions for the life and health of the woman and rape.
  - 3 states, Idaho, Michigan and New York, provide an exception for life only.
  - 4 states provide no exceptions: California, Connecticut, Delaware and Rhode Island.
- 31 states have banned so-called "partial birth" abortion procedures.

TABLE IV-2
Post-Viability and So-Called "Partial-Birth" Abortion Bans

State	Post-Viability Bans		Bans on So-Called "Partial Birth" Abortion Procedures~
	Bans	Exemptions	
United States Total	**40 + DC**	**37**	**31**
Alabama	●	life and health	●
Alaska			●
Arizona	●	life and health	●
Arkansas	●	life, health, and rape	●
California	●	none	
Colorado			
Connecticut	●	none	
Delaware	⊙	none	
District of Columbia	●	life and health	
Florida	●	life and health	●
Georgia	●	life and health	●
Hawaii			
Idaho	●	life only	●
Illinois	●	life and health	●
Indiana	●	life and health	●
Iowa	●	life and health	●
Kansas	●	life and health	●
Kentucky	●	life and health	●
Louisiana	●	life and health	●
Maine	●	life and health	
Maryland	●	life, health, and fetal anomaly	
Massachusetts	●	life and health	
Michigan	●	life only	●
Minnesota	⊙	life and health	
Mississippi			●
Missouri	●	life and health	●
Montana	●	life and health	●
Nebraska	●	life and health	●
Nevada	●	life and health	
New Hampshire			
New Jersey			●
New Mexico			●
New York	●	life only	
North Carolina	●	life and health	
North Dakota	●	life and health	●
Ohio	⊙	life and health	●
Oklahoma	●	life and health	●
Oregon			
Pennsylvania	●	life and health	
Rhode Island	●	none	●
South Carolina	●	life and health	●
South Dakota	●	life and health	●
Tennessee	●	life and health	●
Texas	●	life, health, and fetal anomaly	
Utah	⊙	life, health, and fetal anomaly	●
Vermont			
Virginia	●	life and health	●
Washington	●	life and health	
West Virginia			●
Wisconsin	●	life and health	●
Wyoming	●	life and health	

Notes:

Post-Viability Bans:

- ● State has law
- ⊙ Law is enjoined or not enforced

So-Called "Partial-Birth" Abortion Bans:

- ● State has law
- ~ To the extent that these laws are like Nebraska's, ruled unconstitutional in Stenberg v. Carhart, 530 U.S. 914 (2000), they are unconstitutional and/or unenforceable.

Sources: National Conference of State Legislatures Health Policy Tracking Service unpublished data collected for this report (May 2002).
Data current as of December 2001

Injunction and enforcement data, Alan Guttmacher Institute, *State Policies in Brief* (Washington, D.C.: Alan Guttmacher Institute, April 2002).
Data current as of December 2001

Parental Consent and Notification Laws

Parental consent or notification laws require minor females to receive parental consent or to notify a parent or legal guardian before receiving an abortion. Most states with these laws apply them to girls under age 18, although several set the level to 16 or 17. Some states broaden the definition of who can consent for minors to stepparents, grandparents or other relatives such as adult siblings. Most states with parental consent or notification laws have a judicial bypass procedure that allows a minor to obtain an abortion without informing a parent if the court finds the individual is mature enough to make the decision or that informing her parents would endanger the girl. A few states allow health care providers to waive the requirement.

TABLE IV-3 PARENTAL CONSENT AND NOTIFICATION LAWS

- 43 states have parental consent or notification laws; 12 of these states do not enforce the law.
  - 23 states require parental consent before a female minor may have an abortion.
  - 21 states require parental notification before a female minor may have an abortion (Ohio has both consent and notification laws).
  - 7 states allow notification to or consent by an adult other than the minor's parents.
- 22 of the 23 states with parental consent laws have a judicial bypass; New Mexico does not have a judicial bypass.
- 15 of the 21 states with parental notification laws have a judicial bypass. Maryland, one of the 6 states without a judicial bypass, allows notification to be waived by the treating physician.

Mandatory Waiting Periods

Mandatory waiting period laws require that a woman seeking an abortion receive counseling and then wait a specified period of time before having the procedure. Most states with waiting period laws require a 24-hour wait between the time the woman states her intention of obtaining an abortion and the time the procedure can be performed.

TABLE IV-3 MANDATORY WAITING PERIOD LAWS

- 22 states have mandatory waiting periods before a woman may obtain an abortion; 4 of these laws are currently enjoined or not enforced.
  - 18 states require women to wait 24 hours before receiving an abortion.
  - 3 states require waiting periods of less than 24 hours; South Carolina's waiting period is one hour.
  - Tennessee has a two-day waiting period, but it is currently enjoined.

TABLE IV-3
Abortion Parental Consent/Notification and Mandatory Waiting Period Laws

	Parental Consent and Notification Laws			Mandatory Waiting Period Laws	
State	Parental Consent Law	Parental Notification Law	Age/Exceptions	Waiting Period Laws	Waiting Period
United States Total	**23**	**21**		**22**	
Alabama	●◆			●	24 hours
Alaska	⊙◆		under age 17		
Arizona	⊙◆				
Arkansas		○◆		●	(prior to and not on the same day as procedure)
California	⊙◆				
Colorado		⊙			
Connecticut					
Delaware		⊙◆	under age 16; allows notification to grandparent or mental health professional	⊙	24 hours
District of Columbia					
Florida		⊙◆			
Georgia		○◆			
Hawaii					
Idaho	●◆			●	24 hours
Illinois		⊙◆	Allows notice to grandparent or stepparent.		
Indiana	●◆			●	18 hours
Iowa		○◆	Allows notice to grandparent.		
Kansas		○◆		●	24 hours
Kentucky	●◆			●	24 hours
Louisiana	●◆			●	24 hours
Maine	●◆		Allows treating physician to determine that minor is mentally and physically capable of consenting.		
Maryland		○	Notification may be waived by treating physician.		
Massachusetts	●◆			⊙	24 hours
Michigan	●◆			●	24 hours
Minnesota		○◆			
Mississippi	●◆			●	24 hours
Missouri	●◆				
Montana		⊙◆		⊙	24 hours
Nebraska		○◆		●	24 hours
Nevada		⊙◆			
New Hampshire					
New Jersey		⊙◆			
New Mexico	⊙				
New York					
North Carolina	●◆		allows consent by grandparent		
North Dakota	●◆			●	24 hours
Ohio	⊙◆	○	Allows consent by adult sibling, grandparent or stepparent.	●	24 hours
Oklahoma		⊙			
Oregon					
Pennsylvania	●◆			●	24 hours
Rhode Island	●◆				
South Carolina	●◆		under 17; allows consent by grandparent	●	1 hour
South Dakota		○		●	24 hours
Tennessee	●◆			⊙	48 - 72 hours
Texas		○◆			
Utah		○		●	24 hours^
Vermont					
Virginia		○◆		●	24 hours
Washington					
West Virginia		○◆			
Wisconsin	●◆		Allows consent by sibling 25 years old or older, grandparent, aunt or uncle.	●	24 hours
Wyoming	●◆				

Notes:

Parental Consent/Notification Laws:

- ● State has a parental consent law
- ○ State has a parental notification law
- ⊙ Law is enjoined or not enforced
- ◆ Law has judicial bypass

Waiting Period Laws:

- ● State has law
- ⊙ Law is enjoined or not enforced
- ^ Waived if pregnancy is result of rape or incest, fetus has grave defects, or woman is under 15

Sources: National Conference of State Legislatures Health Policy Tracking Service unpublished data collected for this report (May 2002). **Data current as of December 2001**

Injunction and enforcement data, Alan Guttmacher Institute, State Policies in Brief (Washington, D.C.: Alan Guttmacher Institute, Feb. 2003). **Data current as of February 2003**

EMERGENCY CONTRACEPTION

Approximately half the pregnancies that occur in the U.S. each year are unintended.[153] Health experts estimate that as many as 1.7 million of the more than 3 million unintended pregnancies that occur annually could be prevented by the use of emergency contraception.[154] Emergency contraception is birth control that is used after unprotected sex or in the event of a known contraceptive failure, and must be used within days of unprotected sex to prevent pregnancy.[155] Two forms of emergency contraception are available in the United States. One method is a short-term, high dose of birth control pills, of which there are currently two FDA-approved forms of pre-packaged emergency contraception pills: Preven and Plan B. The second method of emergency contraception is the insertion of an intrauterine device. Both methods work by preventing the fertilized egg from implanting in the uterus. Emergency contraception pills will not end an established pregnancy.[156]

OB/GYNs and family practice physicians support the use of emergency contraception to prevent unintended pregnancy.[157] However, a survey of OB/GYNs found that just under one-third (31%) prescribed emergency contraceptive pills more than five times a year.[158] This section identifies ways that states can increase access to emergency contraceptive pills, including Medicaid coverage and special provisions for the administration of emergency contraception.

Medicaid Coverage

While all state Medicaid programs must cover family planning services, each state defines "family planning" for its own program, leading to variety in the services and contraceptive drugs and devices that are covered.[159] The FDA approved emergency contraception in 1997 as a safe and effective way to prevent pregnancy, and approved a pre-packaged, brand-name emergency contraceptive in 1998.[160] Just over half the states cover emergency contraception in their Medicaid programs.

Direct Access Through Pharmacies

Because emergency contraception only works within days of unprotected sex, the requirement of obtaining a prescription may pose a barrier to access; yet in most states, women must obtain a prescription from a physician for a dose of emergency contraception. Studies have found that many women seek emergency contraception on weekends or after normal business hours, and as a result have difficulty obtaining a prescription from a physician.[161] Many women's health organizations have been advocating for making emergency contraception available without a prescription to enhance its utility and because it meets some of the primary criteria for non-prescription usage–the condition at hand (unprotected sex) is easily diagnosed by the patient and the treatment regimen is easy to follow. In one such non-prescription effort, a few states are explicitly allowing pharmacists to offer emergency contraception directly to women seeking the medication without a prescription from a doctor.[162] Pharmacists typically operate at later hours than physicians and may be more easily accessible.

TABLE IV-4
Emergency Contraception

State	Medicaid Coverage⌘	Emergency Room Mandates for Sexual Assault Survivors	Pharmacist Provision of Emergency Contraception Without Physician Contact~
United States Total	**27 + DC**	**7**	**4**
Alabama			
Alaska	●		●
Arizona	●		
Arkansas			
California	●	●	●
Colorado			
Connecticut			
Delaware	●		
District of Columbia	●		
Florida			
Georgia	●		
Hawaii	●		
Idaho			
Illinois		●	
Indiana	●		
Iowa			
Kansas			
Kentucky	○		
Louisiana			
Maine			
Maryland	○		
Massachusetts	●		
Michigan	●		
Minnesota			
Mississippi	N/A		
Missouri	●		
Montana			
Nebraska	●		
Nevada	●		
New Hampshire			
New Jersey	●		
New Mexico	N/A	●	●
New York	●	●*	
North Carolina	●		
North Dakota	●		
Ohio		●*	
Oklahoma			
Oregon	●		
Pennsylvania	●		
Rhode Island	●		
South Carolina	●	●	
South Dakota			
Tennessee			
Texas			
Utah	○		
Vermont	●		
Virginia	●		
Washington	●	●	●
West Virginia			
Wisconsin	○		
Wyoming	N/A		

Notes:
- ● State has the policy
- ○ State has a limited policy (whether emergency contraception is covered by Medicaid depends on context of visit)
- ~ In these states, a woman may obtain emergency contraception from a pharmacy without first contacting a physician.
- N/A State did not respond to the survey
- * A health care provider electing not to provide EC must refer the patient to another provider.
- ⌘ The survey conducted for these data did not specifically ask states to define emergency contraception.

Sources: **Information on Medicaid Coverage,** The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2001), Table II-3, p.17. **Data current as of January 2000**

Information on Emergency Room and Pharmacist Provisions, Alan Guttmacher Institute, State Policies in Brief (New York: Alan Guttmacher Institute, February 2003); Information for New Mexico (pharmacy provision), New Mexico Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc., *The New Mexico Board of Pharmacy,* December 2002, [online] http://www.nabp.net/ftpfiles/newsletters/nm/nm122002.pdf. **Data current as of May 2003**

Emergency Room Mandates

There are an estimated 32,000 rape-related pregnancies annually in women over the age of 18.[163] However, studies have found that many hospitals do not routinely offer emergency contraception to women who have been raped. Some hospitals do not have a protocol for offering emergency contraception to rape survivors, and some religious facilities such as Catholic hospitals do not provide emergency contraception because of religious objections.[164] Some states have begun to mandate that emergency rooms provide information about and access to emergency contraception for women who have been raped.

TABLE IV-4 EMERGENCY CONTRACEPTION

- 27 states and the District of Columbia cover emergency contraception as a family planning service under their Medicaid program.
  - In 4 of these states, the context of the Medicaid beneficiary's visit determines if emergency contraception is covered as a family planning service.
- 4 states, Alaska, California, New Mexico and Washington, allow pharmacists to dispense emergency contraception without a prescription.
- 6 states require emergency room staff to administer emergency contraception to sexual assault survivors upon request; one state, Illinois, does not require provisionof emergency contraception, but does require hospitals to develop and implement protocols to ensure rape survivors receive medically accurate information about emergency contraception.

RELIGIOUS OR MORAL REFUSAL CLAUSES CONCERNING PROVISION OF REPRODUCTIVE HEALTH SERVICES

Women's access to reproductive health care is limited by providers' use of refusal clauses. Several states allow refusal clauses or exemptions to providers, employers, and/or insurers who have moral or religious objections to offering certain services. The federal Church Amendment, passed shortly after the Supreme Court's 1973 *Roe v. Wade* decision that legalized abortion, allows individual or institutional health care providers that receive federal funding or who work for entities receiving such funding, to refuse to perform or assist in performing abortions if these procedures conflict with their individual or their facilities' religious or moral convictions.[165] By 1974, more than half the states had also adopted such provisions, allowing providers to deny provision of abortion services.[166] During the mid-to-late 1970s, many states adopted laws that allowed refusal clauses for contraception and sterilization as well.[167]

The Church Amendment also prohibits discrimination against health care providers because of their nonparticipation. The law, however, does not provide criteria for determining when a health care facility may claim a religious or moral refusal clause, resulting in great variation among states in how they allow use of these exemptions.

The scope of these exemptions has broadened over the last 30 years, from individual clinicians and facilities to entities such as insurers and employers seeking so-called "conscience" exemptions from a range of medical services, as well as more indirect forms of involvement in reproductive health care, such as providing insurance coverage for contraception.[168] A wave of mergers between secular and non-secular institutions and the participation of some Catholic managed care organizations in state Medicaid programs has spurred the claim of refusal clauses and has raised questions about the impact of these exemptions on access.[169] As a result, states are struggling to reconcile the interests of providers seeking these exemptions, patients who expect comprehensive care, and state requirements regarding health care providers who receive public funding.[170]

A number of states that allow refusal clauses require written notification of the intent to refuse to provide reproductive health services. Some states require notification only for refusal to provide abortion and/or sterilization services, while a small number of states require notification for refusal to participate in any reproductive health service. Many of the exemptions tied to contraceptive and infertility coverage mandates require that the entity notify consumers in writing of their refusal to participate in the service.

This section examines moral and religious-based exemptions as they pertain to abortion, family planning services, and infertility coverage.

Religious or Moral Refusal Clauses Concerning Abortion Services

Abortion was the first service that became subject to refusal clauses under the Church Amendment. Since then, most states have passed their own laws allowing for providers to invoke refusal clauses. These state laws often move beyond the federal law, allowing exemptions for both public and private entities; however, some states have concluded that these exemption laws apply only to private institutions, since public institutions must comply with state constitutional privacy and reproductive rights laws.[171] The majority of exemptions require the service to be provided if a woman's life is in danger. The majority of states also protect exempted providers from discrimination; fewer than ten provide anti-discrimination protection for those who do perform abortions.[172]

TABLE IV-5 REFUSAL CLAUSES CONCERNING ABORTION SERVICES

- 45 states allow individual health care providers to refuse to perform or participate in abortions; North Carolina allows exemptions only for doctors and nurses.
- 21 states allow any health facility to refuse to perform or participate in abortions.
- 20 states allow only hospitals to refuse to perform or participate in abortions.
- A total of 41 states allow both individual and institutional exemptions.
- 23 states allow providers to refuse providing abortion services for any reason; 21 states allow refusal clauses for religious or moral reasons and Colorado provides a refusal clause only for religious reasons.
- Federal or state courts in 2 states have ruled state abortion exemptions unconstitutional because they found that when applied to public facilities, or facilities serving a similar purpose, they amounted to an unconstitutional interference with the right to an abortion, as well as other state and federal constitutional rights.

TABLE IV-5
Religious or Moral Refusal Clauses Concerning Abortion Services

State	Exempted Individuals/Entities: Individual Health Care Providers	Exempted Entities: Any Health Facility	Exempted Entities: Hospitals Only	Basis for Exemption
United States Total	**45**	**21**	**20**	
Alabama				
Alaska	●		●◆	any
Arizona	●	●		religious/moral
Arkansas	●		●	any
California	●			religious/moral
Colorado	●		●	religious
Connecticut	●			any
Delaware	●		●	any
District of Columbia				
Florida	●	●		religious/moral
Georgia	●	●		religious/moral
Hawaii	●		●	any
Idaho	●		●	religious/moral
Illinois	●	●		any
Indiana	●		●	religious/moral
Iowa	●		●**	religious/moral
Kansas	●		●	any
Kentucky	●	●		religious/moral
Louisiana	●	●		any
Maine	●	●		any
Maryland	●		●	any
Massachusetts	●	●**		religious/moral
Michigan	●	●		religious/moral
Minnesota	●	●**		any
Mississippi				
Missouri	●		●	religious/moral
Montana	●	●		religious/moral
Nebraska	●	●		any
Nevada	●	●		religious/moral
New Hampshire				
New Jersey	●	●^		any
New Mexico	●		●	religious/moral
New York	●			religious/moral
North Carolina	●*	●		religious/moral
North Dakota	●		●	any
Ohio	●		●	any
Oklahoma	●		●**	any
Oregon	●		●**	any
Pennsylvania	●	●**		religious/moral
Rhode Island	●			religious/moral
South Carolina	●	●**		any
South Dakota	●		●	any
Tennessee	●		●	any
Texas	●	●**		any
Utah	●		●**	religious/moral
Vermont				
Virginia	●	●		religious/moral
Washington	●	●**		any
West Virginia				
Wisconsin	●		●	religious/moral
Wyoming	●	●**		any

Notes:
- ● State allows moral/religious exemption
- * Doctors and nurses only
- ** Applies to private entities only
- ^ A court has ruled these provisions unconstitutional as applied to non-sectarian, non-profit hospitals. *Doe v. Bridgeton Hospital Association,* 366 A.2d 641 (NJ 1976), cert. Denied, 433 U.S. 914 (1977).
- ◆ A court has ruled this law unconstitutional as applied to "quasi-public" institutions and has issued a permanent injunction. *Valley Hospital Association v. Mat-Su Coalition for Choice*, 948 P. 2d 963 (Alaska 1997).

Source: National Conference of State Legislatures Health Policy Tracking Service, "Conscience Clause: Abortion," unpublished data collected for this report (December 2001). **Data current as of December 2001**

Religious or Moral Refusal Clauses Concerning Family Planning Services

A number of states allow religious and moral exemptions from providing reproductive health services other than abortion. Some health care organizations such as hospitals and HMOs sponsored by religious institutions, particularly Catholic organizations, argue that the provision of contraception and contraceptive sterilization conflicts with the tenets of their religion. In addition, some religious employers have also sought exemptions from state contraceptive coverage mandates.[173]

TABLE IV-6 REFUSAL CLAUSES CONCERNING FAMILY PLANNING SERVICES

- 22 states allow individual health care providers exemptions from providing family planning services.
  - 12 states allow exemptions for religious or moral reasons, 7 allow exemptions for religious reasons and 3 allow exemptions for any reason.
  - 8 states allow providers to withhold information and/or counseling about contraceptives.
  - 8 of the state laws are limited to sterilization services.
- 27 states allow exemptions for various health care entities from providing family planning services; some states allow exemptions for more than one category of provider.
  - 12 states allow exemptions for any health facility: 7 for moral or religious reasons, 4 for religious reasons and 1 for any reason; 6 of the laws are limited to sterilization and 7 apply only to private entities.
  - 6 states allow exemptions for hospitals only: 3 only for moral reasons and 3 for religious reasons only; 3 of the laws are limited to sterilization.
  - 12 states allow exemptions for employers: 11 only for religious reasons and 1 for moral or religious reasons.
  - 4 states allow exemptions for insurers: 2 for moral or religious reasons and 2 only for religious reasons.

TABLE IV-6
Religious or Moral Refusal Clauses Concerning Family Planning Services

State	Exempted Entities: Individual Health Care Providers	Any Health Facility	Hospitals Only	Employers	Insurers
United States Total	**22**	**12**	**6**	**12**	**4**
Alabama					
Alaska					
Arizona				⊙	
Arkansas	●	●~			
California				⊙	
Colorado	⊙*	⊙*~			
Connecticut				⊙	●
Delaware				⊙	
District of Columbia					
Florida	⊙*				
Georgia	⊙*				
Hawaii				⊙	
Idaho	●**		●**		
Illinois	●*	●*			
Indiana					
Iowa					
Kansas	○**	○**			
Kentucky	●**	●**			
Louisiana					
Maine	⊙*	⊙*~		⊙	
Maryland	○**		○**	⊙	
Massachusetts	●* **	●* **~		⊙	
Michigan					
Minnesota	○* (state employees only)				
Mississippi					
Missouri				●	●
Montana	●* **	●* **~			
Nebraska					
Nevada					⊙
New Hampshire					
New Jersey	●		●		
New Mexico		●**		⊙	
New York	● (social service employees only)				
North Carolina			○**	⊙	
North Dakota					
Ohio					
Oklahoma					
Oregon	● (Dept. of Human Services employees only)				
Pennsylvania	●**	●**~			
Rhode Island	●**			⊙	
South Carolina					
South Dakota					
Tennessee	⊙*	⊙*~			
Texas					⊙
Utah					
Vermont					
Virginia			⊙*		
Washington					
West Virginia	⊙	⊙			
Wisconsin	●		●		
Wyoming	⊙				

Notes:
- ● State allows moral/religious exemption
- ○ State allows exemption for any reason
- ⊙ State allows religious exemption
- * Individual providers allowed to withhold information/counseling about contraceptives.
- ** Law is limited to sterilization
- ~ Applies to private entities only

Sources: National Conference of State Legislatures Health Policy Tracking Service, "Conscience Clause: Family Planning/Contraceptive Coverage, 2002," unpublished data collected for this report (December 21, 2001). **Data current as of December 2001**

Information on Employers and Insurers, National Women's Law Center, unpublished data collected for this report (on file with NWLC); Alan Guttmacher Institute, State Policies in Brief (New York: Alan Guttmacher Institute, April 2002). **Data current as of May 2002**

Religious or Moral Refusal Clauses Concerning Infertility Treatment Mandates

A number of laws that require coverage for the treatment of infertility allow employers or insurers to refuse to provide coverage based on moral or religious objections. Unlike many of the abortion and contraception exemptions, which tend to be broader in reach, infertility exemptions are found exclusively within infertility treatment mandates and apply only to religious entities.

TABLE IV-7 REFUSAL CLAUSES CONCERNING INFERTILITY TREATMENT MANDATES

- 5 of the 15 states that mandate private insurance coverage for treatment of infertility allow religious and/or moral exemptions for religious entities.
  - 2 states allow exemptions for religious employers and insurers, 2 states allow exemptions for employers only and 1 for insurers only.
  - 2 states allow exemptions for religious or moral reasons and 3 for religious reasons.

✶ ✶ ✶

Reproductive health services have long been subject to political, judicial, religious and moral debate. Consequently, this has generated high levels of state regulation, particularly on access to abortion. Reproductive health care is an integral component of women's total health care needs, yet women face numerous limits on access to vital services.

Foremost, states have imposed heavy restrictions on abortion services, with the majority of states maintaining provider regulations, bans on certain abortion procedures, and parental consent and notification laws. Many states also have waiting periods before a woman may receive an abortion. These restrictions operate in different ways toward the same goal of erecting barriers to women seeking abortions. Conversely, far fewer states have passed clinic access laws, which facilitate access to abortion.

About half of state Medicaid programs provide coverage for emergency contraception. Very few states have moved to facilitate broader access to EC though, either through emergency room mandates for sexual assault survivors or through direct pharmacy offering without a physician visit.

States have also limited access to reproductive health care for women by broadly allowing providers to invoke religious or moral exemptions from providing important reproductive health services. The majority of states allow individual providers to decline provision of abortion services for religious or moral reasons. Though several of these states require that women be notified about alternate providers, many women have limited means to seek out alternate providers or are in areas that have few providers to begin with. These exemptions have also been extended to withhold basic family planning services, including contraception.

TABLE IV-7
Religious or Moral Refusal Clauses Concerning Infertility Treatment Coverage

State	Exempted Entity		Basis for Exemption
	Religious Employer	Religious Insurer	
United States Total	**4**	**3**	
Alabama			
Alaska			
Arizona			
Arkansas			
California	●	●	religious/moral
Colorado			
Connecticut			
Delaware			
District of Columbia			
Florida			
Georgia			
Hawaii			
Idaho			
Illinois		●	religious/moral
Indiana			
Iowa			
Kansas			
Kentucky			
Louisiana			
Maine			
Maryland	●		religious
Massachusetts			
Michigan			
Minnesota			
Mississippi			
Missouri			
Montana			
Nebraska			
Nevada			
New Hampshire			
New Jersey	●		religious
New Mexico			
New York			
North Carolina			
North Dakota			
Ohio			
Oklahoma			
Oregon			
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota			
Tennessee			
Texas	●	●	religious
Utah			
Vermont			
Virginia			
Washington			
West Virginia			
Wisconsin			
Wyoming			

Notes: ● State has the policy

Source: "Conscience Clause: Infertility, Insurer Notice and Exemption Requirements," National Conference of State Legislatures Health Policy Tracking Services unpublished data collected for this report (December 31, 2001). **Data current as of December 2001**

V. OTHER WOMEN'S HEALTH-RELATED SERVICES

Ensuring that state policies allow women to access the full range of needed health services requires attention to a wide range of policy areas and issues. Many important public health services do not fall into a distinct funding stream or program area, yet these services are crucial for developing the infrastructure needed to meet women's total health care needs.

Beyond administering Medicaid and regulating private insurance, states can create programs that support healthy lifestyles for women. Some states have laid the groundwork for coordinating and overseeing some of these services through offices of women's health. Some states have done this through a more formalized structure where others have set up offices or commissions within health agencies. States can facilitate access to health-related services that address specific threats to women's health, such as violence, HIV/AIDS, or help with costs of prescription drugs for seniors. These programs are often critical for women and help fill the gaps left by programs such as Medicaid, Medicare, and private insurance.

The following chapter looks at state offices of women's health, and examines state policies on violence against women, women and HIV, and prescription drug access.

OFFICES OF WOMEN'S HEALTH

A state office of women's health can assist states in addressing women's health access issues. These offices can develop a state's agenda on women's health issues; provide policy guidance to the governor's office, state legislature, and the state department of health; serve as a clearinghouse and resource for information on women's health for the public; and fund direct health care services.

The effectiveness and scope of responsibility of women's health offices varies considerably. Most offices provide policy analysis to officials in the department of health, provide referrals for services and public education, and coordinate research and data collection on women's health issues. Some offices provide direct services, including breast and cervical cancer screenings and bone density screenings. Some offices exclude reproductive health services, because these services are often provided through Title X program offices or other state health offices. Some women's health offices report directly to the state health department, while others report to lower level officials.

TABLE V-1 STATE OFFICES OF WOMEN'S HEALTH

- 13 states have offices of women's health created by the legislature, executive order or administrative action.
  - The offices have budgets ranging from $70,000 to more than $5 million; 6 of the 13 receive direct funding that must be used for these offices.
  - Staffing ranges from no full-time employees to 15 employees.

TABLE V-1
State Offices of Women's Health

State	Office of Women's Health	How Established	Receives Direct Funding	FY 2002 Budget ($)	Staffing (Full-Time Employees)	Scope of Responsibility
United States Total	**13**		**6**			
Alabama						
Alaska						
Arizona						
Arkansas						
California	●	executive order	yes	940,000	10	Policy analysis and advocacy, service referrals, public education, research and data collection.
Colorado						
Connecticut						
Delaware	●	legislation	no	--	1	Service referrals, research and data collection; office also houses Title X Family Planning grant program.
District of Columbia						
Florida						
Georgia	●	legislation	yes	500,000	--	Develops state plan to address women's health issues, conducts education and awareness activities, serves as clearinghouse for information, provides referrals, collects data; excludes reproductive health issues.
Hawaii						
Idaho						
Illinois	●	administrative action	yes	5,600,000	15	Serves as clearinghouse, conducts research and data collection, provides grants to local health departments and community organizations; excludes reproductive & maternal health and domestic violence.
Indiana	●	legislation	yes	175,000	5	Screenings, service referrals, research and data collection; excludes reproductive health services.
Iowa						
Kansas						
Kentucky	●	legislation	no	--	3	Resource center for all aspects of women's physical and mental health.
Louisiana						
Maine						
Maryland	●	executive order	yes	300,000*	3 *	Service referrals, research and data collection; includes reproductive health.
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri	●	administrative action	no	--	2	Office advises director of state Health Department on women's health issues; also provides referrals, facilitates coordination of services, and provides consultation on research and data collection.
Montana						
Nebraska	●	legislation	no	--	2	Serves as clearinghouse, conducts strategic planning and policy analysis, coordinates pilot projects, provides referrals and technical assistance on women's health issues.
Nevada						
New Hampshire						
New Jersey						
New Mexico						
New York						
North Carolina	●	legislation	no	--	0	Office provides advocacy on women's health issues.
North Dakota						
Ohio	●	legislation	no	361,000	4	Service referrals, research and data collection.
Oklahoma						
Oregon						
Pennsylvania						
Rhode Island						
South Carolina						
South Dakota						
Tennessee	●	legislation	no	--	0	Provides direct services and referrals; statute also authorizes office to make policy recommendations to the Commissioner of Health, conduct education and outreach activities, and perform data collection and analysis; houses Title X Family Planning grant program.
Texas						
Utah						
Vermont						
Virginia						
Washington						
West Virginia						
Wisconsin	●	legislation	yes	68,500	1.5	Office provides leadership and consultation for state Health Department on women's health issues.
Wyoming						

Notes: ● State has an Office of Women's Health
* Due to a budget shortfall and hiring freeze, funds allocated by the governor have not been distributed and staff positions not filled.
-- Data not available from the state

Source: National Conference of State Legislatures Health Policy Tracking Service, "Offices of Women's Health Requirements," unpublished data collected for this report.
Data current as of May 2002

VIOLENCE AGAINST WOMEN

Violence against women, including domestic violence and sexual assault, is a critical but often neglected women's health issue. Nearly one-third of American women (31%) report being physically or sexually abused by a husband or boyfriend at some point in their lives.[174] In addition, nearly one-fifth of women (18%) reported experiencing a completed or attempted rape at some time in their lives.[175] There are several ways that states can facilitate access to assistance for victims of violence and lessen the impact of violence. The three types of policies described below provide examples of how states can assist victims of domestic violence and sexual assault.

Domestic Violence Health Care Protocols, Screening, and Training

The medical care system can be an important venue for identifying and providing assistance to victims of domestic violence. Each year, more than 1 million women seek medical care for injuries related to battering.[176] Furthermore, about one-third of women who seek care in emergency rooms do so because of injuries inflicted by a violent partner.[177] Health care providers are in a unique position to identify women who are victims of violence and health care settings can provide safety and privacy for women who have been abused. However, women who have experienced violence are more likely to have unmet medical needs.[178] Some states require that providers screen for domestic violence and mandate the development of protocols to assist health care providers in identifying and treating domestic violence victims. States can also give training to providers in detecting abuse and providing health care to victims.

Sexual Assault Training for Health Care Providers, Police, and Prosecutors

Recognizing that survivors of sexual assault have unique needs when seeking health care and interacting with law enforcement, some states require that health care providers, police personnel, and prosecutors receive special training to assist sexual assault victims. This training improves evidence collection, increases sensitivity to survivors and reduces further trauma, and encourages survivors to seek legal redress.

TABLE V-2 VIOLENCE PROTOCOLS, TRAINING AND SCREENING FOR HEALTH CARE PROVIDERS AND LAW ENFORCEMENT PERSONNEL

- 9 states require domestic violence treatment protocols, 3 states require screening for domestic violence and 11 states require provider training.
  - 3 states, California, New York and Pennsylvania, require protocols, screening and provider training.
- 7 states require training of health care providers to assist survivors of sexual assault and 14 states require training of police and/or prosecutors to assist survivors of sexual assault.
  - 6 states require training for both health care providers and police/prosecutors.

TABLE V-2
Violence Protocols/Training/Screening and Insurance Anti-Discrimination Laws

	Domestic Violence Health Care Provider Protocols, Screening and Training			Insurance Anti-Discrimination Laws				Sexual Assault Health Care Provider, Police/Prosecutor Training	
State	Protocols	Screening	Training	Health	Life	Disability	Property/ Casualty	Health Care Provider	Police/ Prosecutor
United States Total	**9**	**3**	**11**	**40**	**34**	**26**	**26**	**7**	**14**
Alabama				●	●	●	●		
Alaska	●		●	●	●	●	●	●	●
Arizona				●	●	●	●		
Arkansas									
California	●	●	●	●	●	●	●	●	●
Colorado				●	●	●	●		
Connecticut				●				●	●
Delaware				●	●	●	●		
District of Columbia									
Florida			●	●	●	●	●		●
Georgia				●	●	●	●		
Hawaii				●	●	●	●		
Idaho									
Illinois				●	●	●		●	●
Indiana				●	●	●			
Iowa	●			●	●	●	●		
Kansas				●	●		●		
Kentucky			●	●			●	●	●
Louisiana				●					
Maine				●	●	●			
Maryland				●	●				●
Massachusetts				●	●	●	●		●
Michigan				●	●				
Minnesota				●	●				
Mississippi									
Missouri				●	●	●	●		
Montana				●	●	●	●		
Nebraska				●	●	●	●		
Nevada				●					
New Hampshire	●		●	●	●	●	●		
New Jersey				●					●
New Mexico				●	●	●	●		●
New York	●	●	●	●	●	●	●	●	●
North Carolina									
North Dakota							●		
Ohio	●		●	●	●				●
Oklahoma			●						
Oregon				●	●	●	●		
Pennsylvania	●	●	●	●	●	●	●	●	
Rhode Island				●	●				
South Carolina									
South Dakota									
Tennessee				●					
Texas	●			●	●				●
Utah				●	●	●			
Vermont									
Virginia				●	●	●	●		
Washington			●	●	●	●	●		●
West Virginia	●		●	●	●		●		
Wisconsin				●	●	●	●		
Wyoming									

Note: ● State has the policy

Sources:

Domestic Violence Health Care Provider Protocols, Screening and Training:
Family Violence Prevention Fund, State-by-State Report Card on Health Care Laws and Domestic Violence (San Francisco: Family Violence Prevention Fund, 2001), [Online] http://endabuse.org/statereport/list.php3. **Data current as of August 2001**

Insurance Anti-Discrimination Laws:
Terry Fromson and Nancy Durburow, Insurance Discrimination Against Victims of Domestic Violence (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998), updated with data from Terry Fromson, Women's Law Project (February 2002). **Data current as of February 2002**

Sexual Assault Health Care Provider, Police/ Prosecutor Training:

Neal Miller, Review of State Sexual Assault Laws, 1998 Legislative Codes (Alexandria: Institute for Law and Justice, 1999), [Online] http://www.ilj.org/sa/sexaltpr.htm.

Neal Miller, 1999 Domestic Violence, Stalking, and Sexual Assault Legislation: State by State Analysis of 1999 Legislation (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/99StateLawUpdate.htm.

Neal Miller, 1999 Violence Against Women Legislation (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/99SessionLaw.htm.

Neal Miller, A Review of State Domestic Violence Related Legislation: A Law Enforcement and Prosecution Perspective (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/vawa1.html.

Neal Miller, 2000 Legislative Session: Violence Against Women Legislation (Alexandria: Institute for Law and Justice, 1999), [Online] http://www.ilj.org/dv/2000SessionLaw.pdf. **Data current as of November 2000**

Insurance Anti-Discrimination Laws

States can also assist domestic violence victims through laws that prohibit insurance discrimination based on a history of domestic violence. Although federal law prohibits insurers' use of domestic violence as a pre-existing condition exclusion,[179] a 1994 U.S. House Judiciary subcommittee found that half of the nation's 16 largest insurers considered a history of domestic violence when issuing policies and setting rates.[180] These practices may discourage victims from seeking help for fear of losing their insurance coverage if the abuse is reported to a health provider or law enforcement official. States can offer greater protection with laws that prohibit insurers from using a history of domestic violence victimization when selling insurance. Various states have enacted such laws with regard to four types of insurance: health, life, disability and property/casualty.

TABLE V-2 DOMESTIC VIOLENCE INSURANCE ANTI-DISCRIMINATION LAWS

- 40 states prohibit discrimination in health insurance policies based on a history of domestic violence, 34 states prohibit discrimination in life insurance policies, 26 states prohibit discrimination in property/casualty insurance, and 26 states prohibit discrimination in disability insurance.
  - 22 states prohibit discrimination based on a history of domestic violence in all four types of insurance.

WOMEN AND HIV/AIDS

The AIDS epidemic has taken a growing toll on women, especially minority and low-income women, since the disease was identified in 1981. Women represent an estimated 30% of new HIV infections in the United States.[181] In just over a decade, the percentage of all new AIDS cases among adult and adolescent women has more than tripled, from 7% of all AIDS cases in 1986 to 26% of all AIDS cases in 2001.[182] The incidence of AIDS has increased most dramatically among women of color, with African-American and Latina women accounting for 81% of these new infections.[183] While HIV/AIDS affects women of all ages, it is most common among women in their childbearing years. In 1999, 86% of all new cases of AIDS reported in women were among those ages 20 to 49.[184]

HIV Testing of Pregnant Women

The finding that the anti-AIDS drug AZT can dramatically reduce the likelihood of perinatal transmission of HIV increased the drive to identify pregnant women who are HIV positive.[185] However, as of 2001, 44% of pregnant women did not receive an HIV test.[186] In 1995, the U.S. Public Health Service (PHS) issued guidelines recommending universal counseling and voluntary HIV testing of all pregnant women.[187] Since 1995, these guidelines have been revised, most recently in 2003, to state that HIV testing should be a routine part of prenatal care for all women regardless of risk and to encourage states to require automatic testing for pregnant women, unless a woman specifically refuses the test.[188] The issue of whether HIV testing for pregnant women should be voluntary or mandatory has remained controversial. All states and the District of Columbia have certified to the CDC that they have measures in place to implement the 1995 PHS guidelines, which state that testing must be voluntary and that informed consent must be obtained as per relevant state laws.[189] Some states have already gone beyond these guidelines and have passed laws that require automatic testing of pregnant women with provisions for women to specifically opt out and refuse the test. Other states require providers to offer the test to pregnant women.

TABLE V-3 HIV TESTING OF PREGNANT WOMEN

- 7 states automatically test pregnant women for HIV unless a woman specifically refuses the test.
- 11 states require providers to offer HIV tests to pregnant women.
- 32 states and the District of Columbia have voluntary testing as per the CDC's 1995 guidelines.

TABLE V-3
HIV Testing of Pregnant Women

State	Providers Required to Test Unless Woman Refuses	Providers Required to Offer Test	Voluntary Testing
United States Total	**7**	**11**	**32 + DC**
Alabama			●
Alaska			●
Arizona			●
Arkansas	●		
California		●	
Colorado			●
Connecticut	●		
Delaware			●
District of Columbia			●
Florida		●	
Georgia			●
Hawaii			●
Idaho			●
Illinois			●
Indiana		●	
Iowa		●	
Kansas			●
Kentucky		●	
Louisiana		●	
Maine			●
Maryland		●	
Massachusetts			●
Michigan	●		
Minnesota			●
Mississippi			●
Missouri			●
Montana			●
Nebraska			●
Nevada			●
New Hampshire			●
New Jersey		●	
New Mexico	●*		
New York	●		
North Carolina			●
North Dakota			●
Ohio			●
Oklahoma			●
Oregon			●
Pennsylvania			●
Rhode Island		●	
South Carolina			●
South Dakota			●
Tennessee	●		
Texas	●		
Utah			●
Vermont			●
Virginia		●	
Washington		●	
West Virginia			●
Wisconsin			●
Wyoming			●

Note: ● State has the policy
* Effective June 20, 2003

Source: The Henry J. Kaiser Family Foundation, "HIV Testing for Mothers and Newborns, 2000," State Health Facts Online, [Online] http://www.statehealthfacts.kff.org, citing National Conference of State Legislatures, Health Policy Tracking Service, updated per correspondence with Lillian MacEachern, National Conference of State Legislatures, May 2002. **Data current as of April 2003**

AIDS Drug Assistance Programs

Since 1987, the federal government has provided funds to every state and the District of Columbia to help the uninsured and underinsured with HIV/AIDS pay for medications. States administer these AIDS Drug Assistance Programs (ADAP) and establish income eligibility rules and guidelines for covered medications. Most states provide additional state funds for ADAPs, but are not required to do so in order to receive federal funds.[190] ADAPs grew in size and importance in the mid-1990s with the development of more effective medications to treat HIV/AIDS.

ADAPs are an important resource for women of modest resources who are living with HIV/AIDS. More than one-fifth (21%) of HIV-positive women age 18 and older are uninsured and nearly two-thirds earn less than $10,000 annually.[191] Women represented 21% of ADAP clients as of June 2001.[192] Women's representation in ADAP ranges from a low of 6% in New Mexico, to a high of 34% in New Jersey.[193]

TABLE V-4 ADAP INCOME ELIGIBILITY LEVELS

- 50 states and the District of Columbia have AIDS Drug Assistance Programs.
- Eligibility for ADAPs is based on income; requirements range from 125% to 500% of the FPL.

TABLE V-4
ADAP Income Eligibility Levels

State	Income Eligibility (% FPL)
United States Total	
Alabama	250
Alaska	300
Arizona	300
Arkansas	300*
California	400
Colorado	300
Connecticut	400
Delaware	500+
District of Columbia	300
Florida	350
Georgia	300**
Hawaii	400
Idaho	200***
Illinois	400
Indiana	300
Iowa	200
Kansas	300
Kentucky	300
Louisiana	200
Maine	300
Maryland	400
Massachusetts	<$50,000 per year
Michigan	450
Minnesota	300
Mississippi	400
Missouri	300
Montana	300
Nebraska	200
Nevada	400
New Hampshire	300
New Jersey	500
New Mexico	300
New York	<$44,000 per year
North Carolina	125
North Dakota	400
Ohio	300
Oklahoma	200
Oregon	200
Pennsylvania	<$30,000 per year
Rhode Island	400
South Carolina	300***
South Dakota	300
Tennessee	300
Texas	200
Utah	200
Vermont	200
Virginia	300/333~***
Washington	300
West Virginia	250
Wisconsin	300
Wyoming	200

Notes: FY 2002 Eligibility
- * To be medically eligible, the individual must have a CD4 cell count <350 or a viral load of >55,000.
- ** To be medically eligible, the individual must have a CD4 cell count <500 and a viral load of >55,000.
- *** To be medically eligible, the individual must have a CD4 cell count <500.
- \+ Delaware has a sliding scale up to 500% of the FPL.
- ~ 333% for Northern Virginia only
- FPL 100% of the federal poverty level was $8,860 for a family of one in 2002.

Source: National ADAP Monitoring Project, *Annual Report,* (Menlo Park: The Henry J. Kaiser Family Foundation, April 2003), [Online] http://www.kff.org/content/2003/20030430a/6071v2.pdf. **Data current as of June 2002**

PRESCRIPTION DRUG COVERAGE

In addition to Medicaid assistance with prescription drug coverage, states can develop separate programs to help alleviate some of the barriers to accessing prescription medications for women who are not covered by Medicaid. Women, particularly women over age 65, are disproportionately affected by the crisis in affordable medications, as women are more likely to use prescription drugs, make up a greater share of older Medicare beneficiaries, and are poorer.[194] Hence, women over age 65 spend 20% more for prescription drugs than men the same age.[195]

Non-Medicaid State Pharmacy Assistance Programs

To aid with the gaps in prescription drug coverage, many states have established their own drug assistance programs. (Information on state Medicaid programs' coverage of prescription drugs is contained in Chapter III and Table III-11.) Targeted to low-income Medicare beneficiaries and people with disabilities who do not qualify for Medicaid assistance, these programs vary significantly in their structure, eligibility requirements and benefits. Most offer direct subsidies for enrollees, but some are discount programs that allow enrollees to purchase prescriptions at a reduced rate at pharmacies participating in the program. Some programs require a one-time or annual membership fee and some require a copayment.

TABLE V-5 STATE PHARMACY ASSISTANCE PROGRAMS

- 32 states and the District of Columbia have state-sponsored pharmacy assistance programs for low-income seniors and people with disabilities who receive Medicare but do not qualify for Medicaid.
  - 8 of the pharmacy assistance programs are discount programs.
- 12 states have programs that are not yet operational.

✶ ✶ ✶

This chapter speaks to the struggle that states have in moving beyond federal mandates, and taking advantage of tremendous opportunities to proactively close some of the gaps in women's health care access. A state office on women's health can provide the infrastructure and leadership to coordinate a concerted effort to increase women's access to health care, but few states have created such offices, and many existing offices have limited resources and influence.

States have taken measures to address the widespread incidence of violence against women by recognizing the importance of training the medical and justice systems to better serve survivors of violence. The majority of states explicitly prohibit insurers from discriminating against victims of domestic violence in the provision of health, life, disability, or property/casualty insurance coverage.

States have played a role in addressing the epidemic of HIV/AIDS among women. Most states have implemented voluntary testing programs for pregnant women, which has helped dramatically reduce the incidence of mother-to-child transmission in the U.S. ADAPs and other state pharmacy assistance programs help low-income HIV/AIDS patients and seniors acquire costly medications, but the current state fiscal crises threaten such programs' long-term solvency.

TABLE V-5
Non-Medicaid State Pharmacy Assistance Programs

State	State-Funded Program[&]	Age/Disability Status Requirements	Annual Income Limit (Single/Married) ($)	Cost-Sharing	Notes
United States Total	**32 + DC**			**18**	
Alabama					
Alaska					
Arizona	○	Medicare eligible	17,180		Must reside in county w/o HMO prescription drug coverage.
Arkansas	○^	65	6,872		Waiver authorized by state; not yet approved by federal govt.
California	●	Medicare beneficiaries	none	discount program~	
Colorado					
Connecticut	●	65/disabled: >18 on SSI or SSDI	20,000/27,100		
Delaware (1)	●	65/disabled: SSDI-eligible	16,488/22,128		
Delaware (2)	●	65	12,500/17,125		
District of Columbia	●		17,180		Must be patient of DC Healthcare Alliance & ineligible for other drug ben. program.
Florida (1)	●	65: eligible for both Medicare and Medicaid	10,200		
Florida (2)	●	Medicare beneficiaries	none	discount program	
Georgia					
Hawaii					
Idaho					
Illinois (1)	●	65/disabled: 16	21,218/28,480		
Illinois (2)	○^	65	17,200/23,220		
Indiana	●	65	11,964/16,128		
Iowa	●^	Medicare beneficiaries	none	discount program; $20 enrollment fee	
Kansas	●	67	12,525/16,875	30% copayment	Excludes prescriptions for acute illness; max. reimb./individual is $1,200/yr.
Kentucky					
Louisiana					
Maine (1)	●^	Medicare beneficiaries	300% FPL		Court action on waiver is pending.
Maine (2)	○	none		discount program	Program delayed by legal challenge.
Maryland (1)	●	none	10,000/10,850		Assets limited to $4,500.
Maryland (2)	●	65 or Medicare eligible	25,770/34,830		Benefits limited to $1,000/yr.
Maryland (3)	●^	Medicare beneficiaries	15,033/20,318	65% copayment	Must not have other drug coverage; program contingent on federal waiver approval.
Massachusetts	●	65	16,142 for full coverage / Disabled: 15,698	sliding scale premium subsidy for incomes up to $42,950	
Michigan	●	65	17,720/23,880	$25 annual fee	
Minnesota	●	65	10,632/14,328		Limits liquid assets to <$10,000 per individual; $18,000 per couple.
Mississippi					
Missouri	○	none	17,000/23,000	40% copayment;$250-500 deductible	
Montana					
Nebraska					
Nevada	●	62	family: 21,500		
New Hampshire	●	65	none	discount program	Pilot program; no enrollment fee.
New Jersey (1)	●	65/disabled: 21	19,739/24,203	$5 copayment	
New Jersey (2)	●	65	19,740-29,739 / 23,204-34,203	50% copayment	
New Mexico	○	65	none	discount program	
New York	●	65	35,000/50,000		
North Carolina (1)	●	65	13,290		Lmt. to ind. with CVD or diabetes.
North Carolina (2)	○	65	17,180/23,220		Lmt. to ind. with CVD, COPD or diabetes.
North Dakota					
Ohio					
Oklahoma					
Oregon (1)	○	65	15,891/21,478	$50 annual fee; 50% copayment	Assets lmtd. to $2,000; no other drug ben. program in prior 6 months; other ben.cap of $2,000/yr.
Oregon (2)	○	65	not yet established	discount program	Discount not to exceed Medicaid rate for prescriptions.
Pennsylvania (1)	●	65	14,000/17,200		
Pennsylvania (2)	●	65	16,000/19,200		
Rhode Island	●	65	16,490-36,225 / 20,613-41,400		3 levels of coverage based on income.
South Carolina	●	65	15,505/20,895	$10-$21 copayment; $500 deductible/yr.	
South Dakota					
Tennessee					
Texas	○	Medicare eligible			
Utah					
Vermont (1)	●^	65/disabled: receives SSI or Medicare benefits	13,368/17,988		
Vermont (2)	●	65/disabled: receives SSI	15,600/20,988		Limited to maintenance drugs.
Vermont (3)	●^	65 or disabled	20,052/26,988		Limited to maintenance drugs.
Virginia					
Washington					
West Virginia	●	60	none	discount program	
Wisconsin	○	65	240% FPL	$20 enrollment fee	
Wyoming (1)	●	none	8,860		
Wyoming (2)	○	none	17,720		

Notes:
- ● State has program
- ○ Program not yet operational
- ^ Program receives federal funds
- ~ Discount programs provide a reduced retail price for participants, but do not provide state subsidy for purchase of prescription drugs.
- SSI Supplemental Security Income
- SSDI Social Security Disability Insurance
- CVD Cardiovascular Disease
- COPD Chronic Obstructive Pulmonary Disease
- FPL 100% of the federal poverty level (FPL) was $8,860 for a family of one in 2002.
- & Number of bullets exceeds 33 because some states have multiple programs

Source: National Conference of State Legislatures, "State Pharmaceutical Assistance Programs," May 9, 2002, [Online] http://www.ncsl.org/programs/health/drugaid.htm. **Data Current as of May 2002**

VI. CONCLUSION

The scope of state-level policies affecting women's access to health care is quite broad. This assessment of state efforts finds mixed results. In large measure, many of the recent state activities have served to improve access. In the area of health coverage, states have made significant inroads. States have been on the forefront of a wide range of insurance mandates that have served to give insured women in some states coverage for contraceptives, direct access to OB/GYNs without a referral, and mandatory coverage of a broad range of key screening services of importance to women throughout their lifespans. Most low-income pregnant women are eligible for prenatal care coverage under Medicaid and many states have taken advantage of greater federal flexibility to broaden Medicaid eligibility standards that allow more low-income parents to qualify for coverage. Medicaid has also been used as an important vehicle to improve access to family planning services for low-income women in many states; and a new federal law gives states the opportunity to extend coverage to uninsured low-income women with breast or cervical cancer. It also provides significant financial protection to women who are seniors or have disabilities.

Despite these advances, many women still lack access to basic health care services, and insurance coverage is still beyond their reach. Coverage under Medicaid for childless adults is still uncommon and eligibility levels for parents are still extremely low in many states. One in five women in the U.S. lacks any insurance coverage, either because their employers don't offer coverage and they can't afford to purchase individual policies, or they can't afford to pay the premiums and cost-sharing associated with their employer-based plans. For some, Medicaid is a critical safety net, but many will never qualify for Medicaid regardless of how poor they get.

In addition, there has been some key legislation at the state level that has resulted in restricted access to certain services, and in other areas that are important for women, there has been limited action. For example, access to abortion services has been increasingly limited by policies that impose waiting periods, burdensome regulations on abortion providers, and restrictions on teen access without parental consent. Similarly, in many important areas, such as facilitating access to emergency contraception or mandates on important screening services for common infections such as chlamydia, states have been relatively inactive. Consequently, access to health care services is still problematic for many women in the United States.

While states have done much to advance women's health coverage and access, more work needs to be done to better understand the relationship between specific state efforts to improve access and the potential for improvements in women's health status. For example, are service- or disease-specific expansions effective in addressing women's access or are broader expansions more beneficial and cost-effective in the long run? How should states incorporate women's access into their larger health care agendas?

While these questions remain, it is clear that states can be on the frontlines in ensuring that women get the care they need. As states contend with unprecedented fiscal crises though, it is unclear what additional efforts they will be able to afford to improve women's access to care. In times of economic downturn, low-income women are even more susceptible to the barriers to health care. During the coming years, states will face great challenges in meeting the growing health needs of their most vulnerable residents under tight fiscal constraints.

This report details a broad range of approaches including legislative, regulatory and financing mechanisms, that state policymakers can use to ensure that women obtain the full range of services they need to improve their health and well-being.

VII. METHODOLOGY

This report is designed to present an accurate, broad assessment of state policies affecting women's access to important health care services and the challenges that states must meet to improve that access. The report examines state policies affecting women's access, including statutes, regulations, executive orders and state programs.

The policy indicators detailed in this report are those that fall under state control that most affect women's access to health care services for which recent, quantifiable data were available. The staffs of the National Women's Law Center and Henry J. Kaiser Foundation selected specific policy indicators. There are many important access issues, such as those concerning substance abuse programs, for which reliable state-by-state data were not available or where state policies were too complicated to be communicated in the format of this report, such as policies to make nursing home and home care more affordable. Hence this report does not attempt to detail all the ways in which states can improve women's access to health care services.

The information contained in the tables that form the basis of this report was compiled from published or online sources specific to the issues analyzed as detailed in the footnotes. Where noted, additional information was compiled by the Health Policy Tracking Service of the National Conference of State Legislatures, the National Women's Law Center and the Henry J. Kaiser Family Foundation. Data analysis was conducted by the National Women's Law Center and the Henry J. Kaiser Family Foundation.

Data concerning federal poverty levels were obtained from the U.S. Department of Health and Human Services website, located at http://aspe.hha.gov/poverty/poverty.htm. Each year, the Department of Health and Human Services designates three federal poverty levels for any given family size–one level for the 48 contiguous states, another level for Alaska, and another level for Hawaii. In cases where the federal poverty level is cited within the notes on a table, only the level for the 48 contiguous states is cited. Calculations for Alaska and Hawaii are based on their respective federal poverty levels.

While the policies covered in this report can improve women's access to health care, states' implementation of these policies is a crucial component of whether and how much improvement is realized. Generally, this report does not explore the effectiveness of state implementation efforts or subsequent judicial actions because such data are not routinely or consistently available.

This report reflects policies that were in place from the beginning of 2000 through April of 2003. The tables indicate the date that the data were collected and the date through which the data are current. Additional data may have become available and some state policies altered between the time data collection ended and the report was published.

VIII. GLOSSARY

AIDS Drug Assistance Programs (ADAPs): State-managed, federally funded programs that provide low-income persons living with HIV/AIDS with coverage for HIV/AIDS-related prescription drugs.

Assets: Also referred to as resources, items of economic value that are not income. Included are financial instruments such as savings accounts, personal property such as an automobile, and real estate (other than an individual's home).

Beneficiary: An individual who is eligible for and enrolled in the Medicaid or Medicare program in the state in which he or she resides.

Capitation/Capitated Payments: A dollar amount established to cover the cost of health care services delivered to a person for a specified period of time. The term usually refers to a negotiated per capita rate to be paid to a health care provider by a managed care organization for a pre-defined range of services.

Categorical Eligibility: Medicaid restricts eligibility to members of certain groups or categories, such as children, the aged, or individuals with disabilities. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and resource tests imposed by the states in which they reside.

Centers for Disease Control and Prevention (CDC): The CDC is a federal agency that promotes public health and quality of life by working to prevent and control disease outbreaks, injury and disability.

Colonoscopy: An examination of the rectum and entire colon using a lighted instrument called a colonoscope. This procedure can detect precancerous or cancerous growths throughout the colon, including areas not accessible with sigmoidoscopy.

Co-insurance: A method of payment in which the covered expenses are shared by the health plan and the patient. For example, a health plan may cover 80% of the health service cost and the patient must pay the remaining 20%.

Copayment: A cost-sharing arrangement in which a health plan member pays a specified charge for a specified service (e.g., $10 for an office visit), usually at the time the service is rendered.

Deductible: A specified amount of money a health plan member must pay before insurance benefits begin, usually an annual amount.

Department of Health and Human Services (DHHS): The federal department with oversight responsibility for Medicaid and Medicare and other health-related programs.

Disabled: For purposes of SSI eligibility, a person is disabled if he or she is unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death, or that has lasted or can be expected to last for a continuous period of at least 12 months.

Double Contrast Barium Enema (DCBE): A series of x-rays of the entire colon and rectum taken after a patient is given an enema with barium solution to detect precancerous or cancerous growths throughout the colon.

Emergency Contraception: A back-up method of birth control that, when used within days of unprotected sex, can prevent pregnancy. Emergency contraception is available as a prepackaged regimen of high-dose birth control pills or in the form of an intrauterine device. Emergency contraceptive pills will not interrupt an established pregnancy and is not the same as the medical abortion drug, mifepristone or RU-486.

Enjoined: An existing law is enjoined when a court order is in effect that prohibits enforcing that law.

Entitlement Program: A program that creates a legal obligation on the federal government to any person, business, or unit of the government that meets the criteria set in law. Entitlement programs such as Medicare and Medicaid are often also often referred to as "direct" or "mandatory" spending.

Family Planning: The use of birth control measures designed to regulate the number and spacing of children in a family.

Fecal Occult Blood Test: A chemical assay of stool sample that detects hidden blood in the stool, a sign of possible colorectal cancer.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is the reference point for eligibility for several public programs; it is adjusted annually for inflation. In 2003, the FPL was $12,120 for a family of two; it was $15,140 in Alaska and $13,940 in Hawaii.

Fee-for-service: A payment system by which doctors, hospitals and other providers bill and are reimbursed a specific amount for each service performed after services have been rendered.

Financial Eligibility: To qualify for Medicaid, an individual must meet both categorical eligibility requirements and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but generally include limits on the amount of income and resources an individual is allowed to have.

Flexible Sigmoidoscopy: A test in which a thin, lighted tube called a sigmoidoscope is inserted into the rectum and lower colon to search for precancerous or cancerous growths.

Food and Drug Administration (FDA): A federal agency whose mission is to protect public health by assessing the safety of new drugs and medical devices and preventing injury or illness due to unsafe or ineffective products.

Free Access: Also called Freedom of Choice, the requirement of Medicaid managed care plans to assure individuals of childbearing age access to a full range of family planning and reproductive health services from any qualified provider.

Gatekeeper: A provider, usually a primary care physician, who is responsible for coordinating and approving all health care services a patient in a health care plan seeks or receives.

Judicial Bypass: A procedure that allows minors who would be required by state law to seek parental consent or notification to obtain an abortion by appearing before a judge, who determines whether the minor meets certain criteria to have an abortion without parental involvement, usually based on her maturity or other circumstances that would make parental involvement not in her best interest.

Low-income: Used in this report to define those with earnings below 300% of the federal poverty level ($36,360 for a family of two in 2003).

Mammogram: A safe, low-dose x-ray of the breast used to detect breast changes in women who have no signs or symptoms of breast cancer.

Managed Care Organization (MCO): A health plan that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with a network of providers who deliver services and frequently shares financial risk, typically relying on a primary care physician to act as a gatekeeper.

Medically Needy: An optional Medicaid eligibility group who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid's categorical requirements, but their incomes are too high to qualify them for coverage. Instead, they qualify by "spending down"–reducing their income by the amount of their medical expenses.

Medicaid: Medicaid is the nation's major publicly financed program for providing health and long-term care coverage to low-income people and people with disabilities. Medicaid is a means-tested entitlement program financed by the state and federal governments and administered by the states. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design their programs.

Medicare: Medicare is the federal health insurance program that covers 34 million Americans aged 65 and over and another 5 million younger adults with permanent disabilities. Medicare is a social insurance program that serves all eligible beneficiaries without regard to income or medical history.

Necessary to Save the Life of the Woman: A case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Pap Smear: A test in which cells are collected from the cervix (the lower, narrow end of the uterus) for examination under a microscope to detect cancer or precancerous changes.

Presumptive Eligibility: The option available to states to extend limited Medicaid coverage to certain population groups prior to a formal income assessment by the State Medicaid agency if their qualified provider determines that their income falls within the state's eligibility threshold.

Primary Care Case Management (PCCM): A health management system under which a primary care provider contracts with a state Medicaid program to act as a "gatekeeper" to locate, coordinate and monitor covered primary care services for beneficiaries.

Primary Care Provider: A provider, usually a physician, who is trained in one of the primary care specialties and who treats and is responsible for coordinating the care of a health plan member.

Premium: Money paid by beneficiaries in advance for insurance coverage.

Resources: See Assets.

Resource Test: A calculation of an individual's assets (see above) used, in addition to income, to determine eligibility for various state and federal assistance programs.

Section 209(b) State: In amendments to the Social Security Act enacted in 1972, Congress created the Supplemental Security Income (SSI) program of cash assistance for low-income seniors and individuals with disabilities. Section 209(b) of those amendments allowed states the option of continuing to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled rather than extending Medicaid coverage to all of those individuals who qualify for SSI benefits.

Section 1115 Waiver: Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to promoting the objectives of the Medicaid program while continuing to receive federal Medicaid matching funds.

Section 1915(b) Waiver: Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and statewide requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds.

Spousal Impoverishment: The eligibility rules that states are required to apply in cases where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.

Supplemental Security Income (SSI): A federal entitlement program that provides cash assistance to individuals who are low-income, over age 65, blind, or living with disabilities. Individuals receiving SSI benefits are eligible for Medicaid coverage in all states except section 209(b) states, which have opted to use more restrictive 1972 criteria in determining Medicaid eligibility for SSI recipients.

Viability: The point at which a fetus/child can live a sustained life outside the mother's uterus.

Waivers: Various statutory authorities under which the Secretary of the Department of Health and Human Services may, upon request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute.

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