Mandated Insurance Benefit Laws: Important Health Protections for Women and Their Families

What Are Mandated Insurance Benefits, and Why Do They Exist?

Mandated insurance benefits are benefits that, by law, must be included in a health insurance policy or contract. Federal and state governments mandate specific health benefits to prevent insurance companies from excluding coverage for certain conditions and from placing stringent limits on covered services. Many laws that mandate health benefits are inspired by real-life instances of insurance company practices driving health care decisions. For example, in the mid-1990's—after learning of women who were sent home from the hospital too soon after giving birth—federal and state policymakers alike responded to the disturbing trend of 'drive-by deliveries' by making new laws that established a minimum postpartum stay for mothers and newborns.[1]

Most insurers complain bitterly about mandated benefits and argue that they increase the cost of insurance, and some health reform proposals seek to limit or eliminate state mandated benefits. However, mandated insurance benefit laws are important: they improve the value of insurance to women because they guarantee that the insurance policies women purchase will include vital health services and procedures. Attempts to limit these laws as part of reform should be rejected.

How Do Mandated Insurance Benefit Laws Work?

Mandated benefits generally fall into three categories: (1) types of health care services or treatments that must be covered; (2) health care providers that are entitled to reimbursement; and (3) coverage eligibility requirements for dependents or other related individuals.[2] Tables 1 and 2 display a selected group of mandate laws enacted by each state, for the first two categories.

Mandate laws can be enacted at either the federal or state level, and they can apply to coverage offered in either the group insurance market (where small or large employers purchase insurance to offer to their workers), the individual insurance market (where individual people and families purchase insurance directly from insurers), or both. In some instances, a benefit is regulated by both the federal and a state government.

Do Mandated Benefits Increase the Cost of Health Insurance Premiums?

The most common argument against the establishment of mandated health benefit laws is that they increase the cost of private health insurance premiums, thereby discouraging employers and individuals from offering or purchasing health coverage. Over the past two decades, many studies have explored the cost and coverage impacts of mandated health insurance benefits, using different methodologies and reporting wide-ranging results.[3] There is a general consensus that mandated health benefit laws do increase premium costs but only to a limited degree.

The U.S. Congressional Budget Office (CBO), for example, has reported that the additional costs of mandated insurance benefits are modest. The CBO estimated that the marginal costs (i.e. the total costs of compliance for those health plans that did not previously offer the

benefit) for five of the most expensive mandated health benefits—including requirements to cover mental health and substance abuse treatment—would increase premiums anywhere from 0.28 to 1.15 percent.[4] Additionally, when considering the establishment of new mandated health benefit laws—as well as the preservation of existing laws—advocates should be aware of the cost savings that can result when women and their families have access to the health services that they need. If a woman forgoes necessary health care because it is not covered by her insurance policy, her health problems are likely to become more complex and more costly in the future. In contrast, when coverage of a health service is mandated by law and is thus included in a woman's health policy, she is more likely to seek the appropriate care in a timely manner, saving costs in addition to improving her health and well-being.

Federal Mandates

There are currently just a few federally mandated health benefit laws:

- The Pregnancy Discrimination Act of 1978 requires employers with 15 or more workers who offer health benefits to provide the same level of coverage for pregnancy as is provided for other medical conditions;
- The Newborns' and Mothers' Health Protection Act of 1996 requires health plans that offer maternity coverage to cover a minimum number of days in hospital following childbirth;
- The Mental Health Parity Act of 1996 requires the same annual or lifetime dollar limits for mental health benefits as is provided for other physical health

A New Federally-Mandated Benefit? : The Breast Cancer Patient Protection Act

The 110th Congress is considering The Breast Cancer Patient Protection Act (H.R. 758, sponsored by Representative Rosa DeLauro) which would ensure that insurance companies cannot restrict a hospital stay in connection with a mastectomy to less than 48 hours. Importantly, the proposal does not mandate that every patient stay in a hospital for that length of time, but for those patients whose physicians recommend a 48-hour stay, the mandate would ensure that insurance companies cannot deny coverage.

The legislation addresses the phenomenon of 'drive-through mastectomies,' whereby healthcare providers—limited by health insurance coverage—send a patient home too soon after their surgeries, while they are still weak, fatigued, and in pain. During a Congressional hearing on the bill in May 2008, a woman who had a drive-through mastectomy shared her harrowing experience, which highlights the need for mandate laws that will protect women's health:

> *I was in shock—my God, my entire breast had just been removed! I felt like a butchered animal. And though my family really wanted to be there for me, they really couldn't understand all of the feelings I was going through. I just wished that I had been in the hospital, so I could have shared my fears with a doctor or a nurse…The worst part was emptying the drainage tubes…We had to empty the drains and then measure and record the bloody fluid…I ended up getting a staph infection and had to seek medical help and in the end, I was six weeks late starting my chemotherapy…It's not right for an insurance company to dictate how a physician must treat a patient. I pay for health insurance to protect myself, in case the worst happens. And when it did happen to me, I found out just how little coverage I really had.*[5]

In September 2008, the U.S. House of Representatives voted to pass the Breast Cancer Patient Protection Act by a wide margin. The U.S. Senate has yet to take up the bill.

benefits when offered by group health plans and insurers; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (enacted as part of the Emergency Economic Stabilization Act) goes further and requires the same deductibles, co-payments and out-of-pocket expenses, and treatment limitations for mental health and physical health benefits; and,

- The Women's Health and Cancer Rights Act of 1997 requires coverage for breast reconstruction following a health plan-covered mastectomy or lumpectomy, as well as prostheses and treatment of physical complications in all stages of mastectomy.

State Mandates

States have generally gone much further than the federal government in mandating benefits to protect their residents' health care needs. Today, all 50 states and the District of Columbia have enacted various mandate laws that protect patients with dozens of different health care needs. Just two benefits are mandated in all 51 jurisdictions: newborn and maternal lengths of stay and breast reconstruction after mastectomy or lumpectomy. Other benefits, such as diabetic supplies and education, or mammography screening, have been mandated by a large majority of the states. Importantly, a mandate law only applies to the health insurance plans sold in the particular state that has passed the law.

While states play a primary role in regulating health insurance companies, they have limited ability to regulate health benefits when an employer is self-insured. Many large businesses self-insure, and more than half of all workers with job-based coverage are covered by a self-insured health plan.[6] Instead of paying premiums to an insurance company for coverage, a self-insured employer assumes risk itself and pays medical claims for employee plan enrollees as they arise.

Federal law exempts self-insured health plans from state regulation.[7,8] However, federal insurance mandates do apply to self-insured plans; thus, even self-insured employer plans must adhere to the few federal insurance mandates, including those that require coverage for pregnancy-related care, minimum hospital stays after birth, mental health parity, and reconstructive breast surgery after covered mastectomies.

How Do Mandate Laws Protect Women and Their Families?

Some mandated insurance benefit laws guarantee that health insurance policies cover the types of care that women need to stay healthy. Many of the health insurance mandates that states have adopted (and continue to adopt) relate to health care services that women need to lead healthy and productive lives. As Table 1 demonstrates, state mandates include requirements to cover important preventive health care benefits like mammography and cervical cancer screenings, as well as services that help women manage chronic physical and mental illnesses, such as diabetes education and supplies or mental health parity.[9] Mandated benefit laws also guarantee that women have access to the safe and reliable contraception that is an essential component of their reproductive health care—over half of all states require insurers to cover contraceptive prescriptions at the same level as other covered prescription drugs.[10]

It is important to note that though a mandate law may address coverage for a certain important health service, it could still fall short of providing women with full coverage for the care they need. For example, a mandate law may require that health plans cover mental health services, but still allow the plans to impose unrealistically-low annual limits on that

Lessons from the States:
Oregon Enhances Access to Contraceptive Services

In May 2007, Oregon Governor Ted Kulongoski signed the Access to Birth Control Act, making Oregon the 24th state to require insurers to provide equitable coverage of prescription contraceptives (additional states mandate insurers to *offer* equitable coverage of contraceptives or have interpreted state anti-discrimination laws as requiring contraceptive equity). The measure, which applies to employer-sponsored group health plans, requires health insurance plans to provide the same level of coverage for birth control as they do for other prescription drugs. In addition to contraceptive equity, the Act requires hospital emergency rooms in Oregon to offer women who have been victims of sexual assault, or that they believe have been a victim of sexual assault, information about and access to emergency contraception.

coverage. Or, a law may mandate a specific level of coverage for a service only if a plan offers the service in the first place. For example: a mandate for maternity coverage may state that if a plan covers maternity care then it must cover a certain type of prenatal screening test as part of that care.

Some mandated insurance benefit laws require insurers to reimburse certain non-medical or non-physician providers. State insurance mandates also include requirements that insurance policies reimburse non-medical providers such as social workers, and non-physician providers such as nurse-midwives and nurse-practitioners. These laws help ensure that women and their families, when possible, have a choice in health care providers; for example, some women of childbearing age prefer to receive their gynecological or obstetric care from a certified nurse-midwife rather than an obstetrician. In areas where physician providers are in short supply, laws that require insurance policies to reimburse health care services provided by non-physician and non-medical providers can also improve access to timely health care.

In addition, most states have mandate laws that make it easier for women enrolled in managed care plans to get health care from an obstetrician or gynecologist. While managed care arrangements typically require enrollees to access specialists through a referral from a primary care provider, these mandates—commonly called 'Direct Access to OB/GYN' mandates—allow women to seek health care from an obstetrician or gynecologist directly, without first obtaining a referral.

Some mandated insurance benefit laws also require insurers to extend health benefits to dependent family members. Mandated insurance benefit laws do more than guarantee important health services for women—these laws also provide protections for families by requiring health insurance policies to cover certain types of dependents. For example, over three-quarters of the states mandate that health insurance policies cover adopted children on the same terms and conditions as biological children, and the majority of states require insurers to continue coverage for dependent children with disabilities, even after the child has reached maturity.

Mandated benefit laws that require insurers to merely offer a health benefit may not be very beneficial to women and their families. Mandated insurance benefit laws can be classified according to whether they require the insurer or plan to provide coverage in all policies (meaning that the benefit must be included in the policy) or merely offer one or more policies with the specific coverage to potential enrollees (meaning that the benefit

must be offered to the prospective buyer in one of more policies made available by the insurer). A mandate to offer coverage simply makes the coverage available—usually with an additional or higher premium, and perhaps at a high and unaffordable cost for those who need the benefit. Why would an employer who is purchasing coverage for a group of workers include a benefit within a plan just because an insurer must offer it? Hence, an offer law is a compromise that precludes a full coverage law and, from a consumer's perspective, may be the same as having no mandate at all.[11]

Even when a health benefit is mandated by state law, insurers may not be in compliance with state regulations. There is some evidence that health insurance companies do not always comply with a state's mandated health benefit laws. For example, a 1995 study of state mandates for mental health services across the states reported a non-compliance rate of 10 to 15 percent.[12] The laws must be enforced for mandated benefit laws to truly protect women and their families from financial risk and unmet health needs.

The Wrong Direction for Health Reform: Proposals That Would Eliminate Mandated Health Benefits

Some types of health reform plans, if implemented, would limit or eliminate laws that mandate health benefits and other important consumer health protections, such as regulations that limit premium rates or that prohibit insurers from taking pre-existing conditions into account. These proposals are based on the premise that 1) mandate laws and other insurance regulations increase the cost of health insurance and are unnecessary for certain populations and 2) policies that are exempt from many mandates will be more affordable, encouraging more people who cannot find a more comprehensive health plan to buy the plans. These proposals might allow:

- Buying and Selling Insurance 'Across State Lines': Currently, state residents can purchase health insurance sold only within their own state. Federal and state policymakers alike, however, have proposed health reforms that would essentially allow individuals to purchase health insurance products licensed in any state, regardless of the consumer protections that the individual's home state government has adopted. A proposed federal bill called the Health Care Choice Act of 2007 (H.R. 4460, introduced by Representative John Shadegg of Arizona), for example, would allow an insurance company to declare a 'home state' (likely to be the state with the fewest mandate and consumer protection laws) and offer insurance plans approved in that state to people across the country.

- Association Health Plans: Another health reform proposal considered at the federal level would create purchasing coalitions known as Association Health Plans (AHPs). AHPs could buy coverage from insurance companies or become insurance providers themselves by paying claims from their own funds. Since AHPs would be created at the federal level, they would be exempt from state benefit mandates and consumer protection laws and would be subject only to very minimal federal regulations.

- 'Mandate-Lite' Health Insurance: Some states have passed laws that permit health insurers to offer products commonly referred to as 'mandate-lite,' 'minimum (or limited) benefit,' or 'affordable' plans. These products are exempt from many of a state's benefit mandate laws, allowing insurers to sell less expensive policies—with leaner benefit packages—to certain populations. Mandate-lite policies are typically designed for small businesses, since they often face challenges in securing affordable coverage for their

workers, or for previously uninsured individuals. In some cases, a state may even provide publicly-funded subsidies for small businesses or individuals to purchase a mandate-lite plan, essentially undermining its protections for those who can least afford to pay for more comprehensive coverage.

Insurance plans that are exempt from state regulations may be less expensive than more comprehensive insurance products, but they also provide less value to consumers and—by limiting or excluding coverage for certain conditions—expose policyholders to greater levels of financial risk. Proposals that eliminate mandate laws might raise the number of insured people, but they would also reduce the number of people insured against chronic or expensive conditions like diabetes, depression, or breast cancer.

The number of underinsured Americans (i.e. those with insufficient coverage that leaves them vulnerable to financial risk and unmet health needs) is increasing rapidly—a disturbing trend given that underinsured adults are almost as likely as the uninsured to go without needed medical care and incur medical debt—and these proposals will only add to this growing problem.[13] So-called "reforms" that permit insurers to sell health insurance products that are exempt from state mandate and consumer protection laws will undermine states' efforts to meet the needs of their residents and will put women's health at risk. Without strong national standards for comprehensive health coverage, we will continue to need mandated insurance benefit laws.

What Can Women's Advocates Do to Establish or Preserve Important Health Insurance Protections?

Women's advocates can find out which health insurance benefits are mandated in their state, and ensure that their community members understand the protections that do or do not exist under their current state law.
Tables 1 and 2 of this toolkit piece will help women's advocates determine whether their state has a law in place that mandates (selected) health benefits or providers. To fully understand the scope or limitations of a mandate law, however, it may be necessary for advocates to dig deeper with regards to their state insurance laws and regulations (e.g. to determine whether the law applies to the group insurance market, the individual insurance market, or both). Contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in accessing or interpreting laws related to a state's mandated insurance benefits.

Women's advocates can support benefit mandate legislation that increases women's access to vital health services, providers, and insurance coverage for dependent family members.
As new mandated benefit laws are introduced at the federal and state level, advocates should support those legislative efforts. Specifically, advocates should promote mandate laws that require the actual provision of benefits versus the mere offering of benefits.

Women's advocates can oppose legislation that would limit or eliminate important benefit mandate laws and other consumer health protections.
Such legislation might include proposals to allow insurers to sell health insurance across state lines, proposals to establish Association Health Plans, and legislation that would allow insurers to sell 'mandate-lite' policies. These health reforms would undermine states' efforts and limit their abilities to meet the needs of their residents, and will not further the goal of protecting and improving the health of all Americans. Providing less comprehensive insurance exposes families to health and financial risks; this is no solution to the health care crisis.

For further reading, see:

Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Blue Cross and Blue Shield Association, Dec. 2007).

National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide* (Aug. 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

National Conference of State Legislatures, *NCSL 50-State Legislative Tracking Web Resources: Health Insurance Mandates* (updated June 2008), http://www.ncsl.org/programs/lis/lrl/50statetracking.htm#Insurance

Henry J. Kaiser Family Foundation, *Managed Care & Health Insurance*, http://www.statehealthfacts.org/comparecat.jsp?cat=7 (last visited Aug. 2008).

References

1 David A. Hyman, MD, JD, *Commentary: What Lessons Should We Learn From Drive-Through Deliveries?*, Pediatrics, 107(2): 406-407 (Feb. 2001), http://pediatrics.aappublications.org/cgi/content/full/107/2/406.

2 Greg Scandlen, Employee Benefit Research Institute, *The Changing Environment of Mandated Benefits*, Government Mandating of Employee Benefits, 177-183 (1987).

3 New Jersey Department of Human Services, *Mandated Health Insurance Benefits: A Critical Review of the Literature* (Jan. 2007), http://www.cshp.rutgers.edu/DOWNLOADS/7130.PDF.

4 Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Jan, 2000), http://www.cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf. The benefits included in these CBO estimates are: alcoholism treatment, drug abuse treatment, mental health treatment, chiropractor services, and continuation of coverage.

5 Alva Williams, U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Hearing on the Breast Cancer Patient Protection Act of 2007, *Testimony: A Breast Cancer Survivor from North Carolina Speaks Out Against "Drive-Through" Mastectomies* (May 21, 2008), http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.052108.Williams-testimony.pdf.

6 William Pierron and Paul Fronstin, Employee Benefit Research Institute, *Issue Brief No. 314, ERISA Pre-emption: Implications for Health Reform and Coverage* (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

7 The federal ERISA law makes it easier for multi-state employers to administer employee benefits uniformly across states, but the legislation can also restrict states' abilities to enact substantial health reforms.

8 National Conference of State Legislatures, *Managed Care State Laws and Regulations, Including Consumer and Provider Protections* (update Mar. 2008), http://www.ncsl.org/programs/health/hmolaws.htm.

9 A law that mandates health plans to cover mental health services is generally known as a mental health mandate, and is distinct from a mental health parity mandate. A parity mandate typically requires that if a health plan provides mental health coverage, then that coverage must be equivalent to the coverage that the plan provides for physical health care.

10 National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide* (Aug. 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf.

11 Miriam J. Laugesen et al., *A Comparative Analysis of Mandated Benefit Laws*, Health Services Research, 41(3p2): 1081-1103 (June 2006).

12 Gail A. Jensen et al., *Mental Health Insurance in the 1990s: Are Employers Offering Less to More?* Health Affairs 17(3): 203 (May/June 1998). Cited by: John R. Graham, Pacific Research Institute, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (July 2008), http://www.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf.

13 Specifically, "underinsured" is defined either as having medical expenses (excluding premiums) that represent 10 percent or more of income; medical expenses (excluding premiums) for low income people (defined as being below 200 percent of the federal poverty level) that represent 5 percent or more of income; or a deductible that represents 5 percent or more of income. Cathy Schoen et al., The Commonwealth Fund, *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, Health Affairs Web Exclusive, 102:298-309 (June 10, 2008), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615.

Table 1: State Mandates for Selected Women's Health Benefits

While this table provides an overview of mandate activity in and across the states, it does not reflect the specific details of each state's mandate law. The sources used do not generally distinguish between the many types of mandate laws, nor the types of insurers who are subject to the law. Depending on how a mandate law is written, it may do little to benefit health consumers. Some of the laws address coverage for a certain health service, but fall short of actually requiring all insurance companies to provide comprehensive coverage for the service. For instance, a mandate law may require that insurers merely offer one or more policies with the specific coverage to potential enrollees, rather than include the coverage in each policy that it sells. Other mandate laws require a specific level of coverage for a service only if a plan offers the service in the first place (i.e. A law requires coverage for a type of prenatal screening test, but it is only relevant for those health plans that choose to cover maternity care.)

Women's advocates can contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in reviewing the specific details of their state's mandated benefit laws.

	Preventive Health Services				*Behavioral Health Services*		TOTAL
	Breast Cancer Screening[1]	Cervical Cancer Screening[1]	Ovarian Cancer Screening[1]	Osteoporosis Screening[1]	Eating Disorder Parity[2,3]	Mental Health Parity[2,3]	
Alabama	●						1
Alaska	●	●					2
Arizona	●				●	●	3
Arkansas	●				●	●	3
California	●	●		●	●	●	5
Colorado	●					●	2
Connecticut	●				●	●	3
District of Columbia	●	●					2
Delaware	●	●	●		●	●	5
Florida	●			●			2
Georgia	●	●	●	●			4
Hawaii	●					●	2
Idaho	●					●	2
Illinois	●	●		●		●	4
Indiana	●					●	2
Iowa	●					●	2
Kansas	●	●		●			3
Kentucky	●			●	●	●	4
Louisiana	●	●		●		●	4
Maine	●	●			●	●	4
Maryland	●			●	●	●	4
Massachusetts	●	●			●	●	4
Michigan	●						1
Minnesota	●	●	●		●	●	5
Mississippi	●						1
Missouri	●	●		●	●	●	5
Montana	●					●	2
Nebraska	●				●	●	3
Nevada	●	●				●	3
New Hampshire	●				●	●	3
New Jersey	●	●			●	●	4
New Mexico	●	●			●	●	4
New York	●	●		●	●	●	5
North Carolina	●	●	●	●	●	●	6
North Dakota	●						1
Ohio	●	●				●	3
Oklahoma	●	●		●		●	4
Oregon	●	●			●	●	4
Pennsylvania	●	●					2
Rhode Island	●	●			●	●	4
South Carolina	●	●				●	3
South Dakota	●					●	2
Tennessee	●	●		●	●	●	5
Texas	●	●		●		●	4
Utah					●	●	2
Vermont	●				●	●	3
Virginia	●	●				●	3
Washington	●				●	●	3
West Virginia	●	●			●	●	4
Wisconsin	●	●					2
Wyoming	●	●					2
TOTAL	50	29	4	14	24	39	

see page 10 for notes

Table 1, Continued

	Reproductive Health Services				*Mastectomy Services*		TOTAL
	Contraceptive Equity[4,5]	Infertility Diagnosis and Treatment[1]	Maternity Care[8]	Minimum Maternity Stay[9]	Minimum Inpatient Mastectomy Stay[1]	Reconstructive Surgery after Mastectomy[1]	
Alabama				●			1
Alaska				●		●	2
Arizona	●			●		●	3
Arkansas	●	●		●	●	●	5
California	●	●	●	●	●	●	6
Colorado	●		●	●			3
Connecticut	●			●	●	●	4
District of Columbia				●		●	2
Delaware	●			●		●	3
Florida				●	●	●	3
Georgia	●		●	●	●		4
Hawaii	●	●	●	●			4
Idaho	●		●	●			3
Illinois	●	●	●	●	●	●	6
Indiana				●		●	2
Iowa	●			●			2
Kansas				●		●	2
Kentucky	●			●	●	●	4
Louisiana		●		●		●	3
Maine	●		●	●	●	●	5
Maryland	●	●	●	●	●	●	6
Massachusetts	●		●	●			3
Michigan	●[6]		●	●		●	4
Minnesota	[7]		●	●		●	3
Mississippi				●			1
Missouri	●			●		●	3
Montana	●[6]		●	●	●	●	5
Nebraska				●		●	2
Nevada	●			●		●	3
New Hampshire	●		●	●		●	4
New Jersey	●	●	●	●		●	5
New Mexico	●		●	●	●		4
New York	●	●	●	●	●	●	6
North Carolina	●		●	●	●	●	5
North Dakota	[7]			●		●	2
Ohio	[7]			●			1
Oklahoma	[7]			●	●	●	3
Oregon	●		●	●	●	●	5
Pennsylvania				●	●	●	3
Rhode Island	●			●	●	●	4
South Carolina				●	●	●	3
South Dakota				●			1
Tennessee				●			1
Texas	●	●		●	●	●	5
Utah				●		●	2
Vermont	●		●	●			3
Virginia	●		●	●	●	●	5
Washington	●		●	●			3
West Virginia	●			●		●	3
Wisconsin	●[6]			●		●	3
Wyoming	[7]			●			1

see page 10 for notes

Notes and Sources:

1 Source: Kaiser Family Foundation, *State Health Facts Online*, http://statehealthfacts.org. All data is for 2008. Mandates listed apply only to managed care organizations (MCOs), though source does not specify whether the law applies to individual insurance policies, group insurance policies, or both.

2 Source: National Women's Law Center, *Making the Grade on Women's Health: A National and State-by-State Report Card* (2007), http://hrc.nwlc.org. Data is for 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

3 A parity mandate law is a specific type of mandate which typically requires that if a health plan provides coverage for a certain service, then that coverage must be equivalent to the coverage that the plan provides for physical health care.

4 Source: National Women's Law Center, *Contraceptive Equity Laws in Your State: Know Your Rights-Use Your Rights, A Consumer Guide,* (Aug, 2007), http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf. Data is for 2007. Mandate may apply to individual insurance policies, group insurance policies, or both.

5 Contraceptive equity mandate laws generally require that if a health insurance policy issued in the state provides coverage for prescription drugs generally, it must also provide coverage for any prescription drug or device that has been approved by the United States Food and Drug Administration (FDA) for use as a contraceptive. Most also require that if an insurance policy provides coverage for outpatient health care services, it must provide coverage for outpatient contraceptive services, such as consultations, examinations, procedures, and other medical services.

6 Coverage requirement is a product of litigation based on state anti-discrimination laws, rather than an insurance regulation or law mandating contraceptive equity.

7 The state has a law that mandates HMOs to cover "family planning services." Unlike other states' contraceptive equity mandate laws, the law in this state does not explicitly refer to coverage for contraceptive drugs or devices as part of family planning services; as such, the state may not interpret the law as a specific requirement to cover these services.

8 Sources: The National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (Sept. 2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf?docID=601; Ed Neuschler, Institute for Health Policy Solutions, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* (2004), http://www.marchofdimes.com/TaxCreditsJan2004.pdf. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

9 Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Dec. 2007). Data is for 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.

Table 2: State Mandates Requiring Reimbursement or Referral for Selected Health Providers

While this table provides an overview of mandate activity in and across the states, it does not reflect the specific details of each state's mandate law. The sources used do not generally distinguish between the many types of mandate laws, nor the types of insurers who are subject to the law. Depending on how a mandate law is written, it may do little to benefit health consumers. Some of the laws address coverage for a certain health service, but fall short of actually requiring all insurance companies to provide comprehensive coverage for the service. For instance, a mandate law may require that insurers merely offer one or more policies with the specific coverage to potential enrollees, rather than include the coverage in each policy that it sells.

Women's advocates can contact the National Women's Law Center at reformmatters@nwlc.org for technical assistance in reviewing the specific details of their state's mandated benefit laws.

	Provider								
	Direct Access to OB/GYN[1,2]	Chiropractors[3]	Nurse Midwives[3]	Nurse Anesthetists[3]	Nurse Practitioners[3]	Optometrists[3]	Psychologists[3]	Speech/ Hearing Therapists[3]	TOTAL
Alabama	●	●		●		●	●		5
Alaska	●	●	●		●	●	●	●	6
Arizona	●	●			●	●	●		4
Arkansas		●		●		●	●	●	6
California	●	●	●		●	●	●	●	7
Colorado		●	●	●	●	●	●		7
Connecticut	●	●	●		●	●	●		6
District of Columbia	●							●	2
Delaware	●	●	●		●	●			5
Florida		●	●	●		●	●		6
Georgia		●				●	●		4
Hawaii	●				●	●	●		3
Idaho	●								1
Illinois		●				●	●		4
Indiana	●	●		●		●	●		4
Iowa	●	●			●	●			3
Kansas		●		●	●	●	●		6
Kentucky	●	●				●			3
Louisiana	●	●	●			●	●	●	6
Maine	●	●	●		●	●	●		6
Maryland	●	●	●	●	●	●	●	●	8
Massachusetts		●	●	●	●	●	●	●	8
Michigan		●	●			●	●		5
Minnesota		●	●	●	●	●	●		7
Mississippi	●	●			●	●	●		5
Missouri	●	●			●	●	●	●	6
Montana	●	●	●	●	●		●		6
Nebraska	●	●	●			●	●		4
Nevada		●	●	●	●	●	●	●	8
New Hampshire		●	●		●	●	●		6
New Jersey		●	●			●	●	●	5
New Mexico		●	●	●	●	●	●		6
New York		●	●			●	●	●	6
North Carolina		●	●		●	●	●		6
North Dakota		●	●	●	●		●		5
Ohio		●	●			●	●		5
Oklahoma		●	●			●	●	●	5
Oregon	●				●	●	●		4
Pennsylvania		●	●	●	●	●	●	●	8
Rhode Island		●	●	●	●				5
South Carolina		●				●	●		4
South Dakota		●	●	●	●	●	●		6
Tennessee		●	●		●	●	●	●	6
Texas		●			●	●	●	●	6
Utah	●	●	●		●	●	●	●	7
Vermont		●				●			2
Virginia		●	●			●	●	●	6
Washington		●	●		●	●	●		6
West Virginia	●	●	●		●	●			5
Wisconsin	●	●			●	●	●		5
Wyoming		●		●	●	●	●	●	6
TOTAL	23	47	31	17	32	46	43	18	

see page 12 for notes

Notes and Sources:

1 A "Direct Access to OB/GYN" mandate requires that managed care programs allow women to have direct access to broad reproductive, gynecologic and health maintenance services, without having to obtain a referral. This is particularly an issue for a female enrollee if she does not select the OB/GYN as her primary care provider.

2 Source: Kaiser Family Foundation, *State Health Facts Online*, http://statehealthfacts.org. Data is from 2008. Mandate applies only to managed care organizations (MCOs), though the source does not specify whether the law applies to individual insurance policies, group insurance policies, or both.

3 Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 2007 Survey of Plans* (Dec. 2007). Data is from 2007. Mandate may apply only to managed care organizations (MCOs), and may apply to individual insurance policies, group insurance policies, or both.