

Reproductive Health Care and Health Reform

Women's reproductive health is too often segregated from women's health care in general, and women's reproductive needs have come to be seen as a secondary set of concerns rather than an integral part of their health and wellbeing. Yet, reproductive health is a key determinant of overall women's health. To be truly comprehensive, health care must include women's reproductive health needs.

Advocates have an important role to play in ensuring that reproductive health is not marginalized in health reform. It is essential they are armed with facts about the importance of reproductive health to women's health, how reproductive health services are covered in the current health care system, and how different health reform proposals might affect that coverage. It is also essential to secure a seat at the health reform table early in the discussions to make sure women's advocates' voices are heard. This piece is designed to assist advocates in taking those steps. It provides general information about the significance of reproductive health, as well as the kinds of services that should be included in health reform proposals. It then focuses on three reproductive health services—abortion, contraception, and maternity care—offering advocates an assessment of current coverage, an examination of how health care reform may affect coverage, and concrete steps to take.

Facts about Women's Reproductive Health Care

Comprehensive, affordable health care that includes reproductive health care is essential for women's well-being. Consider these facts:

- Access to family planning services is critical to preventing unintended pregnancies and enabling women to control the timing and spacing of their pregnancies, which in turn reduces the incidence of maternal death, low birth weight infants, and infant mortality.¹
- Women rely on prescription contraceptives for a range of medical purposes in addition to birth control, such as regulation of cycles and endometriosis. Hormonal contraceptives can also provide other health benefits, such as decreasing the risk of ovarian and endometrial cancer, protecting against ectopic pregnancy, and preventing bone density loss.²
- Birth control enables women to engage in preventive behaviors and ensures that they are visiting doctors' offices, which can contribute to the early detection of diseases through regular health screenings.
- Nearly half of all women have faced an unintended pregnancy, and one in three will have an abortion at some point in her life.³
- Unintended pregnancy is associated with an increased risk of morbidity for women and adverse effects for infants.⁴
- Inadequate prenatal care can increase risks of low infant birth weight, premature births, neonatal mortality, infant mortality, and maternal mortality.⁵
- In 2003, the most common procedures performed in U.S. hospitals were related to childbirth, with approximately 4 million births in US hospitals that year.⁶

- The maternal mortality ratio in the United States is 13.1 deaths per 100,000 live births, with black women facing a much higher risk than white women of dying from pregnancy-related conditions.⁷
- Women are more likely than men to contract genital herpes, chlamydia, or gonorrhea.⁸ Women suffer more serious complications from sexually transmitted infections, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer from the Human Papillomavirus (HPV).⁹
- Approximately 600,000 hysterectomies are performed each year in the US. Hysterectomy is the second most frequent major surgical procedure among reproductive-aged women.¹⁰
- Between 1995 and 2002, 7.3 million women in the US reported utilizing infertility services.¹¹ Treating infertility can cost from \$200 to almost \$13,000 per cycle, depending on the cause of the fertility problem and the therapy used to treat it.¹² However, private insurance companies do not always cover the costs of treatments, placing them out of financial reach for many families.¹³

As these facts demonstrate, reproductive health is inextricably linked to broader women's health care. It must be part of any health reform effort.

Which Reproductive Health Services Should Be Included in Comprehensive Health Reform Packages?

The debate about which services must be included as part of comprehensive benefits can occur at any stage of the health reform process. It could be a precursor to drafting legislative language that will include reference to certain services. Alternatively, the legislature may pass a bill that broadly addresses the principles of health care reform but leave the details of any proposed plan's benefits package to be worked out at a later time by a separate entity. No matter the stage at which benefits are considered, it is critically important that women's health advocates be involved and engaged in the full health reform debate and that they make the case not only for which benefits to cover but also for their affordability. Comprehensive benefits mean little if coverage is unaffordable. Advocates must work to ensure that health care reform guarantees coverage of reproductive health services, and that women are able to truly secure access to those services, without losing the protections and quality care upon which they have come to rely.



Lessons from the States:

Massachusetts Health Reform Legislation Was Silent on Benefits, Leaving Determinations to a Separate Entity

In Massachusetts, the health care reform legislation passed in 2006 did not specify which benefits would be included. Instead, the law required individuals to obtain "minimum creditable coverage" and created an entity to handle implementation.¹⁴ The entity—the Commonwealth Health Insurance Connector Authority—decided which services must be included in the Commonwealth Choice program, which provides private coverage to individuals, families, and small businesses.¹⁵

Health reform packages must provide the full range of reproductive health services. This includes, but is not limited, to:

- Routine gynecological care
- Maternity (e.g. prenatal, birth, and postpartum) care
- Family planning services
- Abortion
- Testing and treatment for sexually transmitted infections
- Screening for cervical and other cancers
- Sterilization
- Infertility treatment

It is important to note that even if a decision is made to include certain services as part of a benefit package, they still might not be explicitly mentioned in health reform legislation. Instead, they could be encompassed by a broader term, such as “services for pregnant women,” “reproductive health services,” or even “medically-necessary services.” If the exact benefits are not specifically mentioned, then attempts could be made later to exclude certain services, like abortion. For example, advocates could fight for “pregnancy-related services” to be included in legislation, only to find that the entity in charge of defining the covered services in detail did not include abortion in the definition. If broad language is used, advocates must remain vigilant to ensure that key services are not excluded. Getting a seat on the board or entity making determinations, making sure those who get on the board support women’s reproductive health care, and constantly monitoring the board’s work, are all important.

What Other Aspects of Women’s Reproductive Health Should Health Care Reform Address?

In addition to the specific services that should be covered, there are other considerations to take into account when planning for women’s reproductive health care needs. Women need autonomy and privacy when securing their reproductive health care. Providing a choice of provider and confidentiality are essential to guarantee this and must be a part of health reform proposals.

Getting reproductive health services covered is essential, but it is not enough! Advocates must ensure that choice of provider and confidentiality are part of health reform proposals.

Choice of Provider

Choice of provider provisions (also known as “freedom of choice”) protect health plan enrollees by giving them the authority and responsibility for choosing the health care provider best equipped to care for them. In other words, enrollees with freedom of choice are permitted to seek services from providers who are not part of their health plan’s network, without having to get a referral. For example, Medicaid managed care enrollees who are seeking family planning services are guaranteed freedom of choice.¹⁶ This protection recognizes that choice of provider provisions are critical in the context of reproductive health care. This is true because:

- The nature of reproductive health services is sensitive. Requirements for referrals or prior approval may cause women to delay or avoid important care.

- In some cases, patients may prefer to receive reproductive care from a particular physician or other type of health provider.
- Patients may need to look out of their network to find a provider with whom they are comfortable enough to see regularly, and whose advice on preventive care they will heed.
- It is an unfortunate and well-documented reality that some providers will refuse women access to basic reproductive health services.¹⁷ Choice of provider provisions help women avoid these distressing and often humiliating encounters, and make sure that they have a trusted alternative should they be refused reproductive care.

When Considering a “Medical Home” Initiative, Think about Choice of Provider!

A “medical home” (sometimes called a “health care home”) generally refers to a centralized location for health care, with one personal health care provider who coordinates an individual’s care. This personal provider is responsible for all of a patient’s health care needs, including appropriately arranging care with other health professionals. Public and private health insurers have implemented medical home initiatives as strategies to improve health care quality and safety, but a medical home system could conflict with an individual’s desire to see a particular provider or clinic for reproductive health care services. When a health reform plan incorporates a medical home initiative, women’s advocates must ensure that choice of provider for reproductive health is a key component of the medical home guidelines and that the women participating in the initiative understand that they are permitted to seek family planning services from a provider that is not affiliated with their medical home. Alabama’s Patient 1st program provides Medicaid enrollees with a medical home, for example, and the *Patient 1st Rights and Duties* statement notifies program participants of their right “To go to any doctor or clinic for birth control without getting approval from your personal doctor. You do not have to use your personal doctor for birth control or any family planning services.”¹⁸

Confidentiality

Confidentiality is crucial when it comes to reproductive health services. Patients who fear that their use of services will not be kept private may delay or forgo important services central to their and their family’s health.

Confidentiality is particularly important for young women. Although a significant body of state and federal law explicitly guarantees confidential access to services for teens or does so by implication,¹⁹ some reform plans could change that. For example, plans that propose to extend the age for dependent care coverage would extend coverage to more young women under their parents’ plans. Several states have already done this. While extending the age for dependent coverage can provide certain young adults with more options for health insurance, this kind of coverage may compromise confidentiality since parents would be informed about the services their dependent child secures through Explanation of Benefit statements. Research indicates that lack of confidential services can discourage young women from seeking needed reproductive health care services, and is potentially harmful to teens’ health and wellbeing.²⁰

Federal Health Care Reform

Health care reform at the national level must also include provisions that will preserve and expand access to reproductive health care services. Federal health care reform has important implications for state-level coverage of reproductive health care. Women’s advocates should take the following questions into account when considering federal health care reform and its potential impact:

- Will the federal health care reform plan affect state laws related to reproductive health services, including abortion and contraception? For instance, does the federal health care reform plan set a floor or a ceiling in terms of what states must or can offer?
- How are health care services and procedures defined? For example, if a bill uses the term “medically necessary,” what does that mean? Or, if a bill refers to “pregnancy-related services,” what is included?
- Who would determine the health services that must be included in newly-created health insurance plans or products? Would it be Congress or an independent entity?
- What are the important technicalities underlying the way that health care is delivered and financed? For example, what is the source of funding for services?
- Are there “refusal clauses” that allow providers or institutions to refuse to provide care? Will they injure patients seeking care? How do these provisions interact with state laws ensuring access to care?

State-level women’s advocates have a critical role to play in federal health care reform. They need to understand what is happening on the federal level so that they can translate what federal reform would mean for coverage of reproductive health services in their state. By engaging state officials and state policymakers early in the federal reform process, women’s advocates can also ensure that their voices are heard when federal reforms that would affect state coverage are considered.

In conclusion, comprehensive health care reform holds the promise of sustaining access to the reproductive services—as well as other key health care services—that women sorely need. For some, it continues care they already rely upon. For others, it offers an opportunity for coverage and access to reproductive health care that they are currently lacking. No one should lose services or benefits because of a health care reform plan that does not take into account women’s reproductive health care needs.

The reforms pursued now will affect women’s ability to secure access to quality care for decades to come. Access to the full range of reproductive health services must be part of the comprehensive benefits guaranteed to individuals.



What Can Women’s Advocates Do to Ensure That Health Reform Preserves and Expands Access to Reproductive Health Care Services?

Women’s advocates can support comprehensive health reform at the state and national levels. Educate policymakers about the kind of health reform that meets women’s needs, and why. If the state is moving forward with health care reform, make sure an advocate or a person friendly to reproductive issues is at the table when benefits are discussed.

Women’s advocates can learn more about the reproductive health services that should be included in a benefits package.

The attached case studies go into depth on three of those services—abortion, contraception, and maternity care. The case studies will explore how each reproductive health service is currently covered, the potential impact of health care reform on coverage, and next steps for ensuring coverage for these particular services.

Women’s advocates can learn how federal health care reform proposals could affect coverage of reproductive health services in their state.

The case studies that accompany this section of the *Reform Matters Toolkit* describe the various ways that women’s advocates can gather information about the current status of coverage and access to reproductive health services in their state. (See the “What can women’s advocates do...” sections of each case study.) If advocates need more assistance in identifying the specific ways that federal health reform might affect reproductive health service coverage and access in their state, they can contact the *Reform Matters* project team at reformmatters@nwlc.org.

Women’s advocates can raise awareness of the effects that a federal reform proposal may have on state coverage and access to reproductive health services.

Once women’s advocates have an understanding of how a particular federal health care reform proposal can affect access to and coverage of reproductive health services in their state, they can work with state officials and policymakers to weigh in at the federal level on whether it is a good or bad proposal.

Women’s advocates can become part of the health care reform movement and conversation.

Learn about the important issues in health care reform, find out who the key players are at the state level, stay updated on federal reform plans as they develop, and figure out how to join the conversation about health care reform.

- For a list of groups working on health reform in each state, go to www.uhcan.org and click on “State Connections.”
- For national groups and campaigns working on health reform, go to www.uhcan.org and click on “National Connections” or visit www.healthcareforamericanow.org.
- By visiting the National Women’s Law Center *Reform Matters* project website, www.nwlc.org/reformmatters/, advocates can sign up to receive NWLC alerts and updates on health reform, and to participate in monthly conference calls hosted by the project team.



For further reading, see:

Wendy Chavkin, et al., Columbia University Mailman School of Public Health, *Women’s Health and Health Care Reform: The Key Role of Comprehensive Reproductive Health Care* (Oct. 2008), <http://www.jiwh.org/attachments/Women%20and%20Health%20Care%20Reform.pdf>

Adam Sonfield, *Toward Universal Insurance Coverage: A Primer for Sexual and Reproductive Health Advocates*, (2008) *Guttmacher Policy Review* 11(1): 12-16 (2008), <http://guttmacher.org/pubs/gpr/11/1/gpr110111.pdf>

Case Study

CASE STUDY: ABORTION COVERAGE AND HEALTH CARE REFORM**Facts about Insurance Coverage of Abortion**

Currently, women's access to insurance coverage for abortion depends on the source of funding. Abortion is generally covered in private insurance plans. Low-income women who qualify for Medicaid, on the other hand, generally receive coverage for abortion only in certain limited circumstances.

For those women who have abortion coverage, it is critical that any health care reform efforts preserve that coverage. But preserving coverage is not enough. Health care reform is also an opportunity to provide abortion coverage to women in need.

How is Abortion Currently Covered?**Public Insurance Coverage**

Medicaid, the primary health care program for low-income people, is run jointly by the federal and state governments. Each state administers its own Medicaid program under federal guidelines, and the federal government contributes more than half of the program's costs.²¹

- **Federal Medicaid Funding for Abortion.** The federal Medicaid program covers abortion for women enrollees whose pregnancy is the result of rape or incest or whose life is in danger.²² Yet, many women on Medicaid—low-income women whose health is at risk or who seek an abortion for other reasons—are left without coverage. Today, by restricting coverage to cases of rape, incest, or life endangerment only, Medicaid pays for less than 1 percent of all abortions.²³ For the women on Medicaid who do not meet the narrow exceptions, lack of coverage can mean serious hardship. These women may be forced to divert money essential to meet other basic necessities, continue the pregnancy to term, or seek unsafe, illegal abortions.²⁴
- **State Medicaid Funding for Abortion.** The federal restrictions on Medicaid funding for abortion affect only federal funds. States are free to use their own funds to cover additional abortion services. Seventeen states use their own funds to cover medically necessary abortions for Medicaid beneficiaries.²⁵ While four of these states do so voluntarily, thirteen do so because a court held that such funding was required under the state constitution.²⁶

Private Insurance Coverage

- **Private Group Insurance Coverage.** Because private group insurance (i.e. the employer-provided health insurance that a majority of Americans depend on for coverage) follows medical standards and considers abortion a medical procedure, it is generally covered. Federal law requires some coverage by employers. The Pregnancy Discrimination Act of 1978, which amended Title VII of the Civil Rights Act of 1964,

State Bans on Public Funding of Abortion

Some states have laws, regulations, or constitutional provisions broadly restricting public funding of abortion. These provisions generally only allow public funding for abortion when the woman's life is at risk. Courts have blocked such laws to the extent that they conflict with federal Medicaid requirements that also require funding for abortions due to rape or incest. Courts in some states have gone even further, blocking the laws and ordering the state to fund all medically necessary abortions.²⁷ Depending on the type of health care reform being pursued in the state, these laws may come into play.

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State Bans on Private Insurance Coverage of Abortion

Five states (ID, KY, MO, ND, and OK) prohibit private insurance plans from covering abortions except in certain circumstances.³⁰ Four of the states (KY, MO, ND, and OK) apply the prohibition to all insurance policies issued in the state.³¹ In Idaho, Kentucky, Missouri and North Dakota, coverage is prohibited except where a woman's life is endangered. Oklahoma includes rape and incest along with its life endangerment exception. Abortion coverage in each of the five states is allowed only through purchase of an additional rider and payment of an additional premium. Also, three states (MN, MS, and WA) permit insurers to refuse to provide abortion coverage.³² These restrictions mean that even women with private insurance in those states can face particular hardship trying to secure access to abortion coverage.

requires employers with 15 or more employees to pay for health insurance benefits for abortions when the life of the mother is endangered. It also requires employers to cover medical complications arising from an abortion.²⁸

■ Private Individual Insurance Coverage.

No published data on abortion coverage in the private individual insurance market—where individuals and families purchase coverage directly from insurers—has been found. As with private group insurance coverage, abortion should typically be covered in the individual insurance market as “surgery” or any other medical procedure. However, it can be very difficult for women to obtain insurance at all in the individual market; those who do have access to this type of insurance often face expensive premiums or limited coverage.²⁹

State Employee Insurance Coverage

Some state employees face restrictions on abortion coverage. Certain states, like

Kentucky, have laws that specifically prohibit state employee health insurance policies from covering abortion.³³ Other states with more general laws banning public funding for abortion may apply those restrictions to state employees or other groups whose health insurance coverage is funded (at least in some part) by the state. For example, the Colorado state constitution prohibits public funding for abortion. The Colorado Attorney General issued an opinion applying the constitutional prohibition to the state employee health insurance plan.³⁴

Federal Employee Insurance Coverage

The federal government is one of the largest employers in the nation, with 1.2 million women of childbearing age enrolled in its health benefits program.³⁵ Congress restricts abortion coverage in the Federal Employee Health Benefits Plan (FEHBP). It is available only when a woman's life is in danger or when the pregnancy is the result of rape or incest.³⁶

How Will State Health Care Reform Proposals Affect Abortion Coverage?

The outcome of specific state health care reform efforts on abortion coverage is impossible to predict, since it depends on the particular health care reform proposal as well as the state's existing laws regarding abortion coverage under public and private insurance plans. This section describes lessons from two states that have implemented, or are thinking about implementing, a comprehensive health reform plan. They serve as examples of the different factors that can have an impact on abortion coverage under state health reform.

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Lesson from the States:

How Abortion Became a Covered Service in the Massachusetts Public/Private Plans

Massachusetts adopted a health care reform approach that blends public funding and private insurance coverage. Though the reform legislation did not specify which services would be covered in health insurance benefit packages, abortion became a covered service under the state's new and expanded public and private health insurance plans. A number of factors contributed to this outcome:

- Massachusetts is one of the 17 states that funds medically necessary abortions for Medicaid recipients in the state. This coverage is based on the state constitution, which a court interpreted to require the state to fund medically-necessary abortions for women enrolled in public programs.³⁷
- Abortion is already covered by private insurance, thereby resulting in its inclusion as a benefit in the state's new private health insurance products as simply maintaining the status quo.
- Members of the Commonwealth Connector board—the entity responsible for implementing many parts of the state's health reform plan—understood the importance of covering a comprehensive set of women's reproductive health services.
- There is a long tradition of health care advocates working together in the state, including those who focus on women's health in particular and those who work on access to health care more generally.
- The presence of religious health care providers was limited. For example, there are no sectarian health plans in Massachusetts and only a small number of hospitals in the state are Catholic.

Although the combination of these particular factors may not be present in many other states,³⁸ its experience can inform efforts by women's advocates in other states pursuing health reform.



Lesson from the States:

How a Single Payer Plan Could Have Restricted Women's Access to Abortion in Colorado

Legislation enacted in Colorado in 2006 established the Blue Ribbon Commission for Healthcare Reform "to study and establish health care reform models to expand coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents."³⁹ The Commission evaluated five distinct health care reform proposals, including a single-payer plan.^{40, 41} Adoption of a single-payer health plan in Colorado could have resulted in women losing access to abortion coverage, since this state has a constitutional provision prohibiting public funding for abortion. A single payer health plan's funding source—taxes collected from individuals and employers—would

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arguably be subject to the constitutional provision. Consequently, women in Colorado who now have access to abortion coverage through private insurance could lose this covered benefit if the state adopted a single payer model. NARAL Pro-Choice Colorado submitted comments to the Commission, highlighting concerns about the constitutional provision's impact and the need to ensure women's right to safe, legal abortion in the state.⁴²

Ultimately, the Commission did not recommend a single-payer plan, but this example illustrates the critical role that advocacy groups can play in identifying and highlighting problems and areas of concern.



What Can Women's Advocates Do to Figure Out the Impact of Potential Health Reform Proposals in Their State?

In order to ensure that advocates are prepared to make the case for inclusion of abortion in any state health care reform, it is essential to understand the state's current laws on abortion coverage.

Research whether the state prohibits public funding of abortion.

If so, are there any exceptions? Does it apply across-the-board or only to certain groups or programs? Or is the state one of the 17 that funds medically-necessary abortions for women in the state Medicaid program?

Review and understand the state's legal and regulatory landscape.

Key sources include the state constitution, state laws and regulations, court cases interpreting the state constitution, laws, and regulations. Key information is available on NARAL Pro-Choice America's website, http://www.naral.org/choice-action-center/in_your_state/. Select the state and look under "Restrictions on Low-Income Women's Access to Abortion."

Research whether the state prohibits insurance companies from offering abortion coverage.

Look under "Insurance Prohibition for Abortion" for the state on NARAL's website.

Find out whether the state permits insurers to decline to pay for abortions or offer coverage.

Look under "Refusal to Provide Medical Services" for the state on NARAL's website.

Contact the National Women's Law Center at the email address: reformmatters@nwlc.org.

The Center is available for assistance in figuring out how a health reform proposal can affect abortion coverage in a state.

*Case Study***CASE STUDY: CONTRACEPTIVE COVERAGE AND HEALTH REFORM****Facts about Insurance Coverage of Contraception**

For the most part, insurance coverage of contraception has become widespread. However, any health care reform efforts must ensure that contraceptive coverage is not restricted, and that availability is improved. Women who still lack contraceptive coverage must either pay out-of-pocket for prescription contraception, use over-the-counter methods that may not be as effective, or not use contraception at all.⁴³ Additionally, plans may not cover the full range of FDA-approved contraceptive methods, leaving women unable to choose the method best suited to their needs. Health care reform presents an opportunity to ensure insurance coverage of contraception for those who need it.

How is Contraception Currently Covered?**Public Insurance Coverage**

- **Medicaid.** Medicaid provides vital contraceptive coverage to the millions of low-income women of reproductive age who depend on the program for their health care. Family planning services and supplies are specified as a “mandatory benefit” under Medicaid, so states must include them among the services provided to beneficiaries. However, Medicaid law does not explicitly define “family planning” and each state is permitted to decide (within certain guidelines) which services and supplies to cover. States are most likely to classify medical procedures directly related to contraception, prescription and over-the-counter contraceptive supplies, and sterilizations as family planning. For instance, coverage of prescription contraception is nearly universal among state Medicaid programs, and two-thirds of the states also cover over-the-counter contraceptive methods such as condoms.⁴⁴
- **Title X.** Title X is a federal program devoted to providing family planning services and information. While it is not a health insurance program, per se, Title X does provide public funding to cover contraception and other family planning services for 5 million low-income women and men each year in 4,400 health centers across the country. For the most part, clients of Title X programs are low-income, uninsured, and do not qualify for Medicaid.⁴⁵ Fees for services are based on the client’s income.

Private Group Insurance Coverage

The majority of employer sponsored insurance plans provide coverage for prescription contraception. According to data from 2003, 88 percent of all firms covered oral contraceptives, while 72 percent of all firms covered all five FDA-approved reversible contraceptives. Yet, in the same year, 99 percent of all firms offered some level of prescription drug benefits.⁴⁶ Clearly, there are some employers that exclude prescription contraceptives from otherwise comprehensive plans.

State Employee Insurance Coverage

Inclusion of contraception in state employee health insurance plans is almost universal among states.⁴⁷

Federal Employee Insurance Coverage

Congress enacted legislation in 1999 requiring all health insurance plans available to federal employees to include coverage of prescription contraceptives if other prescription drugs are covered.⁴⁸

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What Does the Law Require?

Contraceptive coverage not only makes good policy sense, it is required by law in many places. Federal law requires employers to provide coverage of contraception when they have an otherwise comprehensive prescription benefit plan. In addition, some states require insurers to do the same. Studies have shown that the combination of these laws played a clear role in the sharp increase in contraceptive coverage in the private insurance market between 1993 and 2002.⁴⁹

Employer-Sponsored Insurance

- **Federal Law.** Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act of 1978, prohibits sex discrimination, including pregnancy discrimination, by employers with 15 or more employees, including in the health insurance benefits these employers provide to their employees.⁵⁰ Employers that provide health insurance that covers prescription drugs and devices but excludes prescription contraceptives are in violation of Title VII's prohibition against sex discrimination. In December 2000, the Equal Employment Opportunity Commission (EEOC), which enforces Title VII, issued a ruling confirming that such exclusion of contraceptive coverage is a Title VII violation.⁵¹
- **State Law.** Almost every state has a law against sex discrimination in employment along the same lines as Title VII. Michigan, Montana, and Wisconsin have explicitly interpreted their laws like Title VII's contraceptive coverage requirements.⁵²

All Private Insurance Policies Issued in a State

Twenty-four states have enacted legislation specifically requiring that health insurance policies issued in the state that provide coverage for prescription drugs generally must provide coverage for any prescription contraceptive drug or device (often referred to as “contraceptive equity”). The states are: Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, and West Virginia.⁵³ Some of these state laws include religious refusal clauses—exceptions to the contraceptive equity mandate for religious employers or insurers whose religious tenets prohibit the use of contraceptives.

Additionally, there are several states that mandate coverage of “family planning services” by HMOs, but do not appear to have interpreted these laws to require coverage of contraceptive drugs and devices. These states are: Minnesota, North Dakota, Ohio, Oklahoma, and Wyoming.⁵⁴

Some states have mandated “offer” laws, but not coverage. For example, Texas and Virginia require insurers to offer contraceptive coverage as an employer option, but do not require employers to purchase this coverage.⁵⁵ Similarly, Colorado, Idaho, and Kentucky require small-group and/or individual market carriers to offer standardized plans that include coverage of contraceptives, but do not require employers to select these plans.⁵⁶ It is important to note that Title VII trumps state laws when it provides greater protections.

Gaps Remain

Although the combination of anti-discrimination laws and state contraceptive coverage laws ensure contraceptive equity for numerous women, gaps remain:

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- Title VII applies only to employer-sponsored plans. An estimated 10.3 million Americans obtain health insurance from private insurance other than employer-provided plans.⁵⁷ This includes people who are: self-employed; employed by employers who offer no health insurance; part-time, temporary, and contract workers; early retirees too young for Medicare; and unemployed or disabled but not eligible for public insurance. Women are disproportionately represented in several of these categories, such as part-time, temporary, and contract workers.
- Title VII also applies only to employers with 15 or more employees. Less than a fifth of all U.S. employers have 15 or more employees and some 14 million workers are employed by entities that fall beneath this threshold.⁵⁸
- Twenty-six states do not have a contraceptive coverage law for private insurance companies.
- State contraceptive coverage laws do not apply to self-insured health plans. Many large employers do not use private insurance companies to provide health insurance to their employees. Rather, they “self-insure” and use insurance companies only to administer benefits while paying employee claims directly. Many large businesses self-insure, and more than half of all workers with job-based coverage are covered by a self-insured health plan.⁵⁹ The coverage that these workers receive is not subject to state insurance company contraceptive coverage laws.
- Religious employer exceptions in some state contraceptive coverage laws can leave employees without coverage for contraception.
- Some states have laws permitting certain health care professionals or institutions to refuse to provide contraceptive services.⁶⁰ Women who face these refusals may have a hard time finding someone else to help them, especially if their insurance plan only covers certain providers.

How Will Health Care Reform Proposals Affect Contraceptive Coverage?

Most insurers and employers recognize the benefits of contraceptive coverage. However, some issues might arise in efforts to secure coverage in health care reform proposals:

- The free market approach seeks to eliminate insurance mandates altogether,⁶¹ thereby threatening legal mandates for contraceptive coverage.
- Moves away from employer-sponsored coverage would make Title VII contraceptive coverage requirements inapplicable.

Advocates need to ensure that all current mandated benefits, like contraceptive coverage, are protected in health reform proposals.



What Can Women’s Advocates Do to Figure Out the Impact of Potential Health Reforms in Their State?

In order to be prepared to advocate for contraceptive coverage in health care reform, women’s advocates need to understand a state’s current laws on the topic.

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Research whether the state has a contraceptive equity law or another law governing insurance coverage of contraceptives.

Detailed explanations about each state's contraceptive coverage law, including any religious employer exemptions, are available from the National Women's Law Center in the report **Contraceptive Equity Laws In Your State: Know Your Rights—Use Your Rights**, available at <http://www.nwlc.org/pdf/ConCovStateGuideAugust2007.pdf>.

Find out whether the state allows certain providers or institutions to refuse to provide contraception.

Does a contraceptive equity law have an exemption for religious employers? Go to Guttmacher's State Center at <http://www.guttmacher.org/statecenter/> and look for State Policies in Brief. Find the one entitled "Refusing to Provide Health Services" for details on which individuals and entities are allowed to refuse contraception services.

Contact the National Women's Law Center at the email address: reformmatters@nwlc.org.

The Center can provide assistance in figuring out how a health reform proposal can affect contraceptive coverage in a state.

Case Study

CASE STUDY: MATERNITY COVERAGE AND HEALTH REFORM**Facts about Insurance Coverage of Maternity Care**

Three-quarters of American women become mothers during their lifetimes.⁶² Maternity care—the health care that a woman receives during pregnancy, childbirth, and postpartum—is one of the most common types of medical care that women of reproductive age will receive. Maternity care is also expensive. In 2006, the average cost of an uncomplicated hospital-based vaginal birth was \$7,488; an uncomplicated birth by Cesarean section cost an average of \$13,194.⁶³ Notably, these are just the costs related to the birth itself—they do not include expenses for prenatal visits, vitamins and other pregnancy-related medications, or postpartum care.

Despite this need, insurance benefits for maternity care can be exceedingly difficult—if not impossible—for some women to obtain. A woman's access to maternity benefits may depend on factors such as:

- Whether she has access to employer-sponsored health insurance (ESI) through either her own job or that of her spouse. A federal law—the Pregnancy Discrimination Act of 1978—requires employers with 15 or more workers to provide the same level of coverage for pregnancy as is provided for other medical conditions. Correspondingly, the fair employment laws in almost all states consider discrimination based on pregnancy to be sex discrimination, and the majority of these laws apply to employers that are smaller than those covered by Title VII.⁶⁴ As a result of state and federal anti-discrimination protections, most women with job-based health insurance receive maternity benefits.
- Her income level. Low-income women who do not have job-based health coverage may qualify for maternity benefits through their state's Medicaid or State Children's Health Insurance (SCHIP) program.⁶⁵ States have used these programs to extend health coverage to pregnant women at income levels typically much higher than the eligibility levels for other adults. Federal law requires states to cover pregnant women in families with incomes of up to 133 percent of the federal poverty level (FPL), but most have expanded eligibility beyond that minimum level. For example, the District of Columbia—which has the highest upper income limit for pregnant women under Medicaid, covers pregnant women in families with incomes up to 300 percent of the FPL (for 2008, this is \$52,800 for a family of three).⁶⁶

Maternity Coverage in the Individual Insurance Market

If a woman does not have access to employer-sponsored coverage and does not qualify for health insurance through a public program like Medicaid or SCHIP, she may attempt to purchase coverage directly from an insurance company in the individual insurance market. Most individual market health insurance policies, however, do not cover maternity care at all. Consider these facts about maternity care and the individual insurance market:

- An uninsured woman who wants to purchase individual market coverage after she is already pregnant will probably not receive any offers of maternity coverage at all—in most states, individual market insurers are allowed to deny coverage to a pregnant applicant. Even if they are required to issue a policy, insurers are generally allowed to consider the pregnancy as a “pre-existing condition” and will exclude coverage for maternity services.⁶⁷

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- Even if a woman is not currently pregnant, it is very unlikely that an insurer will provide or even offer maternity benefits as part of her regular insurance policy. While a handful of states have enacted laws requiring all individual market insurers to cover maternity care,⁶⁸ research conducted by the National Women’s Law Center (NWLC)—and available in the report *Nowhere to Turn: How the Individual Insurance Market Fails Women*—indicates that the vast majority of individual market health insurance policies do not include coverage for maternity care. After reviewing over 3,500 policies available to a 30-year-old healthy woman in state capitals across the nation,⁶⁹ NWLC found that just 12 percent included comprehensive maternity coverage (i.e. coverage for pre- and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) within the insurance policy. Another 9 percent of the policies examined included some level of maternity coverage that was not comprehensive.⁷⁰ The NWLC findings are in agreement with the results of an earlier study of 25 cities across the country, which reported that most available insurance plans did not include maternity benefits—even plans with the highest premium costs—and the few plans that did provide these benefits had waiting periods or high levels of out-of-pocket spending for the services.⁷¹
- If maternity benefits are not included in her insurance policy, a woman may be able purchase optional maternity coverage (called a “rider”) for an additional premium. Even when a maternity rider is available, however, the additional cost can be prohibitively expensive. In the aforementioned *Nowhere to Turn* report, for instance, NWLC identifies maternity riders that cost over \$1000 per month, and these costs are in addition to a woman’s regular insurance premium.

Maternity Care and “Consumer-Directed Health Care”

A certain type of health insurance arrangement that proponents call “Consumer-Directed Health Care” has specific consequences for maternity care. This arrangement—which combines a high-deductible health plan (HDHP) with a tax-sheltered health savings account (HSA)—is becoming more common in both the employer-sponsored health insurance and individual insurance markets. Pregnant women enrolled in such plans might be exposed to high out-of-pocket costs, particularly when complications arise.

HDHPs, as their name implies, have a deductible (i.e. a specified amount that health plan enrollees must pay out-of-pocket for health care charges before the insurer will begin to pay) that is higher than that of traditional plans. While HSA guidelines permit certain preventive services to be exempt from a deductible, this is a voluntary option for health plans.⁷⁶ And unlike other preventive services such as well-child care, prenatal care is typically subject to a HSA-qualified deductible. This significant cost-sharing might keep some women from obtaining prenatal care services. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the issue. A 2007 study demonstrated the range in out-of-pocket maternity care costs that women could face under several different plan options—from a low of \$3,000 for an uncomplicated pregnancy with vaginal delivery to a high of \$21,194 for a complicated pregnancy with a Cesarean section delivery.^{77, 78}

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- Riders may also involve a waiting period (one or two years, for example) during which a woman pays the monthly rider premium but cannot use the maternity benefits.⁷² Maternity riders are also often limited in scope. In *Nowhere to Turn*, NWLC reports that it is quite common for a rider to limit the total maximum benefit to amounts such as \$3,000 (available only after a 10-month waiting period for a rider option identified in the District of Columbia) or \$5,000 (available only after a 12-month waiting period for an Arkansas rider option).⁷³
- A woman's age has an impact on whether maternity benefits are available and at what cost—a 25-year-old woman is likely to have significantly more options, at a more affordable price, for maternity benefits than her 35-year-old counterpart.⁷⁴
- Past maternity care experiences can also have an impact; women who have given birth by Cesarean section (C-section) may encounter additional barriers when trying to purchase coverage through the individual market. An insurance company may charge a woman who underwent a previous C-section a higher premium, impose an exclusionary period during which it refuses to cover another C-section, or reject her for coverage altogether unless she has been sterilized or is beyond childbearing age.⁷⁵

How Can Health Reform Improve Access to Maternity Coverage?

There are a number of ways that state-level health reforms can improve access to maternity coverage. States can raise eligibility levels or simplify enrollment processes for public health insurance programs so that more women can obtain coverage during pregnancy. They can also prohibit insurers from treating pregnancy as a pre-existing condition, or establish new insurance benefit mandate laws that require insurers who sell policies in the state to cover maternity care.⁷⁹ Consider the experiences of these two states:

- In **California**, several bills to reform the private insurance market were considered during the 2007-2008 legislative session, in the wake of a failed bipartisan plan for more comprehensive health reform. Among these bills was A.B. 1962, sponsored by Assemblymember Hector De La Torre, which intended to ensure fair, affordable access to maternity coverage in health care benefits, regardless of the type of insurance plan offered. The legislation, which was ultimately vetoed by Governor Schwarzenegger, would have required nearly all individual and group health insurance policies that cover hospital, medical, or surgical expenses to also cover maternity services for women in California. The law included a comprehensive definition of maternity services, including prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care.⁸⁰ Importantly, this was the second time that the Governor vetoed such a measure; his veto messages in both instances claim that because of their cost implications, mandate laws are unsound until the passage of comprehensive health reform addressing access to affordable health coverage.⁸¹
- **Vermont** passed a comprehensive health reform plan in 2006, which included the creation of Catamount Health, a state-subsidized health insurance plan open to all uninsured residents. Catamount Health offers a standard insurance plan, with benefits similar to the typical private plan in the state, through two private insurers. When enrollment in Catamount Health began in October 2007, these insurers were permitted to treat pregnancy as a pre-existing condition and thus excluded coverage for maternity

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care in the health insurance policies they offered to pregnant women.⁸² In response to public outcry, state officials moved quickly to address this access barrier, and in June 2008 enacted a new package of health reforms that removed pregnancy from the list of pre-existing conditions for which insurers are able to deny coverage.⁸³



What Can Women's Advocates Do?

Advocates can take the following steps to ensure that maternity care is covered as part of health care reform.

Find out whether the state already has laws that prohibit insurers from treating pregnancy as a pre-existing condition, or laws that require insurers or health plans to cover maternity benefits.

Consider which insurers or health plans are subject to any requirements (i.e. Does the law only affect Health Maintenance Organization (HMO) plans?) and also whether the scope of maternity benefits is defined by the law (i.e. Are prenatal or post-partum visits included as part of the required maternity coverage?). This information is available by reviewing state laws and regulations firsthand, by contacting the National Women's Law Center at reformmatters@nwlc.org, or by contacting the state office of insurance. For help with the latter suggestion, the National Association of Insurance Commissioners (NAIC) has an interactive website with links to each state's insurance department: http://www.naic.org/state_web_map.htm.

Support efforts to expand eligibility for public health insurance programs so that more lower-income pregnant women can get coverage.

Public insurance program eligibility levels for pregnant women are already higher than levels for other, non-pregnant adults. However, there is still room for improvement, especially in those states that cover pregnant women only at or near the federally-mandated minimum level.⁸⁴ Advocates can determine a state's current Medicaid/SCHIP eligibility level for pregnant women by visiting The Kaiser Family Foundation tool "State Health Facts Online" at: <http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4>.

Promote efforts to recognize maternity coverage—including prenatal, birth, and postpartum care—as a basic health benefit, including "benefit mandates" that require insurers to include coverage for maternity care in all health insurance policies.

The importance of adequate maternity care—especially prenatal care—cannot be overestimated. If a woman visits a healthcare provider early and regularly during her pregnancy, birth defects and other complications can be prevented or appropriately managed. But a precursor to timely care is having the finances or insurance coverage to pay for it; when pregnant women are uninsured, they are considerably less likely to get proper prenatal care.⁸⁵ Adequate and affordable maternity coverage is essential for the health of mothers and their children—it should not be a luxury to which only some women have access.

Support efforts around federal health reform that will guarantee access to affordable maternity coverage.

It is especially critical that health reform plans at the federal level include maternity care as part of a comprehensive health benefit package, since only federal action will guarantee that women across the nation have access to the maternity care they deserve. Until this type of federal solution becomes reality, however, women's advocates must work to ensure that maternity care is included as a basic and affordable health benefit in all health insurance policies sold in their state.

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federally-mandated minimum level): AL, ID, ND, SD, UT, and WY. Four states use Medicaid and/or SCHIP to cover pregnant women in families with incomes up to 150 percent of the FPL: AZ, KS, MT, and WV. See: Kaiser Family Foundation, *Income Eligibility Levels for Pregnant Women under Medicaid or SCHIP by Annual Income and as a Percent of Federal Poverty Level (FPL), 2008*, <http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4> (Last Visited Nov. 5, 2008).

- 85 Amy Bernstein, *Insurance Status and Use of Health Services by Pregnant Women* (Oct. 1999), http://www.marchofdimes.com/files/bernstein_paper.pdf; Susan Egarter et al., *Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women*, *American Journal of Public Health* 92(3): 423–427 (March 2002).

2008

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/lr/50statetracking.htm#Insurance>

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

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- 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@nwl.org for technical assistance in reviewing the specific details of their state’s mandated benefit laws.

	Provider								TOTAL
	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	
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.

Bare-Bones Health Plans: Is Something Better than Nothing?

Some states currently allow private insurance companies to sell bare-bones health insurance plans—policies that offer limited benefits and minimal coverage in exchange for less-expensive premiums.¹ While these basic plans do offer individuals some coverage, they also expose plan enrollees to significant levels of health and financial risk. Due to their specific health care needs and patterns of use, women are particularly ill-served by these plans. Health reform that promotes bare-bones health plans as a means of expanding affordable health coverage is a move in the wrong direction and will only increase the number of *underinsured* Americans—individuals who are more likely to go without needed care because of their insurance plan’s inadequate coverage.

What Are Bare-Bones Health Plans and How Do They Work?

Bare-bones health insurance plans are intended to appeal to individuals who want some insurance coverage, but who cannot afford or do not wish to pay for higher-priced comprehensive plans.² Bare-bones plans typically offer limited coverage that excludes many critical services. Bare-bones policies are generally sold at significantly lower prices than traditional plans with more comprehensive health benefits. But in return for lower premiums, individuals covered under these plans will likely find themselves with:

- **Fewer benefits.** Bare-bones health insurance includes fewer benefits than traditional health insurance plans. For example, these plans may exclude coverage for prescription drugs, mental health or substance abuse treatment, maternity services, or cancer care.
- **More limitations on benefits that are covered.** Bare-bones policies often limit the coverage on the benefits that are provided. While even traditional health plans place some limits on coverage, the restrictions that some bare-bones plans impose on benefits are often more severe. For example, many traditional health insurance plans do not limit the number of days a person can be in the hospital, nor do they impose annual coverage limits. In contrast, bare-bones policies often cap hospital coverage at a certain number of days in a year and usually only cover a certain amount of costs incurred during a hospital stay. Individuals enrolled in these plans are thus left to pay, often in full, any costs incurred for longer hospital stays or for treatment expenses above the annual coverage limit. This can leave families with thousands of dollars in medical bills—even though they technically have health insurance.³
- **Higher levels of out-of-pocket spending.** Bare-bones plans often have high deductibles, co-pays, and other cost-sharing requirements. Some bare-bones plans, for example, include deductibles of \$1000 or more for an individual, or several thousands of dollars for a family.⁴ Because of these high out-of-pocket expenses, individuals may be required to pay large medical bills before their insurance begins to cover costs. Some health plans, often called “high deductible health plans,” also have steep out-of-pocket costs and high deductibles.⁵ However, these plans typically do not have the skimpy benefit packages and limits on coverage characteristic of bare-bones policies.

Employers may offer bare-bones health plans to their workers as a lower-cost option alongside more traditional coverage plans, or they may provide bare-bones health coverage

as the only option for employees. This type of health plan may be particularly appealing to small businesses since these businesses have the most difficulty obtaining affordable coverage for their workers. Indeed, many states have enacted laws explicitly allowing insurers to market bare-bones health plans to small businesses—these laws are sometimes called “mandate-lite,” “limited-benefit,” or “mandate-free” laws because the plans are exempt from many of the state’s health benefit mandates (i.e. requirements that insurers include coverage for certain important health benefits in the policies that they sell).⁶ Women might also purchase a bare-bones health plan directly from an insurer through the individual insurance market.⁷ In general, the health plans that are available through the individual insurance market have more limited benefits and require greater levels of cost-sharing than employer-provided health insurance, though not all individual market plans are bare-bones health plans.

Bare-Bones Plans: A Bad Deal for Women and Families

Due to the lack of coverage for many health benefits and the limited coverage on included benefits, bare-bones plans present women and their families with significant health and financial risks.

- **The limited benefits offered under bare-bones plans disproportionately affect women’s access to health care, including preventive health care services.**

Bare-bones health plans may fail to cover basic health care services essential to a woman’s health. On average, women have greater health care needs than men.⁸ In particular, women have reproductive health needs that require regular medical visits including maternity care and pre- and post-natal care. Additionally, women of all ages are more likely to take prescription drugs on a regular basis, including oral contraceptives. Women also suffer from certain conditions at higher rates than men, including chronic conditions that require regular treatment such as arthritis, asthma, and diabetes.⁹

Because of the unique health needs women have, they require comprehensive health insurance that can adequately cover these needs. But bare-bones health plans often exclude certain benefits that are a critical part of maintaining women’s health, including prescription drug coverage and maternity care. Women may be less likely to access preventive care such as regular primary care visits and annual gynecological exams if these critical preventive services are not covered under bare-bones plans.

- **Limited coverage and caps on existing benefits put women at increased financial risk.**

Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care services than men.¹⁰ Women, therefore, need health insurance that covers their health care needs without leaving them with thousands of dollars of unpaid medical bills.

Bare-bones plans leave women with significant financial risk because these plans may not cover a woman’s full health care costs. For example, while many bare-bones plans purchased on the individual market exclude coverage for maternity care altogether, those plans that do offer coverage often impose severe limits.¹¹ Under these limitations, even routine pregnancies could leave a woman responsible for significant out-of-pocket

costs. More complicated pregnancies could leave a woman with limited resources in serious debt.

Women who have high health care expenses—such as those with disabilities, chronic conditions, and serious illnesses—are most likely to be negatively affected by the limited coverage and caps on benefits. These individuals generally have higher health care costs, which might exceed the low limits of bare-bones plans. For example, a woman who is admitted into the hospital for multiple days as a result of a severe asthma attack may be left with thousands of dollars in medical bills because her bare-bones plan imposes limits (either in days or dollar amounts) on inpatient hospital stays. Additionally, some plans cover only 5 or 6 visits per year for radiation therapy for cancer.¹² Women who suffer from cancers such as breast cancer and need radiation therapy, however, usually require 5 visits per week over the course of numerous weeks.¹³



LESSONS FROM THE STATES:

“Cover Florida” Creates Bare-Bones Plans to Expand Coverage to the Uninsured

With close to 4 million uninsured residents—one of the highest uninsured rates in the country—Florida faces significant challenges in providing residents with affordable, adequate health care coverage. To address this growing problem, Governor Charlie Crist signed a law in May 2008 that allows insurance companies to offer stripped-down plans to state residents between the ages of 19 and 64 who have been uninsured for six months or longer. All insurance carriers who participate in the program must offer one plan with catastrophic and inpatient coverage and one without these benefits. Neither of the plans will cover important benefits such as treatments for cancer or mental illness.¹⁷ By offering a less valuable, limited benefit package, insurance companies can offer policies for approximately \$150 a month, a cost considerably lower than the average price of a traditional, comprehensive health policy.¹⁸ However, individuals who want coverage for excluded services would have to purchase supplemental insurance.¹⁹ Participating insurers are expected to introduce Cover Florida plans in early 2009.²⁰

The “Cover Florida” plan is not the state’s first attempt at introducing bare-bones plans as a solution to its health care problems. In 2002, the state implemented “Health Flex,” a program that allowed insurers to offer limited-benefit plans to low-income residents. Today, only 3 of Florida’s 67 counties offer Health Flex plans, and the program has had very low enrollment rates, an experience shared by other states who have allowed insurers to sell bare-bones policies.²¹ Reports have suggested that individuals may not consider these plans to be worth the money.²² The vast majority of individuals who have Health Flex plans use subsidies provided by counties. In fact, Health Flex’s 2007 annual report acknowledged that the future of the Health Flex Program depended largely on the availability of government or private funding sources to subsidize part of the program’s costs.²³ Unlike Health Flex plans, however, Cover Florida plans will not offer enrollees any subsidies to help pay the \$150 monthly premium.²⁴ This lack of subsidies, along with the limited benefits, further decrease the chance that Cover Florida will be an affordable, adequate health care option for Florida residents.

■ **High cost-sharing makes bare-bones plans unaffordable for lower-income women and their families.**

On average, women earn less than men. They also typically need and use more health services.¹⁴ It is not surprising, then, that women report more difficulty paying for health care than men. Because of the challenges women face paying for health care costs, affordability is a key component to whether a woman is able to obtain the health care services she needs. The high cost-sharing requirements of bare-bones plans—including premiums, co-pays, and deductibles—leave women with high out-of-pocket expenses for health care. Especially for low-income women, this may be more than they can afford. While premiums for bare-bones health plans may be lower than those for more comprehensive coverage, the money saved on lower premiums of bare-bones plans is often spent on higher deductibles and other forms of cost-sharing involved in bare-bones plans. These cost-sharing mechanisms, such as co-pays and deductibles, may also lead women to avoid needed health care.¹⁵ One study, for example, found that some women decided to forgo mammograms altogether when required to contribute even a small co-pay of \$10 to \$20.¹⁶

Bare-Bones Plans Are Not Good Health Reform

Bare-bones plans are a risky deal for women and their families and fail to offer an effective solution to the growing number of uninsured and underinsured in America.

Pursuing bare-bones health plans as a reform strategy will do little to reduce the number of uninsured Americans. Instead, these plans will increase the number of underinsured Americans. Historically, limited-benefit products have not sold well.²⁵ Many insurers are reluctant to sell bare-bones policies, and consumers—aware of the many problems with this type of coverage—are uninterested in buying them. Those that do purchase these plans will join the ranks of the 25 million underinsured Americans—individuals who have health coverage that does not adequately protect them from high medical expenses.²⁶ According to a recent study, more than half of the underinsured go without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment.²⁷

Bare-bones plans will further segment the health insurance market and will not help control rising health care costs. Bare-bones plans are intended for those individuals in good health who think they won't need comprehensive coverage. Therefore, these plans will lead healthy, low-cost enrollees away from plans with comprehensive coverage and leave sicker and poorer Americans concentrated in traditional, comprehensive insurance plans.²⁸ This division of the pool of insured people fails to spread medical risk between those with high and low medical expenses. As a result, the premiums for those in traditional plans may significantly increase.

The high out-of-pocket costs that accompany bare-bones plan may compel financially-concerned individuals to delay or forgo preventive care. This may lead to the development or worsening of illnesses, which the health care system will have to address at a later stage. Treatment for these advanced conditions will likely be far more expensive than the cost of preventing the illness in the first place.



What Can Women's Advocates Do?

Women's advocates can spread awareness about the risks and dangers of bare-bones health plans, and explain why these plans will not help solve America's health care problems.

Bare-bones health plans lack coverage for important health benefits and place limits on the benefits that are covered. Consequently, these health plans present women and their families with significant health and financial risks. Promoting bare-bones health plans will not lead to reductions in America's overall health care costs, but will lead to an increase in the number of underinsured Americans.



For further reading, see:

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Sherry Glied et al., The Commonwealth Fund, *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221524.

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- 2 Comprehensive health insurance plans cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Comprehensive plans include coverage for all necessary care, including preventive care and a full range of reproductive health services. See: "Women and Health Reform: An Introduction to the Issues" section of the *Reform Matters Toolkit* for a discussion of comprehensive benefits.
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- 4 *Id.*
- 5 See: "Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs" section of the *Reform Matters Toolkit* for detailed information on high-deductible health plans.
- 6 See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.
- 7 For a discussion on the challenges women face obtaining health insurance coverage in the individual market see: National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), <http://action.nwlc.org/site/PageServer?pagename=nowheretoturn&JServSessionId.001=kn5chpapp1.app1>.
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- 10 *Women and Health Coverage*, *supra* note 8; Also: A Harvard Medical School analysis of 2003 Medical Expenditure Panel Survey (MEPS) data found that women's median health expenditures are \$997 higher than men's. While only one third of insured men under 45 spent \$1,050 or more each year in medical costs, over half of insured women reached this figure. See: Steffie Woolhandler and David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, *Society of General Internal Medicine*, 22(6): 879-881 (June 2007), <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2071952>.
- 11 For a discussion of the challenges women face obtaining maternity coverage in the individual market see *Nowhere to Turn*, *supra* note 7.
- 12 BlueCross BlueShield of Tennessee, *CoverTN Plan A Schedule of Benefits*, <http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanA.pdf> (last visited Nov. 3, 2008); BlueCross BlueShield of Tennessee, *CoverTN Plan B Schedule of Benefits*, <http://www.bcbst.com/health-plans/cover-tennessee/covertn/PlanB.pdf> (last visited Nov. 3, 2008), cited by Families USA, *Limited-Benefit Plans: Expanding Coverage or Holding Your State Back?* (October 2008), <http://www.familiesusa.org/assets/pdfs/limited-benefit-plans.pdf>.

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- 15 *Id.*
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- 21 *Limited-Benefit Policies*, *supra* note 1 .
- 22 Kevin Sack, *New Florida Law Allows Low-Cost Health Policies*, *The New York Times*, May 22, 2008.
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- 26 Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, *Health Affairs Web Exclusive*, w298–w309 (June 10, 2008).
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