

Update: December 2000

## State Policies on Access to Gynecological Care and Contraception

### Overview

Today, women's medical needs are increasingly shaping the health policy agenda. Since 1995, a quiet revolution has taken place at the state level. Thirty-eight states and the District of Columbia have adopted policies to give women enrolled in managed care greater access to obstetricians and gynecologists (ob/gyns). Thirteen states have passed laws requiring private insurers to cover contraception, all since 1998. A dozen states have taken action to expand their Medicaid programs to provide low-income, uninsured women access to family planning and eighteen states have expanded Medicaid eligibility to all poor parents, the majority of them women. These actions have the ability to influence the health care of millions of women.

This issue brief assesses women's coverage of gynecological care and contraceptives. It also reviews the current status of state and federal policies designed to increase access to ob/gyns under managed care, improve insurance coverage of contraceptives, and provide low-income women health insurance under Medicaid.

### The Importance of Gynecological Care

Women visit the doctor more often than men, particularly during their reproductive years.<sup>1</sup> Women also use the health care system differently than men, relying on a primary care provider, an obstetrician/gynecologist (ob/gyn), or both for their care. Ob/gyns are specialists in women's health who provide information and care related to reproductive and sexual health, as well as periodic general screening and counseling services. While these services are an important part of routine gynecological care, about 12% of women report that they did not have a regular gynecological exam during the past two years.<sup>2</sup>

Women often split their care between a primary care practitioner and an ob/gyn specialist. Many women ages 18-64 see both an ob/gyn and a family practitioner (41%) for their regular care and 7% rely exclusively on an ob/gyn.<sup>3</sup> For much of a woman's health needs, it is difficult to draw a precise distinction between primary care and specialty gynecological services. Having access to both primary care and gynecological care is very important for women.

In the case of gynecological care, research has shown that access to ob/gyns, in addition to other types of primary

care doctors, makes a difference for women. Those who visit an ob/gyn are more likely to receive recommended preventive gynecological services such as a pelvic exam (94% compared to 35% by other practitioners) and a Papanicolaou (Pap) smear (94% versus 33%), the prime method for early detection and prevention of cervical cancer.<sup>4</sup> Ob/gyns often also provide more extensive counseling about family planning (31% to 12%) and sexually transmitted diseases and HIV/AIDS (22% versus 14%).<sup>5</sup> These and other preventive health services are recommended by experts, including those of the U.S. Preventive Services Task Force, a government-convened group of experts (Figure 1).

Figure 1

#### Selected Preventive Health Services Recommendations

**Cervical Cancer Screening:** Papanicolaou (Pap) smears should begin with the onset of sexual activity and be repeated at least every 3 years, following normal Pap tests 3 years in a row.

**Breast Cancer Screening:** All women 19-64 should get a clinical breast exam (CBE) at their annual gyn exam. Routine screening for breast cancer every 1-2 years, with mammography alone or mammography and annual CBE, is recommended for women 50-69.

**STDs/HIV:** All adolescent and adult patients should be advised about risk factors for human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs), and counseled appropriately about effective measures to reduce the risk of infection.

**Contraceptive Counseling:** Periodic counseling about effective contraceptive methods is recommended for those at risk for unintended pregnancy.

Source: U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services, Second Edition*. U.S. Dept. of Health and Human Services, Washington D.C.: 1996.

### Managed Care and Access to Ob/Gyns

Today, three-quarters of insured women under age 65 are enrolled in managed care.<sup>6</sup> Managed care plans usually require enrollees to choose a primary care provider who is responsible for general health services, including preventive care, and referrals to specialists such as ob/gyns. Patient preferences and growing concerns about the need for more preventive care specific to women have led both the health care industry and legislators to increase direct access to ob/gyns under managed care.

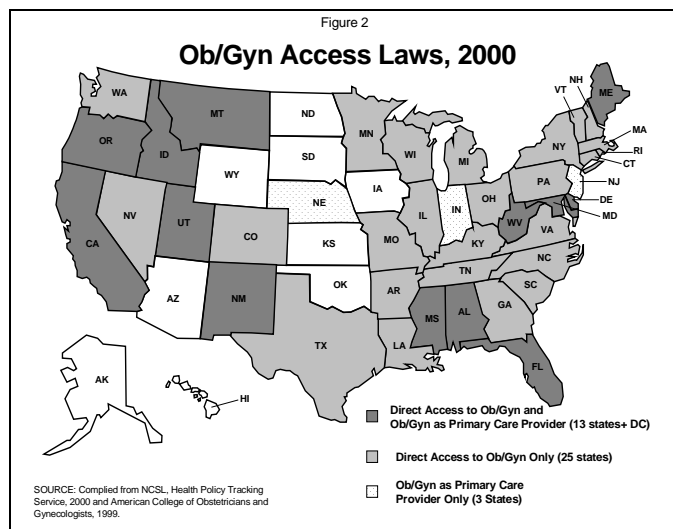
The genesis of the efforts to regulate plans occurred in the mid-1990s, when some insurers were accused of providing

inadequate coverage for postpartum care – typically only one night of hospitalization for labor and delivery. Intense media coverage fueled legislative activity to end this practice, which was dubbed “drive-through delivery.” Between 1995 and 1996, 29 states adopted laws or regulations setting minimum coverage for postpartum hospital stays.<sup>7</sup> In 1996, Congress set a nationwide standard with the Newborns’ and Mothers’ Health Protection Act.<sup>8</sup>

Federal action had a far-reaching effect because states that had not yet passed specific legislation now addressed this issue. The new federal law also had an impact on the states that had adopted “drive-through delivery” legislation because not all health plans in those states were subject to the new laws. This is because the Employee Retirement Income Security Act of 1974 (ERISA)– passed by Congress in part to protect multi-state employers from conflicting state regulation of their benefit plans – limits the impact of these regulations in the states.<sup>9</sup> ERISA does not allow states to apply rules to self-insured employer health plans (those that act like insurance companies and assume some or all of the risk of paying for coverage), so these plans are exempt from most state laws like the ones passed to deter “drive-through deliveries,” but usually not from federal laws. An estimated 48-72 million Americans receive coverage from a self-insured plan.<sup>10</sup>

**State Action**

Today, 38 states and the District of Columbia have adopted policies to regulate access to ob/gyns (Figure 2).<sup>11</sup> These measures often mirror the approaches taken by health plans: eliminating the requirement for a referral, often called “direct access,” and/or permitting women to designate ob/gyns as primary care providers. The first state direct access law was passed in Maryland in 1994. Over the next six years, an additional 37 states and the District of Columbia approved similar policies. (Table 1).



At the same time, 16 states and the District of Columbia adopted laws or regulations requiring managed care plans to enable women to choose an ob/gyn as their primary care provider. Thirteen states and the District of Columbia give women both options.

In some instances, states have provided additional protections for women enrolled in managed care plans. Most states with direct access provisions have also sought to ensure that health plans do not place extensive limits on ob/gyn visits. Exercising their right to regulate insurance, 22 states and the District of Columbia do not limit the number of annual visits, four states set a minimum of two per year, and nine cover at least one visit. Sixteen states with direct access laws also require insurers to notify women of the provision. Nine states bar health care plans from imposing surcharges or added co-payments.

**Federal Response**

While state legislation has moved forward, Congress has struggled to find consensus on the federal government’s role in regulating managed care. The enactment of a federal statute would reach employers in all states, including those that have yet to adopt their own laws. It could also apply to self-insured companies, which are currently exempt from most state insurance regulations under ERISA.

Measures at the federal level that have been considered have varied, including those that would improve access to ob/gyns through stand-alone legislation, such as the state laws, and omnibus patients’ rights bills. Legislative proposals have differed greatly by the sorts of employers who would be affected; the degree to which insurers would be allowed or required to provide ob/gyn access; the type of access provided (“direct access” and/or primary care provider status to ob/gyns); and the scope of services available to women. Final federal action on these bills has stalled.

**Public Opinion**

Surveys show that there is strong support for policies to provide greater access to ob/gyns under managed care. A 1998 Kaiser Family Foundation/Harvard University survey on consumer protections in managed care found that 82 percent of those polled reported that they would favor a law requiring health plans to allow a woman to see a gynecologist without pre-approval, and 63% still supported these measures even if it meant that insurance premiums would go up.<sup>12</sup> This has remained an issue for voters; in a recent survey on women’s health priorities in the 2000 election, 81% of women and 62% of men said that it was very important for elected officials to address the issue of requiring managed care plans to allow women to visit their ob/gyns without having to get a referral.<sup>13</sup>

Recent surveys of women and employers indicate that there are still some restrictions in accessing ob/gyns. In a 1998 survey of women, the Commonwealth Fund found that three-quarters of women under age 65 who were enrolled in managed care plans reported they needed a referral for a specialist, and less than one-quarter (23%) said they did for ob/gyns.<sup>14</sup> According to a 2000 Kaiser Family Foundation/ Health Research and Educational Trust (KFF/HRET) employer survey, 54% of workers enrolled in their firm’s largest HMO plan were permitted to use an

ob/gyn as their primary care provider. This figure was down somewhat from the year before, when 67% of those employees had the same option.<sup>15</sup>

### Private Insurance Coverage of Contraception

Since the early 1980s, the proportion of women in the U.S. practicing birth control has been on the rise. By 1995, nearly two-thirds (64%) of women ages 15-44 were using some form of contraception, versus only half (52%) in 1982.<sup>16</sup> There are a host of reasons why women at risk for pregnancy do not use contraception or fail to utilize it effectively. One factor is cost,<sup>17</sup> particularly for reversible birth control methods that require a visit to the doctor or a prescription (Figure 3).

Figure 3  
**Costs of Commonly Used Contraceptives**

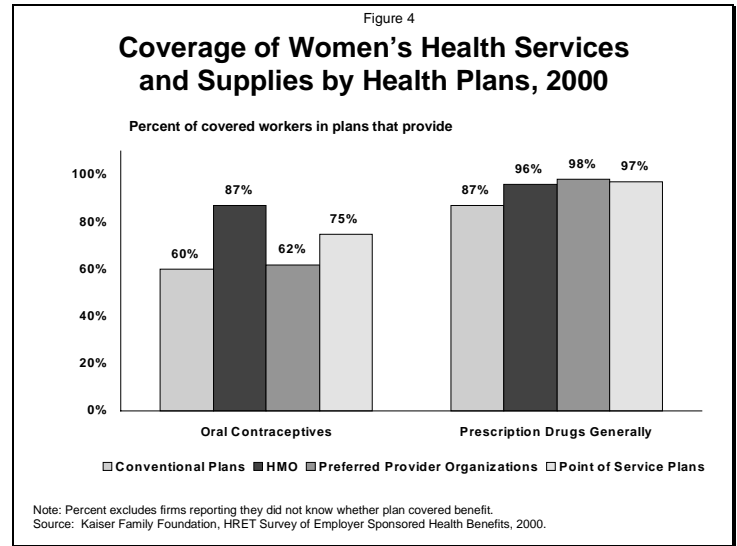
Oral Contraceptives	\$250/year + \$40 office visit
Injectables	\$120/year + \$40 office visit
Diaphragm	\$35 + \$40 office visit
Implants	\$365 + \$330 insertion/\$100 removal
Copper-T IUD	\$184 + \$200 insertion/\$70 removal

Note: based on costs in managed care setting.  
Hatcher, RA, et al. *Contraceptive Technology, Seventeenth Edition*. Ardent Media, Inc., New York: 1998.

During their childbearing years, women's out-of-pocket health expenditures are 68% more than that of their male counterparts.<sup>18</sup> A primary reason for this increased expense is reproductive health services, mostly pregnancy-related care, and to a lesser extent, contraception.<sup>19</sup> Many private insurance plans do not cover the full range of contraceptive options, although Medicaid – the nation's health insurance program for the poor – typically does. However, a sizable number of women ages 18-44 (20%) have neither private insurance nor Medicaid.<sup>20</sup> When resources are limited, some women may forego birth control altogether or use a less-expensive method that may not be the most appropriate for them.

Over two-thirds of women ages 18-44 rely on private insurance to help them finance medical care.<sup>21</sup> Yet coverage of contraception by these insurers varies greatly. A recent survey of employers by the Kaiser Family Foundation and the Health Research and Educational Trust shows significant gaps in coverage of oral contraception by type of plan (Figure 4).<sup>22</sup> In this study, the degree to which contraception is covered stood in marked contrast to the basic coverage provided for other prescription drugs and devices.

Research finds that extending coverage for contraceptives does result in increased premiums costs, although the costs may not be significant. According to a study commissioned by the Alan Guttmacher Institute, adding coverage for all five reversible birth control methods would cost a total average of \$21.40 per employee per year – just over \$17 of which would be paid by employers.<sup>23</sup>



### State Action

As of October 2000, thirteen states have enacted legislation to guarantee comprehensive insurance coverage of reversible contraception (Table 2).<sup>24</sup> In 1998, Maryland became the first state to pass such a law. These laws provide coverage for contraceptive services and supplies under the same terms and conditions as coverage for other prescription drugs. All of the state laws cover contraceptive drugs and devices; many states – Delaware, Hawaii, Iowa, Maine, Maryland, Nevada, New Hampshire, North Carolina, and Vermont – explicitly mention that insurers must also include birth control-related services such as counseling, exams, and insertion/removal where applicable (Figure 5).



An additional nine states have more limited provisions on the books, either as laws, regulations, or insurance department directives.<sup>25</sup> Some – Colorado, Kentucky, New Jersey, Virginia – merely require insurers to offer health plans that cover contraception. Others only require HMOs to cover contraceptive drugs, including Minnesota, New Mexico, and Oklahoma. Texas and Idaho mandate a benefit only for birth control pills. There are a handful of states that require HMOs to cover family planning services, but the term is

undefined in the regulations and may not include contraceptives. In some states, the regulations have been interpreted to include counseling, but not contraception.

One of the greatest issues of contention in legislative battles over contraceptive coverage has been whether to exempt employers and/or insurers whose religious tenets or beliefs conflict with the use of birth control. Of the thirteen states with comprehensive contraceptive coverage measures, nine have a form of religious exemption that some call a "conscience clause."<sup>26</sup> The definition of what constitutes a "religious employer" or "religious organization" – and thus, who may opt out – varies among the states.

Employers that are excluded by religious exemptions are not the only ones potentially exempted by state laws. In addition, ERISA exempts self-insured employers from contraceptive coverage provisions as it does from ob/gyn mandates.

### *Federal Response*

All employers – including multi-state and self-insured companies – would be covered under a bill that was introduced in the 106<sup>th</sup> Congress called the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). The measure would have required an insurer to cover birth control drugs and devices if it provides prescription benefits and to cover contraceptive services like other outpatient care. First introduced in 1997, EPICC has yet to see action on the House or Senate floor. However, for fiscal years 1999 and 2000, Congress approved spending bills with separate provisions, often called "riders," that extend a contraceptive benefit to government employees and their dependents who are covered under the Federal Employees Health Benefits Program.<sup>27</sup> Because the contraceptive benefit provision has been a rider, it must be reauthorized annually as part of the federal appropriations process.

### *Public Opinion*

A sizeable proportion of the public supports legislation that would guarantee contraceptive benefits under private insurance. In 1998, a Kaiser Family Foundation poll found that about three-quarters of Americans agreed with policies to require insurance plans to cover contraception – even if premiums were to rise as a result. Majorities of both women and men held this view, although women expressed greater support: 78% of women (48% "strongly support" and 30% "somewhat support") compared to 66% of men (36% "strongly support" and 30% "somewhat support").<sup>28</sup>

## **Medicaid Coverage for Gynecological Care: New Benefits for Low-Income Women**

The percentage of women without employer-based private insurance or government-sponsored benefits is striking, reaching 18% in 1998.<sup>29</sup> Uninsured women are significantly less likely to receive medical services, including reproductive care. For example, in a survey by the Commonwealth Fund, only 55% of them reported having a Pap test in the

past year, compared to 73% of women with employer-sponsored private insurance.<sup>30</sup>

Increasing costs of employer-based coverage and changes in eligibility for public programs account for many of the women who lack insurance. According to the 1998 Commonwealth Fund survey of women, two-thirds (68%) of currently or recently uninsured women are either employed or live in a family with at least one full-time worker.<sup>31</sup> A recent Urban Institute study found that half of women leaving welfare (49%) – many presumably to enter the workforce – were uninsured after one year; 28% were covered under private insurance and 22% had Medicaid, the joint federal-state health program for the poor.<sup>32</sup>

Eligibility for Medicaid is typically very restrictive for adults. Historically, only women poor enough to qualify for cash assistance or those who were disabled and receiving Supplemental Security Income could receive medical care through Medicaid. But laws passed by Congress in the 1980s expanded Medicaid, establishing a nationwide "floor" of eligibility for all pregnant women with incomes under 133% of the federal poverty level; states, at their option, can cover pregnant women with incomes up to 185% of poverty or higher. Although these policies provide important care to low-income pregnant women, coverage is limited to pregnancy-related care and ends 60 days after a woman gives birth, unless she meets other eligibility requirements.

### *State Action*

Due to the de-linking of Medicaid and welfare in the mid-90s, states can now establish higher income standards to provide Medicaid to previously ineligible families with children. With the passage of the Personal Responsibility and Work Opportunity Reconciliation Act in 1996, traditional welfare benefits through Aid to Families with Dependent Children (AFDC) were replaced with a block grant to states called Temporary Assistance for Needy Families (TANF). This change effectively terminated automatic Medicaid coverage for people with cash assistance. It created a new eligibility category to extend coverage to families with children, regardless of whether or not they receive public assistance through TANF, under Section 1931 of the Social Security Act. Seven states now have adopted plans under Section 1931 to extend eligibility to both parents and children in families with incomes below poverty.<sup>33</sup> This coverage is only available to families, leaving a large number of poor childless adults ineligible and still uninsured.

Since 1993, some states have used Medicaid as a vehicle to provide family planning benefits to low-income, uninsured women – regardless of pregnancy status or beyond the 60-day post-partum period. Because the federal government matches 90 cents for every dime a state spends on family planning, the Medicaid expansion is a relatively inexpensive way for states to improve access to these services.

To expand Medicaid coverage of family planning services for uninsured women, states must obtain a waiver from the

Health Care Financing Administration (HCFA), the federal agency that oversees Medicaid. These waivers, called section 1115 Research and Demonstration waivers, allow states to experiment with changes in Medicaid, but must not cost the Federal government more than what it would otherwise spend on Medicaid. This approach may be even more attractive to states in the wake of the 1996 federal welfare reform law, which provides added incentives – including monetary bonuses to the states – for reducing the number of unintended pregnancies.<sup>34</sup>

those women who would otherwise lose Medicaid at the end of the postpartum period or all women who meet state-established income criteria. At the close of the 106<sup>th</sup> Congress, this legislation had yet to see any action.

A new Medicaid benefit, however, has the potential to assist a very needy group of women. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 was just passed by Congress and signed by the President at the end of October, 2000.<sup>38</sup> Creating a new Medicaid eligibility option, this law allows states to use Medicaid to expand coverage for low-income, uninsured women with breast and cervical cancer. Women diagnosed with these cancers through a specific screening program (the National Breast and Cervical Cancer Early Detection Program) can obtain coverage through Medicaid for the duration of their cancer treatment, at state option.

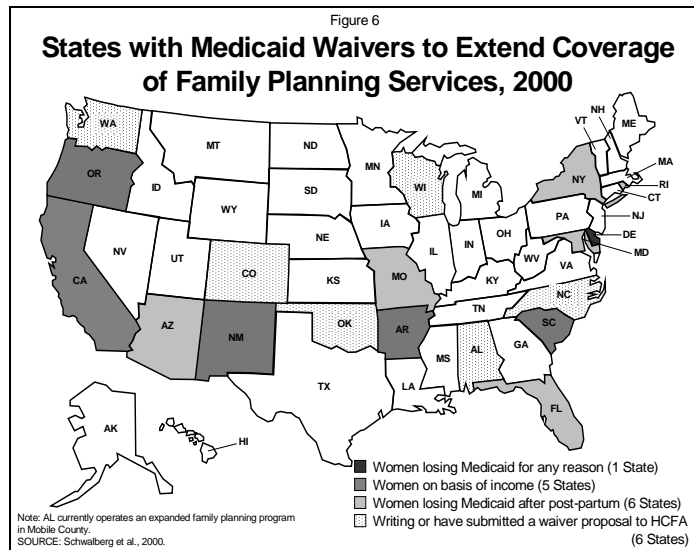
### Public Opinion

There is significant public support for funding family planning services for low-income women and covering the uninsured. In a recent Kaiser Family Foundation survey on health priorities for women in the 2000 election, 62% of respondents said it was very important for elected officials to address funding family planning services for low-income women.<sup>39</sup> Furthermore, almost three-quarters of respondents (74%) said it was very important for elected officials to address the issue of helping uninsured people to get health insurance, also a key health priority for women.<sup>40</sup>

### Conclusion

Public opinion, legislative action, and even insurer practices are generally pointing in one direction: greater attention to the health needs of women, particularly in their reproductive years. Few nationwide reforms by Congress have been enacted. In the meantime, some state legislatures have stepped in, increasing access to care where insurance is insufficient or non-existent.

The vast majority of states have already adopted measures to improve access to ob/gyns in managed care, possibly setting the stage for the next wave of consumer protection legislation. Requirements that private insurers include coverage for birth control have begun to take hold, making it likely that many more states will debate and possibly adopt these measures in the next few years. As more states provide family planning services through expanded Medicaid programs, this model may become more widely adopted, especially if the numbers of uninsured women continues to be significant. In these and other future policy debates, women – as health care consumers, elected officials, and advocates – will undoubtedly play a central role.



Twelve states have received approval to implement Medicaid expansion for family planning (Figure 6).<sup>35</sup> Six of these make services available to women who lost Medicaid coverage at the end of the postpartum period; the length of coverage ranges from two to five years. One state makes family planning services available for two years to women who lose Medicaid for any reason. Finally, five states have gone a step further, basing eligibility solely on income rather than on previous Medicaid enrollment (Table 2). Six additional states are awaiting waivers.<sup>36</sup>

Some states have also broadened these expansions beyond basic family planning services like contraception.<sup>37</sup> They include coverage for exams and counseling, sterilization, screening of STDs and HIV, treatment for STDs, and over-the-counter contraceptive supplies. One state, California, even includes limited diagnostic services for infertility and preconception counseling.

### Federal Response

States must go through an often-complicated process to receive approval from HCFA to establish these programs. To facilitate state adoption of Medicaid family planning expansions, legislation that was introduced by the late Senator Chafee during the 106<sup>th</sup> Congress would have eliminated the requirement that states obtain waivers before implementing a family planning expansion program. The Family Planning State Flexibility Act would have enabled states to obtain a 90% federal match to provide these benefits to women with incomes up to 185% of the poverty level. States could choose whether to cover only

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- <sup>1</sup> Woodwell, DA, *Advance Data. No. 305. National Ambulatory Medical Care Survey: 1997 Summary*, (PHS) 99-1250.
- <sup>2</sup> Kaiser Family Foundation/Los Angeles Times/Essence/Latina. *A National Survey of Women About Their Reproductive Health Care*, 1999.
- <sup>3</sup> Weisman CS, Henderson J. Unpublished analysis of the *Commonwealth Fund 1998 Survey of Women's Health*.
- <sup>4</sup> The Gallop Organization for ACOG. *A Gallop Study of Attitudes About the Use of Obstetrician/Gynecologists for Primary Care*, Princeton, N.J., 1993.
- <sup>5</sup> The Gallop Organization for ACOG, 1993.
- <sup>6</sup> Collins, KS, et al. *Health Concerns Across A Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health*, May 1999.
- <sup>7</sup> American College of Obstetricians and Gynecologists (ACOG). *State Laws and Regulations Requiring Insurance Coverage for Postpartum Care, 1995-1997*, November 1997.
- <sup>8</sup> 29 U.S.C. §§1185 and 42 U.S.C. §§300qq-4, 300qq-51.
- <sup>9</sup> 29 U.S.C. §1001.
- <sup>10</sup> Calculations based on data from the Kaiser Family Foundation (KFF)/Health Research and Educational Trust (HRET) *Survey of Employer-Sponsored Health Benefits*, 2000.
- <sup>11</sup> State information in this paragraph is compiled from the National Conference of State Legislatures Health Policy Tracking Service and the ACOG Department of State Legislative & Regulatory Activities.
- <sup>12</sup> The Kaiser Family Foundation/Harvard University. *National Survey of Americans' Views on Consumer Protections in Managed Care*, 1998.
- <sup>13</sup> The Kaiser Family Foundation/SELF magazine. *A National Survey on Women's Health Policy Priorities and Election 2000*, 2000.
- <sup>14</sup> Collins, KS, et al., 1999.
- <sup>15</sup> KFF/HRET, 2000.
- <sup>16</sup> Piccinino, LJ, Mosher, WD. "Trends in Contraceptive Use In the United States: 1982-1995," *Family Planning Perspectives*, (30)1: 1998.
- <sup>17</sup> Brown, SS, Eisenberg, L, eds. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Committee on Unintended Pregnancy, Institute of Medicine: National Academy Press, 1995.
- <sup>18</sup> Women's Research and Education Institute (WREI). *Women's Health Insurance Costs and Experiences*, 1994.
- <sup>19</sup> WREI, 1994.
- <sup>20</sup> Urban Institute estimates reflecting 1998 data prepared for the Kaiser Commission on Medicaid and the Uninsured. Based on March 1999 Current Population Survey, Bureau of the Census.
- <sup>21</sup> Urban Institute estimates reflecting 1998 data prepared for the Kaiser Commission on Medicaid and the Uninsured. Based on March 1999 Current Population Survey, Bureau of the Census.
- <sup>22</sup> KFF/HRET, 2000.
- <sup>23</sup> Darroch, JE. *Cost to Employer Health Plans of Covering Contraceptives*, The Alan Guttmacher Institute, June 1998.
- <sup>24</sup> National Conference of State Legislatures Health Policy Tracking Service.
- <sup>25</sup> From state statutes, National Conference of State Legislatures Health Policy Tracking Service (HPTS) October 2000, and National Women's Law Center et. al., August 2000; updated information via personal communication with HPTS.
- <sup>26</sup> California, Delaware, Hawaii, Maine, Maryland, North Carolina, and Rhode Island allow employers to opt out, Nevada's exemption applies to insurers, while Connecticut's encompasses both.
- <sup>27</sup> Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998, P.L. No. 105-207 §656. Treasury, Postal, and General Government Appropriations Act of 2000, P.L. 106-58 §656.
- <sup>28</sup> Kaiser Family Foundation. *National Survey on Insurance Coverage of Contraceptives*, 1998.
- <sup>29</sup> Urban Institute estimates reflecting 1998 data prepared for the Kaiser Commission on Medicaid and the Uninsured. Based on March 1999 Current Population Survey, Bureau of the Census.
- <sup>30</sup> Collins, KS, et al., 1999.
- <sup>31</sup> Collins, KS, et al., 1999.
- <sup>32</sup> Garrett, B, Holahan, J. "Health Insurance Coverage After Welfare," *Health Affairs*, Jan/Feb 2000.
- <sup>33</sup> Personal communication with the Center for Budget and Policy Priorities. For further information, see *Medicaid Eligibility for Families and Children* from the Kaiser Family Foundation, Forthcoming 2001.
- <sup>34</sup> The Kaiser Family Foundation. *Welfare Policy and Reproductive Health: "Capping a Family's Benefits,"* November 1998.
- <sup>35</sup> Schwalberg R, et al. *Medicaid Coverage of Family Planning Services: Results of a National Survey*. For the Kaiser Family Foundation, 2000.
- <sup>36</sup> Schwalberg R, et al., 2000. These states include Alabama, Colorado, North Carolina, Oklahoma, Wisconsin, and Washington.
- <sup>37</sup> Schwalberg R, et al., 2000.
- <sup>38</sup> P.L. 106-354.
- <sup>39</sup> KFF/SELF, 2000.
- <sup>40</sup> KFF/SELF, 2000.

**Table 1: State Policies on Access to Obstetrical and Gynecological Services, November 2000**

Direct Access to Women's Health Services under Managed Care: State Mandates					
	Insurers required to allow women to self refer to Ob/Gyn without plan or PCP preapproval	Insurers required to allow women to choose a participating Ob/Gyn as their PCP	Additional co-pay or surcharge for direct access prohibited	Enrollees must be notified about direct access requirement	Annual limits on visits
United States Total	38 + DC	16 + DC	9	16	
Alabama	X	X			none
Alaska					
Arizona					
Arkansas	X				none
California	X	X			
Colorado	X				none
Connecticut	X	*			none
Delaware	X	X	X	X	minimum of 1
District of Columbia	X	X			none
Florida	X	X			annual
Georgia	X			X	none
Hawaii					
Idaho	X	X			none
Illinois	X			X	none
Indiana		X			
Iowa					
Kansas					
Kentucky	X				none
Louisiana	X	*			2 routine
Maine	X	X			one
Maryland	X	X			none
Massachusetts	X		X		none
Michigan	X			X	none
Minnesota	X				none
Mississippi	X	X			none
Missouri	X				1 annual
Montana	X	X	X	X	none
Nebraska		X			
Nevada	X				none
New Hampshire	X			X	annual
New Jersey		X			
New Mexico	X	X	X	X	
New York	X			X	minimum of 2
North Carolina	X			X	none
North Dakota					
Ohio	X		X		none
Oklahoma					
Oregon	X	X			annual
Pennsylvania	X				none
Rhode Island	X				one
South Carolina	X			X	minimum of 2
South Dakota					
Tennessee	X				minimum of 1
Texas	X		X	X	none
Utah	X	X	X	X	none
Vermont	X				minimum of 2
Virginia	X			X	one annual
Washington	X		X	X	none
West Virginia	X	X	X	X	
Wisconsin	X			X	none
Wyoming					

PCP: Primary Care Provider

\*State gives some, if not all, insurers the option to choose ob/gyns as PCPs.

Source: Compiled by the Kaiser Family Foundation, based on the National Conference of State Legislatures Health Policy Tracking Service, October 2000, and the American College of Obstetricians and Gynecologists, July 1999.

**Table 2: State Policies on Access to Family Planning, November 2000**

	State Legislation on Insurance Coverage of Contraceptives			States with Medicaid Waivers to Cover Family Planning			
	Total	Comprehensive	Limited	Total	Women losing Medicaid at end of post-partum period	Women losing Medicaid for any reason	Women who meet income criteria (% of FPL/duration of coverage)
United States Total	22	13	9	12	6	1	5
Alabama					*		
Alaska							
Arizona				X	X (2 Years)		
Arkansas				X			X (133%)
California	X	X		X			X (200%, 1 Year)
Colorado	X		X <sup>1,2</sup>				
Connecticut	X	X					
Delaware	X	X		X		X (2 Years)	
District of Columbia							
Florida				X	X (2 Years)		
Georgia	X	X					
Hawaii	X	X					
Idaho	X		X <sup>2,5</sup>				
Illinois							
Indiana							
Iowa	X	X					
Kansas							
Kentucky	X		X <sup>1,2</sup>				
Louisiana							
Maine	X	X					
Maryland	X	X		X	X (5 Years)		
Massachusetts							
Michigan							
Minnesota	X		X <sup>4</sup>				
Mississippi							
Missouri				X	X (2 Years)		
Montana							
Nebraska							
Nevada	X	X					
New Hampshire	X	X					
New Jersey	X		X <sup>1,3</sup>				
New Mexico	X		X <sup>4</sup>	X			X (185%, 2 Years)
New York				X	X (2 Years)		
North Carolina	X	X					
North Dakota							
Ohio							
Oklahoma	X		X <sup>4</sup>				
Oregon				X			X (185%, 1 Year)
Pennsylvania							
Rhode Island	X	X		X	X (2 Years)		
South Carolina				X			X (185%)
South Dakota							
Tennessee							
Texas	X		X <sup>5</sup>				
Utah							
Vermont	X	X					
Virginia	X		X <sup>1</sup>				
Washington							
West Virginia							
Wisconsin							
Wyoming							

<sup>1</sup>Insurers must offer at least one plan that covers contraceptives.

<sup>2</sup>Only applies to basic, standard, or catastrophic plans.

<sup>3</sup>Only applies to individual or small group plans.

<sup>4</sup>Only HMOs required to provide coverage of contraceptives.

<sup>5</sup>Only required to offer oral contraceptives.

FPL-Federal Poverty Level-was \$13,880 for a family of 3 in 1999.

\*Alabama currently operates an expanded family planning program in Mobile County.

Source: Insurance coverage of contraceptives compiled by the Kaiser Family Foundation, based on state statutes, the National Conference of State Legislatures Health Policy Tracking Service, October 2000, and the National Women's Law Center et al., August 2000. Medicaid Waiver data from Schwalberg, R. et al. 2000.