EXECUTIVE SUMMARY

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

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

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

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

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

KEY FINDINGS

PRIVATE INSURANCE COVERAGE

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

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

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

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

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

MEDICAID

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

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

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

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

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

REPRODUCTIVE HEALTH SERVICES

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

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

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

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

OTHER WOMEN'S HEALTH-RELATED SERVICES

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

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

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

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

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