II. PRIVATE INSURANCE COVERAGE

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

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

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

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

SCREENING COVERAGE MANDATES

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

Breast Cancer Screening Coverage Mandates

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

TABLE II-1 BREAST CANCER SCREENING COVERAGE MANDATES

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

TABLE II-1
Breast Cancer Screening Coverage Mandates

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

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

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

Cervical Cancer Screening Coverage Mandates

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

TABLE II-2 CERVICAL CANCER SCREENING COVERAGE MANDATES

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

TABLE II-2
Cervical Cancer Screening Coverage Mandates

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

Notes:

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

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

Colorectal Cancer Screening Coverage Mandates

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

FIGURE II-1 AMERICAN CANCER SOCIETY COLORECTAL CANCER SCREENING RECOMMENDATIONS

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

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

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

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

TABLE II-3 COLORECTAL CANCER SCREENING COVERAGE MANDATES

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

TABLE II-3
Colorectal Cancer Screening Coverage Mandates

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

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

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

Osteoporosis Screening Coverage Mandates

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

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

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

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

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

TABLE II-4 OSTEOPOROSIS SCREENING COVERAGE MANDATES

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

TABLE II-4
Osteoporosis Screening Coverage Mandates

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

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

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

Chlamydia Screening Coverage Mandates

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

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

TABLE II-5 CHLAMYDIA SCREENING COVERAGE MANDATES

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

TABLE II-5
Chlamydia Screening Coverage Mandates

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

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

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

NON-SCREENING REPRODUCTIVE HEALTH COVERAGE MANDATES

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

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

Contraceptive Coverage Mandates

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

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

FIGURE II-3 FDA-APPROVED METHODS OF PRESCRIPTION CONTRACEPTION

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

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

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

TABLE II-6 CONTRACEPTIVE COVERAGE MANDATES

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

TABLE II-6
Contraceptive Coverage Mandates

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

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

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

Infertility Treatment Coverage Mandates

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

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

TABLE II-7 INFERTILITY TREATMENT COVERAGE MANDATES

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

TABLE II-7
Infertility Treatment Coverage Mandates

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

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

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

Post-Mastectomy Coverage Mandates: Hospital Stays

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

TABLE II-8 POST-MASTECTOMY STAY COVERAGE MANDATES

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

Post-Mastectomy Coverage Mandates: Reconstructive Breast Surgery

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

TABLE II-8 RECONSTRUCTIVE BREAST SURGERY MANDATES

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

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

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

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

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

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

MENTAL HEALTH PARITY

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

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

Mental Health Parity Laws

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

TABLE II-9 MENTAL HEALTH PARITY LAWS

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

TABLE II-9
Mental Health Parity Laws

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

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

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

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

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

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

MANAGED CARE

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

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

Access to OB/GYNs

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

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

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

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

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

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

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

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

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

Continuity of Care

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

TABLE II-11 MANAGED CARE CONTINUITY OF CARE COVERAGE MANDATES

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

TABLE II-11
Managed Care Continuity of Care Provisions

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

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

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

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

Coverage of Clinical Trials

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

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

TABLE II-12 MANAGED CARE CLINICAL TRIAL COVERAGE

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

TABLE II-12
Managed Care Clinical Trial Coverage

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

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

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

External Review Processes

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

TABLE II-13 MANAGED CARE EXTERNAL REVIEW

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

✶ ✶ ✶

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

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

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

TABLE II-13
Managed Care External Review

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

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

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

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

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