Improving Coverage: Using State Law to Maximize Access to Family Planning and Abortion Services
About the National Health Law Program

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals. Founded in 1969, NHeLP advocates, educates, and litigates at the federal and state levels. NHeLP promotes quality reproductive health coverage, access, and services within the larger context of comprehensive, fully integrated, quality care.

Our work recognizes the critical role of government in ensuring that all women and families, and particularly low-income people, have affordable access to safe, high-quality, comprehensive reproductive health care. We work to mainstream sexual and reproductive health in a seamless system of quality affordable care, so that every person can make their own reproductive health decisions with dignity.
Access to abortion and contraceptive services is a necessary part of comprehensive health care. Maximizing the potential of private health insurance and Medicaid requires strong laws and policies that ensure that individuals have comprehensive, affordable coverage and timely access to family planning and abortion services. Laws and policies on coverage and access to these critical health care services vary significantly from state to state. Some of these laws promote and protect access to care, while others erect barriers.
I. Introduction

Women consider a number of factors when determining whether to become or remain pregnant, including age, educational goals, economic situation, the presence of a partner and/or other children, medical conditions, mental health, and whether they are taking medications that are contraindicated for pregnancy.1 In 2014, there were sixty-two million women of reproductive age (ages fifteen to forty-four) in the United States.2 Over seventy percent of these women were at risk of unintended pregnancy, meaning that they were sexually active with a male, capable of becoming pregnant, and neither pregnant nor seeking to become pregnant.3 Each year, half of the pregnancies in the United States are unintended (unwanted or mistimed).4 By age forty-five, more than half of all women in the United States have experienced an unintended pregnancy, and three in ten have had an abortion.5

In 1995, the Institute of Medicine urged a new national norm – that every pregnancy is a planned pregnancy.6 To achieve that goal, individuals need access to family planning and abortion services. For many individuals, cost is a barrier to obtaining necessary health care services. Enrolling in private health insurance coverage or in Medicaid can remove some of these financial barriers and help individuals access necessary services. Maximizing the potential of private health insurance and Medicaid, however, requires strong laws and policies that ensure that individuals have comprehensive, affordable coverage and timely access to family planning and abortion services. Laws and policies on coverage and access to these critical health care services vary significantly from state to state. Some of these laws promote and protect access to care, while others erect barriers.

To learn more about this variation, we researched laws and policies that affect coverage and access to family planning and abortion services in eleven states: California, Florida, Kentucky, New Hampshire, New Mexico, North Carolina, Minnesota, Missouri, Pennsylvania, Washington, and Wisconsin. These states present diversity of location, population, political landscape, and policy choices regarding implementation of the Affordable Care Act (ACA). We reviewed statutes, regulations, case law, and Medicaid agency policies affecting coverage of family planning and abortion services. Where available and relevant, we also reviewed sample Medicaid managed care contracts or Medicaid agency “requests for proposals” from managed care entities.

This report first provides a brief overview of the private health insurance market and Medicaid. Then, we turn to federal and state laws and policies that can have a substantial effect on access to family planning and abortion services, and highlight promising or problematic laws and policies in the eleven states that we reviewed.

We recognize that this analysis does not capture all of the laws and policies that affect access to family planning or abortion services, including laws that criminalize certain abortions or single out and impose unnecessary requirements on abortion clinics and providers.7

This report is intended to further inform advocates and policymakers about areas in which state laws and policies can hinder or improve coverage and access to family planning and abortion services. We hope that this information will contribute to state-based efforts to improve access to these services.
II. Background

The ACA brought historic reforms to the private health insurance market and Medicaid, enabling millions of individuals to enroll in quality, comprehensive, and affordable insurance. As of March 2015, over sixteen million people had gained coverage under the provisions of the ACA.8

A. THE PRIVATE HEALTH INSURANCE MARKET

Some individuals have the opportunity to enroll in health insurance through their employer. Both federal and state agencies (the Department of Labor, the Department of Health and Human Services (HHS), and state departments of insurance) regulate employer-sponsored plans.9 Federal and state laws establish baseline consumer protections for individuals enrolled in these plans.

Individuals who do not have access to affordable health insurance through an employer may choose to purchase a health plan on the private market. Under the ACA, individuals have the option to purchase a “qualified health plan” (QHP) through a health insurance Marketplace.10 Some states have set up their own Marketplaces, administered by a state agency or non-profit organization.11 Other states work with the federal government to run a partnership Marketplace. Most states have left it to the federal government to operate a federally-facilitated Marketplace (FFM) and perform all Marketplace functions.12 HHS and state departments of insurance regulate and oversee QHPs.13

Financial assistance is available to certain low- and middle-income individuals who enroll in a QHP.14 Tax credits, which lower premiums, are available to individuals with incomes between 100% and 400% of the federal poverty level (FPL).15 Cost-sharing subsidies, which reduce out-of-pocket expenses (co-pays, co-insurance, and deductibles), are available to individuals with incomes below 250% FPL.16

B. MEDICAID

Medicaid is a cooperative federal and state program. States must follow federal Medicaid requirements, and in return, the federal government reimburses states for a portion of their Medicaid costs. Within certain federal parameters, states have some flexibility in determining eligibility criteria, covered services, and protections for beneficiaries.

The federal government makes federal financial participation (FFP) available for services covered under the state’s Medicaid program and for administrative costs the state incurs to operate the program.17 Each state has its own reimbursement rate for covered services, which is called the federal medical assistance percentage (FMAP) and can range from 50% to 83%.18 States receive a higher FMAP for certain expenditures. For example, all states receive a 90% FMAP for expenditures attributable to offering, arranging, and furnishing family planning services and supplies.19

Each state must designate a single state agency that is responsible for administering its Medicaid program.20 To receive FFP, the state agency must maintain a comprehensive state Medicaid plan that describes the nature and scope of the state’s Medicaid program and has been approved by the Secretary of HHS.21 When there is a change in federal law or policy or a material change in state law, policy, organization, or operation of the program, the state agency must submit a state plan amendment (SPA) to the Secretary of HHS for approval.22

Before the ACA, to qualify for Medicaid, individuals had to meet certain income requirements and also fit into a particular eligibility category – children, parents of dependent children, pregnant women, seniors, or individuals with a disability. The ACA requires states to expand their Medicaid programs to cover individuals with incomes below 133% FPL who do not fit into one of the traditional eligibility groups.23 However, the U.S. Supreme Court’s decision in National Federation of Independent Business v. Sebelius effectively transformed this requirement into an option for states by holding that the federal government is not entitled to withhold federal Medicaid dollars from a state that refuses to expand.24 To date, twenty-nine states and the District of Columbia have expanded their Medicaid programs.25 Of the states that we reviewed, California, Kentucky, Minnesota, New Hampshire, New Mexico, Pennsylvania, and Washington have implemented the Medicaid Expansion.26

Affordable coverage, however, remains out of reach for individuals in states that have not expanded their

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Medicaid programs. Some individuals do not qualify for Medicaid because their state has not adopted the Medicaid Expansion, but also do not qualify to receive premium tax credits for purchasing a QHP through a Marketplace because their household income is too low. According to the Kaiser Family Foundation, “[n]ationally, nearly four million poor uninsured adults fall into th[is] ‘coverage gap’ that results from state decisions not to expand Medicaid.”

In addition to expanding eligibility for full-scope Medicaid coverage, the ACA created a new option for states seeking to provide family planning and family planning-related services to individuals who do not otherwise qualify for Medicaid. Before the ACA, states could provide this coverage through a family planning demonstration project (also known as an 1115 waiver because states establish a project under § 1115 of the Social Security Act). The ACA now allows states to incorporate this limited-benefit family planning services coverage into their Medicaid programs through a state plan amendment (SPA). While a demonstration project is time-limited, a SPA is a more permanent change to a state’s Medicaid program.

### III. Family planning coverage

#### A. PRIVATE HEALTH INSURANCE COVERAGE OF FAMILY PLANNING SERVICES

The ACA requires most group and individual health insurance plans, sold inside and outside of the Marketplaces, to cover certain preventive services for women, as described in guidelines issued by the Health Resources and Services Administration (HRSA), a federal agency within HHS. The HRSA guidelines require coverage of “[a]ll Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.”

The contraceptive coverage requirement includes all over-the-counter (OTC) contraceptive methods “as prescribed,” management of side effects, counseling for continued adherence, removal of contraceptive devices, and all other clinical services needed for the provision of a contraceptive. Importantly, plans must cover these services and supplies without cost-sharing, which means that plans cannot charge enrollees a co-pay or co-insurance or require enrollees to meet their deductible before providing coverage. This is a critical protection, as some of the most effective contraceptives, long-acting reversible contraceptives or LARCs (such as intrauterine devices (IUDs) and implants), are also the most expensive upfront. Research establishes that eliminating cost-sharing obligations leads to increased use of contraceptives.

The contraceptive coverage requirement represents a great stride forward for women, yet, challenges and gaps in coverage remain. Federal regulations permit group health plans established or maintained by certain religious employers to refuse to provide coverage for contraceptive services as required under the ACA. The regulations define a religious employer as a church, church association, or other similar bodies.

Between 2012 when the contraceptive coverage requirement went into wide-scale effect and 2013, the proportion of privately insured women between 18 and 39 with no out-of-pocket cost for their oral contraceptives increased from 15% to 67%; for injectable contraception, from 24% to 57%; for the vaginal ring, from 20% to 74%; and for the intrauterine device, from 45% to 62%.

NOTE: CONTRACEPTIVE EQUITY LAWS – EXCEPTIONS FOR RELIGIOUS ENTITIES

Most state contraceptive equity laws were passed long before the federal contraceptive coverage requirement, and some include exceptions for entities or individuals with religious or moral objections to contraceptives that are broader than those that exist under federal law. For example, New Mexico’s contraceptive equity statute allows any “religious entity” – an undefined term – to “exclude prescription contraceptive drugs or devices from the health coverage purchased.” However, under federal law, in state laws with “broader religious exemptions and accommodations with respect to health insurance issuers than those in the [federal rules], the exemptions and accommodations will be narrow to align with those in the final federal regulations.” Only one state – Illinois – allows religious exemptions for secular entities.

Further, federal law fails to recognize the role that men play in preventing unintended pregnancy. The ACA’s contraceptive coverage requirement does not apply to men or require coverage of male contraceptive methods such as male condoms or vasectomies.

Even women enrolled in a plan subject to the contraceptive coverage requirement might still encounter barriers to timely access to the contraceptive of their choice without cost-sharing. Federal regulations implementing the contraceptive coverage requirement permit plans to use “reasonable medical management techniques to determine the frequency, method, treatment or setting” for an item or service. While federal regulations do not define the term “medical management,” it is broadly understood to encompass insurer practices that aim “to control costs and promote efficient delivery of care.” Insurers routinely use medical management techniques such as prior authorization, quantity limits, and step therapy (requiring trial and failure of one drug or device before another will be covered), to control the availability of covered benefits. Insurers use these techniques to override a provider’s clinical judgment about whether a patient should receive a particular service or treatment.

When applied to contraception, these medical management techniques can delay or deny access to appropriate contraception, resulting in lapsed or inconsistent contraceptive use and increased risk of unintended pregnancy. Federal guidance provides some examples of permissible medical management techniques and some important limitations with respect to contraception. In May 2015, the Departments made clear that plans must cover without cost-sharing at least one form of contraception in each of the FDA-approved contraceptive methods for women. Within each of the methods, plans and issuers “may impose cost-sharing (including full cost-sharing) on some items and services to encourage an individual to use other specific items and services within the chosen contraceptive method.” For example, plans may choose not to cover or may charge cost-sharing for brand-name contraceptive drugs that have a generic equivalent. Plans may also use cost-sharing to “encourage use” of one of several FDA-approved hormonal IUDs. Importantly, however, if an enrollee’s provider determines that a particular contraceptive product is medically necessary, the plan or issuer must defer to the provider’s determination and cover the contraceptive without cost-sharing. Plans must provide such an exception through a process that is “easily accessible, transparent, and sufficiently expedient” and not “unduly burdensome” on the enrollee or provider. Ongoing monitoring and enforcement is needed to ensure that plans adhere to this requirement.

Finally, the federal contraceptive coverage requirement allows issuers to require enrollees to obtain a prescription for FDA-approved methods of contraception that are available OTC. Requiring women to obtain a medically unnecessary prescription imposes an additional barrier and undermines access to care. State laws regulating contraceptive coverage (often referred to as contraceptive equity laws) can play a critical role in filling these gaps.
Of the states in our review, Florida, Kentucky, Minnesota, Missouri, and Pennsylvania do not have a contraceptive equity law in effect. Missouri had a contraceptive equity law in effect that contained a broad refusal clause. However, a federal district court declared the law invalid in 2013, finding the refusal clause in direct conflict with the federal contraceptive coverage requirement. As a result, Missouri state law no longer requires that private health plans provide contraceptive coverage. Of course, Missouri plans must still comply with the federal contraceptive coverage requirement.

New Mexico, New Hampshire, North Carolina, Washington, and Wisconsin generally require regulated plans to cover contraceptive services, drugs, and/or devices on the same terms as other outpatient services and/or prescription drugs and devices. While some of these laws prohibit regulated plans from singling out contraceptives for more restrictive cost-sharing or medical management, none of them prevent plans from imposing cost-sharing or engaging in medical management techniques that are inappropriate when applied to contraception.

California’s contraceptive equity law, recently amended by Senate Bill 1053 (SB 1053), stands out for seeking to fill these gaps and fulfill the full promise of the ACA. As of 2016, most new health plans must cover all FDA-approved contraceptive drugs, devices, and products without cost-sharing. The law also prohibits these private health insurance plans, as well as Medicaid managed care plans, from utilizing medical management techniques that can prevent or delay access to contraception.

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Notwithstanding these important protections, SB 1053 falls short in three respects. First, it does not apply to men or require coverage of male contraceptive methods. As a result, male enrollees might not have coverage or timely access to family planning services without cost-sharing. Second, it does not require coverage of OTC contraceptives without a prescription. Third, the law maintains a previously existing exemption for certain religious employers. The narrow exemption is effectively the same as the exemption for religious employers in the federal contraceptive coverage requirement.

### B. MEDICAID COVERAGE OF FAMILY PLANNING SERVICES

Federal Medicaid law requires states to cover "family planning services and supplies" without cost-sharing. As with most other Medicaid services, states have some discretion to determine what family planning services and supplies to cover in their programs, as long the coverage is “sufficient in amount, duration, and scope to reasonably achieve its purpose.” Notably, federal Medicaid law does not explicitly require coverage of “[a]ll FDA-approved methods.” Family planning services may include (1) patient counseling and education; (2) examination and treatment by medical professionals; (3) laboratory examinations and tests; (4) medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; and (5) infertility services, including sterilization reversals. It is possible that states may also cover OTC contraceptives without a prescription as a family planning service.

States also must ensure that enrollees are “free from coercion and mental pressure and free to choose the method of family planning to be used.” If the range of family planning services and supplies available in a state is not sufficient to offer beneficiaries meaningful alternatives, the effect on enrollees could be coercive. In addition, Medicaid enrollees have the right to receive family planning services and supplies from the provider of their choice, even if that provider is out-of-network, as long as the provider participates in the Medicaid program.

Some Medicaid enrollees, and in particular the ACA’s Medicaid expansion population, receive their benefits through Alternative Benefit Plans (ABPs), formerly known as Medicaid benchmarks. ABPs must cover family planning services and supplies and are also subject to the ACA’s contraceptive coverage requirement.
1. Coverage for full-scope Medicaid beneficiaries

The scope of coverage for family planning services and supplies varies among states. Some states choose not to cover particular family planning services. States have also adopted different policies regarding under what circumstances they cover particular family planning services and supplies. These practices are troubling, as research shows that women who have access to the contraceptive method of their choice are more likely to use the method consistently and effectively. When women use contraception consistently, their risk of unintended pregnancy drops significantly.

HIGHLIGHTS FROM OUR ELEVEN STATE REVIEW

Coverage of family planning services differs among the eleven states that we reviewed. Some of the states explicitly exclude coverage of certain family planning services. For example, North Carolina does not cover diaphragms or OTC contraceptives, except that the state will cover OTC emergency contraception with a prescription. Missouri does not cover “condoms and devices or supplies” available as OTC products. While Missouri covers intrauterine devices (IUDs) and related insertion procedures, the state does not allow providers to bill for IUD removal. This alarming payment policy effectively denies women coverage of this critical service.

Problematically, Florida does not cover family planning services for individuals under age eighteen who are not married, a parent, or pregnant, unless they have written consent from a parent or guardian or unless the provider determines that without the family planning services, they “will suffer from probable health hazards... based on sexual activity or other medical reasons.” Florida’s policy poses a potential obstacle to minors seeking confidential family planning services.

In contrast, other states require comprehensive coverage of contraceptive methods. Washington, for example, explicitly requires Medicaid managed care plans to cover all FDA-approved contraceptive methods. Although some states that we reviewed, including California, cover OTC contraceptive drugs and supplies with a prescription, Washington covers OTC contraceptive drugs and supplies without a prescription, allowing women to directly access the care that they need.

New Mexico stands out for taking steps to ensure that women have timely access to post-partum IUDs and implants. Most state Medicaid programs pay hospitals for prenatal care and services provided at the time of labor and delivery using a set fee (generally referred to as “global billing”) that does not take into account the high cost of these contraceptive methods. Consequently, many hospitals do not provide placement of an IUD or implant immediately postpartum. However, New Mexico allows hospitals to bill separately for placement of IUDs and implants immediately postpartum. This billing policy gives women access to these methods without delay, reducing the risk of unintended pregnancy and improving birth spacing.

2. Family planning expansion through a demonstration project or a state plan amendment

Federal law allows state Medicaid programs to cover family planning and family planning-related services for individuals who are not otherwise eligible for Medicaid. Historically, states implemented this coverage through time-limited family planning demonstration projects. However, the ACA creates a new option for states, allowing them to provide this limited-scope coverage through a SPA. These family planning expansion programs are a crucial source of contraceptive coverage for low-income individuals, particularly in states that have not expanded their Medicaid programs.

Family planning demonstration projects (§ 1115 waivers)

States may request and obtain from CMS a waiver of certain Medicaid requirements to implement a research and demonstration project that furthers the objectives of the Medicaid program. These waivers must be designed to test, experiment, or pilot innovative concepts that promote access to Medicaid services; they are not merely coverage alternatives. Waivers must be cost-neutral and are time-limited – states seeking an extension must obtain a renewal from CMS.

States have significant flexibility in designing family planning demonstration projects, including defining distinct eligibility criteria. States have generally developed two eligibility models: (1) provide coverage to individuals on the basis of income (as well as age and/or gender); or (2) provide coverage to women losing Medicaid coverage. Some demonstration projects incorporate both of these models. A number of states allow individuals to apply for a family planning demonstration project at their provider’s office. Some states, for example, use presumptive eligibility, which allows individuals to receive services on the basis of preliminary information pending the state’s determination of their eligibility. Importantly, presumptive eligibility permits individuals to receive family planning services at their initial visit.

States negotiate with CMS to determine the scope of services covered in these family planning demonstration projects. As in traditional Medicaid, states receive a 90% FMAP for family planning services.
States may also cover family planning-related services, which are eligible for the standard FMAP. Family planning-related services are described in more detail below.

**State plan amendments**

Congress recognized the effectiveness of family planning demonstration projects, and in the ACA, gave states the option to incorporate this single-benefit coverage into their Medicaid programs through a SPA.

Under the SPA option, states must provide coverage to men and women who are not pregnant and have an income at or below the level for pregnant women in the state’s Medicaid program or Children’s Health Insurance Program.79 Unlike with the demonstration projects discussed above, states cannot exclude men or minors from coverage. However, states have some flexibility to decide how to count income, which can affect an applicant’s eligibility.80 Federal law also gives states the option to provide a period of presumptive eligibility to individuals who appear to qualify for coverage.81

States must provide the same package of family planning services to individuals enrolled in a SPA family planning expansion and to individuals enrolled in full-scope Medicaid.82 States have the option to cover family planning-related services, which are “medical diagnosis and treatment services that are provided pursuant to a family planning service visit in a family planning setting.”83 Family planning-related services include treatment for sexually transmitted infections (STIs) and treatment for complications resulting from family planning services.84

Family planning demonstration projects and SPAs play a critical role post-ACA implementation. Millions of adults do not qualify for Medicaid or for federally-subsidized coverage in a QHP, and as a result, likely remain uninsured. Moreover, family planning expansion programs help provide care to individuals moving between insurance programs and to individuals in need of confidential access to family planning services. For uninsured women who only see a family planning provider, these programs can also serve as a gateway to full-scope coverage.

**HIGHLIGHTS FROM OUR ELEVEN STATE REVIEW**

With the exception of Kentucky, all of the states discussed in this report have implemented a family planning demonstration project or a SPA.

**State Family Planning Expansion Programs**

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* As this publication went to print, Pennsylvania has stated that it intends to convert to a state plan amendment.

**Family planning demonstration projects**

Florida, Minnesota, Missouri, Pennsylvania, and Washington provide family planning services through family planning demonstration projects.85 The states we reviewed use different eligibility criteria and cover different services. Florida and Missouri have relatively restrictive eligibility requirements. In Missouri, uninsured women ages eighteen to fifty-five (adolescents are excluded) with household incomes at or below 201% FPL ($23,658 for an individual) qualify for the family planning demonstration project. Missouri also offers one year of coverage to women who were eligible for Medicaid on the basis of pregnancy and lost their Medicaid eligibility at the end of the postpartum period.86 Florida covers women ages fourteen to fifty-five who have household incomes below 191% FPL and have lost Medicaid pregnancy coverage. The state also offers family planning services for a period of two years to women who meet the

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**TIP: DETERMINING THE SCOPE OF MEDICAID COVERAGE**

In addition to state statutes and regulations, the Medicaid state plan, Medicaid provider manuals, billing and coding instructions for providers, and contracts with Medicaid managed care plans are all valuable sources of information. Most states have made at least some of these materials available online. In addition, most SPAs and 1115 waiver documents are available at Medicaid.gov.
same age and income criteria and have lost Medicaid coverage for a reason other than the termination of pregnancy coverage. In contrast, Washington covers uninsured men and women who have household incomes at or below 250% FPL, as well as women who have lost Medicaid pregnancy coverage. Minnesota is the only state in our review that uses presumptive eligibility for individuals who apply for coverage through the demonstration project.

**State plan amendments**
California, New Hampshire, New Mexico, North Carolina, and Wisconsin provide family planning services through a SPA. They all set their income eligibility level at or slightly below their Medicaid eligibility levels for pregnant women. The states use different methods to count an applicant’s income, and these methods can affect an applicant’s eligibility. For example, North Carolina counts the income of each household member when computing household income. New Hampshire uses a more generous method, counting the income of the applicant alone and also adding one member to the household size. Wisconsin and New Hampshire have adopted the presumptive eligibility option, entitling individuals to receive services pending resolution of their application. In California, individuals may enroll at their provider’s office. In addition, California provides retroactive coverage, meaning that Medicaid will cover family planning services received during the three months before an enrollee applied for coverage.

As noted above, states must provide the same family planning services to individuals enrolled in full-scope Medicaid and to individuals enrolled in a family planning SPA. Thus, the variations in coverage discussed above in the full-scope Medicaid section also affect individuals enrolled in a SPA. States also differ with respect to the scope of covered family planning-related services. California, for example, covers a wide range of STI treatments, urinary tract infections, and blood tests, as well as complications arising from a family planning service. Although North Carolina covers treatments for STIs and STDs, it does not cover other family planning-related services, such as complications arising from a family planning procedure. In addition, North Carolina refuses to cover services received in an emergency room. This is troubling, as women – in particular women who are victims of sexual assault – sometimes seek family planning services and supplies such as emergency contraceptives or screening or prophylactic treatment for STIs in an emergency room.

**3. Utilization controls**
Federal law allows states to adopt methods and procedures to safeguard against unnecessary utilization of care and services. Often referred to as utilization controls, these methods and procedures may include placing “appropriate” limits on covered services or requiring prior authorization for certain services. Federal regulations also acknowledge that Medicaid managed care organizations may adopt their own utilization controls, including requiring prior authorization for services. In addition to prior authorization, common utilization controls include step therapy (requiring trial and failure of one drug before authorizing an alternative drug) and quantity limits on services or prescription drugs.

Some state Medicaid programs impose utilization controls on family planning services. In addition, some states fail to prevent Medicaid managed care plans from using their own problematic medical management techniques, including step therapy, to restrict access to family planning services. Such state policies can delay or prevent access to appropriate contraceptive methods and increase the risk of unintended pregnancy. These policies might also violate federal regulations that require states to ensure that Medicaid enrollees are “free from coercion and mental pressure and free to choose the method of family planning to be used.”
A few of the state Medicaid programs that we reviewed impose limits on family planning services and supplies. North Carolina, for example, limits individuals enrolled in the family planning SPA to one annual exam and six periodic family planning visits each year. In addition, North Carolina and New Hampshire do not allow Medicaid enrollees to receive more than three months of oral contraceptives at a time. Wisconsin limits enrollees to a 100-day supply of oral contraceptives. In contrast, women in New Mexico are entitled to receive a one-year supply of oral contraceptives. Similarly, Washington requires pharmacies and clinics to dispense a one-year supply of oral, transdermal, or intra-vaginal hormonal contraceptives unless contraindicated. These state policies are beneficial, as research shows that dispensing a one-year supply of oral contraceptives may reduce the risk of unintended pregnancy. In fact, the Centers for Disease Control and Prevention and the U.S. Office of Population Affairs recommend that individuals receive a one-year supply of oral contraceptive pills, patches, or rings.

Several of the states that we reviewed have taken steps to protect Medicaid enrollees in managed care plans from problematic utilization controls. For example, Pennsylvania’s Medicaid managed care contract explicitly prohibits plans from requiring prior authorization for family planning services. Enrollees can receive all covered family planning services without having to obtain prior approval from their managed care plan. Washington’s contract prohibits Medicaid managed care plans from imposing quantity limits on OTC contraceptives and requires plans to dispense a one-year supply of other contraceptives. In addition, California’s recently amended contraceptive equity law prohibits Medicaid managed care plans from delaying or restricting access to contraception.

**Summary of State Policy Goals: Family Planning Coverage**

All individuals should have affordable access to the contraceptive of their choice without delay and regardless of their source of health coverage, age, or gender. Accordingly, states should:

- Ensure that all health insurance issuers cover all FDA-approved contraceptive drugs, devices, and products, including methods available OTC, without cost-sharing. States should also prohibit issuers from using medical management techniques to delay or restrict access to contraception.

- Ensure that Medicaid enrollees have coverage for all family planning services and supplies, including OTC contraceptives without a prescription. States should not use or allow Medicaid managed care plans to use medical management techniques to control access to family planning services.

- Adopt a family planning SPA to extend coverage of family planning and family planning-related services to individuals who do not qualify for full-scope Medicaid, do not have access to affordable private health insurance, are transitioning between insurance programs, and/or need confidential access to services.
IV. Abortion coverage

Abortion is a constitutional right and a common health care service. In 2011, over one million abortions were performed in the United States. By age forty-five, three in ten women in the United States will have an abortion. The leading physical and mental health associations categorize abortion as a critical health care service. For example, the American College of Obstetricians and Gynecologists considers abortion “an essential component of women’s health care.” Likewise, the American Psychiatric Association position statement on abortion “affirms that the freedom to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications.” Yet, existing federal and state laws drastically restrict abortion coverage. As a result, this routine health care service remains out of reach for too many women.

NOTE: STATE LAW RESTRICTIONS ON ABORTION

States have adopted various restrictions on abortion, including gestational limits, counseling and waiting period requirements, minor consent requirements, and targeted regulations of abortion providers. These dangerous laws delay or eliminate access to abortion and affect low-income women most dramatically.

A. RESTRICTIONS ON PRIVATE HEALTH INSURANCE COVERAGE OF ABORTION

When Congress passed the ACA, only five states had laws restricting private insurance coverage of abortion. In fact, studies conducted in the early 2000s revealed that most individuals enrolled in employer-sponsored plans had abortion coverage. The ACA, however, renewed state interest in restricting coverage of abortion by expressly permitting states to enact laws prohibiting or limiting QHP coverage of abortion services. As of the date of this publication, twenty-five states have banned some or all private insurance plans from covering some or all abortion services.

Notably, however, the ACA also affirms that not only may states repeal laws that prohibit abortion coverage, but they may also pass laws that require abortion coverage. In addition, the ACA makes clear that it does not preempt such state laws. In states that do not ban abortion coverage, QHPs that cover abortion in circumstances other than rape, incest, or life endangerment must comply with “special rules” regarding funding of abortion coverage for federally subsidized enrollees.

B. STATE FUNDING OF ABORTIONS

Low-income women and women of color account for a disproportionate number of unintended pregnancies, and as a result, a disproportionate number of abortions. Hispanic women account for 25% of abortions, non-Hispanic black women account for 30%, non-Hispanic white women account for 36%, and women of other races account for 9%. Of the women who obtain an abortion, 42% have incomes below 100% FPL. Low-income women and women of color face the greatest barriers to accessing abortion services, in part because they are more likely to rely on Medicaid for coverage.
After the Supreme Court’s 1973 decision in Roe v. Wade upholding a woman’s constitutional right to an abortion pre-viability, Medicaid applied the same coverage standards to abortion services that it applied to other health services. Medicaid accordingly covered abortions in the same way as it covered other physician, surgical center, or hospital services; abortions were not singled out or treated differently. Six years later, Representative Henry Hyde introduced an amendment to the annual Labor and Health, Education, and Welfare (now HHS) appropriations bill that prohibited the use of federal funds to pay for abortion unless the life of the woman would be endangered by the pregnancy. Congress has passed a version of the Hyde Amendment with every Labor and HHS Appropriations Act since then. The current version of the Hyde Amendment allows the use of federal funds to pay for abortions only when necessary to save the life of the woman and in cases of pregnancies resulting from rape or incest. In Harris v. McRae, the Supreme Court upheld the constitutionality of the Hyde Amendment and also ruled that the Medicaid statute does not require states to pay for medically necessary abortions for which federal funding is unavailable under the Hyde Amendment. However, state Medicaid programs must cover abortions for which federal funding is available. CMS guidance makes clear that these abortions are medically necessary and participating states are required to cover them. In addition, states can use their own funds to cover all abortions, regardless of whether federal funding is available, but unfortunately, most do not. Of the seventeen states that cover most or all abortion services with state funds, four offer coverage through legislation and thirteen under a state court order.

Prior to the Hyde Amendment, Medicaid did not single out or treat abortions differently. Because of the Hyde Amendment, federal funds pay for abortions in Medicaid only when the abortion is necessary to save the life of the woman and in cases of pregnancies resulting from rape or incest.
In stark contrast, a Washington statute guarantees the use of state funds to pay for all abortion services. When the state provides “directly or by contract, maternity care benefits, services, or information to women through any program administered or funded in whole or in part by the state,” the state must also provide women otherwise eligible for the program with “substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies.” Consequently, Washington must provide abortion coverage for women enrolled in Medicaid or a public employer-sponsored health plan.

Due to a court order, California covers all abortions for Medicaid enrollees. Similarly, as a result of court orders, Minnesota and New Mexico cover most abortions for Medicaid enrollees. Wisconsin uses state funds to cover abortions in very limited circumstances – when a physician certifies that due to a previously existing medical condition, an “abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman.”

### Summary of State Policies on Abortion Coverage

<table>
<thead>
<tr>
<th>State</th>
<th>Covers abortions beyond Hyde for Medicaid enrollees</th>
<th>Covers all or most lawful abortions for Medicaid enrollees</th>
<th>Restricts abortion coverage in private health plans</th>
<th>Restricts abortion coverage in public employer-sponsored plans</th>
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<tbody>
<tr>
<td>California</td>
<td>YES</td>
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<tr>
<td>Florida</td>
<td>NO</td>
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<td>YES – QHPs</td>
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<tr>
<td>Kentucky</td>
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<td>YES – all private plans</td>
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<td>Minnesota</td>
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<tr>
<td>Missouri</td>
<td>NO</td>
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<td>YES – all private plans</td>
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<td>New Hampshire</td>
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<td>New Mexico</td>
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<td>North Carolina</td>
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<td>YES – QHPs</td>
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<tr>
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<td>YES – QHPs</td>
<td>YES</td>
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<tr>
<td>Washington</td>
<td>YES</td>
<td>NO – Covers abortion when necessary to prevent long-lasting physical health damage</td>
<td>YES – QHPs</td>
<td>NO</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>YES</td>
<td>NO – Covers abortion when necessary to prevent long-lasting physical health damage</td>
<td>YES – QHPs</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Summary of State Policy Goals: Abortion Coverage

All individuals should have access to affordable abortion services regardless of their source of health coverage. Accordingly, states should:

- Ensure that all women enrolled in Medicaid or a state-sponsored insurance plan have comprehensive, affordable abortion coverage.
- Require private health insurance plans to provide comprehensive, affordable abortion coverage.
V. Refusal clauses

Women face barriers to care when entities, institutions, or individuals rely on refusal clauses or so-called "conscience clauses" to deny access to needed services. Refusal clauses are statutory or regulatory provisions that allow insurers, health care facilities, and/or individuals to refuse to cover, pay for, or provide health care services as otherwise required by law or prevailing standards of medical care.146 Refusals are most common in the context of abortion, sterilization, family planning, emergency contraception, infertility treatments, and services for transgender individuals.

At the federal level, an annual appropriations rider known as the Weldon Amendment addresses the refusal to provide health coverage that violates a payer’s religious or moral beliefs. Weldon prohibits federal agencies and state and local governments from "discriminating" against health care entities that refuse to "provide, pay for, provide coverage of, or refer" for abortions.147 First passed in 2004, the law defines health care entities to include health care providers, facilities, and health plans.148 In addition, as mentioned above, certain non-profit and for-profit employers with religious objections to contraceptives may refuse to pay for or provide coverage for contraception.149

Moreover, some institutions refuse to allow willing providers to offer certain reproductive health services on their premises. This is particularly problematic with the proliferation of Catholic hospitals and health systems. According to the Catholic Health Association, nearly fourteen percent of all hospital beds in the United States are in a Catholic hospital.153

HIGHLIGHTS FROM OUR ELEVEN STATE REVIEW

Several of the states that we reviewed have a general refusal clause in effect explicitly permitting health plans to refuse to cover services. The scope of these refusal clauses varies significantly. Pennsylvania, for example, has enacted a broad refusal clause that prohibits a public institution, official, or agency from penalizing a person, association, or corporation operating a health plan because the person, association, or corporation refuses to cover a “particular form of health care services” for moral or religious reasons.154 Similarly, a Missouri statute allows any person or entity to refuse to cover or pay for abortion, sterilization, or contraception if contrary to their “religious beliefs or moral convictions.”155

Other states we reviewed have adopted a refusal clause that acts as an opt-out to their contraceptive equity requirement.156 New Mexico’s contraceptive equity law, for example, has a refusal clause that would allow any “religious entity” purchasing coverage to exclude prescription contraceptives from coverage.157 However, as noted above, the narrower refusal clause in the ACA contraceptive coverage requirement preempts this state law provision, and the state should be allowing opt-outs only when permitted by the narrower federal law.158 Wisconsin’s and New Hampshire’s contraceptive equity laws do not contain a refusal clause.159 As a result, all affected health plans in these states must comply with the state contraceptive coverage requirement.

Unfortunately, coverage for health care services might not translate into access to services when refusal clauses allow health care facilities or providers to refuse to provide services on the basis of personal, moral, or religious objections. Indeed, with the exception of New Hampshire, every state that we reviewed has enacted a refusal clause that allows

NOTE: CHURCH AND COATS AMENDMENTS

Federal law allows individuals and institutions to refuse to provide certain services that violate their religious or moral beliefs. Shortly after the Supreme Court’s 1973 decision in Roe v. Wade, Congress enacted the Church Amendment. It allows individuals to refuse to “perform or assist in the performance of” abortion or sterilization services, as well as other health service programs or research activities if contrary to their religious or moral beliefs.150 It also prohibits the federal government from predicing federal funding to institutions or individuals on the provision of abortion or sterilization services. Church also protects individuals from discrimination because they willingly provide abortion or sterilization services. No federal agency or court has fully defined the contours of the Church Amendment.

In addition, the Coats Amendment permits postgraduate physician training programs (including residency programs) and individual providers to refuse to: provide, require, or undergo abortion training; provide abortion services; and refer for abortion training or services.151 Training programs cannot be denied accreditation on the basis of such refusal.152

Most states also have refusal clauses in place that allow certain individuals and institutions to refuse to provide abortion services.
certain individual health care providers and/or facilities to refuse to provide abortion services. Pennsylvania has enacted a relatively broad refusal clause that allows providers, hospitals, and other facilities to refuse to provide both abortion and sterilization services.\textsuperscript{160} In contrast, California has enacted a relatively narrow refusal clause, permitting individual providers, as well as certain non-profit hospitals, facilities, and clinics organized or operated by a religious organization, to refuse to perform abortions, except in emergencies.\textsuperscript{161}

**NOTE: ANTI-GAG RULES**

So-called “gag rules” that prohibit providers from advising patients about particular services that are not covered interfere with the provider-patient relationship and might prevent individuals from receiving timely family planning and abortion services. To protect consumers, the federal Medicaid statute prohibits managed care plans from limiting the medical advice and information that a provider may give to his or her patient, regardless of whether the service is covered by the plan.\textsuperscript{162} Unfortunately, the federal statute also contains a refusal clause that allows Medicaid managed care organizations to opt out of “provid[ing], reimburs[ing] for, or provid[ing] coverage of, a counseling or referral service” to which they object on moral or religious grounds.\textsuperscript{163} As a result, while the provider is permitted to provide information and counseling, the managed care plan does not have to reimburse the provider for providing such services.

A number of states have also enacted laws that prevent managed care plans from imposing gag rules. For example, a North Carolina statute prohibits insurers that issue private plans from limiting discussion between a participating provider and a patient about clinical treatment options, the risks associated with the options, or a recommended treatment.\textsuperscript{164}

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**Summary of State Policy Goals: Refusal Clauses**

States should:

- Ensure that the religious beliefs of an individual’s insurer or employer do not dictate the scope of his or her health care coverage.

- Ensure that all enrollees have meaningful access to all covered services. State and federal agencies should hold managed care organizations and other health service delivery systems accountable for ensuring that all covered services are available.

- Require health care institutions to deliver services according to prevailing standards of medical care.
VI. Access to services in managed care

Managed care was developed as a mechanism to ensure the efficient use of health care services, improve health outcomes, and reduce health care costs. In most managed care arrangements, plans receive a set per-member-per-month payment in return for providing health care services. While the original promise of managed care was better health outcomes, these capitated plans have a clear incentive to limit access to services in order to maximize profits. Almost three quarters of Medicaid beneficiaries are enrolled in managed care.¹⁶⁵ Most individuals with private insurance, including individuals who obtained coverage through a Marketplace, are enrolled in some type of managed care.

In most forms of managed care, enrollees must obtain services from a specific network of providers. In general, these managed care plans also require enrollees to receive a referral from their primary care provider before seeking services from another provider. In other forms of managed care, such as PPOs, enrollees may receive services out-of-network, but face higher cost-sharing requirements when doing so. Although these requirements create barriers to care for all enrollees, they uniquely affect enrollees seeking family planning and abortion services.

A. PROVIDER NETWORKS – NETWORK ADEQUACY

Network adequacy refers to a health plan’s ability to provide meaningful access to covered services in a timely and culturally appropriate manner. Federal and state laws impose network adequacy requirements on certain managed care plans.¹⁶⁶ For example, the ACA requires all QHPs to ensure that their provider networks are “sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”¹⁶⁷ In addition, QHPs must contract with “a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers…”¹⁶⁸ Essential community providers (ECPs) primarily care for low-income, medically underserved individuals. Federal rules require QHPs sold on a federally-facilitated or state-partnership Marketplace to offer contracts in “good faith” to a variety of ECPs, including family planning clinics, and contract with at least 30% of the ECPs in the service area.¹⁶⁹ Unfortunately, the federal rules do not explicitly require QHPs to contract with family planning clinics.

NOTE: PRIVATE HEALTH PLANS

There are many types of private health plans. HMOs and PPOs are two of the most common.

Health maintenance organizations (HMOs):
HMO plans hire or contract with a network of providers, and with few exceptions, enrollees must receive services from these providers. Enrollees must also obtain a referral from their primary care provider before seeing any specialist.

Preferred provider organizations (PPOs):
PPO plans contract with providers and facilities to create a network of participating providers. Enrollees have a financial incentive to see participating providers, meaning that enrollees face higher cost-sharing requirements when seeing out-of-network providers. Enrollees do not need a referral from a primary care provider in order to see a specialist.

NOTE: MEDICAID MANAGED CARE ENTITIES

State Medicaid programs can deliver benefits through several types of managed care entities, including:

Managed care organizations (MCOs) and prepaid health plans (PHPs):
MCOs and PHPs are “capitated” plans, meaning that they receive a per-member-per-month payment from the state in return for providing health care services to enrollees. MCOs and PHPs typically require enrollees to use a specific network of providers. MCOs (which are often HMOs) have a comprehensive risk contract with the state – they must provide inpatient hospital services and a minimum number of outpatient services. In contrast, PHPs provide more limited services to enrollees.

Primary care case managers (PCCMs):
PCCMs are primary care providers or group practices that receive a per-member-per-month payment in return for locating, coordinating, and monitoring health care services. As a result, PCCMs do not have the same financial incentive as MCOs and PHPs to limit access to health care services. In addition, individuals who have PCCMs are not restricted to a specific network of specialists.
In Medicaid, federal law requires states to ensure that MCOs and PHPs maintain a provider network that is "sufficient to provide adequate access to all services covered under the contract."\(^{170}\) In particular, states must ensure that each MCO and PHP considers the following when establishing and maintaining its network: (1) the anticipated Medicaid enrollment; (2) the expected utilization of services; (3) the numbers and types of providers, in terms of training, experience, and specialization, required to furnish covered services; (4) the numbers of network providers who are not accepting new patients; and (5) the geographic location of providers and Medicaid enrollees, considering distance, travel time, and the means of transportation that Medicaid enrollees ordinarily use.\(^{171}\) In addition, states must establish and ensure that plans meet standards for timely access to care and services.\(^{172}\)

Despite these federal network adequacy standards, some enrollees experience barriers to accessing covered services in a timely manner. For example, some managed care plans fail to contract with providers located within reasonable travel times or distances or to ensure that appointments are available within a reasonable amount of time. Plans also fail to contract with sufficient numbers and types of providers to ensure that enrollees have access to all covered services in-network. This is a particular problem for women seeking reproductive health services (especially abortion services), as the federal standards do not explicitly require plans to consider the numbers of providers who refuse to offer certain services due to religious objections. A plan could compile a network that appears to have sufficient numbers and types of providers to deliver timely access to covered services, when in fact, some or all covered reproductive health services are not available in-network.

To help secure meaningful access to care for enrollees, states should adopt additional network adequacy standards. Of course, without robust federal and state monitoring and enforcement of these laws, even strong network adequacy standards might not translate into timely access to all covered services for enrollees.

**TIP: MEDICAID MANAGED CARE CONTRACTS**

Medicaid managed care contracts should outline plans’ obligations in detail. If a state has not posted its contracts online, advocates can access them through their state public records law. Advocates should ensure that at a minimum, the contracts reflect existing federal and state law. Some states might be open to incorporating additional enrollee protections into their managed care contracts.

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**ADDITIONAL RESOURCES: NETWORK ADEQUACY**

NHeLP has written extensively on network adequacy standards. The following resources contain specific recommendations for developing strong, comprehensive network adequacy requirements and might be helpful as you advocate with your state.

Recommendations by the National Health Law Program for Modernization of the Federal Medicaid Managed Care Regulations (pg. 33-37) [www.healthlaw.org/modernization-fed-mmc-reg](http://www.healthlaw.org/modernization-fed-mmc-reg)


Network Adequacy in Medicaid Managed Care: Recommendations for Advocates [www.healthlaw.org/mmc-network-recommendations](http://www.healthlaw.org/mmc-network-recommendations)

NHeLP Comments on Notice of Benefit and Payment Parameters for 2016 [www.healthlaw.org/comments-notice-benefits-payments](http://www.healthlaw.org/comments-notice-benefits-payments)

NHeLP Comments on NAIC’s Managed Care Plan Network Adequacy Model Act [www.healthlaw.org/comments-naics-mc](http://www.healthlaw.org/comments-naics-mc)

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**HIGHLIGHTS FROM OUR ELEVEN STATE REVIEW**

Most of the states that we reviewed require both private and Medicaid managed care plans to ensure that enrollees have access to primary care providers within a specific travel time or distance from their residence or work place. Notably, North Carolina and Wisconsin have not adopted such standards for private health plans.\(^{173}\) Some states have also adopted specific travel time or distance standards for specialty care providers. In New Hampshire, for example, certain private plans must ensure that 90% of enrollees have access to at least two primary care providers who are accepting new patients within fifteen miles or forty minutes average driving time from their residence. The same percentage of enrollees must also have access to certain specialty care providers, including OB/GYNs, within forty-five miles or sixty minutes travel time.\(^{174}\) Similar time and distance standards apply to Medicaid managed care plans.\(^{175}\)
Several states have also established specific standards with respect to maximum waiting times for appointments and/or minimum provider-to-enrollee ratios. In California, for example, both private and Medicaid managed care plans must provide one primary care provider for every 2000 enrollees and one physician for every 1200 enrollees. In addition, Medicaid plans and certain types of private plans must ensure that enrollees have access to a provider within forty-eight hours for an urgent care appointment (ninety-six hours if the services require prior authorization), ten business days for a primary care appointment, and fifteen business days for a specialty care appointment.

In addition, several states with state-based Marketplaces have adopted their own standards for including ECPs in QHP provider networks. Some of these standards are weaker than the federal rules that govern QHPs sold on a federally-facilitated or state-partnership Marketplace. Minnesota, for example, requires plans sold inside and outside of the Marketplace, as well as Medicaid managed care plans, to offer a provider contract to each ECP in the plan’s service area. While this requirement is stronger than the federal rule on offering contracts to ECPs, Minnesota’s standards (unlike the federal standards) do not appear to require QHPs to contract with a particular number or percentage of ECPs. In contrast, California does not require QHPs to offer contracts to a particular number or percentage of ECPs, but does require QHPs to contract with 15% of the entities in each geographic region that participate in the 340B program. This requirement is weaker than the federal requirement, which requires QHPs to contract with 30% of available ECPs.

Washington stands out for adopting network adequacy standards designed to ensure that women have access to family planning and abortion services. State insurance regulations require plans to contract with a sufficient number of each type of practitioner providing women’s health care services, including physicians, physician assistants, licensed midwives, and certain advanced registered nurse practitioners. These regulations do not, however, require a minimum provider-to-enrollee ratio. Washington, along with several other states, requires Medicaid managed care plans to make a reasonable and fair effort to contract with family planning agencies.

Although necessary, these network adequacy protections are not sufficient to ensure that enrollees have access to covered family planning and abortion services. No state that we reviewed has adopted standards that explicitly require managed care plans to account for providers who refuse to offer certain services due to moral or religious objections. As noted above, this might allow plans to form networks that appear sufficient to provide covered services, but do not ensure in-network access to family planning or abortion services.

B. ACCESS TO OUT-OF-NETWORK PROVIDERS

For women seeking reproductive health services, the ability to see an out-of-network provider may be critical to ensure access to necessary services. Due to the intimate nature of family planning and abortion services, every woman should have timely access to a provider whom she trusts and who is familiar with her health history, even if this provider does not contract with her managed care plan. In addition, in-network providers might refuse to provide covered services.

According to CMS guidance, health plans subject to the federal contraceptive coverage requirement must allow enrollees to receive required services out-of-network without cost-sharing if no in-network provider offers the services. Federal Medicaid law requires managed care plans to allow individuals to receive family planning services from the provider of their choice, whether in- or out-of-network. If an enrollee prefers to see an out-of-network provider, the plan must not impose an additional cost on the enrollee. Further, if an enrollee does not have access to a certain service in-network, Medicaid MCOs and PHPs must provide timely access to the service out-of-network at no additional cost to the enrollee. This protection is vital for women seeking an abortion, especially women who are medically fragile and need to receive this service in the hospital.

Due to the intimate nature of family planning and abortion services, every woman should have timely access to a provider whom she trusts and who is familiar with her health history, even if this provider does not contract with her managed care plan.
A number of the states in our review have protections in place for enrollees in private managed care plans. These states generally require private managed care plans to provide access to out-of-network providers for covered services that are not available in-network. For example, New Hampshire regulations require plans to allow enrollees to access services out-of-network when there is no “health care provider with appropriate training and experience within its network who can meet the particular health care needs of the covered person.” At least one state that we reviewed – Minnesota – requires private plans to allow enrollees to receive family planning services from the provider of their choice, even if that provider is out-of-network.

In Medicaid, the states we reviewed have generally incorporated federal Medicaid law on access to out-of-network providers into their state Medicaid regulations and/or Medicaid managed care contracts. Most of the contracts explicitly allow enrollees to obtain family planning services from the provider of their choice. However, the Wisconsin HMO contract indicates that enrollees may receive family planning services from “any Medicaid-certified family planning clinic.” In fact, under federal law, Medicaid enrollees have the right to receive family planning services from any qualified Medicaid provider, whether that provider is in- or out-of-network, or an individual provider or clinic.

C. DIRECT ACCESS TO PROVIDERS
As noted above, some managed care plans require enrollees to have a referral from their primary care provider before obtaining services from another provider. This can pose a serious problem for enrollees who do not feel comfortable discussing family planning or abortion services with their primary care provider or whose primary care provider refuses to provide a referral for these services for moral or religious reasons.

The ACA offers a partial solution to this problem by prohibiting most new group and individual health plans that require enrollees to designate a primary care provider from requiring prior authorization or a referral for female enrollees seeking covered obstetrical or gynecological care. These plans must provide female enrollees with direct access to in-network providers authorized under the applicable state law to deliver obstetrical or gynecological care. However, the ACA does not preclude plans from requiring that a directly accessed provider notify the primary care provider of treatment decisions. Such a requirement would raise serious confidentiality concerns, as enrollees might not feel comfortable sharing their family planning decisions with their primary care provider.

In Medicaid, federal law prohibits managed care plans from requiring individuals to have a referral from their primary care provider before receiving family planning services from the provider of their choice. In addition, federal regulations require MCOs and PHPs to allow a female enrollee to directly access an in-network women’s health specialist for “routine and preventive services” if she does not have a women’s health specialist as her designated primary care provider. CMS has not issued guidance on the definition of “routine and preventive services.” Given that abortion is a common procedure, plans should include abortion as a routine service. However, the regulations do not protect women whose primary care provider is a women’s health specialist who refuses to provide a referral for abortion services.

Washington and California stand out for allowing female Medicaid managed care enrollees to see out-of-network providers for abortion services without restriction. In Washington, however, women enrolled in Medicaid managed care currently do not receive abortion services through their MCO; instead, enrollees receive abortion services on a fee-for-service basis. Although the state requires the MCO to coordinate and refer enrollees to abortion services “through all means possible,” enrollees might still experience barriers to accessing abortion care outside of their MCO. In contrast, California requires Medicaid MCOs to enter into two contracts – one for abortion services and one for other Medicaid services. As noted above, Washington and California both use state funds to cover all abortions for Medicaid enrollees.

TIP: MEDICAID MANAGED CARE CONTRACTS AND FREEDOM OF CHOICE
Strong, clear contract language can help to ensure that Medicaid managed care plans understand and follow the federal freedom of choice protection. New Mexico’s managed care contract is a good example:

“The CONTRACTOR shall give each adolescent and Adult Member the opportunity to use his or her own PCP or go to any family planning provider for family planning services without requiring a referral...Family planning providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services that are Covered Services, regardless of whether they are providers for Centennial Care. Unless otherwise negotiated, the CONTRACTOR shall reimburse providers of family planning services pursuant to the Medicaid fee schedule.”
All of the states in our review have a statute or regulation in place giving women enrolled in private plans direct access to certain obstetrical and gynecological services. Some of the state requirements appear as broad as the federal requirement. Washington, for example, requires plans to allow female enrollees to directly access the type of health care practitioner of their choice for appropriate covered women’s health care services. Women’s health care services include, but need not be limited to “[m]aternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate, and medically appropriate follow-up visits” for these services.201 Minnesota requires health plans to allow female enrollees to directly access providers who specialize in obstetrics and gynecology for evaluation and necessary treatment for obstetric conditions or emergencies, maternity care, and evaluation and necessary treatment for gynecologic conditions or emergencies, including annual preventive health exams.202 Similarly, Pennsylvania requires health plans to provide enrollees with direct access to obstetrical and gynecological services, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care.203

In contrast, a number of state requirements seem narrower than the federal requirement. New Hampshire, for example, only requires health plans to allow enrollees to directly access maternity care, an annual gynecological visit, and follow-up care for obstetrical or gynecological conditions identified during a maternity care or annual gynecological visit.204 Similarly, Florida only prohibits plans from requiring enrollees to have prior authorization before visiting an obstetrician or gynecologist for an annual visit or for medically necessary follow-up care “detected at that visit.”205 The scope of these state laws becomes even more significant when they apply to plans that are not required to comply with the direct access requirement in the ACA.

With respect to Medicaid managed care plans, several of the states include the federal regulations regarding direct access to a women’s health specialist almost verbatim in their state regulations or contracts with managed care plans.206 In other states, including Pennsylvania, the direct access requirement for private plans also applies to Medicaid managed care plans.207 These states have essentially defined “routine and preventive services” for Medicaid managed care plans. Importantly, Pennsylvania’s requirement (described above) appears to allow women to directly access covered abortion services from an in-network provider.

Kentucky’s Medicaid regulations require MCOs to allow enrollees to access any covered service provided by a women’s health specialist without a referral.208 In addition to this protection, MCOs in Kentucky must “[h]ave a referral process in place if a provider declines to perform a service because of an ethical reason.”209

Medicaid beneficiaries enrolled in MCOs or PHPs have a right to an appeal if the plan denies access to services.210 In some states, Medicaid managed care enrollees must appeal with the managed care plan before filing an appeal with the state. In certain circumstances, managed care enrollees have a right to an expedited appeal decision from the managed care plan. However, the federal standard outlining when plans must provide an expedited appeal decision is based on urgent medical need.211 As a result, the appeal process might not provide adequate recourse to women who need family planning or abortion services immediately, but have been denied prior authorization. For example, the federal standard might not guarantee an expedited appeal decision for a woman who is nearing the point in her pregnancy when she will no longer have access to an abortion due to state restrictions on the procedure.

In addition, individuals enrolled in most private managed care plans (including QHPs) have a right to appeal adverse decisions through both an internal and external process.212 In some states, enrollees use the state’s external review process, while in other states, enrollees use a federal process. Enrollees should look to their member handbooks, their state insurance departments, and the Center for Consumer Information & Insurance Oversight for more information about their appeal rights.213
Summary of State Policy Goals: Accessing Services in Managed Care

In addition to having coverage for family planning and abortion services, individuals enrolled in a Medicaid managed care plan or private health plan should have timely access to a trusted provider who delivers these services. Accordingly, states should:

- Adopt specific, quantitative network adequacy standards for Medicaid managed care plans and private health plans that ensure enrollees have timely access to family planning and abortion services in-network. The standards should require managed care plans to account for whether services are meaningfully available in-network, and for providers who refuse to provide particular reproductive health services due to moral or religious objections.

- Require Medicaid managed care plans and private health plans to provide timely access to out-of-network providers for services not available in-network. States should also require all plans to allow individuals to receive family planning services from an out-of-network provider at no extra cost, even if the services are available in-network.

- Require Medicaid managed care plans and private health plans to allow female enrollees to access in-network providers for family planning and abortion services without a referral from their primary care provider. At a minimum, states should require plans to have in place a clear and transparent override process when a primary care provider refuses to provide a referral for a service due to moral or religious objections.

VII. Conclusion

The ACA has led to significant gains in access to women’s health care services. Fulfilling the promise of the ACA, however, requires continued efforts to expand coverage and fight back against restrictive state laws and policies. State decisions regarding Medicaid and private health insurance coverage can tremendously impact the health and well-being of individuals within those states. We hope the various policies that we spotlighted will help advocates and policymakers identify ways in which their own state laws and policies can be improved to increase access to these services.
Glossary


**Centers for Medicare and Medicaid Services (CMS):** The agency within the United States Department of Health and Human Services (HHS) that is responsible for administering the Medicaid program.

**Cost-sharing:** The portion of health care expenses not covered by the insurer that the enrollee must pay. These out-of-pocket costs may include a co-pay, co-insurance, and/or a deductible.

**Demonstration project:** A project operating pursuant to § 1115 of the Social Security Act, which gives the Secretary of HHS authority to waive certain Medicaid requirements to enable a state to implement an experimental, pilot, or demonstration project that promotes the objectives of the Medicaid program. Demonstration projects are also known as 1115 waivers.

**Federal Poverty Level (FPL):** Each year, HHS uses a formula to establish the FPL for a particular household size. In fiscal year 2015, the FPL for a family of four is $24,250. For most Medicaid eligibility groups, individuals must have a household income below a certain percentage of the FPL to qualify for assistance. The FPL is also used to determine eligibility for federal subsidies to pay for private insurance through a Marketplace.

**Food and Drug Administration (FDA):** The agency within HHS responsible for approving drugs, medical devices, and vaccines and other biologicals for sale in the U.S.

**Federal Medical Assistance Percentage (FMAP):** The federal government reimburses states for a substantial portion of their Medicaid costs. The percentage of federal funds available for Medicaid expenditures is called the FMAP. HHS calculates each state’s FMAP annually based on the state’s average per capita income.

**Health insurance Marketplace:** Under the ACA, some individuals have the option to purchase a qualified health plan (QHP) through a virtual health insurance Marketplace, also known as a Health Benefit Exchange. Some states have established their own Marketplaces, while others have partnered with the federal government to run a Marketplace. In states that did not set up their own state-based Marketplace or partner with the federal government, the federal government operates a federally-facilitated Marketplace (FFM) and performs all Marketplace functions in accordance with state and federal law.

**Medicaid:** A federal-state partnership program that provides health care services to millions of low-income individuals. States are not required to participate, but all states and D.C. do so. States receive significant federal funding for their programs in exchange for following the federal Medicaid statute, regulations, and other requirements.

**Over-the-counter (OTC):** Drugs, medical devices, and medical supplies available without a prescription. OTC contraceptives include drugs and supplies such as emergency contraception, male and female condoms, and spermicides.

**Qualified health plan:** A health insurance plan available for purchase through a health insurance Marketplace. QHPs must meet certain federal and state consumer protection requirements, including minimum scope of coverage and limits on cost-sharing.

**State plan:** The state document that describes the nature and scope of the state’s Medicaid program and assures the federal government that the program will be operated according to the federal Medicaid statute, regulations, and other requirements. To receive federal funding, each state must have a state plan that has been approved by the Secretary of HHS.

**State plan amendment (SPA):** A document that a state must submit to CMS to reflect changes in federal statute, regulations, or court decisions or material changes in state law, policy, organization, or operation of their Medicaid program. SPAs must be approved by the Secretary of HHS.
Throughout this report we refer to “women” because that is generally the term used in the studies and laws that we discuss. However, our intent is to use an inclusive definition of women to include trans women, genderqueer women, and gender nonconforming individuals who are significantly female-identified.


In addition, this report does not address coverage of family planning and abortion services for individuals enrolled in other public programs, including Medicare or the Children’s Health Insurance Program.


A few states, including California, Florida, New York, and Nevada, regulate health insurers through a Department of Insurance and another agency such as a Department of Managed Care.

See generally 42 U.S.C. §§ 18021, 18031, 18041.


The Supreme Court is currently considering the legality of providing financial assistance to individuals in states that have not established a state-based Marketplace. See King v. Burwell, 759 F.3d 358 (4th Cir. 2014), cert. granted, 135 S. Ct. 475 (2014). A decision is expected in the summer of 2015.

26 U.S.C. § 36B(c)(1)(A). In addition, certain lawfully present immigrants with incomes below 100% FPL have access to tax credits. Id. § 36B(c)(1)(B).

42 U.S.C. § 18071(c)(2).
See 42 U.S.C. §§ 1396b(a), 1396d(b).


19 42 U.S.C. § 1396b(a)(5).

20 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

21 See generally 42 U.S.C § 1396a; 42 C.F.R. § 430.10.

22 45 C.F.R. § 205.5; 42 C.F.R. § 430.12.

23 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). States must provide a 5% income disregard, making the actual eligibility level 138% FPL. See 42 U.S.C. §§ 1396a(e)(14)(C), 1396a(e)(l)(l); 42 C.F.R. § 435.603(d)(4). As was the case before the ACA, individuals must also reside in the state in which they apply for Medicaid and meet certain immigration status requirements. For the rules on determining state residency, see 42 C.F.R. § 435.403. For immigration status requirements, see 42 U.S.C. §§ 1396a(b)(3); 8 U.S.C. §§ 1611-1613, 1641; 42 C.F.R. § 435.406.


26 Although Wisconsin has not expanded its Medicaid program, it does cover childless, non-pregnant, uninsured adults who have incomes up to 100% FPL through a § 1115 waiver. See CMS, SPECIAL TERMS AND CONDITIONS 11-W-00 29315, WISCONSIN BADGERCARE REFORM SECTION 1115 DEMONSTRATION 2 (Dec. 30, 2013).


29 42 U.S.C. § 300gg-13(a)(4). Grandfathered plans – those that existed on March 23, 2010 and have not changed substantially – do not have to comply with the requirement until they lose their grandfathered status. See 42 U.S.C. § 18011; 45 C.F.R. §§ 147.130(d), 147.140(c). This allowance for grandfathered plans “is temporary, intended to be a means for gradually transitioning employers into mandatory coverage.” Gilardi v. U.S. Dep’t of Health & Human Servs., 733 F.3d 1208, 1241 (D.C. Cir. 2013) (Edwards, J., concurring in part, dissenting in part).


32 42 U.S.C. § 300gg-13(a); 45 C.F.R. § 147.130(a)(1).

33 See, e.g., Kelly Cleland et al., Family Planning as Cost-Saving Preventive Health Service, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011); Jeffrey F. Peipert et al., Preventing Unintended Pregnancies by Providing No-Cost Contraception, 120(6) OBSTETRICS & GYNECOLOGY 1291, 1291-92 (2012).

34 See 45 C.F.R. § 147.131(a)

35 See id. § 147.131(b)-(c).
A number of non-profit entities that currently qualify for an accommodation have claimed that the accommodation process itself violates their rights under the Constitution and the Religious Freedom Restoration Act because it requires them to facilitate a third-party’s payment for contraception. See, e.g., Geneva Coll. v. U.S. Dep’t of Health & Human Servs., Nos. 13-3536, 14-1374, 14-1376, 14-1377 slip. op. (3d Cir. Feb. 11, 2015).

36 Id. § 147.131(c).


39 N.M. STAT. ANN. §§ 59A-22-42(D), 59A-46-44(c).


42 45 C.F.R. § 147.130(a)(4).


44 For more information about medical management, see ERIN ARMSTRONG, NAT’L HEALTH LAW PROGRAM, MEDICAL MANAGEMENT AND ACCESS TO CONTRACEPTION (2013), available at http://www.healthlaw.org/publications/medical-management-and-access-to-contraception#.

45 42 U.S. Dep’t of Labor, Health & Human Servs., & Treasury, Frequently Asked Questions about Affordable Care Act Implementation Part XXVI, at 4-6 (2015), available at http://www.cms.gov/CCII/O/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf. The FDA has approved the following 18 contraceptive methods for women: (1) sterilization surgery; (2) surgical sterilization implant; (3) implantable rod; (4) copper IUD; (5) IUD with progestin; (6) shot/injection; (7) combined oral contraceptives; (8) progestin only oral contraceptives; (9) extended/continuous use oral contraceptives; (10) patch; (11) vaginal contraceptive ring; (12) diaphragm with spermicide; (13) sponge with spermicide; (14) cervical cap with spermicide; (15) female condom; (16) spermicide alone; (17) Plan B/Plan B One Step/Next Choice emergency contraception; and (18) ella emergency contraception. See Food & Drug Admin., Office of Women’s Health, Birth Control Guide, http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf (last visited May 12, 2015).

46 Id. at 4.


48 U.S. Dep’t of Labor, Health & Human Servs., & Treasury, Frequently Asked Questions about Affordable Care Act Implementation Part XXVI, at 4 (2015), available at http://www.cms.gov/CCII/O/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf. A provider’s determination that a particular contraceptive product is medically necessary “may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service.” Id.

49 Id. at 4.


51 See MO. ANN. STAT. § 376.1199.

52 See MO. STAT. ANN. § 376.1199.
Improving Coverage: Using State Law to Maximize Access to Family Planning and Abortion Services


Cal. Health and Safety Code § 1367.25(a)(1)-(2); Cal. Ins. Code § 10123.196(b)(1)-(2). Where the FDA has approved one or more therapeutic equivalents of a particular contraceptive, plans do not have to cover more than one version of the contraceptive. But, when medically necessary for an enrollee, plans must provide coverage or a non-covered version. Id.


However, men enrolled in qualified health plans in California should have coverage of vasectomies because the state's essential health benefits benchmark plan covers the service. See California EHB Benchmark Plan, http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/california-ehb-benchmark-plan.pdf (last visited April 8, 2015).


42 U.S.C. §§ 1396d(a)(4)(C), 1396a(a)(10). States do not have to cover family planning services and supplies for individuals who qualify for Medicaid due to their status as medically needy. See also 42 U.S.C. § 1396o(a)(2)(d); 42 C.F.R. § 447.56(a)(2)(ii) (prohibiting imposition of cost-sharing for family planning services and supplies).

42 C.F.R. § 440.230(b); CMS, State Medicaid Manual § 4270.B.


CMS, State Medicaid Manual § 4270.B.1. Procedures performed for medical reasons, such as removal of an IUD due to an infection, are not family planning services. Id. States must cover these medically necessary services for women entitled to full-scope Medicaid benefits, but will not get the enhanced 90% FMAP.

42 C.F.R. § 441.20.

42 U.S.C. §§ 1396a(a)(23), 1396n(b); 42 C.F.R. § 431.51(b)(2).

See 42 C.F.R. § 440.347(a); 45 C.F.R. §§ 156.115(a)(4); 147.130(a)(1)(iv).


See N.C. Div. of Medical Assistance, Medicaid and Health Choice Clinical Coverage Policy No. 1E-7, Family Planning Services 6 (undated), available at http://www.ncdhhs.gov/dma/mp/1E-7.pdf. The state does cover the procedure to fit a diaphragm. Id. at 5.

70 Id. at 144.


75 42 U.S.C. § 1315(a).

76 See id. § 1315(e)-(f).


78 Id.

79 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XXI), 1396a(ii)(1)


81 42 U.S.C. § 1396r-1c.

82 CMS, Dear State Health Official Letter 2-3 (July 2, 2010)


84 CMS, Dear State Health Official Letter 2-3 (July 2, 2010); CMS, Dear State Medicaid Director Letter (April 16, 2014).


86 See CMS, Special Terms and Conditions 11-W-00 236/7, Missouri Women’s Health Services Program Section 1115 Family Planning Demonstration 7 (Dec. 30, 2014), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mo/mo-health-services-program-ca.pdf.


See CMS, Special Terms and Conditions 11-W-00183/5, Minnesota Family Planning Program 5 (Dec. 29, 2011). See also Letter from Eliot Fishman, Dir., Children and Adults Health Programs Group, to Jim Golden, Medicaid Dir., Minn. Dep’t of Human Servs. (July 22, 2014) (renewing the § 1115 waiver through Dec. 31, 2015 under the same terms and conditions).

North Carolina set the SPA income eligibility level one percentage point below the eligibility level for pregnant women. See N.C. Dep’t of Health & Human Servs., State Plan Amendment 14-0005-MM1 (effective Oct. 1, 2014).


See N.H. Dep’t of Health & Human Servs., State Plan Amendment 13-008 (effective July 1, 2013); Wis. Dep’t of Health Servs., State Plan Amendment 10-0009 (effective Nov. 1, 2010).


See 42 U.S.C. §§ 1396a(a)(30); 1396b(i)(4). See also 45 C.F.R. §§ 456.1 – 456.725.

See 42 C.F.R. § 440.230(d) (allowing states to “place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”) See also 42 U.S.C. § 1396r-8(d) (allowing states to require prior authorization for outpatient prescription drugs).

See 42 C.F.R. §§ 438.210(a)(3)(iii) (allowing plans to place limits on services for the purpose of utilization control so long as the services furnished can reasonably be expected to achieve their purpose), 438.201(b)-(d) (establishing requirements for prior authorization processes).

See 42 C.F.R. § 441.20.


Id. at 17; N.H. Code R. He-W 570.08(f).

Wis. Admin. Code DHS § 107.10(e)(8).

N.M. Code R. § 8.324.4.18(C)(3).


Id.


See 42 U.S.C. § 18023(a).


42 U.S.C. § 18023(a), (c)(1); 45 C.F.R. §§ 156.280(b), (h)(1).

42 U.S.C. § 18023(c)(1); 45 C.F.R. § 156.280(h)(1).

See 42 U.S.C. § 18023(b)(2); 45 C.F.R. § 156.280(3).

See Mo. Ann. Stat. § 376.805 (allowing coverage of abortions only when necessary to save the life of the woman); Ky. Rev. Stat. Ann. § 304.5-160 (allowing coverage of abortions only when necessary to save the life of the woman).


130 Id.


134 Harris v. McRae, 448 U.S. 297 (1980).

135 CMS, Dear State Medicaid Director Letter (Dec. 28, 1993), (Feb. 12, 1998)

136 See id.


143 See Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779, 799 (Cal. 1981) (“Once the state furnishes medical care to women in general, it cannot withdraw part of that care solely because a woman exercises her constitutional right to choose to have an abortion.”) See also CA. Dep’t of Health Care Servs., Provider Manuals, Obstetrics, Abortions (2010).
144 For New Mexico, see New Mexico Right to Choose/NARAL v. Johnson, 975 P.2d 841, 844 (N.M. 1998) (finding that New Mexico must cover abortion for Medicaid enrollees when pregnancy “aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical or mental health of an individual”); N.M. Admin. Code § 8.310.2.12(O)(1). For Minnesota, see Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17, 32 (Minn. 1995) (holding that Minnesota cannot refuse to provide an abortion to a Medicaid enrollee when necessary for “therapeutic reasons” and leaving the decision whether to obtain such an abortion to the woman and her doctor); Minn. Dep’t of Human Servs., Provider Manual, Reproductive Health, Abortion Services (2013) available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137809#.


148 Id.

149 See 42 C.F.R. § 147.130; Burwell v. Hobby Lobby Stores, Inc. 134 S. Ct. 2751 (2014).


152 Id. at § 238n(b).


158 The state refusal clause might affect enrollees in a group or individual health plan that is not subject to the ACA contraceptive coverage requirement, such as a grandfathered plan.


State network adequacy laws vary with respect to the types of managed care plans that they regulate. For example, some state laws apply to PPOs, while others do not.

45 C.F.R. § 156.230(a)(2).

45 C.F.R. §§ 156.235(a)(1), 156.230(a)(2).


42 C.F.R. § 438.206(b).

42 C.F.R. § 438.206(b)(1).

42 C.F.R. § 438.206(c)(1).


N.H. Code R. Ins. 2701.04 (requiring managed care plans to meet geographic accessibility standards), 2701.06 (setting forth specific geographic accessibility standards), 2701.03(k) (defining managed care plans).


See Minn. Stat. Ann. §§ 62Q.19 (setting forth the requirement for certain health plan companies, as defined in §§ 62Q.01(4)(1)), 62K.10 (requiring health carriers offering individual or small group health plans to comply with § 62Q.19); Minn. DEPT’ OF HUMAN SERVS., CONTRACT FOR MEDICAID ASSISTANCE AND MINNESOTA CARE MEDICAL CARE SERVICES, 2015 FAMILIES AND CHILDREN MODEL CONTRACT 170, 173 (2015) (noting that Medicaid managed care plans must comply with § 62Q.19).


WASH. ADMIN. CODE §§ 284-43-250(3)(c), 284-43-130. Women’s health care services explicitly include contraceptive services and pregnancy termination. Id. § 284-43-250(1)(a).

See WASH. STATE HEALTH CARE AUTH., WASHINGTON APPLE HEALTH 2015 MANAGED CARE CONTRACT 204-05 (2015); N.M. HUMAN SERVS. DEP’T, AMENDED AND RESTATED MEDICAID MANAGED CARE SERVICES AGREEMENT AMONG NEW MEXICO HUMAN SERVICES DEPARTMENT, NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE, MOLINA HEALTHCARE OF NEW MEXICO 89 (2013) (requiring plans to make “best efforts to contract with public health providers for family planning services…”); Mo. OFFICE OF ADMIN., DIV. OF PURCHASING AND MATERIALS MGMT., RFP B3Z15077, AMENDMENT 1 – MO HEALTHNET MANAGED CARE – CENTRAL, EASTERN, AND WESTERN REGIONS 26 (2014) (requiring plans to include “Title X and STD providers” in their networks).


42 U.S.C. §§ 1396a(a)(23), 1396n(b); 42 C.F.R. § 431.51(b)(2).


42 C.F.R. § 438.206(b)(4)-(5).

N.H. CODE R. INS. 2701.08(b) (setting forth the requirement for health carriers), 2701.03(i) (defining health carrier). See also CAL. CODE REGS. tit. 28, § 1300.67.2.2(c)(7)(B); CAL. CODE REGS., tit. 10, § 2240.1(e).

MINN. STAT. §§ 62Q.14 (setting forth the requirement for health plan companies), 62Q.01 (defining health plan company); MINN. DEP’T OF COMMERCE AND MINN. DEP’T OF HEALTH, MINN. BULLETIN NO. 96-2, MINN. STATUTES SECTION 62Q.14 (1996).

As noted above, North Carolina does not currently use MCOs or PHPs to provide physical health services to Medicaid enrollees, and as a result, access to out-of-network providers is not an issue for Medicaid beneficiaries seeking family planning or abortion services. Importantly, however, North Carolina does make clear that individuals enrolled in PCCMs do not need a referral from their PCP to access family planning services. See N.C. DIV. OF MEDICAL ASSISTANCE, MEDICAID AND HEALTH CHOICE CLINICAL COVERAGE POLICY No. 1E-7, FAMILY PLANNING SERVICES 6 (undated), available at http://www.ncdhhs.gov/dma/mp/1E-7.pdf.


N.M. HUMAN SERVS. DEP’T, AMENDED AND RESTATED MEDICAID MANAGED CARE SERVICES AGREEMENT AMONG NEW MEXICO HUMAN SERVICES DEPARTMENT, NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE, MOLINA HEALTHCARE OF NEW MEXICO 91 (2013). Centennial Care is the name of the New Mexico Medicaid program.

See WASH. ADMIN. CODE § 182-532-100(2)(c); Email from Cal. Dep’t of Health Care Servs., Medi-Cal Managed Care Div., to Plan Partners (Dec. 5, 2012) (on file with NHeLP).


196 42 U.S.C. § 300gg-19a(d); 45 C.F.R. § 147.138(a)(3). Like the contraceptive coverage requirement, however, the direct access requirement does not reach “grandfathered” health plans. See 42 U.S.C. § 18011; 45 C.F.R. § 147.140(c) (noting that § 2719A of the Public Health Services Act does not apply to “grandfathered” health plans).


198 See 42 U.S.C. §§ 1396a(a)(23), 1396n(b); 42 C.F.R. § 431.51(b)(2).

199 42 C.F.R. § 438.206(b)(2).

200 However, under the federal regulations, if a Medicaid managed care plan refuses to pay for a counseling or referral service due to a moral or religious objection, the state must provide information to enrollees on how and where to obtain the service. 42 C.F.R. § 438.10(f)(6)(xii).

201 Wash. Rev. Code Ann. §§ 48.42.100(4) - (5) (setting forth the requirement for health care carriers), 48.42.100(1) (defining health care carriers).


211 42 C.F.R §§ 438.408, 438.410.


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