

Legislative Brief

California Health Insurance Mandates for Women

California law requires group health insurance policies (including managed care plans) to provide certain benefits for women. The California benefit mandates are in addition to the federal benefit mandates affecting coverage for women, such as the Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act and the Affordable Care Act.

This legislative brief provides an overview of California's health insurance mandates for women.

BREAST CANCER COVERAGE

Health insurance policies must provide coverage for breast cancer screening, diagnosis and treatment. Coverage for breast cancer screening and diagnosis must be consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's or enrollee's physician.

Breast cancer treatment includes coverage for prosthetic devices and reconstructive surgery to restore and achieve symmetry for the patient related to a mastectomy. Coverage for prosthetic devices and reconstructive surgery must be subject to the deductible and coinsurance requirements applied to the mastectomy and the terms and conditions applicable to other benefits.

In addition, health insurance policies that provide coverage for mastectomies and lymph node dissections must:

- Allow the length of hospital stay to be determined by the attending physician in consultation with the patient, consistent with sound clinical principles and processes; and
- Cover all complications from a mastectomy, including lymphedema.

California Health Insurance Mandates for Women (continued)

CERVICAL CANCER SCREENINGS

Health insurance policies that include coverage for treatment or surgery of cervical cancer must provide coverage for an annual cervical cancer screening test upon referral of a patient's physician, nurse practitioner or certified nurse midwife. This coverage includes the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the federal FDA, upon the referral of the patient's health care provider.

CONTRACEPTIVE COVERAGE

Health insurance policies that provide coverage for outpatient prescription drug benefits must include coverage for a variety of federal FDA-approved prescription contraceptive methods, under the same terms and conditions that apply to other benefits. If an insured's or enrollee's health care provider determines that none of the methods designated by the insurer is medically appropriate for the patient's medical or personal history, the insurer must provide coverage for some other FDA-approved prescription contraceptive method prescribed by the health care provider. The coverage must be the same for a covered spouse and covered non-spouse dependents.

A religious employer may request an insurance policy without coverage for contraceptive methods that are contrary to the employer's religious tenets. If a religious employer makes this request, an insurance policy must be provided without coverage for those contraceptive methods. A "religious employer" is a nonprofit organization that:

- Has the inculcation of religious values as its purpose;
- Primarily employs persons who share its religious tenets; and
- Primarily serves persons who share its religious tenets.

This mandate does not exclude coverage for prescription contraceptive supplies ordered by a health care provider for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for prescription contraception that is necessary to preserve the life or health of an insured or enrollee.

INFERTILITY TREATMENT

Health insurance policies must offer coverage for infertility treatment, except in vitro fertilization, under terms and conditions as may be agreed upon between the group policyholder or subscriber and the insurer.

California Health Insurance Mandates for Women (continued)

“Infertility” means either:

- The presence of a demonstrated condition recognized by a licensed physician as a cause of infertility; or
- The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Infertility treatments include procedures consistent with established medical practices in the treatment of infertility by licensed physicians, such as diagnosis, diagnostic tests, medication, surgery and gamete intrafallopian transfer.

This mandate does not require an employer that is a religious organization to offer coverage for forms of infertility treatment in a manner that is inconsistent with the religious organization's religious and ethical principles. This exemption also applies to an insurer that is a subsidiary of an entity whose owner or corporate member is a religious organization.

Health maintenance organizations (HMOs) that offer coverage to employers with fewer than 20 employees are not subject to this mandate.

MAMMOGRAMS

Health insurance policies must provide the following mammogram coverage (upon the referral of a nurse practitioner, certified nurse midwife or physician) for breast cancer screening or diagnostic purposes:

- A baseline mammogram for women **ages 35 to 39**;
- A mammogram for women **ages 40 to 49** every two years or more frequently based on a physician's recommendation; and
- A mammogram every year for women **ages 50 and over**.

This mandate does not require coverage for mammograms provided by a nonparticipating provider, unless the insured or enrollee is referred to that provider by a participating physician, nurse practitioner or certified nurse midwife providing care.

A similar mammography coverage mandate applies to managed care plans, such as HMOs and certain preferred provider organizations (PPOs).

California Health Insurance Mandates for Women (continued)

MATERNITY BENEFITS

Maternity Services – Effective July 1, 2012

Effective **July 1, 2012**, health insurance policies must provide coverage for maternity services for all insureds covered under the policy. Covered maternity services must include:

- Prenatal care;
- Ambulatory care maternity services;
- Involuntary complications of pregnancy;
- Neonatal care; and
- Inpatient hospital maternity care, such as labor and delivery and postpartum care.

This description of covered maternity services will remain in effect until guidance is issued under the federal Health Care Reform law defining the scope of benefits to be provided under the law's maternity benefit requirement. After this guidance is issued, the health care reform definition will apply to this mandate. This mandate does not apply to managed care plans, such as HMOs.

Maternity Services – Parity Mandate

Health insurance policies that provide maternity coverage cannot:

- Contain a copayment or deductible for inpatient hospital maternity services that exceeds the most common amount for other covered inpatient services; or
- Contain a copayment or deductible for ambulatory care maternity services that exceeds the most common amount for ambulatory care services provided for other covered medical conditions.

In addition, if a policy or plan has covered a person continuously from conception, it cannot contain any exclusion, reduction or other limitations as to coverage, deductibles or coinsurance provisions for involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the policy or plan. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy and toxemia.

California Health Insurance Mandates for Women (continued)

Minimum Length of Stay

Health insurance policies that provide maternity coverage cannot restrict benefits for inpatient hospital care to a time period less than **48 hours** following a normal vaginal delivery and less than **96 hours** following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if:

- The early discharge decision is made by the treating physician in consultation with the mother; and
- A post-discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician, is covered.

The follow-up visit must be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. It must include, at a minimum, parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal or neonatal physical assessments. The treating physician, in consultation with the mother, will determine whether the post-discharge visit should occur at home, the contracted facility or the treating physician's office after assessment of certain factors. These factors include the transportation needs of the family and environmental and social risks.

In addition, health insurance policies may not restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the first portion of the hospital stay.

Prenatal Testing and Screening

Health insurance policies that provide maternity benefits must offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. This coverage must be offered under the terms and conditions that are agreed to by the insurer and the group policyholder or subscriber.

Health insurance policies that provide maternity benefits must also cover participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the California Department of Health Services. However, an insurer that provides coverage for maternity benefits cannot require participation in the statewide prenatal testing program as a prerequisite to eligibility for, or receipt of, any other service under the plan or policy.

California Health Insurance Mandates for Women (continued)

OSTEOPOROSIS

Health insurance policies must include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis. The services may include all federal FDA-approved technologies, including bone mass measurement technologies as deemed medically appropriate.

MORE INFORMATION

For more information on health insurance mandates in California, please contact your Fickewirth Benefits Advisors representative.

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