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Women, Poverty, Access to Health Care, and the Perils of Symbolic Reform

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I. INTRODUCTION

This article looks at health care through gendered eyes. We sift though available data on access to health care, health status, and health treatments to determine whether men and women experience health care differently in the United States. While we do not doubt that overt gender-based discrimination occasionally occurs in health care, [1] this article focuses on the importance of

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1. Indeed, Congressional enactment of the National Institutes of Health Revitalization Act of

unintended consequences and unconscious bias. We also explore the impact of symbolism about women's roles on the process of health care reform. The results have important implications for policy makers, advocates, and health care providers.

The United States has a large and complex health care system. Health care consumed $1.1 trillion, over 13%, of the Gross Domestic Product in 1998.[2] A little over half of the health care expenditures came from private funds; slightly less than half of the expenditures were paid from public funds.[3] Virtually every layer of government makes public expenditures, from the federal Medicare program down to immunization programs run by local governments. Health care services were provided in nearly 6,000 hospitals[4] by over 812,000 physicians[5] and other types of heath care providers.[6]

Given the enormity of the system, one might reasonably ask whether the objectives of this paper are quixotic. Where should researchers begin the search for gender-related differences? Part I begins by analyzing data on health care status, treatment, and outcomes for men and women. The data on health care status is intriguing because women have a longer average life expectancy than men. Part II then reviews the conflicting evidence about gender-related differences in health care treatments and outcomes.

Part III carries these themes forward by emphasizing the connection between access to care and access to health insurance. We explore the data on access to health insurance for women and conclude that women and men are insured at similar rates. Women are more likely, however, to be covered

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1993 constituted political recognition of the problems associated with the exclusion of women and minorities from medical research. 42 U.S.C. § 201 (1994). The Act requires inclusion of women and minorities in research trials and establishes an Office for Women and Minority Concerns in the National Institute of Health. *See, e.g.*, 42 U.S.C. § 289a-2 (1994); *see also* OFFICE OF EXTRAMURAL RESEARCH, NAT'L INST. OF HEALTH, INCLUSION OF WOMEN AND MINORITIES POLICY IMPLEMENTATION (2001), *available at* http://grants.nih.gov/grants/funding/women_min/women_min.htm.

2. NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH EXPENDITURES, *at* http://www.cdc.gov/nchs/fastats/hexpense.htm (last visited November 13, 2001).

3. *Id.* (reporting $626.4 billion, or 54.5%, of payments were from private funds and $522.7 billion, or 45.5%, of payments were from public sources).

4. AM. HOSP. ASS'N, FAST FACTS ON U.S. HOSPITALS (1999), *available at* http://www.aha.org/resource/newpage.asp (citing 5,890 "registered" hospitals, This total does not include hospitals not meeting AHA standards).

5. AM. MED. ASS'N, MINORITY PHYSICIANS DATA SOURCE (2000), *available at* http://www.ama-assn.org/ama/pub/article/168-187.html. Only a little over 195,000 of those physicians are women. *Id.* The AMA does not have accurate data on the number of physicians who are members of minority racial or ethnic groups. *Id.* (citing a large percentage of physicians of unknown racial or ethnic background).

6. Almost nine million people provided health care services in 1999. U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, OCCUPATIONAL EMPLOYMENT AND WAGES (2000), *available at* http://www.bls.gov/news.release/ocwage.toc.htm.

by public health insurance programs. [7]

In Part IV, we analyze the role of gender in the private and public insurance markets. We demonstrate how women's increasing political power has resulted in greater regulation of the private insurance market in ways that, at least symbolically, benefit women covered by the private market.[8] Part IV also explores the negative impact of the politicization of public health insurance. Part IV examines the impact of symbolic reforms in the public provision of health benefits. We note that women are disproportionately at risk for governmental intrusion into personal health decisions because they are more likely to be poor or old and, therefore, are more likely to be covered by public insurance programs. [9]

In Part V, we analyze the implications of a gendered analysis of the health care system. We conclude that further research is needed on the relationship between gender, health care treatment, and health care outcomes. Finally, we explore the lessons learned from symbolic attention to women's needs in the private health insurance market and to women's "proper roles" in the public provision of health benefits.

II. WOMEN, HEALTH STATUS, AND THE RISK OF DISPARATE TREATMENT

A. Gender and Health Status

We begin with an analysis of women's health status for two reasons. First, it is commonly known that women, on average, live longer than men. [10] The basis for this disparity must be identified to determine if it could be related to differences in the treatment of males and females within the health care system. Second, women's life patterns and predispositions may give rise to particularly important types of health care needs. Knowledge of these needs might provide a helpful foundation for determining whether our health care system is responsive to women's concerns.

Life expectancy varies by both race and gender. A child born in 1998 has a life expectancy of 73.8 years if male and 79.5 years if female.[11] A white female born in 1998 has an expected life span of 80 years, while a

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7. *See infra* text accompanying notes 60-61.

8. *See infra* text accompanying notes 117-61.

9. *See infra* text accompanying note 162.

10. CENTERS FOR DISEASE CONTROL AND PREVENTION, FASTATS, LIFE EXPECTANCY IN THE UNITED STATES, *at* http://www.cdc.gov/nchs/fastats/lifexpec.htm (last visited Nov. 12, 2001).

11. Robert N. Anderson, *United States Life Tables, 1998*, 48 NATIONAL VITAL STATISTICS REPORTS 1, 2 (Feb. 7, 2001), *available at* http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/48/lifetables98.htm. Life expectancy is the average number of years that a group of infants would live if the infants were to experience throughout life the age-specific death rates prevailing in 1998. *Id.* at 1.

black female born in the same year has an expected life span of only 74.8 years.[12] A black male born in 1998 has a life expectancy of only 67.6 years.[13] White males born in 1998 have a life expectancy of 74.5 years.[14]

Differences in life expectancy between men and women widened by about five years in the first seventy-five years of the twentieth century.[15] Public health authorities contend that the divergence in life expectancies is related to increases in the percentage of male smokers in the early part of the century. In recent years the gap between male and female life expectancy has narrowed.[16] This convergence of life expectancies is thought to be related to recent increases in the percentage of women smokers (and more recent increases in the percentage of women smokers with lung cancer), combined with a decrease in male mortality due to heart disease.[17] Differences between white and black life expectancies, although still significant, are less than half of what they were at the beginning of the 1900s.[18]

Significant gender and race-based differences can also be found in the leading causes of death. The 1998 data demonstrate that men as a group were more likely than women to die of accidents, suicide, chronic liver disease, or homicide.[19] Black men were more likely than black women to

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12. *Id.* at 2.

13. *Id.*

14. *Id.*

15. *Id.* at 3.

16. Anderson, *supra* note 11, at 3.

17. *Id.*

18. *Id.* at 4. The gap in life expectancy was almost sixteen years in 1900 and had declined to six years by 1998. *Id.* The gap declined throughout the century, except for the period between 1983-93, during which the gap widened due to the impact of HIV and homicide on black men. *Id.* The most current reports, based on a preliminary assessment of data from 2000, suggest that the gap in life expectancy between blacks and whites has been reduced to 5.6 years. Arialdi M. Minino & Betty L. Smith, *Deaths: Preliminary Data for 2000*, 49 NATIONAL VITAL STATISTICS REPORTS 3 tbl. a (Oct. 9, 2001). The remaining gap clearly is still a matter of grave concern.

19. Sherry L. Murphy, *Deaths: Final Data for 1998*, 48 NATIONAL VITAL STATISTICS REPORTS 11, 28 (July 24, 2000), *available at* http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/48/48-pre.htm. For women in 1998, the leading causes of death were: heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, pneumonia and influenza, diabetes, accidents, Alzheimer's, kidney disease, or septicemia. *Id.* at 28. For men during the same period, the leading causes of death were: heart disease, cancer, accidents, cerebrovascular disease, chronic obstructive pulmonary disease, pneumonia and influenza, diabetes, suicide, chronic liver disease, and homicide. *Id.* at 27. The 1999 data is similar, with women more likely than men to die of chronic lower respiratory diseases, diabetes mellitus, influenza and pneumonia, nephritis and associated conditions, Alzheimer's disease, and septicimia. Men were more likely than women to die from accidents, suicide, and chronic liver disease and cirrhosis. Robert N. Anderson, *Deaths: Leading Causes for 1999*, 49 NATIONAL VITAL STATISTICS REPORTS 1, 10 (Oct. 12, 2001) tbl. e, *available at* http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/49/49-pre.htm [hereinafter *Deaths: Leading Causes*].

die from accidents, homicide, HIV, and conditions arising in the perinatal period.[20]

The data suggest that some of the differences in death rates are related to social conditions and men and women's behavioral risk factors such as drinking and smoking. Heart disease and cancer are significant sources of mortality for both men and women, making screening and treatment for both groups quite important.[21] Changes in public health strategies and the development of new treatments can affect the likelihood of dying from a particular medical condition. For example, public health interventions and new treatments have affected the likelihood of dying from HIV infection: HIV/AIDS dropped out of the top fifteen causes of death in 1998, after being in the top fifteen for ten years.[22] In 1998, President Clinton announced a new federal initiative to eliminate racial and ethnic disparities in health by 2010.[23] As one aspect of this approach, the federal government established a center to study health disparities at the National Institutes of Health in 2000.[24]

B. Gender, Race, and Disparate Treatment

Major differences in life expectancy and death rates appear to have straightforward explanations; however, several recent studies have raised questions about the possibility of unconscious gender or racial bias in health

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20. Murphy, *supra* note 19, at 34-35. For black men, the leading causes of death in 1998 were: heart disease, cancer, accidents, cerebrovascular disease, homicide, HIV, diabetes, pneumonia and influenza, chronic obstructive pulmonary diseases, and conditions arising in the perinatal period. *Id.* at 34. For black women, the leading causes of death were: heart disease, cancer, cerebrovascular disease, diabetes, pneumonia and influenza, accidents, chronic obstructive pulmonary disease, septicemia, kidney disease, and HIV. *Id.* at 35. Data on Hispanics or other ethnic/racial groups is not available.

The 2000 data confirm the disparity, with blacks more likely than whites to die from accidents, diabetes mellitus, homicide, and HIV. *Deaths: Leading Causes*, *supra* note 19, at 10 tbl. f. Whites were more likely than blacks to die from chronic lower respiratory diseases, influenza and pneumonia, Alzheimer's disease, and suicide. *Id.*

21. *Id.* at 10 tbl. e.

22. Murphy, *supra* note 19, at 34-35. Note that while HIV dropped out of the top fifteen sources of death overall, it remained the leading cause of death in some race/age categories. *Id.* at 2 (indicating that HIV is the leading cause of death for blacks, aged twenty-five through forty-four years).

23. U.S. DEP'T OF HEALTH & HUMAN SERV., OFFICE OF MINORITY HEALTH, THE INITIATIVE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH, http://www.omhrc.gov/OMH/sidebar/aboutOMH.htm (last visited Nov. 12, 2001) (outlining history of the federal initiative).

24. *See* Minority Health and Health Disparities Research and Education Act of 2000, Pub. L. No. 106-525, 114 Stat. 2721 (Supp. 2001); NATIONAL INST. OF HEALTH, ADDRESSING HEALTH DISPARITIES: THE NIH PROGRAM OF ACTION, http://healthdisparities.nih.gov (last visited Nov. 12, 2001).

care treatment.[25] The issue is serious enough that the American Medical Association's Council on Ethical and Judicial Affairs issued a guideline suggesting greater sensitivity to the possibility of disparate treatment.[26] In addition, several scholars have written about the implications of disparities in health care for members of minority racial or ethnic groups.[27]

Studies suggest that men are more likely than women to receive certain high technology and expensive diagnostics tests or treatments. An early study concluded that "males showed significantly higher utilization odds than females for the procedures of hip replacement, . . . pacemaker, . . . endarterectomy . . . angioplasty, . . . defibrillator implant, . . . heart transplantation, . . . and coronary bypass. . . . No statistically significant intergender utilization differences were found for lithotripsy or kidney transplantation."[28] The same study also showed significant differences in utilization associated with the race of the patient: "[w]hites had greater odds over blacks for receiving 5 of 9 procedures, over Latinos for receiving 3, and over Asians for receiving 2."[29]

One controversial study sought to resolve whether physicians' management of patients' chest pain was influenced by the race and sex of their patients.[30] Researchers developed an elaborate study design that used videotaped actors of different races and sexes to present identical case

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25. Mita K. Giacomini, *Gender and Ethnic Differences in Hospital-Based Procedure Utilization in California,* 156 ARCHIVES INTERNAL MED. 1217 (1996). *But see* Traves D. Crabtree et al., *Gender-Dependent Differences in Outcome After the Treatment of Infection in Hospitalized Patients*, 282 JAMA 2143 (1999) (arguing that gender was not associated with greater risk of mortality from all infections and that women appear to be at increased risk of death from hospitalized pneumonia).

26. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559 (1991).

27. *See, e.g.*, DOROTHY E. ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY (1997); Lisa C. Ikemoto, *The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women's Health Needs*, 65 U. CIN. L. REV. 799 (1997) (critiquing gender and race analyses; noting the failure to address issues connected with Asian Pacific Americans in general and Asian Pacific American women in particular; and describing the health status of Asian Pacific American women); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998) (giving examples of disparities and suggesting legal and other remedies); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996); Dorothy Roberts, *The Nature of Blacks' Skepticism About Genetic Testing*, 27 SETON HALL L. REV. 971 (1997).

28. Giacomini, *supra* note 25, at 1220.

29. *Id.* The only situation in which whites received less treatment than non-whites was in the area of total hip replacement, which Asians were twice as likely to receive. *Id.*

30. Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (1999). Previous epidemiological studies had raised the possibility of gender and race disparities in the treatment of heart disease. *Id.* at 625 (references 1-23); *see also* W.H. Giles et al., *Race and Sex Differences in Rates of Invasive Cardiac Procedures in US Hospitals: Data from the National Hospital Discharge Survey*, 155 ARCHIVES INTERNAL MED. 318 (1995) (finding race and sex differentials in rates of invasive cardiac procedures after controlling for other factors that influence rates).

backgrounds to physician experimental subjects.[31] The researchers gave the physicians structured information about the "patients" and asked them to make certain diagnostic and referral decisions.[32] The researchers found that physicians were more likely to refer men and whites for cardiac catheterization than women and blacks.[33] The results appeared to support previous epidemiological studies, which had found "the lowest rates of cardiovascular procedures were among nonwhite women."[34] Researchers suggested that the study might demonstrate unconscious bias.[35] Critics argue, however, that the researchers overstated the statistical significance of their results and inappropriately implied that cardiac catheterization constituted "better" care.[36] The most recent study in this area found that women are less likely than men to undergo a cardiac catheterization even when the referring physician is female.[37]

Research on differential treatment rates continues.[38] Other studies are

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31. Schulman et al., *supra* note 30, at 619. The researchers controlled for the possible effects of different presentations by the patient, occupational background, insurance status, and other possible confounding variables. *Id.*

32. *Id.*

33. *Id.* at 623.

34. *Id.* at 624.

35. *Id.* at 624-25.

36. Lisa M. Schwartz et al., *Misunderstandings About the Effects of Race and Sex on Physicians' Referrals for Cardiac Catheterization*, 341 NEW ENG. J. MED. 279 (1999). The authors note that the actual difference in referral rates between whites and blacks was small (7%) but that the difference was overstated in the original Schulman article because of the use of odds ratios rather than percentages. *Id.* at 280. Further, the referral rates for black men, white women, and white men were identical, with referrals for black women lagging behind. The actual distinction in referral rates would be better expressed as a referral rate of 90.6% for the first three groups and 78.8% for black women. *Id.* at 280-81. Finally, the critics noted that cardiac catheterization is a risky procedure that might be overutilized, with the result that physicians may have given more appropriate care to the black women in the study than the members of the other group. *Id.* at 281.

37. Saif S. Rathore et al., *Sex Differences in Cardiac Catheterization: The Role of Physician Gender*, 286 JAMA 2849 (2001) (describing data from 104,231 Medicare beneficiaries hospitalized for acute myocardial infarction in the mid-1990s). The researchers suggest that "factors other than sexual bias by male physicians toward women account for sex differences in cardiac procedure use." *Id.*

38. *See, e.g.*, Jersey Chen et al., *Racial Differences in the Use of Cardiac Catheterization*, 344 NEW ENG. J. MED. 1443 (2001) (noting that black patients with acute myocardial infarction were less likely to be referred for cardiac catheterization than whites, whether treated by white or black physicians; the mortality rate was lower for blacks); Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471 (2001) (reviewing the Chen study and concluding overt racial bias is unlikely to explain differential rates of cardiac catheterization); L.C. Einbinder & K.A. Schulman, *The Effect of Race on the Referral Process for Invasive Cardiac Procedures*, 57 MED. CARE RES. REV. 162 (2000) (describing stages of physician-communication in cases involving possible invasive cardiac care and suggesting areas where racial differences could lead to miscommunication); S.S. Rathore et al., *The Effects of Patient Sex and Race on Medical Students' Ratings of the Quality of Life*, 108 AM. J. MED 561 (2000) (evaluating medical students who scripted videotapes and rated patients' quality of life and the probability the patient had angina; the results seemed to indicate that medical students were influenced by non-medical factors).

also underway, including those that focus on the possible role of unconscious bias in the design of payment systems for health care. A small body of studies suggests another basis for gender differentials in the system: under reimbursement for procedures more heavily needed by women.[39]

III. ACCESS TO HEALTH CARE FOR WOMEN

A. Access to Health Care and Insurance

Access to health care depends, in part, on access to health insurance. Middle or upper class individuals without insurance may be able to pay for routine care using current income or savings. Routine health care can be prohibitively expensive for uninsured low income persons. More specialized or advanced health care is too expensive for low or moderate income persons. Health insurance is thus an important aspect of gaining access to health care.

Research confirms that people without health insurance have significant unmet health care needs.[40] One study of over 200,000 adults explored the connection between insurance and access to care. About 9.7% of the study group were considered long-term uninsured persons because they had not had insurance coverage within the past year; an additional 4.3% had been uninsured for less than a year.[41] The study found that nearly 40% of long-term uninsured respondents and 33% of short-term uninsured respondents reported they had not been able to see a physician when they needed to do so within the past year because of the cost of care.[42] Only 7% of insured

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39. *See, e.g.*, Peter Cherouny & Calleen Nadolski, *Underreimbursement of Obstetric and Gynecological Invasive Services by the Resource-Based Relative Value Scale*, 87 OBSTETRICS & GYNECOLOGY 328 (1996) (noting that the system for reimbursing physicians for services undervalues invasive procedures that are only performed for women); Barbara A. Goff et al., *Is Adam Worth More than Eve? The Financial Impact of Gender Bias in the Federal Reimbursement of Gynecological Procedures*, 64 GYNECOLOGICAL ONCOLOGY 372 (1997) (concluding that Medicare reimbursement for female-only services is biased in a way that results in lower net reimbursement for gynecological procedures). *But see* Michael L. Berman, Editorial, *Neither Adam nor Eve Seems Worth Very Much Anymore*, 64 GYNECOLOGICAL ONCOLOGY 369 (1997) (critiquing the methodology of the Goff study).

40. John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061 (2000) [hereinafter Ayanian, *Uninsured Adults*]. The study focused on adults from ages eighteen through sixty-four.

41. The overall uninsured percentage was approximately fourteen percent. Other studies have found higher rates of uninsurance among persons in this age group. *See infra* notes 62-111 and accompanying text (reporting that the Census Bureau estimates 15.5% or 42 million people in the United States were uninsured in 1999). The *Unmet Health Needs of Uninsured Adults in the United States* telephone survey excluded respondents who lived in households without a phone, which might account for some of the variance. Ayanian, *Uninsured Adults*, *supra* note 40, at 2068.

42. *Id.* at 2064.

patients reported an inability to secure care based on financial factors.[43] Uninsured adults are less likely than insured adults to have a routine check-up by a physician.[44] Uninsured adults are less likely to receive preventive care such as screening for breast cancer or hypertension.[45] Some studies indicate that uninsured persons are more disadvantaged when seeking care for chronic illnesses than they are when seeking care for acute illnesses.[46]

The Kaiser Commission on Medicaid and the Uninsured reports studies that echo these results.[47] The Kaiser Commission reports that 34% of uninsured survey respondents postponed seeking needed health care because of cost. Further, "[t]wenty percent of uninsured adults did not get needed care at all in the past year for a serious condition compared to only 3% of adults with health coverage."[48] Thirty-nine percent of uninsured persons had skipped a recommended medical treatment or test compared to only 13% of insured persons.[49] Seventy-six percent of non-elderly insured adult women obtained a pap smear within the past year, compared with only 49% of non-elderly uninsured women.[50] Forty percent of the insured women in this group had a mammogram within the past year, compared to only 16% of the uninsured women.[51] The Kaiser Commission report also found differences in access to particular types of health care based on insured status.

> The uninsured are less likely to have a procedure that is relatively costly or where physicians exercise a great deal of discretion (i.e., procedures where there is no clinical consensus on their appropriate use). For example, the probability of uninsured hospitalized patients undergoing coronary artery bypass surgery

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43. *Id.*

44. *Id.* at 2067. One particularly troubling finding was that uninsured persons with the most serious, chronic health conditions were significantly less likely to receive a routine check-up than insured persons with the same health conditions. *Id.*

45. *Id.* at 2065 (indicating that uninsured adults were three to four times less likely to receive these services).

46. *See, e.g.*, Chris Hafner-Eaton, *Physician Utilization Disparities Between the Uninsured and Insured: Comparisons of the Chronically Ill, Acutely Ill, and Well Nonelderly Populations*, 269 JAMA 787 (1993).

47. THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA: A CHART BOOK 58 (2d ed. 2000), *available at* http://www.kff.org/content/archive/1407 [hereinafter KAISER COMM'N, UNINSURED]. For another summary of the recent research, see AM. C. OF PHYSICIANS-AM. SOC'Y OF INTERNAL MED., NO HEALTH INSURANCE? IT'S ENOUGH TO MAKE YOU SICK—SCIENTIFIC RESEARCH LINKING THE LACK OF HEALTH COVERAGE TO POOR HEALTH, http://www.acponline.org/uninsured (last visited Nov. 12, 2001).

48. KAISER COMM'N, UNINSURED, *supra* note 47, at 58.

49. *Id.* at 63.

50. *Id.* at 73.

51. *Id.* Uninsured men were also less likely to have relevant screening tests. Twenty percent of nonelderly insured men had undergone a prostate exam within the past year, compared with only twelve percent of uninsured men. *Id.*

was 29% less compared to those with health insurance and 45% less for total hip replacements.[52]

A few studies indicate that the uninsured are more likely to become seriously ill than insured persons. Some chronic diseases, such as diabetes and certain types of hypertension, can be managed in outpatient settings. For these conditions, hospitalization for treatment is an avoidable outcome[53] and hospitalization for treatment might indicate a lack of appropriate care. In one study, for example, uninsured patients were "twice as likely to be hospitalized" for "diabetes and malignant hypertension" than persons covered by private insurance.[54] Another study found that uninsured persons were more likely to have late stage cancer at the time of diagnosis than insured persons, perhaps due to barriers in seeking earlier care.[55] The effects can be cumulative and serious; some studies indicate, for example, that uninsured persons have a higher risk of dying than insured persons.[56]

While having insurance might be associated with receiving care, the care received may not always be appropriate. Studies suggest that having insurance increases the likelihood of undergoing some procedures with a history of overutilization. Some critics of the Shulman study on cardiac catheterization note, for example, that this risky procedure may be

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52. *Id.* at 75 (citing Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use and Outcomes*, 265 JAMA 374 (1991)); *see also* Mark B. Wenneker et al., *The Association of Payer with Utilization of Cardiac Procedures in Massachusetts*, 264 JAMA 1255 (1990) (noting that privately insured patients were eighty percent more likely to receive an angiogram).

Of course, it is important to remember that more health care is not always better health care. The procedures studied carry a risk of morbidity and mortality. The uninsured may indirectly benefit from decisions to refrain from aggressive therapies where there is no clinical consensus about appropriate use. Some studies have found no significant differences in survival rates based on insured status. *See, e.g.*, John G. Canto et al., *Payer Status and the Utilization of Hospital Resources in Acute Myocardial Infarction: A Report from the National Registry of Myocardial Infarction 2*, 160 ARCHIVES INTERNAL MED. 817 (2000) (comparing different types of insurance and finding a slightly higher in-hospital morbidity for Medicaid and uninsured patients).

53. KAISER COMM'N, UNINSURED, *supra* note 47, at 77.

54. *Id.* (citing Joel S. Weissman et al., *Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland*, 268 JAMA 2388 (1992)).

55. *Id.* at 80 (citing Richard G. Roetzheim et al., *Effects of Health Insurance and Race on Early Detection of Cancer*, 91 J. NAT'L CANCER INST. 1409 (1999)).

56. *See, e.g.*, Peter Franks et al., *Health Insurance and Mortality: Evidence from a National Cohort*, 270 JAMA 737 (1993) (noting a higher mortality rate for uninsured persons, independent of other variables); Jack Hadley et al., *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use and Outcomes*, 265 JAMA 374 (1991) (finding uninsured patients had a higher rate of in-hospital mortality compared to insured patients, even after controlling for disease severity and expected risk of death at admission). *But see* Jorge Yarzebski et al., *Health Insurance Coverage and Outcome Following Acute Myocardial Infarction*, 157 ARCHIVES INTERNAL MED. 758 (1997) (noting that after controlling for various co-variates, researchers found no significant differences in length of stay or in-hospital morbidity following acute myocardial infarction based on a patient's insured status).

overutilized.[57] Another study of cesarean births in California found that women with private, fee-for-service insurance underwent cesarean sections at higher rates than women covered by managed care or Medicaid.[58]

These studies demonstrate that having insurance is an important component of having access to health care. The following sections will examine differences in the ways that men and women gain access to insurance in the United States. For a variety of reasons, women are slightly more likely to be insured than men.[59] More women than men are covered by public rather than private health insurance plans.[60] The differences in insurance status result from the different socioeconomic positions of men and women in society and political decisions about the structure of the health care system.[61]

B. Gender and the Uninsured

Approximately 42 million persons, about 15.5% of the population in the United States, were completely without health insurance for the entire year in 1999.[62] The number of uninsured persons declined slightly from 1998 to 1999, the first decline recorded in over ten years.[63]

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57. *See* Schwartz et al., *supra* note 36, at 281.

58. R.S. Stafford et al., *Trends in Cesarean Use in California,* 168 AM. J. OBSTETRICS GYNECOLOGY 1297, 1300 (1993) (noting that cesarean rates were declining in all groups due to changes in reimbursement and increasing awareness of overutilization).

59. *See infra* text accompanying notes 65-66.

60. *See infra* text accompanying note 66.

61. *See, e.g.,* Steven Miles & Kara Parker, *Men, Women, and Health Insurance,* 336 NEW ENG. J. MED. 218 (1997) (sketching the impact of women's life patterns and socioeconomic status on insurance coverage); Steven Miles, *Gender and Health Insurance,* 23 WM. MITCHELL L. REV. 313 (1997) (discussing the features attributed to gender-based inequalities in American health care systems).

62. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 1999, at tbl. A, http://www.census.gov/prod/www/abs/popula.html#income (last revised Oct. 3, 2000) [hereinafter HEALTH INSURANCE]; *see also* Katherine Swartz, *Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You,* 271 JAMA 64 (1994) (noting that an even greater number of individuals may have been without health insurance at some point during the year).

63. HEALTH INSURANCE, *supra* note 62, at 1.

Chart One: Insured Status in the United States, 1999.[64]

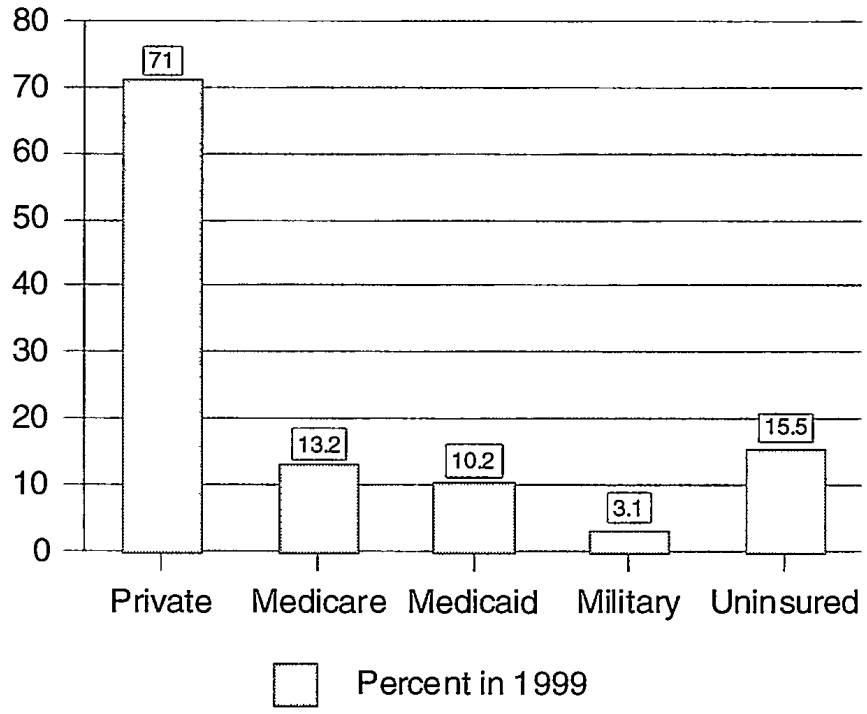

Chart One shows the breakdown between the insured and uninsured population in 1999. The census data reveal that men are slightly more likely to be completely uninsured than women.[65] The difference appears to be related, in part, to the fact that more poor women are insured—perhaps through Medicaid—than poor men.[66] As noted in Chart Two, the uninsured are more likely to be members of racial or ethnic minorities. Hispanics have particularly high rates of uninsurance.

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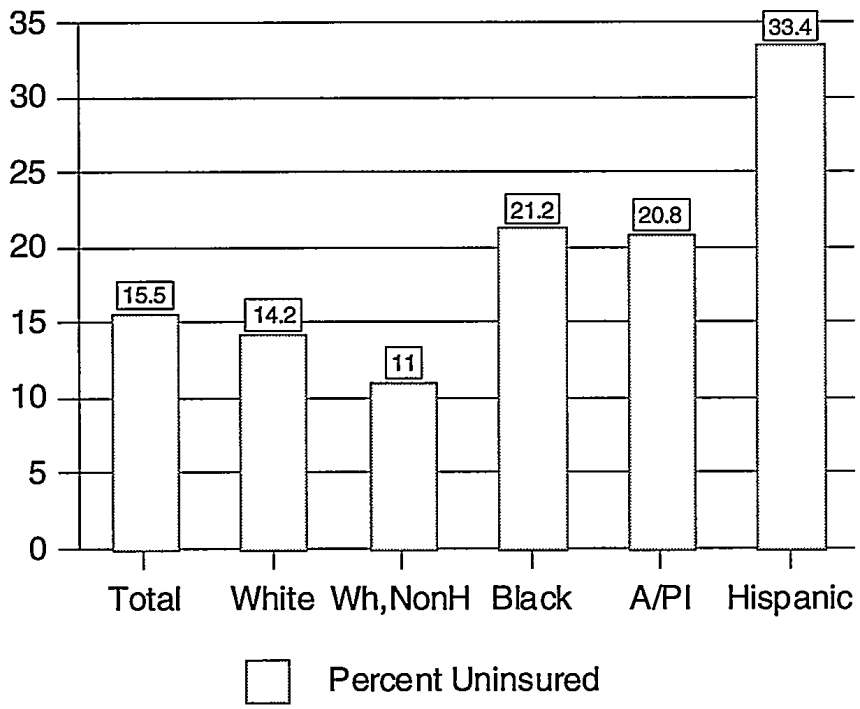
64. *Id.*

65. *Id.* at tbl. B (indicating that 16.5% of men versus 14.6% of women are uninsured).

66. *Id.* at tbl. C (noting that 35% of poor men were uninsured while 30.4% of poor women were uninsured; overall 32.4% of the poor had no health insurance). For a discussion of the role of Medicaid eligibility requirements see *infra* notes 92-102 and accompanying text.

Chart Two: Race and Ethnicity Among the Uninsured, 1999[67]



Other risk factors for lack of health insurance suggest that women as a group constitute a vulnerable population. Work history and income level are associated with the risk of uninsurance. For those aged eighteen through sixty-four, the lowest rate of uninsurance occurred among full-time workers (16.4%), and the highest rate of uninsurance was found among those who did not work (26.5%).[68] Similarly, while 24.1% of persons with a household income below $25,000 and 18.2% of persons with household incomes between $25,000-$49,999 went without insurance, only 8.3% of those with household incomes over $75,000 did not have health insurance.[69]

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67. HEALTH INSURANCE, *supra* note 62, at Fig. 3. The survey sample of 50,000 used to develop these estimates was not large enough to provide a reliable estimate of the uninsurance rate for American Indians or Alaska Natives. *Id.* at 7. A multi-year analysis of the survey data suggests that 27.1% of members of these groups were without health insurance. *Id.*

68. *Id.*, at tbl. B (noting that the percentage of uninsured persons between the ages of 18 and 64 is higher than the 15.5% total rate of uninsured persons noted above). The differential exists because almost all persons over the age of sixty-five are eligible for Medicare; only 1.3% of persons in the over-sixty-five age group are uninsured. *Id.* at 7. Inclusion or exclusion of this age group can thus depress or lift the overall rate of insurance in a given population study. *Id.*

69. *Id.*

C. Women in the Private Insurance Market

Chart One indicates that about seventy-one percent of the population is covered by private health insurance.[70] Almost all of the private health coverage is provided as a benefit of employment.[71] Health insurance is more likely to be provided as a benefit of employment to full-time workers rather than part-time workers.[72] Women are less likely to work full time and typically earn less money than men.[73] Even where employed full time, women are slightly less likely to be have jobs that carry health insurance as a benefit of employment.[74] Women who gain health insurance coverage as a result of their spouse's employment may risk losing coverage through divorce or death of the spouse.[75] As a result, private health insurance policies benefit men rather than women.[76]

D. Women and Coverage by Public Insurance Programs

There are two major public insurance programs: Medicare and Medicaid. Medicare is a federal program that provides coverage for most persons over age sixty-five and certain long-term disabled persons.[77] Medicaid is a joint federal-state program focused on providing coverage to specific subpopulations of the poor.[78] Women are disproportionately eligible for both programs.[79]

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70. *See supra* chart accompanying note 64.

71. HEALTH INSURANCE, *supra* note 64, at 1 (62.8% of the population is covered by employment-based health insurance, leaving 8.2% of coverage provided by private individual or group insurance policies).

72. *Id.* at 8.

73. U.S. CENSUS BUREAU, MONEY INCOME IN THE UNITED STATES: 2000 tbl. A (2001), *available at* http://www.census.gov/hhes/www/income00.html. (showing median income for all households, married couple households, female-headed households, male-headed households, and single men/women; giving statistics for full time employment for men and women); *see also* Roberta Wyn et al., *Falling Through the Cracks: Health Insurance Coverage of Low Income Women* (Feb. 2001), *available at* http://www.kff.org/content/2001/1611.

74. U.S. DEP'T OF LABOR, PENSION AND HEALTH BENEFITS OF AMERICAN WORKERS - NEW FINDINGS FROM THE APRIL 1993 CURRENT POPULATION SURVEY, tbl. F1-F3, http://www.dol.gov/dol/pwba/public/programs/opr/bluebook/f_1.htm (last visited Nov. 12, 2001).

75. For a discussion of the federal government's response to this risk and a discussion of COBRA continuation coverage, see *infra* notes 119-129 and accompanying text.

76. KAISER COMM'N, UNINSURED, *supra* note 47, at 85 (showing 73.4% of adult nonelderly females covered by "private/other" insurance, compared to 74.7% of adult nonelderly men).

77. *See infra* text accompanying note 80.

78. *See infra* text accompanying notes 88-96.

79. *See infra* text accompanying notes 81-83, 99.

1. Medicare

Medicare covers most persons over sixty-five years of age, long-term disabled persons, and persons living with end stage renal disease.[80] Medicare is more likely to cover women than men because women tend to live longer than men.[81] The federal Health Care Financing Administration reports that "[b]ecause of their longer life expectancy, elderly women outnumber men in the Medicare program by 7%. The proportion of female Medicare beneficiaries increases with age: women constitute more than 70% of the Medicare population age 85 and older."[82]

Medicare does not provide coverage for prescriptions and most long-term care.[83] Women are negatively affected by these program limitations because they tend to have more chronic illnesses and are over-represented in nursing home populations.[84] Although Medicare initially offered little preventive health coverage, the program has added coverage of these services over time. Mammograms and pap smears were among the first screening tests covered.[85] However, less than half of Medicare beneficiaries report actually receiving a mammogram or a pap smear within the past year.[86]

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80. HEALTH CARE FINANCING ADMIN., MEDICARE 2000: 35 YEARS OF IMPROVING AMERICANS' HEALTH AND SECURITY 34 (2000), *available at* http://www.hcfa.gov/stats/stats.htm [hereinafter MEDICARE 2000]. Most Medicare beneficiaries who enroll in Medicare's fee for service plan have private, supplemental health plans purchased individually or offered through employment. *Id.* at 25. These private, supplemental plans fill the gaps of Medicare coverage, such as the absence of prescription drug coverage. *Id.* Medicare provides minimal long-term care benefits; nursing home costs are thus ordinarily paid from private funds, a separate long-term care policy, or Medicaid (for beneficiaries meeting the income and assets eligibility tests). AARP PUB. POL'Y INST., THE MEDICARE PROGRAM 7 (Aug. 2001), *available at* http://research.aarp.org/health/dd64_medicare.html. In 1997, 18.7% of beneficiaries' out of pocket expenses were related to prescription drugs and 44% were related to stays in long-term care facilities. MEDICARE 2000, *supra* note 80, at 26.

Low-income Medicare beneficiaries are unlikely to be covered by private, supplemental policies. Low-income or medically needy beneficiaries may receive both Medicare and Medicaid. About 16.5% of Medicare recipients also receive Medicaid. *Id.* at 13. For further information about Medicaid, see *infra* text accompanying notes 87-101.

81. *See supra* text accompanying note 10.

82. MEDICARE 2000, *supra* note 80, at 12 (citations omitted). Men are overrepresented among the disabled beneficiaries, however, by nine percent. *Id.* The fact that women tend to outlive men impacts the program in a number of ways. Almost thirty percent of Medicare beneficiaries live alone; seventy-two percent of those living alone are women. *Id.* at 20. This group is also more likely to be impoverished. *Id.* Older beneficiaries are also more likely to suffer from health problems.

83. *See supra* note 80.

84. About three out of four nursing home residents are women. NADINE R. SAHYOUN ET AL., CENTERS FOR DISEASE CONTROL AND PREVENTION, THE CHANGING PROFILE OF NURSING HOME RESIDENTS: 1985-1997, at 2 (2001), *available at* http://www.cdc.gov/nchs/data/agingtrends/04nursin.pdf.

85. MEDICARE 2000, *supra* note 80, at 38, 47-48.

86. *Id.* at 50 (reporting mammogram and pap smear rates and concluding that they still fall

2. Medicaid

Medicaid is the largest purchaser of health care services in the United States.[87] States participating in Medicaid are required by the federal government to provide medical care to enrolled citizens in exchange for federal subsidies.[88] The program is administered at the federal level by the Centers for Medicare and Medicaid Services (CMS), known until recently as Health Care Financing Administration (HCFA).[89] At the state level, Medicaid is administered through human service agencies. States set their own standards of eligibility in accordance with broad national guidelines established by Congress and monitored by CMS.[90] States also determine the type, amount, duration, and scope of covered services, as well as the distribution of those services, within certain federal guidelines.[91]

Although Medicaid is commonly thought to provide access to health care for "poor people," the program has never had that broad objective. Instead, the program focuses on subgroups of generally poor people who meet special characteristics.[92] First, Medicaid covers certain impoverished families with children, low-income pregnant women,[93] and low-income children under age nineteen.[94] Second, the program covers certain low-income children and adults with disabilities.[95]Third, Medicaid provides supplemental support to impoverished Medicare recipients; Medicaid is used

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short of public health goals). Mammogram rates are slightly lower for African-American or Hispanic recipients. *Id.* at 52.

87. THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER (2000), *available at* http://www.kff.org/content/2001/2248 [hereinafter THE KAISER COMM'N ON MEDICAID AND THE UNIINSURED].

88. Although state participation in Medicaid is voluntary, all states currently participate in the program. *Id.* at 1. In 1998, federal expenditures to states had increased to represent at least half of participating states' Medicaid budgets. *Id.* at 1, 4.

89. *See* CMS: THE MEDICARE, MEDICAID, SCHIP AGENCY, http://www.hcfa.gov (last visited Nov. 16, 2001).

90. *Id.*

91. *Id.*

92. The program focused on the "deserving poor"—mostly women, children, and the disabled-rather than on low income status. For a discussion of these issues, see Martha L. Fineman, *Images of Mothers in Poverty Discourse,* 1991 DUKE L.J. 274, 282 (1991); Sandra J. Tanenbaum, *Medicaid Eligibility Policy in the 1980's: Medical Utilitarianism and the "Deserving" Poor*, 20 J. HEALTH POL., POL'Y & L. 933, 935 (1995) (indicating that welfare reform would appear to constitute a further narrowing of the groups considered "deserving.").

93. "Medicaid coverage for pregnant women ends sixty days postpartum. If the mother does not qualify through another eligibility pathway, she loses her coverage, even though her infant is covered for a full year." THE HENRY J. KAISER FAM. FOUND., MEDICAID'S ROLE FOR WOMEN: FACT SHEET 2 (2000), *available at* http://www.kff.org/content/2000/2205/Medicaidwomenfs.PDF [hereinafter MEDICAID'S ROLE FOR WOMEN].

94. THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 87, at 3.

95. *Id.*

to pay Medicare Part B premiums, deductibles, and copayments for eligible low-income Medicare beneficiaries.[96]

Medicaid's relatively narrow eligibility requirements mean that many low-income persons do not qualify for the program.[97] Medicaid does not cover single adults—even if they are very poor—unless they are disabled.[98] The program is less likely to cover men than women because men cannot be pregnant and are less likely to live long enough (and to be impoverished enough) to be eligible for Medicaid in old age. In fact, Medicaid is a major insurer of women in the United States.[99] In 1994, Medicaid covered twenty-six percent of low-income women.[100] In 1996, federal efforts to reform welfare broke the connection between receipt of welfare benefits and automatic receipt of Medicaid benefits.[101] By 1998, Medicaid covered only twenty-three percent of low-income women.[102]

Discussions regarding poor women's access to health care often emphasize elderly women. Because of a longer average life expectancy, older women are more likely to experience multiple chronic illnesses, disability, and frailty than older men.[103] Older women are more likely than men "to use care in post acute or non-acute care settings."[104] Over seventy

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96. For the poorest Medicare beneficiaries, those who receive Social Security Insurance benefits for elderly or disabled persons, Medicaid provides full supplemental coverage for the services and benefits, such as prescribed drugs and long-term care, that Medicare does not cover. *Id.*

97. States have the discretion to expand eligibility for coverage to include persons who do not meet the stringent requirements for federally mandated coverage. *Id.* at 3.

98. *Id.*

99. Medicaid currently provides over twelve million low-income women with basic health and long-term care coverage. As many as 8.5 million more uninsured low-income women fall outside Medicaid coverage or are eligible but not enrolled. MEDICAID'S ROLE FOR WOMEN, *supra* note 93 at 1.

100. Wyn et al., *supra* note 73, at ix.

101. The Medicaid program's emphasis on women stems from Medicaid's objective when it was created in 1965: to provide medical assistance to welfare recipients and to extend such assistance to additional persons with low income. Prior to 1996, enrollment for Medicaid was administered primarily through state welfare agencies and accompanied determinations and distribution of cash assistance payments under the Aid to Families With Dependent Children. This tradition was consistent with legislative attitudes underlying the creation of Medicaid regarding women and children as the "deserving poor." *See generally* A. Mechele Dickerson, *America's Uneasy Relationship with the Working Poor,* 51 HASTINGS L.J. 19 (1999).

102. Wyn et al., *supra* note 73, at ix. This Kaiser Foundation report notes that the rate of uninsured women increased by three percent and the percentage of women covered by private insurance remained flat. *Id.* The implication is that women dropped Medicaid and became uninsured rather than picking up private coverage. *See infra* notes 164-184 and accompanying text for a discussion of the impact of welfare reform on women and the poor.

103. Lisa A. Foley & Mary Jo Gibson, *Older Women's Access to Health Care: Potential Impact of Medicare Reform* (2000), http://research.aarp.org/health/2000_08_women_1.html; *see also* THE HENRY J. KAISER FAMILY FOUNDATION, WOMEN AND MEDICARE 1 (1999), *available at* http://www.kff.org/content/2001/1639.

104. Foley & Gibson, *supra* note 103, at 6.

percent of nursing home residents and two-thirds of home health care recipients are women.[105] Many cannot afford such expensive care, but only the poorest can qualify for assistance from Medicaid.[106] One study reports that women are subject to health risks due to the stress and strain associated with their status as informal caregivers for family members.[107] Medicaid plays a pivotal role in protecting many older women from crippling out-of-pocket health costs, which tend to exceed costs experienced by older men in terms of actual dollars and percentage of income.[108]

Medicaid covers a broad range of health care services for women, including prenatal care and delivery, preventive services, family planning, and long-term care services.[109] Reproductive health is a key issue for women on Medicaid, the majority of whom are in their prime childbearing years.[110] Some women on Medicaid face obstacles in locating providers because many office-based obstetricians and gynecologists do not participate in Medicaid or are not located in communities where beneficiaries live.[111]

IV. GENDER, ACCESS TO CARE, AND SYMBOLIC HEALTH REFORM

Parts II and III of this Article revealed the health care landscape viewed through gendered eyes. Women and men may have similar health needs, but women possess unique characteristics that warrant special attention. For instance, special concerns tend to implicate women's reproductive roles or longer life span.[112] Women may also be at risk for unconscious bias in treatment or in the design of health care systems.[113] Women are less likely than men to be covered by private health insurance and therefore more likely

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105. THE HENRY J. KAISER FAMILY FOUND., *supra* note 103, at 1.

106. Elderly women with Medicare coverage who also qualify for Social Security Insurance can receive full Medicaid benefits and assistance with Medicare cost-sharing and deductibles. MEDICAID'S ROLE FOR WOMEN, *supra* note 93, at 1. For other poor Medicare beneficiaries, Medicaid pays for some Medicare cost-sharing and deductibles. *Id.* Comparing elderly women to older men, Medicaid figures more prominently as a source of health care coverage for older women. Foley & Gibson, *supra* note 103, at 2-4. One-third of older Medicare beneficiaries are poor or low income. *Id.* at 11. Women comprise three-quarters of the three million Medicare beneficiaries who have incomes at or below the poverty threshold. *Id.* Women disproportionately represent the "near poor" (persons with incomes that fall between 100% and 125% of federal poverty levels) and low income (persons with incomes that fall between 125% and 200% of federal poverty levels). *Id.* Moreover, a disproportionate number of poor beneficiaries are minority women. *Id.*

107. Foley & Gibson, *supra* note 103, at 6.

108. *Id.* at 10.

109. MEDICAID'S ROLE FOR WOMEN, *supra* note 93, at 1-2.

110. *Id.* at 2.

111. *See, e.g.*, John V. Jacobi, *Mission and Markets in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1441 (1997).

112. *See supra* text accompanying notes 10-17.

113. *See supra* text accompanying notes 25-39.

to be covered by public health programs.[114] Women may be negatively affected by this greater reliance on public health programs if it limits access to important types of health care or to a wide range of health care providers.[115] In Part IV, we apply a similar gendered analysis to recent federal efforts to reform health care. Have recent efforts to reform health care truly benefited women, or have such reforms amounted to little more than empty or destructive symbolism?

A. Access to Care in the Private Market

Although the United States has been unable to reach a consensus on either the need for or the structure of a comprehensive national health care system, Congress has adopted a wide range of incremental reforms to the health care system over the past fifteen years.[116] Each reform is built around a perceived inadequacy of the current system. However, as the failure of the Clinton health plan demonstrates, it is not enough to show the current system is flawed. A coalition of interest groups must give a reform measure sufficient political clout to outweigh the likely costs to either private or government coffers. Congressional reformers have responded to coalitions by enacting "fixes" to issues raised by politically powerful middle class voters. Discussions about the importance of swing-voting "soccer moms"[117] have coincided with a burst of recent health care reforms in the private market.[118]

1. COBRA Continuation Coverage

One key feature of our current health care system is that most persons who have private health insurance coverage gain it as a benefit of employment.[119] A person's health care coverage therefore is at risk if she or he: (1) loses a job; (2) moves from full-time to part-time status;(3) divorces the worker with health coverage; or (4) survives the death of an employed spouse. Historically, women are more likely to have periods of temporary employment, to move from full-time to part-time work status, or to be

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114. *See supra* text accompanying notes 60-66.

115. *See supra* text accompanying notes 57-58.

116. *See* text accompanying notes 121-61.

117. *See, e.g.*, Robin Toner, *Going Places: Defining the Target in the Battle for Votes*, N.Y. TIMES, Apr. 30, 2000, at 1 (discussing Republican and Democratic attempts to appeal to suburban women swing-voters); Frank Bruni, *G.O.P. Tries to Counter Lack of Support Among Women*, N.Y. TIMES, Aug. 1, 2001, at A14 (discussing current Republican efforts to appeal to these voters).

118. *See infra* text accompanying notes 121-61.

119. *See supra* text accompanying notes 70-71 and chart 1.

dependent on an employed spouse's coverage.[120] Therefore, women are particularly at risk for the loss of health insurance coverage in this system.

Congress recognized these concerns and enacted the first of several major incremental health reforms in 1986.[121] The provision, known variously as "COBRA" or "COBRA continuation coverage,"[122] appears to reduce the risk of lost coverage through what the statute calls "qualifying events."[123] Persons who would otherwise have lost coverage due to a qualifying event are entitled to maintain access to the employment-based health plan, generally for eighteen or thirty-six months.[124]

COBRA has the potential to be quite helpful to people at risk of the loss of employment-based insurance.[125] The statute's remedy is somewhat illusory, however, because of its payment provisions.[126] Most recipients of COBRA benefits are required to pay 102% of the premium costs of the employer's health plan.[127] Beneficiaries must pay the full cost, which

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120. *See supra* text accompanying notes 72-76.

121. Consolidated Omnibus Budget Reconciliation Act, 29 U.S.C. § 1162 (1994).

122. There are many "COBRA" provisions because the acronym stands for "Consolidated Omnibus Budget Reconciliation Act," a type of statute enacted in many legislative sessions.

123. The statute applies to group health plans offered by non-governmental, non-church employers with twenty or more employees. 29 U.S.C. § 1161 (1994). Under the statute:

> "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:
>
> (1) The death of the covered employee.
>
> (2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
>
> (3) The divorce or legal separation of the covered employee from the employee's spouse. . . .
>
> (5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

Id. (other qualifying events omitted).

124. The period of possible coverage is typically eighteen months for coverage that would have been terminated due to the loss of a job or a reduction in hours. *Id.* The longer period of thirty-six months applies to coverage at risk of loss because of divorce from or death of the covered employee. *Id.* Qualified beneficiaries who are disabled at any time around the time of the qualifying event have a different eligibility time period designed to permit them to use COBRA continuation benefits as a bridge to Medicare coverage. *Id.*

In any event, the coverage can be terminated earlier if, for example, the employer stops offering health care coverage to its current employees. *Id.*

125. Recent debates over the effect of a recession on the numbers of uninsured have included proposals to expand upon the concept underlying COBRA. John D. McKinnon, *Health Insurance Aid is Considered for Stimulus Bill*, WALL ST. J., Oct. 26, 2001, at A2.

126. 29 U.S.C. § 1162(3) (1999). Where the employer is self-insured, the rate is set by the average health care cost per employee. *Id.*

127. *Id.* The premium rate rises to 150% of the average premium rate for the employer after eighteen months of COBRA continuation coverage for certain types of beneficiaries. *Id.*

includes the portion of the premium that ordinarily would have been paid by the employer.[128] Some studies show that COBRA has had only a small impact.[129]

2. Family Medical Leave Act

Congress enacted the Family Medical Leave Act (FMLA) in 1993.[130] The FMLA recognizes the need of some individuals to take time away from work for personal or family medical reasons.[131] Under the FMLA, certain employers are required to give certain employees up to twelve weeks of unpaid leave per year for specified medical or family reasons.[132] Employers must continue to provide health care coverage for the employee on leave.[133] The employee's job security is also guaranteed.[134] The FMLA appears to provide particular benefits for women, who might need pregnancy-related or disability-related leave themselves or who might have primary caretaking responsibility for a sick relative. Much of the FMLA's potential benefit to women is lost, however, because of limitations on the statute's application.[135]

The first two statutory limits are the most significant. First, the FMLA only applies to the government and other large employers.[136] Second, the employee must have worked for the employer for at least twelve months before requesting leave and must have worked at least 1,250 hours during

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128. *Id.*

129. *See, e.g.*, MARK C. BERGER ET AL., U.S. DEP'T OF LABOR, FINAL REPORT, COBRA AND HOUSEHOLD HEALTH INSURANCE DECISIONS (1999), *available at* http://www.dol.gov/dol/pwba/public/programs/opr/H-RES/berger.htm; Leslie Pickering Francis, *Consumer Expectations: Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881, 1911 (1992) (discussing practical issues impairing effectiveness of the statutory scheme).

130. Family Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 (1994).

131. Congress noted in its statements of finding and purpose that the Act's provisions might prove especially helpful to women, since "[d]ue to the nature of the roles of men and women in our society, the primary responsibility for family caretaking often falls on women, and such responsibility affects the working lives of women more than it affects the working lives of men." 29 U.S.C. § 2601(a)(5).

132. 29 U.S.C. § 2612(a).

133. 29 U.S.C. § 2614(c).

134. 29 U.S.C. § 2614(a) (entitling an employee to return to the same or an equivalent position without loss of benefits). Certain key employees are excluded. 29 U.S.C. § 2614(b).

135. *See* text accompanying notes 136-40.

136. 29 U.S.C. § 2611(4) (1994). To be covered, private employers must have fifty or more employees and must engage in activities that impact commerce. *Id.* There also is a separate numerical requirement for an employee to gain eligibility for a leave: the employee must work at a site in the United States that is located within seventy-five miles of at least fifty of the employer's employees. 29 U.S.C. § 2611(2)(B)(ii) (2000); *see also* U.S. DEP'T OF LABOR, FAMILY MEDICAL LEAVE ACT (1993), *available at* http://www.dol.gov/dol/esa/fmla.htm (providing information about compliance for employers and employees).

this annual period.[137] These two requirements combine to limit severely the applicability of the FMLA. Some studies estimate that the FMLA covers only a little over one-half of the working women in the United States.[138]

The third statutory requirement is less restrictive, but it only applies to workers otherwise eligible for the FMLA's protections. Leave may be taken only for certain specified purposes:

> (A) Because of the birth of a son or daughter of the employee and in order to care for such son or daughter;
>
> (B) Because of the placement of a son or daughter with the employee for adoption or foster care;
>
> (C) In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition; or
>
> (D) Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.[139]

The statute defines "serious medical condition" relatively loosely, but limits eligible family members to those that federal law recognizes.[140]

3. HIPAA Amendments

Congress acted again to "fix" perceived deficiencies in the private health insurance market through the Health Insurance Portability and Accountability Act of 1996 and its amendments (HIPAA).[141] Three specific reforms are of potential interest to women: the Women's Health and Cancer Rights Act,[142] the Mental Health Parity Act,[143] and the Newborn's and

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137. 29 U.S.C. § 2611(2)(A) (1994). In other words, the employee has to have worked at least twenty-four hours per week over a fifty-two week period or the equivalent.

138. *See, e.g.*, Emily A. Hayes, *Bridging the Gap Between Work and Family: Accomplishing the Goals of the Family and Medical Leave Act of* 1993, 42 WM. & MARY L. REV. 1507 (2001); Kristin E. Smith & Amara Bachu, *Women's Labor Force Attachment Patterns and Maternity Leave: A Review of the Literature* tbl. 8 (1999), http://www.census.gov/population/www/documentation/twps0032/twps0032.html.

139. 29 U.S.C. § 2612(a)(1) (1994).

140. Under the statute "[t]he term 'serious health condition' means an illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider." 29 U.S.C. § 2611(11). While the first part of the definition appears stringent, part (B) appears to create much greater flexibility.

141. The HIPAA contains many group and individual market reform provisions not discussed here. *See* Health Insurance Portability and Accountability Act of 1996, 26 U.S.C. § 1181 (Supp. IV 1998).

142. 29 U.S.C. § 1185b (Supp. V 1999).

Mother's Health Protection Act.[144] Congress designed each of these provisions to appeal explicitly or implicitly to women who were considered key "swing voters."[145] Each offers narrow, almost symbolic, protection for women's real needs.

The Women's Health and Cancer Rights Act applies to women covered by group or individual health policies. The Act requires these plans to cover breast reconstruction services if the plan already covers mastectomies.[146] This measure appears to benefit the most women because it applies to all types of group and individual health plans. At the same time, the Act only mandates coverage of reconstructive services where mastectomy benefits are already provided.[147] Further, insurance plans that had denied coverage for reconstructive services already faced considerable negative public pressure and might have changed their policies without HIPAA's enactment.[148]

The Mental Health Parity Act includes provisions that are potentially of

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143. 29 U.S.C. § 1185a .

144. 29 U.S.C. § 1185.

145. The Centers for Medicare and Medicaid Services has several web pages devoted to explaining HIPAA and the various amendments discussed here. *See* HEALTH CARE FINANCING ADMINISTRATION, HIPAA INSURANCE REFORM, *at* http://www.hcfa.gov/medicaid/hipaa/content/more.asp (last visited Nov. 18, 2001) [hereinafter HCFA].

146. The Act provides:

> A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—
>
> (1) all stages of reconstruction of the breast on which the mastectomy has been performed;
>
> (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
>
> (3) prostheses and physical complications of mastectomy, including lymphedemas;
>
> in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

29 U.S.C. § 1185b(a) (Supp. V 1999) (describing the group plan provision; similar provisions apply to other forms of covered policies); *see also* 42 U.S.C. § 300gg-6 (2000) (explaining group health plans); 42 U.S.C. § 300gg-52 (discussing individual markets).

147. HIPAA, *supra* note 141.

148. Insurance companies argued, for example, that basic reconstructive services were already covered by health insurance and that only "unnecessary, possibly cosmetic procedures" were excluded. *Law Sought to Force Insurers to Pay for Rebuilding Breasts*, CHI. TRIB., July 15, 1996, at C7; *see also* Dennis Fiely, *Restoration Project, One Doctor Is Fighting to Make Insurers Cover Breast Reconstruction*, COLUMBUS DISPATCH, Nov. 11, 1996, at 1B (discussing views of advocates and insurance companies).

much broader applicability.[149] The Act requires group health plans to provide "parity" between benefits for mental health and other types of health services.[150] This provision could be of great significance to women, who generally utilize mental health services at higher rates.[151] The Act's impact, however, is greatly reduced by a series of limitations. First, employers are not required to offer mental health benefits at all; the Act only requires parity for employers who do offer mental health benefits.[152] Second, the Act only applies to relatively large employers: those with fifty-one or more employees.[153] Third, the Act does not apply to substance abuse treatment, which therefore can be capped at lower dollar amounts.[154] Fourth, the Act includes an "escape hatch" for an employer that can demonstrate the Act would increase its health care costs by more than one percent and that meets certain other requirements.[155] The result of these limitations is that it is difficult to determine whether the parity provisions truly have helped many people.[156] Even these limited benefits may be terminated if Congress fails to act to revive the statute now that it has expired under a special sunset provision.[157]

The final private market reform contained in HIPAA and its amendments is the appealingly titled "Newborn's and Mother's Health Protection Act."[158] The Act generally requires group and individual health insurance plans that offer hospitalization coverage for childbirth to offer at least forty-eight hours of coverage after a normal vaginal birth and ninety-

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149. Mental Health Parity Act, 29 U.S.C § 1185a; *see generally*, Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8 (2000).

150. 29 U.S.C. § 1185a(a)(1).

151. LITA JANS & SUSAN STODDARD, NAT'L INST. ON DISABILITY IN THE U.S., CHARTBOOK ON WOMEN AND DISABILITY IN THE UNITED STATES sec. 5, fig. 23 (1999), *available at* http://www.infouse.com/disabilitydata/womendisability.html (concluding 55.1% of women ages fifteen to fifty-four reported they received mental health services during their lifetimes, whereas 42.3% of men reported utilizing mental health services).

152. 29 U.S.C. § 1185a(b)(1) (Supp. V 1999).

153. 29 U.S.C. § 1185a(c)(1).

154. 29 U.S.C. § 1185a(e)(4).

155. 29 U.S.C. § 1185a(c)(2).

156. For more on the difficulty of assessing the parity provision's impact and costs, see ALAN L. OTTEN, MILBANK MEMORIAL FUND, MENTAL HEALTH PARITY: WHAT CAN IT ACCOMPLISH IN A MARKET DOMINATED BY MANAGED CARE? (1995), *available at* http://www.milbank.org/mrparity.html.

157. 29 U.S.C. § 1185a(f) (codifying the mental health parity provision's "sunset" on September 2001). As of November 2001, Congress remained divided on the proper approach to mental health parity. The Democratic-controlled Senate favored an expanded mental health parity proposal, while the Republican House favored renewal of the basic mental health parity law. *See, e.g.*, *Mental Health Parity Backers Confident about Conference*, CONGRESS DAILY A.M., Nov. 9, 2001, *available at* WL 27552730.

158. *See supra* note 141.

six hours after a cesarean section.[159] The Act gives states the authority to implement similar guidelines for insured employee benefit plans or individual health insurance policies.[160] The Act was designed to redress the widely publicized problem of "drive by deliveries," in which insurance plans allegedly were forcing women to leave the hospital too quickly after giving birth. The Act's real impact appears to be limited. In most cases, early discharge from the hospital is not likely to occur because of the risk of malpractice liability.[161] Once again, a widely publicized federal health care reform appears to have largely symbolic value.

4. Symbols in the Private Market

This review of health care reform's role in the private market has revealed the risks of victory. These federal statutes are victories for individuals interested in reforming the problems created by our employment-based, patchwork system of health care coverage. Each measure undoubtedly will help some segment of the market surmount an obstacle to eligibility for, or use of, needed health care benefits. The difficulty is that these reforms fail to protect large segments of the population. In that sense, the victories, much like the titles of the enacted provisions, carry more symbolic weight than substance.

B. Access to Care in Public Programs

Public health programs are of particular importance because they disproportionately cover women and because the persons covered generally have few other options for securing health care.[162] Unfortunately, the positive symbolism of private market reform is turned on its head in the public sphere. The media image of soccer moms is very different from the media image of mothers on Medicaid,[163] and the implications for public policy are clear. While the FMLA was designed to make it possible for women to maintain access to health care and job security while caring for a new child or sick loved one, welfare reform is about moving poor women away from a caretaking role in which they were deemed overly dependent

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159. 42 U.S.C. § 300gg-4(a)(1) (Supp. V 1999). Women are, of course, free to leave the hospital before the expiration of the statutory period.

160. 42 U.S.C. § 300gg-4(f)(1)(A).

161. Professor David A. Hyman contends that the Act "is a remarkably silly piece of legislation." David A. Hyman, *Drive-Through Deliveries: Is 'Consumer Protection' Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 84 (1999).

162. *See supra* text accompanying notes 59-61.

163. *See generally* Martha L. Fineman, *Images of Mothers in Poverty Discourses*, 1991 DUKE L.J. 274 (1991) (describing media images suggesting that poor women are less moral and that their relatively poor health status is partly attributable to less moral conduct).

on the state. Women in the private market needed protection from third parties to the physician-patient relationship, who might try to dictate appropriate treatment, but women benefiting from public health care programs were thought to need the coercive intervention of third parties.

1. Welfare Reform

Historically, welfare existed to enable a poor white woman to raise her children without having to abandon them to work.[164] Women of color were only grudgingly included within the welfare safety net.[165] The 1980s saw the rise of media images portraying welfare recipients as members of racial or ethnic minorities who were lazy and violent and who squandered public benefits in the course of leading morally reprehensible lives.[166]

Recent changes to welfare policy have had significant consequences, both intended and unintended, on access to Medicaid for large numbers of women. Shifts in public and legislative attitudes toward welfare recipients resulted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).[167] The legislation sought to move more poor families into the workforce by generally eliminating any entitlement to welfare cash assistance.[168] Congress sought to preserve access to health coverage by unlinking Medicaid from the receipt of cash assistance.[169] The legislation has been successful in that nearly every state has experienced a decrease in the number of caseloads for persons receiving state welfare.[170] As caseloads have dropped, however, so has enrollment in Medicaid.[171] Several reasons are cited for this unintended drop in Medicaid participation, including confusion,[172] diversion grants,[173] and unlawful state action.[174] The

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164. Sara Rosenbaum & David Rosseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7 (2001) [hereinafter *Thirty-Five*].

165. *Id.*

166. *See generally* Fineman, *supra* note 163.

167. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. § 601 (Supp. V 1999).

168. *See generally* Sara Rosenbaum & Kathleen A. Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Act and Its Impact on Medicaid for Families with Children*, 60 OHIO ST. L.J. 1443 (1999).

169. For a thorough analysis of the effect of the passage of the PRA, see Joel Ferber & Theresa Steed, *The Impact of Welfare Reform on Access to Medicaid: Curing Systemic Violations of Medicaid De-Linking Requirements,* 45 ST. LOUIS U. L.J. 145 (2001); Rosenbaum & Maloy, *supra* note 168; *see also Thirty-Five*, *supra* note 164, at 7 (detailing the need for modernization of Medicaid).

170. Ferber & Steed, *supra* note 169, at 160.

171. *Id.*

172. *Id.* at 173.

173. *Id.* at 162-64.

"stigma" of being on Medicaid has not been found to be a significant barrier to Medicaid enrollment.[175]

The result is a discrepancy between poor persons who are eligible for health coverage and those who are actually enrolled.[176] Medicaid has served as an important stabilizing force in the American health system by softening the effects of "market failure" in the private insurance industry.[177] Roughly speaking, young women enroll in Medicaid because they are priced out of private insurance, underinsured, or deprived of job-based insurance by their type of work, by divorce, or by responsibilities for insuring children.[178] Failure to maximize Medicaid participation means an unnecessary denial of health care to those without alternative resources or a means to pay.[179] More broadly, the drop in Medicaid participation means poorer health outcomes and more expensive care from a financially fragile public hospital system.[180]

The effect of welfare reform on poor persons with advanced HIV infection provides an example of the negative consequences of recent reform. Medicaid is the primary insurer of persons with AIDS in the United States.[181] While the overall death rates from AIDS are decreasing in the United States,[182] the number of women with AIDS is increasing. As Laurence Lavin writes:

> [U]nless a person becomes ill and seeks care at a facility that enrolls her in a state Medicaid program, she may not know of her ability to access the primary care essential for the prevention and

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174. *Id.* at 173-74.

175. Jennifer P. Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* (2000), http://www.gwu.edu/~chsrp/pdf/stig.pdf.

176. *See supra* text accompanying note 101 (discussing the impact of welfare reform on Medicaid coverage rate for poor women). Those women who have moved into the workforce from the welfare caseloads typically experience a decline in access to health insurance coverage. Stuber, *supra* note 175, at 2. The types of employment sought and obtained by women who have recently left welfare are low-wage, often part-time jobs that are less likely to offer benefits such as health insurance than full-time, higher paying jobs. *Id.* Even where health insurance is offered as a benefit, women who have recently left welfare are less likely to be able to afford the premiums for coverage. *Id.*

177. Rosenbaum & Rosseau, *supra* note 164, at 12, 37-38.

178. *Id.*

179. *See supra* text accompanying note 97.

180. *See supra* note 98 and *infra* text accompanying note 183 (asserting that a decrease in Medicaid eligibility increases the progression of serious diseases and the risk of spreading diseases among low income individuals; such predicaments inevitably result in individuals depending on the government for expensive health care treatment).

181. Laurence Lavin, *AIDS, Medicaid, and Women,* 5 DUKE J. GENDER L. & POL'Y 193, 197 (1998) (citing TONY DREYFUS ET AL., USING PAYMENT TO PROMOTE BETTER MEDICAID MANAGED CARE FOR PEOPLE WITH AIDS 1 (1997)).

182. Ed Susman, *(UPI) AIDS Death Decline 44 Percent in U.S.*, UNITED PRESS INT'L, Feb. 2, 1998, *available at* http://www/aegis.com/default.asp?req=http://www.aegis.com/news/upi/1998/UP980201.html.

> treatment of diseases such as HIV. Medicaid-eligible women therefore may end up with irreversibly deteriorated immune systems before they know they can access care. Low-income women who are at high risk of HIV infection, such as intravenous drug users, especially are affected by these welfare law changes, as they may be less informed or less exposed to information about Medicaid eligibility.[183]

The decline in Medicaid participation is troubling because Medicaid makes a critical difference in access to care.[184]

2. Maternal Control

The societal response to maternal-fetal conflicts provides the final examples of the power of symbolism in health care. In the past decade, policy makers have been concerned about the risks to fetal health created by maternal HIV infection and use of maternal crack cocaine.[185] Both risks were disproportionately associated with low-income women of color, and in both areas the public policy response has flirted with coercion rather than consent.

A woman can transmit HIV to her child during or shortly after the birth process.[186] Researchers discovered in the mid-1990s that administration of antiretroviral drugs could reduce the risk of transmission from about twenty-five percent to eight percent.[187] Many HIV-infected women did not know

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183. Lavin, *supra* note 181, at 201 (1998) (citing SARAH C. SHUPTRINE & GENNY G. MCKENZIE, INFORMATION OUTREACH TO REDUCE WELFARE DEPENDENCY: A NORTH CAROLINA WELFARE REFORM INITIATIVE 1 (1996)).

184. Compared to their uninsured counterparts, women on Medicaid experience fewer barriers to care. MEDICAID'S ROLE FOR WOMEN, *supra* note 93, at 2. Poor persons enrolled in Medicaid are more likely to have a usual source of care, a higher number of annual ambulatory care visits, and a higher rate of hospitalization than poor persons with no public or private health care coverage. John K. Inglehart, *The American Health Care System: Medicaid (Health Policy Report)*, 340 NEW ENG. J. MED. 403-08 (1999) (citing Marc L. Berk & Claudia L. Schur, *Access to Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFFAIRS 169-80 (1998)); *see supra* text accompanying note 109. Medicaid is also an important source of access to family planning services. THE HENRY J. KAISER FAMILY FOUNDATION, COVERAGE OF GYNECOLOGICAL CARE AND CONTRACEPTION: FACT SHEET (Dec. 2000), *available at* http://www.kff.org/content/2000/1557b.

185. NIDA RESEARCH PRIORITIES AND HIGHLIGHTS, DRUG ABUSE AND ADDICTION RESEARCH: THE SIXTH TRIENNIAL REPORT TO CONGRESS, *at* http://www.nida.nih.gov/STRC/Role6.html (last visited Nov. 20, 2001).

186. CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. PUBLIC HEALTH SERVICE RECOMMENDATIONS FOR HUMAN IMMUNODEFICIENCY VIRUS COUNSELING AND VOLUNTARY TESTING FOR PREGNANT WOMEN, 44 MORBIDITY & MORTALITY WKLY. No. RR-7 (1995), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/00038277.htm [hereinafter RECOMMENDATIONS].

187. Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 NEW ENG. J. MED. 1173 (1994).

their HIV status[188] and were not informed about the benefits of antiretroviral therapy. Some of these women preferred not to know their HIV status and feared the personal and professional discrimination that might follow a positive test result.[189]

The public policy debate quickly escalated as proponents of mandatory HIV testing for pregnant women clashed with those who argued that pregnant women should be able to make their own choices about the risks and benefits of testing themselves and their children.[190] After widely publicized debates and the threat of federal intervention,[191] many states enacted statutes supporting the use of "routine" testing.[192] Other states adopted slightly more coercive approaches that required patients to actively refuse testing rather than requiring consent before testing could proceed.[193] The rate of perinatal HIV transmission is now very low. [194]

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188. EILEEN HANSEN, BARRIERS TO HEALTH CARE FOR HIV-POSITIVE WOMEN: DEADLY DENIAL (1998), *available at* http://www.alrp.org/barriers.html.

189. *Id.*

190. *See, e.g.*, Symposium, *Mandatory Testing of Pregnant Women and Newborn: HIV, Drug Use, and Welfare Policy*, 24 FORDHAM URB. L.J. 719-75 (1997) (discussing legal and policy implications of drug testing policies for pregnant women); Melinda Madison, Commentary, *Tragic Life or Tragic Death: Mandatory Testing of Newborns for HIV—Mothers' Rights Versus Children's Health*, 18 J. LEGAL MED. 361 (1997) (discussing conflicts between rights of pregnant women and fetuses).

191. *See, e.g.*, 42 U.S.C.A. § 300ff-33 (West Supp. 2001) (encouraging states to adopt the CDC guidelines regarding routine HIV-testing of pregnant women).

192. In California, for example, prenatal care providers must offer voluntary HIV testing to pregnant women: "The prenatal care provider primarily responsible for providing prenatal care to a pregnant patient shall offer an HIV test . . . to every pregnant patient" unless the patient has already tested positive or has been diagnosed with AIDS. CAL. HEALTH & SAFETY CODE § 125107(c) (West 2001).

193. Some state statutory schemes require women to refuse testing in some circumstances rather than requiring consent before testing may take place. In Connecticut, for example "[e]ach physician giving prenatal care to a pregnant woman . . . shall take or cause to be taken a blood sample . . . provided consent is given for the HIV-related test." CONN. GEN. STAT. ANN. § 19a-90 (2001). But if a pregnant woman does not have an HIV-related test documented in her record at the time of delivery, "the health care provider responsible for the patient's care shall inform the pregnant woman [of the availability of testing] . . . and, in the absence of specific written objection, shall cause such test to be administered." CONN. GEN. STAT. ANN. § 19a-593. *See also* FLA. STAT. ANN. § 384.31 (West 2001) (stating that "[t]he prevailing standard of care . . . requires each health care provider . . . who attends a pregnant woman to counsel the woman about testing for . . . HIV. . . . If a pregnant woman objects to HIV testing, reasonable steps shall be taken to obtain a written statement of such objection, signed by the patient, which shall be placed in the patient's medical record.")

194. *See also* RECOMMENDATIONS, *supra* note 186. The routine testing policies appear to have been at least partially successful. CENTERS FOR DISEASE CONTROL AND PREVENTION, STATUS OF HIV PERINATAL PREVENTION: U.S. DECLINES CONTINUE (Nov. 1999), *available at* http://www.cdc.gov/hiv/pubs/facts/perinatl.htm.

For a recent discussion of the new HIV testing statutes, see, for example, Kelly D. Bryce, *Mandatory HIV Testing of Newborns: Is There a Better Way to Achieve the State's Goal of Preventing Transmission of HIV to Newborns and Ensuring Them Treatment*, 4 QUINNIPIAC HEALTH L.J. 69 (2000).

Cocaine use among pregnant women has elicited similar debates about whether coercive policies toward pregnant women are appropriate. Attempts to criminally prosecute pregnant women for drug delivery or child endangerment during the 1980s and 1990s may have been inspired in part by media images of pregnant women addicted to crack cocaine and newborn "crack babies." Alcohol and tobacco use arguably present a greater danger to fetal health than cocaine or marijuana use.[195]

The Supreme Court recently considered the constitutionality of one hospital's coercive response to the problem of pregnant, drug addicted women.[196] The state hospital in Charleston, South Carolina, entered into an arrangement with the local prosecutor's office under which pregnant women considered at risk for drug use under a protocol underwent mandatory drug testing.[197] Those who tested positive were warned that they would be arrested if they did not enter treatment.[198] Those who refused treatment or who left the treatment program were arrested.[199] Ten women who had undergone testing under the program brought suit, claiming violations of their Fourth Amendment right that forbids unreasonable search and seizure.[200]

The district court found for the defendants, and the United States Court of Appeals for the Fourth Circuit affirmed.[201] The Supreme Court granted certiorari to determine whether the drug testing program could be upheld as a "special needs" exception to the warrant requirement of the Fourth Amendment.[202] Critics of the City's approach argued that the special needs exception should not apply given the close connection between criminal

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195. Fetal Alcohol Syndrome is the leading cause of preventable mental retardation in the United States. LYNN M. PALTROW ET AL., GOVERNMENT RESPONSES TO PREGNANT WOMEN WHO USE ALCOHOL OR OTHER DRUGS: YEAR 2000 OVERVIEW 7 (2000) (citing L. P. FINNEGAN & S. R. KANDALL, MATERNAL AND NEONATAL EFFECTS OF ALCOHOL AND DRUGS IN SUBSTANCE ABUSE, A COMPREHENSIVE TEXTBOOK 513, 529 (J. H. Lowinson et al. eds., 1997)). Evidence of harm from tobacco use seems better established than harm from other drugs. *Id.* (citing Joseph R. DiFranza & Robert A. Lew, *Effect of Maternal Cigarette Smoking on Pregnancy Complications and Sudden Infant Death Syndrome*, 40 J. FAM. PRAC. 385 (1995)).

196. Ferguson v. City of Charleston, S.C., 121 S.Ct. 1281 (2001); *see also* Case Note, *Leading Cases, Fourth Amendment—Search and Seizure—"Special Needs" Exception: Ferguson v. City of Charleston*, 115 HARV. L. REV. 326 (2001).

197. *Ferguson*, 121 S.Ct. at 1284-85.

198. *Id.*

199. *Id.*

200. *Id.* at 1286. The plaintiffs also alleged violations of their fundamental right to privacy under the U.S. Constitution, Title VI of the Civil Rights Act of 1964, 42 U.S.C.A. §§ 2000d-2000d-6 (1994), and a violation of state tort law. Ferguson v. City of Charleston, S. C., 186 F.3d 469 (4th Cir. 1999), *rev'd on other grounds*, 121 S.Ct. 1281 (2001).

201. *Id* at 1286-87.

202. *Id.* at 1287.

prosecution and the search.[203] Proponents noted the risk cocaine presents to fetuses and characterized the testing program as an aspect of the patient's medical treatment.[204] Under this theory the drug test reports to the prosecutor were simply reports of child abuse, as required by state law.[205]

The Supreme Court refused to apply the special needs exception to the hospital's drug testing program. The Court noted that the state hospital's staff members were "government actors, subject to the strictures of the Fourth Amendment."[206] The Court indicated that the hospital's policy of disclosing positive test results to law enforcement constituted a significant invasion of patients' reasonable expectations of privacy.[207] Justice Stevens's opinion for the Court concluded that:

> [t]he critical difference between.... [prior] drug-testing cases and this one, however, lies in the nature of the "special need" asserted as a justification for the warrantless searches. In each of th[e] earlier cases, the "special need" that was advanced as a justification for the absence of a warrant or individualized suspicion was one divorced from the State's general interest in law enforcement.... In this case,... the central and indispensable feature of the policy from its inception was the use of law enforcement to coerce patients into substance abuse treatment.[208]

The Court held that the special needs exception could not be used to save the hospital's testing program from a Fourth Amendment challenge.[209]

Despite the Supreme Court's decision, the *Ferguson* case is a vivid symbol of coercive health policies toward low income, African-American pregnant women. While many maternal behaviors can present a risk of harm to the fetus, the problem of crack cocaine gained salience, at least in part, because of the socioeconomic characteristics of the women and children affected. The case is another warning about the risks of symbolism.

Ironically, women who depend on public sources of medical care are less likely to have access to drug treatment programs and more likely to

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203. *Id.* at 1289-90.

204. *Id.* at 1301-02 (Scalia, J., dissenting).

205. South Carolina was one of the first states to convict a woman for child endangerment for drug use while pregnant. Whitner v. State, 492 S.E.2d 777 (S.C. 1997), *cert. denied*, 523 U.S. 1145 (1998). Given the fetus' status as a "person" under state law, this arguably constituted child neglect. *See Ferguson,* 121 S.Ct. at 1284 n.2.

206. *Id.* at 1287.

207. *Id.* at 1288-89.

208. *Id.* at 1289. The Court distinguished other situations in which physicians are required to report potential criminal conduct to law enforcement. The coercive role of law enforcement "distinguishes this case from circumstances in which physicians or psychologists, in the course of ordinary medical procedures aimed at helping the patient himself, come across information that under rules of law or ethics is subject to reporting requirements...." *Id.*

209. *Id.*

experience restricted access to reproductive health services such as abortion. Poor women generally encounter difficulties gaining access to drug treatment centers for various reasons, including a shortage of spaces and lack of childcare.[210] The Hyde Amendment restricts the use of federal Medicaid funds for abortion to cases in which the pregnancy arose from rape or incest or in which continued pregnancy would endanger the life of the pregnant woman.[211] Recent merger trends in hospital systems that serve the indigent may also reduce access to abortion services.[212]

V. CONCLUSION

This article has provided a gender-sensitive view of three related aspects of the health care system: (1) evidence about gender-related consequences for health status or treatment; (2) access to health care as measured by access to health insurance; and (3) gender-sensitive issues in coverage under private and public health insurance polices. Women and men have many similar health needs, with some differences driven by social and biological factors. Although more research is needed to tease apart potentially confounding variables, women appear to be at risk for unconscious bias in treatment or in the design of health care systems.[213]

Insurance is an important precursor to ensuring adequate access to health care. The uninsured appear to be less likely to receive care and more likely to suffer bad health care outcomes.[214] Women are slightly less likely to be uninsured than men.[215] Women are less likely to be covered by private health insurance and more likely to be covered by public health programs than men.[216]

Finally, we applied a similar gendered analysis to recent federal efforts at health care reform. Have women truly benefited from recent health care reforms or has federal health care reform consisted of empty or even destructive symbolism? While the victories in the private market reforms may be shallow, they are victories. Recent trends in public health care

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210. *See generally* PALTROW ET AL., *supra* note 195.

211. The Alan Guttmacher Institute publishes useful updates on the status of government funding for abortions, http://www.agi-usa.org/sections/abortion.html.

212. In the past ten years, there have been more than 120 mergers and alliances between religious and non-religious hospitals. *See* http://www.mergerwatch.org. In most instances, the result has been the reduction or elimination of reproductive services such as "emergency contraception," tubal ligation, and abortion. *Id.* The Ethical and Religious Directives for Catholic Health Services, compiled by the National Conference of Catholic Bishops, bans services associated with most forms of contraception. *See* http://nccbusccc.org.

213. *See supra* text accompanying notes 25-39.

214. *See supra* text accompanying notes 40-56.

215. *See supra* text accompanying note 59.

216. *See supra* text accompanying note 60.