The Fallacy of Mandating Contraceptive Equity: Why Laws That Protect Women with Health Insurance Deepen Institutional Discrimination

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Introduction

THE RIGHT TO ACCESS CONTRACEPTIVES was cemented by the United States Supreme Court in *Eisenstadt v. Baird*,[1] which held that states cannot prohibit the distribution of contraceptives to individuals, as such prohibition "fundamentally affect[s] . . . the decision whether to bear or beget a child."[2] Although *Eisenstadt* motivated reproductive rights activists to promote laws protecting contraception, the promotion of contraceptive equity laws stems from the more recent phenomenon of insurers covering drugs prescribed to treat male sexual dysfunction without covering birth control for women.[3] Laws protecting the right to access contraception, therefore, focus only on the insured population and primarily aid individuals with private health insurance.[4] The United States' system of health insurance propagates

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1. 405 U.S. 438 (1972).

2. *Id.* at 453.

3. Ctr. for Reprod. Rights, Contraceptive Equity Bills Gain Momentum in State Legislatures (Aug. 2005), http://reproductiverights.org/pub_fac_epicchart.html [hereinafter Ctr. for Reprod. Rights, Contraceptive Equity Bills].

4. *See, e.g.*, Ctr. for Reprod. Rights, Contraceptive Coverage for All: EPICC Act Is Prescription for Women's Equality (Aug. 1, 2005), http://reproductiverights.org/pub_fac_epicc.html [hereinafter Ctr. for Reprod. Rights, EPICC] (discussing lack of contraceptive coverage, which centers around the effect on insured women).

a myth of choice while deepening institutional discrimination through the passage of laws focusing on the insured and overlooking the needs of the uninsured, many of whom are low-income women of color.[5]

Insurance equity laws further inequality in health care between the insured and uninsured populations. The decision to bear or beget a child referenced in *Eisenstadt* is now well-established as the right to choose.[6] Although this right is primarily associated in American society with abortion, choice is an important part of the vernacular surrounding access to health care and, in particular, access to contraception.[7] In reality, however, contraceptives are only an option when they are both available and accessible. Millions of Americans have no insurance at all and therefore cannot access contraceptives.[8]

Options for contraception are vitally important; however, when options do not exist, there can be no choice. Options for contraception must include not only availability, but also accessibility, which must be guaranteed for all. That is, "[j]ust choices are not simply a range of options, but of options that make sense in order to optimize . . . reproductive health."[9] Expanding the rights of the insured while at the same time limiting contraceptive options with such devices as "[p]arental consent laws, for-profit health care, welfare reform policies, and immigration policies impact[s] women's health choices

5. For an in-depth discussion of the lack of true choices among low-income women of color, see Charlotte Rutherford, *Reproductive Freedoms and African-American Women*, 4 YALE J.L. & FEMINISM 255, 258, 273–75 (1992). "The reproductive rights and choices of poor women of color are fairly limited and sometimes non-existent." *Id.* at 255; *see also* Angela Hooton, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 65–67 (2005).

6. *See* NARAL Pro-Choice America, http://www.prochoiceamerica.org/ (last visited Feb. 8, 2008) [hereinafter NARAL]; *see also* Laura Lambert, Planned Parenthood: It's Your Right (2006), http://www.plannedparenthood.org/issues-action/other/montana-6710.htm (stating, for example, that "the connection between privacy, individual rights, and choice is nothing new," in a recent article on a campaign for Planned Parenthood in Montana demonstrating "a woman's right to choose is patriotic").

7. *See* Health Care Freedom of Choice Act, H.R. 636, 110th Cong. (2007). For recent examples of the use of choice in health care in the American vernacular, see Universal Health Care Choice and Access Act, S. 1019, 110th Cong. (2007); NARAL, *supra* note 6.

8. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005, at 20 (2006), *available at* http://www.census.gov/prod/2006pubs/p60-231.pdf.

9. Loretta J. Ross et al., *Just Choices: Women of Color, Reproductive Health, and Human Rights*, *in* POLICING THE NATIONAL BODY: RACE, GENDER, AND CRIMINALIZATION (Jael Silliman & Anannya Bhattacharjee eds., 2002), *reprinted in* RACE, CLASS, AND GENDER: AN ANTHOLOGY 433, 433 (Margaret L. Anderson & Patricia Hill Collins eds., 2007).

and detrimentally affect[s] the quality of care available."[10] A contraceptive equity mandate through the current system of health insurance is an overly simplistic fix to a complex problem, and this fix produces a discriminatory impact on women of color. This Comment takes a close look at the United States' approach to health insurance and various unsuccessful efforts at broadening the health care choices of American women in the form of contraceptive equity laws.

Part I of this Comment examines the two tiers of United States health insurance coverage. Statistics of the number of uninsured individuals in the United States and the inconsistent use of health care by the uninsured provide a backdrop for institutional discrimination. Part II addresses intersectional discrimination by describing the insurance coverage level of women based on race or ethnicity and insurance coverage categories. Part III analyzes contraceptive equity laws that are intended to close a gap between coverage for insured men versus insured women. The laws of California and Georgia demonstrate that limited political agendas, such as those that relate to religious beliefs and influence health insurance laws, along with the differing demographic composition of the two states, determine which women are in greater need of access to contraceptives.

This Comment does not suggest that contraceptive equity laws are unnecessary. Rather, it argues that focusing on laws for the insured deepens the divide between the insured and the uninsured and misappropriates the attention that should be given to contraception and the health care system as a whole. Part IV discusses the human rights implications of the United States' health insurance system in the context of an international human rights framework, highlighting the lack of equal access to contraceptives by women and minorities. Part V outlines policy recommendations for the United States government to reach the goals set forth in international human rights documents. Finally, this Comment concludes with a proposal to integrate the right to health in the national agenda and move away from the state-by-state contraceptive equity framework.

I. The United States' Health Insurance "System"

Nancy Krieger, a preeminent researcher in the study of health disparities, defines discrimination as "a socially structured and sanctioned phenomenon, justified by ideology and expressed in interactions, among and between individuals and institutions, intended to

10. *Id.* at 440.

maintain privileges for members of dominant groups at the cost of deprivation for others."[11] A large segment of the United States population is deprived of adequate health insurance. According to the United States Census Bureau, 46.6 million Americans are uninsured entirely.[12] Furthermore, members of groups that have historically experienced discrimination, including racial and ethnic minorities, are disproportionately represented among the uninsured in the United States.[13] A system which creates separate classes of individuals who are virtually guaranteed different standards of health care services is inherently discriminatory. As a part of the United States' approach to health care, disparity in health insurance coverage constitutes "institutional discrimination."[14]

While health insurance in the United States has existed since the mid-twentieth century, a true national system does not exist.[15] General Comment No. 14[16] on Article 12 of the International Covenant on Economic, Social and Cultural Rights[17] ("ICESCR") identifies the obligation of states to fulfill the right to health by developing and implementing a national health policy.[18] Since the United States does not officially recognize the right to health as a fundamental human right,[19] the United States has never been under a mandate to develop and implement a national health policy.[20] Thus, according to United States health care commentators George Halvorson and George Isham:

11. Nancy Krieger, *Discrimination and Health, in* SOCIAL EPIDEMIOLOGY 36, 41 (Lisa F. Berkman & Ichiro Kawachi eds., 2000).

12. DENAVAS-WALT ET AL., *supra* note 8.

13. *See, e.g.*, KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., THE UNINSURED: A PRIMER—KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 5 (2007) [hereinafter KCMU, THE UNINSURED: A PRIMER 2007], *available at* http://www.kff.org/uninsured/upload/7451-03.pdf.

14. *See* Krieger, *supra* note 11.

15. GEORGE C. HALVORSON & GEORGE J. ISHAM, EPIDEMIC OF CARE 155 (2003).

16. U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14*, U.N. Doc. E/C. 12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment 14*], *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

17. Art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

18. *General Comment 14*, *supra* note 16, para. 36.

19. *See* Office of the High Comm'r of Human Rights, International Covenant on Economic, Social and Cultural Rights, http://www2.ohchr.org/english/bodies/ratification/3.htm (last visited Apr. 2, 2008) [hereinafter OHCHR, ICESCR Ratification] (status of ICESCR ratifications). The United States has signed, but not ratified, the ICESCR, which includes the right to health in article 12. *Id.*; ICESCR, *supra* note 17.

20. HALVORSON & ISHAM, *supra* note 15.

> Our health care delivery system . . . is really a nonsystem with millions of independent, uncoordinated, separately motivated moving parts, each with its own economic priorities and self-focused financial goals . . . . No one in the overall system coordinates the overall patterns of care. No one develops and implements overall strategies for improving population health.[21]

The development of this nonsystem results in a highly disjointed health sector requiring a number of laws to fill gaps in care that exist today.[22] Contraceptive equity laws are an attempt at filling this gap.

The United States does not guarantee health care to all Americans because insurance for health care is primarily obtained from employers.[23] Employers offer coverage on a voluntary basis,[24] although some unionized work sectors may bargain for sufficient health insurance.[25] It is not a requirement that individuals carry health insurance the way it is a requirement for a car owner to carry auto insurance, but most medical care is far too expensive to make going without insurance economically viable. Regardless, 18% of Americans under age sixty-five are doing just that.[26] Although 61% of employers offer health insurance, some employees may not meet eligibility requirements or cannot afford coverage.[27]

Even in the context of collective bargaining agreements, unionized workers are not guaranteed health insurance coverage without eligibility requirements such as a waiting period. For example, after more than four months of striking by grocery chain workers in Southern California, the workers' union had to agree to a contract that included a waiting period of twelve months for individual coverage and thirty months for family coverage.[28] There is a safety-net within the system in the form of government-provided insurance for the elderly and disabled (Medicare), some Americans with very low incomes (Medicaid), and children (State Children's Insurance Program or "SCHIP"); however, millions that are not covered by employers or by

21. *Id.* at xxiii.

22. *Id.* at xxv, 156.

23. *Id.* at 61; John Mullahy & Barbara L. Wolfe, *Health Policies for the Non-elderly Poor, in* UNDERSTANDING POVERTY 278, 295 (Sheldon H. Danziger & Robert H. Haveman eds., 2001); ALINA SALGANICOFF ET AL., KAISER FAMILY FOUND., WOMEN AND HEALTH CARE: A NATIONAL PROFILE 14 (2005).

24. HALVORSON & ISHAM, *supra* note 15, at 244.

25. *See* Marie Gottschalk, *Back to the Future? Health Benefits, Organized Labor, and Universal Health Care*, 32 J. HEALTH POL. POL'Y & L. 923, 925, 931, 956 (2007).

26. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 1–2.

27. *Id.* at 2.

28. Victoria Colliver, *In Critical Condition: Health Care in America*, S.F. CHRON., Oct. 11, 2004, at A1.

the means-tested safety-net programs fall through the gap of insurance coverage.

Most Americans, if insured at all, are insured through their workplaces. Thus, the United States maintains "[a] two-tier system of access to job-based insurance" in which many "are not able to afford their employer's coverage."[29] Even if a worker has coverage, "many low-wage individuals may be unable to appreciate the value of the health insurance package at its full cost because they have greater immediate demands on their wages."[30] The system of insurance that has developed in the United States fails to adequately cover a large portion of the population and thereby creates a less privileged class of citizens. Women of color, as will be discussed *infra*, are members of this less privileged class, and insurance laws typically fail to address their needs with respect to contraception.

A. Who Are the Uninsured?

It is largely the working poor, many of whom are racial minorities, who comprise the uninsured. Even during a period of growing economic wealth in the United States, the face of the uninsured changed very little.[31] In 2006, 39% of adults aged nineteen to thirty-four and 65% of individuals from families that earned below 200% of the federal poverty level were uninsured.[32] Seventy-five percent of uninsured adults went for at least one year without health insurance[33] and "[p]ersistent lack of coverage is far more common among those with low income than among others in the population."[34] The work-

29. Jon R. Gabel, *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny*, 18 HEALTH AFF. 62, 62 (1999).

30. Mullahy & Wolfe, *supra* note 23, at 305.

31. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 1.

32. *Id.* at 4. For the "federal poverty level," the Kaiser Commission on Medicare and the Uninsured uses the United States Census Bureau thresholds. The federal poverty level was $20,614 for a family of four in 2006. *Id.* at 36.

> [T]he Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. The official poverty thresholds do not vary geographically, but they are updated for inflation using Consumer Price Index . . . . The official poverty definition uses money income before taxes and does not include capital gains or noncash benefits (such as public housing, Medicaid, and food stamps).

U.S. Census Bureau, Housing and Household Economic Statistics Division, How the Census Bureau Measures Poverty, http://www.census.gov/hhes/www/poverty/povdef.html (last visited Apr. 16, 2008).

33. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 6; Mullahy & Wolfe, *supra* note 23, at 298.

34. Mullahy & Wolfe, *supra* note 23, at 298.

ing poor consistently make up a large portion of the uninsured, with over 80% of the uninsured in America from working families.[35] Many of the uninsured are not getting coverage from their jobs, and they simply cannot afford insurance.[36] In *Nickel and Dimed*,[37] a book describing the experiences of a low-wage worker in America, Barbara Ehrenreich explains her decision to opt out of insurance coverage at Wal-Mart—the largest private employer in the United States[38]—because "the employee contribution seemed too high"[39] and because other employees thought the insurance was not worth its cost.[40]

The average uninsured rate for workers across all industries was 19% in 2006,[41] with a rate of 37% for construction jobs.[42] There is a marked contrast between the insurance coverage rates of blue- and white-collar jobs[43]—"even in industries where health benefits are better than average, the gap . . . between blue and white collar workers is nearly two-fold or greater. Over 80% of uninsured workers are in blue-collar jobs."[44] Low-wage or blue-collar jobs in services, arts, entertainment, and wholesale and retail industries have the highest uninsured rates with 36% and 23% respectively.[45] Although more of the uninsured are men, because women often qualify for Medicaid,[46] paying

35. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 1, 3, 16. Working families are families that include at least one member who is in the workforce part-time or full-time. *See id.* at 4.

36. *See, e.g.*, *id.* at 16–18. Job-based health insurance declined 48% from 2001 to 2005 and "in 2007, employees in lower-wage firms paid 34% of the premium costs for family coverage compared to 27% paid by employees in higher-wage firms." *Id.* at 18–19.

37. BARBARA EHRENREICH, NICKEL AND DIMED: ON (NOT) GETTING BY IN AMERICA (2001). The author is a sociologist who took a number of service-industry jobs to determine the feasibility of surviving on low wages in the United States.

38. *Id.* at 149; Wal-Mart Facts, http://www.walmartfacts.com/FactSheets/7262006_Corporate_Facts.pdf (last visited Feb. 6, 2008).

39. EHRENREICH, *supra* note 37, at 182.

40. *Id.* at 183.

41. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 19.

42. *Id.*

43. *Id.* "White collar workers include all professionals and managers," and the workers not in those categories are "classified as blue collar." *Id.*

44. *Id.* In 2006, 7% of white-collar workers in the health and social services fields were uninsured, and 18% of blue-collar workers in these fields were uninsured; 6% of white-collar workers in the information, education, and communications fields were uninsured, and 12% of blue-collar workers in these fields were uninsured. *Id.* Only 5% of white-collar workers in the mining and manufacturing fields were uninsured, while 18% of blue-collar workers in these fields were uninsured. *Id.*

45. *Id.*

46. *See* SALGANICOFF ET AL., *supra* note 23. This is because:

> [Women] are disproportionately poorer and thus more likely to meet the [Medicaid program]'s strict income thresholds as well as categorical eligibility criteria (typically limited to women who are pregnant, mothers, disabled or seniors) . . . .

for insurance as a low-paid employee is difficult and often falls to women who work in blue-collar service-industry jobs.[47]

Racial minorities constitute a large percentage of the uninsured and are more likely to be uninsured than whites.[48] This is partially explained by income inequality, but the racial disparity exists in groups both below and above 200% of the federal poverty level.[49] In 2006, 13% of whites were uninsured,[50] while 17% of Asian Americans,[51] 22% of African Americans (or Black, non-Hispanic),[52] about 33% of Native Americans,[53] and 36% of Hispanic or Latino individuals were uninsured.[54] Identifying who is uninsured is the first step toward identifying the discriminatory impact of health insurance laws, particularly on poor women of color who are not covered by contraceptive equity laws.

B. What it Means to Be Uninsured

A lack of health insurance does not guarantee a lack of access to health care, but it does suggest care may not be easily accessible. The "[c]ritically ill, uninsured Americans of all ages usually receive adequate if untimely care under an informal, albeit unreliable, catastrophic health insurance program" because medical care providers have a duty to serve such patients.[55] In 2005, approximately 20% of the uninsured (versus only 3% of the insured) used the emergency room for primary health care.[56] This is far from ideal, and individuals find navigating the process of receiving care in this manner difficult. People without insurance "are more likely to be hospitalized for avoidable health problems," "less likely to receive timely preventive care,"[57]

> [Furthermore, many] women on Medicaid do not have access to employer-sponsored insurance and would otherwise be uninsured.

Id.

47. *Id.* at 16; *see, e.g.*, KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 19.

48. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13.

49. KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., THE UNINSURED: A PRIMER—KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 4 (2006) [hereinafter KCMU, THE UNINSURED: A PRIMER 2006], *available at* http://www.kff.org/uninsured/upload/7451-02.pdf.

50. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

55. Uwe E. Reinhardt, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, 278 J. AM. MED. ASS'N 1446, 1446 (1997).

56. KCMU, THE UNINSURED: A PRIMER 2006, *supra* note 49, at 6.

57. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 8.

and are more likely to be diagnosed in the late-stages of disease.[58] "Having insurance improves health overall and could reduce mortality rates for the uninsured by 10-25%."[59] For example, one study "found that an expansion of Medicaid reduced infant mortality rates, especially among African American infants."[60] Contraceptive coverage is a preventive health measure, so although the uninsured receive care if they are critically ill or there is an emergency, contraception will not be a consideration in these situations. Uninsured women are unlikely to have this choice available to them.

Not only are the uninsured less likely to get preventive, let alone adequate, care,[61] but they are also less likely than the insured to use whatever care is available to them.[62] Individuals "with insurance use more care, controlling for health, age, and location, than those without coverage,"[63] and the insured who have "more extensive coverage"[64] generally use more services "than those with less coverage."[65] Because the uninsured often forgo preventive care,[66] they are more likely to forgo using prescription contraceptives, since one must seek medical advice before receiving a prescription in the United States. More than 50% of the uninsured "do not have a regular place to go when they are sick or need medical advice,"[67] compared to just 20% of those with coverage (either private or public insurance).[68] Without a regular place to go for medical advice, women needing a prescription for contraceptives will have neither consistent access to nor use of common contraceptives like birth control pills. This inadequacy and basic lack of health care indicates the harm caused by the systemic discrimination of the United States' health insurance "system."

Cost is also an issue in delivering health care to the uninsured. There is bitter irony in the fact that, as discussed earlier, those who are uninsured are more likely to be low-income individuals.[69] On the whole, the uninsured do not choose to go without insurance because they do not need it. A 2006 Kaiser Family Foundation survey found

58. *See id.*
59. *Id.*
60. Mullahy & Wolfe, *supra* note 23, at 301.
61. *See id.* at 297–301.
62. *Id.* at 299.
63. *Id.*
64. *Id.*
65. *Id.*
66. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13, at 7–8.
67. *Id.* at 7.
68. *Id.*
69. *Id.* at 1; Mullahy & Wolfe, *supra* note 23, at 298.

that 37% of uninsured individuals chose not to fill prescriptions because of the high cost of doing so.[70] Like other prescription medications, contraceptives are expensive, and therefore, the uninsured will often forgo purchasing them in order to defer short-term costs, without considering the potential long-term consequences.[71] Without insurance coverage, "oral contraceptives can cost between $15 and $45 each month, not counting the annual exam that physicians usually require before they will prescribe the method."[72]

In the family planning context, lack of coverage for preventive services is a particular concern because the cost of not having contraceptive coverage may create an even more costly medical situation—unintended pregnancy. A study on contraceptive use by women receiving abortions between 2000 and 2001 found that "[d]ifficulties getting prescriptions refilled . . . resulted in inconsistent pill use," and although "some higher-income women reported access problems, poor and low-income women were much more likely to do so."[73] The uninsured suffer from a lack of preventive care, substandard care, and the financial burden resulting from such care (or the complete lack thereof).

II. Intersectional Discrimination in Access to Prescription Contraceptives

Fortunately, most women have insurance,[74] and on the whole, women are less likely to be uninsured than men.[75] Twenty percent of

70. KCMU, THE UNINSURED: A PRIMER 2006, *supra* note 49, at 6.

71. *See* Diana M. Bensyl et al., *Contraceptive Use—United States and Territories, Behavioral Risk Factor Surveillance System, 2002*, 54 MORBITY & MORTALITY WKLY. REP., Nov. 18, 2005, at 23, 29 (noting that, for example, 35.4% of insured women versus 28.2% of uninsured women in California used birth control pills in 2002, and 36.7% of insured women versus 24.7% of uninsured women in Georgia used birth control pills in 2002); *see also* PHARMACY ACCESS P'SHIP, NATIONAL SURVEY ON ATTITUDES AND INTEREST FOR PHARMACY ACCESS FOR HORMONAL CONTRACEPTION AMONG WOMEN AT RISK FOR UNINTENDED PREGNANCY 8, 41 (2004), *available at* http://www.pharmacyaccess.org/pdfs/OTCSurveyReport090604.pdf (pointing to a household survey conducted by the Field Research Corporation that found that 63% of women said affordability was a reason for choosing their current birth control method).

72. Adam Sonfield & Rachel Benson Gold, *New Study Documents Major Strides in Drive for Contraceptive Coverage*, GUTTMACHER REP. ON PUB. POL'Y (Guttmacher Inst., New York, N.Y.), June 2004, at 4, 5, *available at* http://www.guttmacher.org/pubs/tgr/07/2/gr070204.pdf.

73. Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 294, 302 (2002), *available at* http://www.guttmacher.org/pubs/journals/3429402.pdf.

74. SALGANICOFF ET AL., *supra* note 23.

75. *Id.*

men were uninsured in 2004 compared to 17% of women.[76] In fact, 66% of American women between the ages of fifteen and forty-four have private insurance;[77] however, poor women of reproductive age tend to be on Medicaid or uninsured.[78] Sixty-four percent of women living below 200% of the federal poverty level responding to the Kaiser Women's Health Survey were uninsured.[79] In 2003, 40% of poor women of reproductive age were uninsured.[80] Low-income status does not guarantee Medicaid insurance, and the need for pregnancy prevention is compounded by the lack of access to prescription contraceptives.

Like income level, race and ethnicity also correlate to insurance status and, consequently, access to prescription contraceptives. The Kaiser Women's Health Survey found that Latinas aged eighteen to sixty-four were the most likely to be uninsured, with rates at about 38%.[81] This is higher than the 2005 national average, which included men.[82] The same survey found that 17% of black women were uninsured, while only 13% of white women were uninsured.[83] The rate for white women is comparable to the national average, which includes both men and women.[84]

Despite the popularity of birth control pills as a contraceptive method, women of color are less likely to use this method of prescription contraception. In 2002, the Centers for Disease Control and Prevention ("CDC") found 69% of Hispanic or Latina women, 79% of black women, and 87% of white women used the pill.[85] However, another reversible contraceptive method requiring a prescription, Depo-Provera, was more likely to have been used by black and Hispanic wo-

76. *Id.*

77. Adam Sonfield, *Preventing Unintended Pregnancy: The Need and the Means*, GUTTMACHER REP. ON PUB. POL'Y (Guttmacher Inst., New York, N.Y.), Dec. 2003, at 10, *available at* http://www.guttmacher.org/pubs/tgr/06/5/gr060507.pdf.

78. *Id.*

79. SALGANICOFF ET AL., *supra* note 23, at 17.

80. Sonfield, *supra* note 77, at 9.

81. *Id.* at 16.

82. *Id.*; KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13 (showing 36% of Hispanics or Latinos were uninsured).

83. SALGANICOFF ET AL., *supra* note 23, at 16.

84. *Id.* In 2006, 22% of blacks and 13% of whites were uninsured. KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13.

85. William D. Mosher et al., *Use of Contraception and Use of Family Planning Services in the United States: 1982–2002*, *in* VITAL & HEALTH STAT. 2, 5–6 (Ctrs. for Disease Control & Prevention, Advance Data No. 350, 2004), *available at* http://www.cdc.gov/nchs/data/ad/ad350.pdf.

men than white women.[86] Depo-Provera is not used nearly as often as the pill,[87] but its higher rate of use amongst women of color illustrates the need for contraceptive equity beyond employer-sponsored insurance.

A woman's choice of contraceptive is complex, so the variety of what is currently available cannot only be covered by insurance plans. Perhaps women of color—who are more likely to be uninsured—are not able to access the same prescription methods that are readily available to insured women, who are largely white. Depo-Provera is an effective method of contraception, but because a prescription is needed less often than for birth control pills,[88] it may be a way of controlling costs for a woman lacking consistent insurance coverage. In focusing on contraceptive equity for the insured, United States politics ignores the widening gap between those with health insurance and those without it. This focus on only expanding coverage for the insured institutionalizes gender, race, and class discrimination.

III. Contraceptive Equity Laws

In 2004, the Guttmacher Institute found that 34.4 million women between thirteen and forty-four needed contraceptive services and supplies[89]— constituting over half of reproductive-age women in the United States.[90] Several state governments and insurers have attempted a number of approaches to provide access to and coverage of prescription contraceptives, but there is no uniformity between the methods,[91] and they do not address the needs of all women of reproductive age. These efforts, known as "contraceptive equity" laws, vary state-by-state as well as across private and government-sponsored health plans.[92] To begin with, "Medicaid has been required to cover

86. *Id.* at 5 ("[Twenty-four] percent of black and Hispanic women, and only 14 percent of white women, have ever used the 3-month injectable contraceptive.").

87. *Id.* In 2002, 82% of women were using oral contraceptive pills compared to 17% using Depo-Provera. *Id.*

88. U.S. Food & Drug Admin. ("FDA"), Birth Control Guide (Dec. 2003), http://www.fda.gov/Fdac/features/1997/babytabl.html.

89. GUTTMACHER INST., WOMEN IN NEED OF CONTRACEPTIVE SERVICES AND SUPPLIES, 2004, at 2 (2006) [hereinafter GUTTMACHER INST., WOMEN IN NEED], *available at* http://www.guttmacher.org/pubs/win/win2004.pdf (referring to women in need of contraceptive services who were "sexually active and able to become pregnant, but did not wish to become pregnant").

90. *Id.*

91. *See* Ctr. for Reprod. Rights, Contraceptive Equity Laws in the States (Jan. 2006), http://reproductiverights.org/st_equity.html.

92. *See id.*

family planning services and supplies since 1972,"[93] but only "a subset of the poor"[94] are covered by Medicaid.[95] Also, at the national level, the United States Congress is considering the Equity in Prescription Insurance and Contraceptive Coverage Act[96] ("EPICC"), which "ensures access to contraception by prohibiting health insurance plans that provide prescription drugs, devices, and outpatient services from excluding coverage of FDA [Food and Drug Administration]-approved prescription contraceptive drugs and devices . . . and related outpatient contraceptive services."[97] The legislation has not passed, despite introduction in 1997, 1999, 2001, and 2005.[98] Finally, as of August 2005, twenty-three state legislatures have passed contraceptive equity laws[99] in light of the fact that:

> The Equal Employment Opportunity Commission has held that it is illegal discrimination under federal law for an employer to provide insurance that covers prescription drugs but does not cover prescription contraception. Yet every year women spend approximately 70% more money out-of-pocket than men spend on health care because their employer's health insurance plan does not cover prescription contraceptives.[100]

Unfortunately, United States insurance laws institutionalize the gap between people with access to wealth and those without access to wealth. While women with insurance should not be denied equal access to all prescription drugs, the current and proposed contraceptive equity legislation leave out a number of women—the uninsured—who have even less means to obtain prescription contraceptives. This Comment presents the contraceptive equity laws of California and Georgia as case studies in how insurance laws are passed and their disparate effects based on the intersection of race, class, and gender.

A. California's Women's Contraception Equity Act

Passed by California's legislature in 1999, the Women's Contraception Equity Act[101] ("WCEA") states:

93. Sonfield, *supra* note 77, at 8.

94. *Id.* at 9.

95. Ctrs. for Medicare & Medicaid Servs., Overview, http://www.cms.hhs.gov/MedicaidGenInfo (last visited Apr. 25, 2006).

96. H.R. 2412, 110th Cong. (2007).

97. Ctr. for Reprod. Rights, EPICC, *supra* note 4.

98. *Id.* at n.15.

99. Ctr. for Reprod. Rights, Contraceptive Equity Bills, *supra* note 3.

100. Ctr. for Reprod. Rights, Contraception, http://reproductiverights.org/wn_contraception.html (last visited Mar. 22, 2008).

101. CAL. HEALTH & SAFETY CODE § 1367.25 (Deering 2007).

> Every group health care service plan contract . . . that is issued, amended, renewed, or delivered on or after January 1, 2000, and every individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000 . . . shall provide coverage for the following, under general terms and conditions applicable to all benefits:
> (1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.[102]

The WCEA further states that "a religious employer may request a health care service plan contract without coverage for federal Food and Drug Administration approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods."[103]

The California Assembly introduced the WCEA in late 1998.[104] The American College of Obstetricians and Gynecologists co-sponsored the bill, presenting contraceptives as medically necessary.[105] The WCEA passed with the understanding that family planning with contraceptives can prevent serious medical consequences. The stated goal of the law included preventing dangerous pregnancies that may harm either a mother or her fetus, as well as reducing rates of ovarian cancer and heart disease with the use of birth control pills.[106]

Catholic organizations were the primary opponents of the bill, but some groups representing insurers and employers also objected to

102. *Id.*

103. *Id.*

104. Legislative Counsel of Cal., Bill Analysis of Assemb. B. 39 (Mar. 9, 1999) [hereinafter Bill Analysis of Assemb. B. 39], *available at* http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0001-0050/ab_39_cfa_19990309_110624_asm_comm.html (providing assembly health committee's legislative history of the Women's Contraceptive Equity Act, which was introduced in December 1998).

105. Legislative Counsel of Cal., Bill Analysis of S.B. 41 (Mar. 17, 1999), *available at* http://www.leginfo.ca.gov/pub/99-00/bill/sen/sb_0001-0050/sb_41_cfa_19990318_124211_sen_comm.html (providing insurance committee's legislative history of the Women's Contraceptive Equity Act).

106. *Id.*

the WCEA.[107] Religious objections to a bill regarding contraception were not surprising; however, the opposition by private businesses with no religious affiliation highlighted the fact that the legislature must first sway the private insurance providers before contraceptive coverage equity may be considered in other insurance arrangements, such as Medicaid. Religious organizations, however, had more of an impact on the WCEA's passage because the California governor would not sign the bill into law without a clause exempting religious employers from covering contraceptives.[108] Thus far, one Catholic organization has brought an appellate level challenge to the WCEA, bringing the case before the California Supreme Court.[109] The Supreme Court held that Catholic Charities did not fall under the "religious employer" exemption in the WCEA.[110] The WCEA defines a "religious employer" as

> an entity for which each of the following is true:
> (A) The inculcation of religious values is the purpose of the entity.
> (B) The entity primarily employs persons who share the religious tenets of the entity.
> (C) The entity serves primarily persons who share the religious tenets of the entity.
> (D) The entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.[111]

The Court did not find that Catholic Charities met these criteria.[112] Catholic Charities also challenged the constitutionality of the WCEA, but the Court upheld it even under a strict scrutiny analysis with respect to the free exercise of religion.[113]

Based on the text of the California law, as of January 1, 2000, the WCEA requires group and individual health or disability plans to provide coverage for prescription contraceptives if the health insurer already covers outpatient drug benefits.[114] A plan that does not offer outpatient drug benefits is not subject to the requirement, nor is a plan administered by a religious employer.[115]

California's WCEA provides neither the reasoning behind the law nor a clear explanation of what plans the law includes in the mandate,

107. *Id.*
108. Bill Analysis of Assemb. B. 39, *supra* note 104.
109. *See* Catholic Charities of Sacramento v. Super. Ct., 85 P.3d 67 (Cal. 2004).
110. *Id.* at 76, 80.
111. CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (Deering 2007).
112. *Catholic Charities*, 85 P.3d at 76.
113. *Id.* at 91–93.
114. *See* CAL. HEALTH & SAFETY CODE § 1367.25.
115. *Id.*

although the bill analysis includes some relevant statistics for passing the law.[116] The text of the WCEA does not require contraceptive coinsurance[117] or other methods of payment to be in line with what the health plans charge for other prescription drugs. This means that the health plans can require the woman purchasing the prescription contraceptive to pay a larger (or smaller) share of the cost than she would otherwise pay for a prescription drug. For example, the insurance company could require the insured to pay 20% of the cost of asthma or any other type of medicine, but 30% of the cost of oral contraceptives.

California has the fifth highest three-year average percentage of people without health insurance coverage in the United States.[118] Twenty-four percent of women between the ages of fifteen and forty-four are uninsured in California.[119] Because the California law covers only insured women, this large uninsured population, along with the employees of organizations that meet the religious exemption, gain nothing from the law. Therefore, contraception equity is a misnomer for the California law.

California's minority populations include 6.2% black or African American, 12.3% Asian American, and 35.9% Hispanic or Latino.[120] As discussed earlier, racial minorities in the United States are insured at lower rates, so California's large Hispanic or Latino population—over one-third of which is likely to be uninsured[121]—indicates that a significant number of the 1.7 million Hispanic or Latina women reported to need contraceptive services and supplies as of 2004 do not benefit from the WCEA.[122]

116. Bill Analysis of Assemb. B. 39, *supra* note 104.

117. Coinsurance means that the insurer (or employer) shares the cost with the insured. *See* BLACK'S LAW DICTIONARY 815 (8th ed. 2004).

118. DENAVAS-WALT ET AL., *supra* note 8, at 76.

119. GUTTMACHER INST., CONTRACEPTION COUNTS: RANKING STATE EFFORTS 3 (2006) [hereinafter GUTTMACHER INST., CONTRACEPTION COUNTS], *available at* http://www.guttmacher.org/pubs/2006/02/28/IB2006n1.pdf.

120. U.S. Census Bureau, 2006 American Community Survey, California—Fact Sheet—American FactFinder, http://factfinder.census.gov (select "California" from drop-down menu) (last visited Feb. 24, 2008) [hereinafter U.S. Census Bureau, California Fact Sheet].

121. *See* KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13. This is because "minorities are much less likely to have health insurance offered through their jobs, to be eligible for the benefit or be able to afford their share of the premiums," and Latinos are very likely to fall into these patterns. *Id.*

122. GUTTMACHER INST., WOMEN IN NEED, *supra* note 89, at tbl.A.

B. Georgia's Contraception Law

Georgia also passed a contraceptive equity bill in 1999 that became effective in July of the same year.[123] The Georgia law states in pertinent part:

> (c) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after July 1, 1999, which provides coverage for prescription drugs on an outpatient basis shall provide coverage for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive. . . . [N]othing contained in this Code section shall be construed to require any insurance company to provide coverage for abortion.
> (d) No insurer shall impose upon any person receiving prescription contraceptive benefits pursuant to this Code section any:
> (1) Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level, receiving benefits for prescription drugs; or
> (2) Reduction in allowable reimbursement for prescription drug benefits.[124]

The text of the law itself describes the reasoning and statistics behind the legislation, including why pregnancy should be prevented and the unequal financial burdens imposed on women versus men.[125] The law states:

> (a) The General Assembly finds and declares that:
> (1) Maternal and infant health are greatly improved when women have access to contraceptive supplies to prevent unintended pregnancies;
> (2) Because many Americans hope to complete their families with two or three children, many women spend the majority of their reproductive lives trying to prevent pregnancy;
> (3) Research has shown that 49 percent of all large group insurance plans do not routinely provide coverage for contraceptive drugs and devices. While virtually all health care plans cover prescription drugs generally, the absence of prescription contraceptive coverage is largely responsible for the fact that women spend 68 percent more in out-of-pocket expenses for health care than men; and
> (4) Requiring insurance coverage for prescription drugs and devices for contraception is in the public interest in improving the health of mothers, children, and families and in providing for health insurance coverage which is fairer and more equitable.[126]

123. GA. CODE ANN. § 33-24-59.6 (2007).
124. *Id.* § 33-24-59.6(c)–(d).
125. *Id.* § 33-24-59.6(a).
126. *Id.*

The law also explicitly defines its terms so it is clear which health plans must provide contraceptive coverage.[127] The law states:

> [T]he term:
> (1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, provider sponsored health care corporation, or other insurer or similar entity.
> (2) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title.[128]

As of July 1, 1999, all group and individual health insurers or plans operating in Georgia are required to provide prescription contraceptives if outpatient prescriptions have been provided by the plan.[129] The law explicitly excludes abortion,[130] but at some point, the abortion exclusion could be interpreted to include prohibition of emergency contraception, depending on Georgia's definition of abortion. The text of the law further requires parity between what is paid for prescription contraceptives and other types of drugs.[131]

The impetus for California's and Georgia's contraceptive equity laws was the same, although the text of the laws demonstrates an ideological difference. Given that both laws were passed by the state legislatures in 1999,[132] and lawmakers recognized that women were paying more out-of-pocket for prescription drugs than men, the coverage of drugs for men for Viagra contributed to the passage of the laws.[133] Georgia's law includes specific language explaining why the law is important, defining which plans are subject to the law, and prohibiting discriminatory payment mechanisms for contraceptives versus other prescription drugs.[134]

127. *Id.* § 33-24-59.6(b).
128. *Id.*
129. *Id.* § 33-24-59.6(c).
130. *Id.*
131. *Id.* § 33-24-59.6(d).
132. *Id.* § 33-24-59.6; CAL. HEALTH & SAFETY CODE § 1367.25 (Deering 2007).
133. Ctr. for Reprod. Rights, Contraceptive Equity Bills, *supra* note 3.
134. GA. CODE ANN. § 33-24-59.6.

Georgia has the eleventh highest three-year average percentage—for 2003 to 2005—of people without health insurance coverage in the United States.[135] Twenty-two percent of women between the ages of fifteen and forty-four are uninsured in Georgia.[136] Georgia is 29.8% black or African American, 2.7% Asian American, and 7.4% Hispanic or Latino.[137] In Georgia, non-Hispanic black women who needed contraceptive services and supplies in 2004 comprised nearly 16% of all the reproductive-age women in Georgia, and 24.8% of the reproductive-age women needed publicly funded contraceptives.[138] Unlike the California law, the Georgia law does not include an exemption for religious employers. Nevertheless, there is a large uninsured reproductive-age population in Georgia, which is slightly above the national average of 21% for reproductive-age women.[139] This group of women, therefore, does not benefit from the law. Furthermore, an employer who objects to covering contraceptives may have an incentive to take prescription drug coverage away from all employees.

C. The Fallacy of Mandating Contraceptive Equity

The California and Georgia statutes demonstrate the politics of insurance laws. The enactment of these laws deepens the divide between the haves and the have-nots because the number of women that need prescription contraceptives, particularly among racial and ethnic minorities, grows each year.[140] The demographic composition of minorities in California and Georgia highlights the insurance and contraceptive needs of Latina and African American women, but the demographic composition of the entire United States requires further analysis to show how far institutional discrimination has gone. Enacted health care legislation, such as the contraceptive equity laws in California and Georgia, tends to focus on protecting the insured. In securing expanded coverage for insured Americans, the privilege of having insurance and the intersection with gender, socioeconomic,

135. DeNavas-Walt et al., *supra* note 8, at 76.

136. Guttmacher Inst., Contraception Counts, *supra* note 119.

137. U.S. Census Bureau, 2006 American Community Survey, Georgia—Fact Sheet—American FactFinder, http://factfinder.census.gov (select "Georgia" from drop-down menu) (last visited Feb. 24, 2008) [hereinafter U.S. Census Bureau, Georgia Fact Sheet].

138. *See* Guttmacher Inst., Women in Need, *supra* note 89, at tbl.A. These figures are calculated by dividing 332,530 non-Hispanic black women by 2,111,180 women aged thirteen to forty-four, and 522,940 women needing publicly funded services and supplies divided by 2,111,180 women aged thirteen to forty-four.

139. Guttmacher Inst., Contraception Counts, *supra* note 119.

140. *See generally id.* (demonstrating the increased need for contraceptives by showing statistics from 2000, 2002, and 2004).

and racial or ethnic characteristics amplify the deficiencies of the underprivileged, including the uninsured.

Although the demographics and incomes of California and Georgia residents differ significantly,[141] both states have uninsured rates above the national average[142] and comparable rates of need for, and use of, prescription contraceptives, particularly birth control pills.[143]

Employed women who do not have private health insurance are also likely to need contraceptives. In 2004, over 2.3 million women in California and nearly 523,000 women in Georgia were in need of publicly funded contraceptive services and supplies.[144] Furthermore, although Medicaid may help to pay for some of these costs, statistics indicate that it cannot meet the needs of most of these women because many are either ineligible for the program or do not know how to enroll.[145] Therefore, while the standard of living may be higher in California, the average earnings for women in both states are unlikely to be high enough to meet a woman's need for contraceptive services and supplies.

The most common type of contraception women use is oral contraceptives, or birth control pills.[146] The CDC found 33.7% of women in California and 33.9% of women in Georgia use oral contraceptives.[147] Consequently, it is imperative that both, if not all, states have consistent support through insurance or access programs for women to continue their chosen method of contraception.

Although Medicaid covers contraceptives, there is pending federal legislation mandating contraceptive coverage, and several states have passed contraceptive equity laws. Yet, there is still not enough prescription contraceptive coverage to ensure adequate access for women intending to avoid pregnancy. California and Georgia provide examples of states that have recognized the importance of prescrip-

141. *Compare* U.S. Census Bureau, California Fact Sheet, *supra* note 120 (listing California's demographics), *with* U.S. Census Bureau, Georgia Fact Sheet, *supra* note 137 (listing Georgia's demographics).

142. DeNavas-Walt et al., *supra* note 8, at 76.

143. Guttmacher Inst., Women in Need, *supra* note 89, at tbl.A (calculating these figures by taking the total number of women needing contraceptives and dividing it by all the women in the given state, which yields approximately 53% for California and 49% for Georgia).

144. *Id.*

145. Sonfield, *supra* note 77, at 9.

146. *See* Bensyl et al., *supra* note 71, at 4–5, 11; Mosher et al., *supra* note 85, at 1, 5 (noting that the condom is listed as the most common form of contraception, but this is excluded since this discussion is about what women use themselves).

147. Bensyl et al., *supra* note 71, at 11.

tion equity, but "coverage gaps are still glaring among employer-purchased plans unaffected by a state mandate" affecting "more than half of American women of reproductive age."[148]

IV. International Human Rights as a Framework for Contraceptive Equity

The national approach to health insurance and the passage of so-called contraceptive equity laws set the stage for the discriminatory impact on poor women of color. International human rights doctrines provide the framework upon which United States health care and women's access to contraception should be based.

As a founding member of the United Nations, the United States adopted the Universal Declaration of Human Rights[149] ("UDHR") in 1948.[150] The UDHR includes rights that directly apply to health and discrimination. Article 25 of the UDHR states, in part, that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."[151] Article 2 of the UDHR sets forth that all humans are entitled to the rights listed in the document "without distinction of any kind."[152]

While the UDHR "is not a legally binding document,"[153] the International Covenant on Civil and Political Rights[154] ("ICCPR") and the ICESCR are considered legally binding for the nations that have ratified these documents.[155] These covenants are more explicit in describing the rights mentioned in the UDHR. The ICCPR states that "the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground,"[156] thus guaranteeing the right to nondiscrimination. The

148. Sonfield & Gold, *supra* note 72, at 14 (referring to the states that do not mandate contraceptive equity).

149. G.A. Res. 217A (III), art. 25(1), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948) [hereinafter UDHR].

150. Office of the High Comm'r of Human Rights, U.N. Dep't of Pub. Info., Universal Declaration of Human Rights (1997), http://www.unhchr.ch/udhr/miscinfo/carta.htm [hereinafter OHCHR, UDHR].

151. UDHR, *supra* note 149.

152. *Id.* art. 2.

153. OHCHR, UDHR, *supra* note 150.

154. Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR].

155. *See* Vienna Convention on the Law of Treaties, arts. 2, 16, May 23, 1969, 1155 U.N.T.S. 331.

156. ICCPR, *supra* note 154, art. 26.

ICESCR includes the right to "the highest attainable standard of physical and mental health"[157] or, simply, the "right to health."[158]

The United States, through domestic civil rights laws and ratification of the ICCPR, has demonstrated a commitment to nondiscrimination; however, the United States has not ratified the ICESCR,[159] which implies the government deems the rights espoused in this covenant less critical than those in the ICCPR and other international instruments. While holding the rights of the ICCPR in the highest regard, the United States underemphasizes human rights violations related to economic, social, and cultural rights. This is particularly evident in the government's inaction with respect to the right to health addressed in the ICESCR.

The obligation to *respect* the right to health includes "refraining from denying or limiting equal access for all persons,"[160] and the United States government should evaluate the health system to identify whether the rights of the uninsured are being respected.[161] Other forms of legislation which guarantee equal access and sustain the right to health satisfy the obligation to *protect.*[162] Finally, the third legal obligation is to *fulfill* the right to health, which the United States government can accomplish by recognizing that the right to health exists.[163] This may be the first and easiest step for the United States and may ultimately lead to the recognition that the existing health system discriminates against the uninsured.

Two documents, the Convention on the Elimination of All Forms of Discrimination Against Women[164] ("CEDAW") and the Convention on the Elimination of All Forms of Racial Discrimination[165] ("CERD"), are also relevant in addressing United States health insurance since groups which have historically been discriminated against—such as blacks and Latinos—are disproportionately uninsured, as discussed in Part III. Article 12.1 of CEDAW instructs states to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of

157. *Id.*; ICESCR, *supra* note 17, art. 12(1).

158. *See generally General Comment 14, supra* note 16 (stating that the "right to health" is a shorthand phrase for the "right to the highest attainable standard of health").

159. OHCHR, ICESCR Ratification, *supra* note 19.

160. *General Comment 14, supra* note 16, para. 34.

161. *Id.*

162. *Id.* para. 35.

163. *Id.* para. 36.

164. Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].

165. Dec. 21, 1965, S. TREATY DOC. No. 95-18 (1994), 660 U.N.T.S. 195 [hereinafter CERD].

equality of men and women, access to health care services, including those related to family planning."[166] The United States has not ratified CEDAW[167] and thus has no legal obligation to adhere to the standards it sets out; however, it is important to note that a country that has a commitment to nondiscrimination is expected to include this tenet in the provision of health care services.[168]

CERD, which the United States has ratified,[169] also lists health-related rights.[170] States are instructed to "guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . . rights,"[171] including those in Article 5(e)(iv): "The right to public health, medical care, social security and social services."[172] While the United States ratified CERD with reservations,[173] the reservations do not contradict the need to comply with the provisions in Article 5(e)(iv) because "the reservation regarding private conduct does not remove the obligations imposed by CERD regarding relationships within health care settings."[174] The United States government is obligated to eliminate all forms of racial discrimination, including those related to health.[175]

On the basis of its ratification of various international human rights treaties, the United States has demonstrated a documented commitment to nondiscrimination. Because the ICESCR has not been ratified by the United States,[176] the United States government can argue against an obligation to uphold the right to health. If, however, discrimination in the United States' health policy is perpetuated by

166. CEDAW, *supra* note 164, art. 12(1).

167. Office of the High Comm'r of Human Rights, Convention on the Elimination of All Forms of Discrimination Against Women, http://www2.ohchr.org/english/bodies/ratification/8.htm (last visited Apr. 2, 2008) (status of CEDAW ratifications). The United States has signed, but not yet ratified, CEDAW. *Id.*

168. CEDAW, *supra* note 164, art. 12(1).

169. CERD, *supra* note 165; Office of the High Comm'r of Human Rights, Convention on the Elimination of All Forms of Racial Discrimination, http://www2.ohchr.org/english/bodies/ratification/2.htm (last visited Apr. 2, 2008) (status of CERD Ratifications). The United States ratified CERD in 1994. *Id.*

170. CERD, *supra* note 165.

171. *Id.* art. 5.

172. *Id.* art. 5(e)(iv).

173. *Id.*; PHYSICIANS FOR HUMAN RIGHTS, THE RIGHT TO EQUAL TREATMENT 23–24, 24 n.50 (2003), *available at* http://physiciansforhumanrights.org/library/documents/reports/report-rightequaltreat-2003.PDF.

174. PHYSICIANS FOR HUMAN RIGHTS, *supra* note 173, at 24 n.50.

175. *Id.* at 24.

176. OHCHR, ICESCR Ratification, *supra* note 19.

not guaranteeing certain health provisions, such as prescription contraceptives for the uninsured, the government should have an obligation to uphold its commitment to nondiscrimination as directed by the ICCPR and CERD, as well as United States law. While the United States justice system recognizes negative civil and political rights, such as the right not to be discriminated against, it has typically refused to recognize a constitutional right to health care, which is a positive economic, social, and cultural right.[177] When a system of health care essentially guarantees the deprivation of some, examining such a system through the lens of a discrimination framework—and thus a civil and political rights framework—is essential to a call for an institutional policy change.

The two-tiered system of United States health insurance and its noncompliance with human rights doctrine translates into choice being available only to those with resources. Legislation is necessary to address the gaps in coverage between women who can readily access contraceptives and those who cannot. Contraceptive equity laws are a flawed attempt to address the needs of women seeking prescription contraceptives.

V. Recommendations to Address Contraceptive Inequity

The United States' uninsured population is nearing fifty million.[178] As discussed in Part I, research on the uninsured—both outside the government and within it—provides striking evidence that not guaranteeing insurance coverage leads to inequality and discrimination.[179] The promise of increased contraceptive coverage within insurance plans is irrelevant for millions of uninsured women, but broad-based policy changes shifting away from the insured and to-

177. Leslie P. Francis, *Legal Rights to Health Care at the End of Life*, 282 J. AM. MED. ASS'N, 2079, 2079 (1999).

> Rights may be either positive or negative. A positive, or welfare, right would be the right to actually receive care. A negative right, [is a] right of noninterference .... [T]here is one health care exception. Prisoners have the right under the 8th Amendment not to be subjected to cruel and unusual punishment; this right is violated when incarcerated people do not receive adequate health care.

Id. (quoting Estelle v. Gamble, 429 U.S. 97 (1976)).

178. DENAVAS-WALT ET AL., *supra* note 8.

179. *See generally* KCMU, THE UNINSURED: A PRIMER 2007, *supra* note 13 (providing detailed statistics on the uninsured and the disparities that exist between and among racial minorities and low-income families); KCMU, THE UNINSURED: A PRIMER 2006, *supra* note 49 (providing additional details from the previous year); DENAVAS-WALT ET AL., *supra* note 8 (illustrating the correlation between being uninsured, minority status, and poverty).

wards health care for all may enable women to decrease the number of unintended pregnancies. As the Guttmacher Institute has noted:

> [F]or the millions of Americans with no insurance coverage at all, the reality or even the promise of increased coverage for contraception is essentially irrelevant. These women must scrape together the necessary funds themselves or depend on services provided by family planning clinics subsidized by the government—clinics that are chronically under funded . . . . Until this situation is comprehensively addressed, universal access to the services and contraceptive methods women need to prevent unintended pregnancy will continue to be only a dream.[180]

A. National Health Insurance

Ultimately, if there is political will, encouraged by the will of the general public, the United States government will finally act to change current health policy in order to protect, respect, and fulfill the right to health. The current policies create the need for patches, such as ad-hoc insurance laws, rather than considering an overhaul of the system. As required by Article 12 of the ICESCR, the United States needs a comprehensive national health insurance policy so that the privilege of contraception is not limited to those women who already have the power to fight for it. Even if a legislative act were not passed, the United States government should consider imposing a systematic monitoring and evaluation process on the current system in order to fill gaps in coverage. This will ensure that the burden of unintended pregnancy does not continue to fall primarily on underinsured women.

B. A Contraceptive-Specific Program

An alternative to a national health insurance program that specifically addresses the need for prescription contraception is to make the commonly used prescription contraceptives available from pharmacies over-the-counter without a prescription, as the Pharmacy Access Partnership suggests. The Pharmacy Access Partnership advocates access to contraceptives, most often emergency contraception, directly from a pharmacist rather than getting a prescription from a physician who may require a doctor's visit before providing the prescription.[181] Over-the-counter contraceptives save women from needing insurance or access to a clinic as well as the cost of a doctor's visit, which may allow for more consistent use of the very common form of contracep-

180. Sonfield & Gold, *supra* note 72, at 14.

181. *See* Pharmacy Access P'ship, *supra* note 71, at 3–12.

tion—birth control pills. The Pharmacy Access Partnership surveyed women to determine whether they would be interested in over-the-counter contraceptives, and most were concerned with potential health risks.[182] Many women, however, stated they were likely to use contraceptives like the pill if they did not need a prescription.[183] In some ways, moving prescription contraceptives into the over-the-counter drug market is more radical than creating a national health insurance system, but it is a solid option to bring actual contraceptive equity to American women.

Unfortunately, over-the-counter birth control pills could become prohibitively expensive. One example of this phenomenon exists in diabetes care, where glucose testing strips have become too expensive for many low-income individuals despite their wide availability.[184] However, the wide availability of popular prescription contraceptives would bring the United States closer to true contraceptive equity rather than equity between men and women with private health insurance. Most of the contraceptives that are effective for women looking to prevent unwanted pregnancy are available by prescription only, although condoms are not.[185] Therefore, if women intend to use oral contraceptives, and they become available without a prescription, women without insurance will not need to rely solely on men to wear condoms, which have a higher failure rate for preventing pregnancy than most female contraceptives.[186]

The United States government is committed to respecting, protecting, and fulfilling many civil rights, including nondiscrimination.[187] Therefore, the United States should be obligated to remedy

182. *Id.* at 7. Health risks vary depending on the type of contraceptive that is used. Some of the risks for oral contraceptives ("combined pill") include: "Dizziness; nausea; changes in menstruation, mood, and weight" and "rarely, cardiovascular disease, including high blood pressure, blood clots, heart attack, and strokes." FDA, *supra* note 88.

183. PHARMACY ACCESS P'SHIP, *supra* note 71, at 10.

184. Phyra M. McCandless, Obtaining a Sustainable Supply of Affordable Blood Glucose Testing Strips for the Shepherd's Clinic in Baltimore City: A Step Toward Diabetes Management for Uninsured Americans 12–14 (May 5, 2005) (unpublished M.P.H. capstone paper, Johns Hopkins School of Public Health) (on file with author).

185. *See* FDA, *supra* note 88.

186. *Id.*

187. *See, e.g.*, International Covenant on Civil and Political Rights, Dec. 16, 1966, S. TREATY DOC. No. 95-20 (1992), 999 U.N.T.S. 171; Office of the High Comm'r of Human Rights, International Covenant on Civil and Political Rights, http://www2.ohchr.org/english/bodies/ratification/4.htm (last visited Apr. 2, 2008) (status of ICCPR ratifications). The United States ratified the ICCPR in 1992, subjecting it to the obligations under the treaty, including nondiscrimination. *See* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 173, at 17.

the current system of health insurance in some way, as it implicitly discriminates against low-income individuals and minorities.

VI. Conclusion

While many nations recognize the right to health, the United States government does not recognize this human right.[188] The negative human right to be free from infringement of liberty should include the right not to be denied access to contraceptives under both United States law and international treaties. While poor or war-torn nations with little infrastructure have scant hope of "redress[ing] inequalities in health,"[189] as Paul Farmer aptly recognizes, the United States government "refuse[s]" to do so.[190] This refusal is borne out in the United States by the employer-based health insurance system.

Analysis of the California and Georgia contraceptive equity laws demonstrates that the employer-based health insurance system benefits those who can convince employers and their supporters that changes should be made to protect them, but leaves out groups who lack political power. Furthermore, there are groups, such as religious employers, that play enough of a role in politics to ensure that access to contraception can never be universal. The effects will vary by state and, to a greater extent, by community.

In theory, the contraceptive equity laws equalize prescription benefits offered to men and women. In practice, however, the employer-based system has forced these laws to focus solely on private insurers, to the detriment of the millions of uninsured women who are unlikely to be able to afford consistent contraceptive coverage in the way their insured counterparts may. This disadvantage is compounded by factors such as race and class. Since minorities are often identified as needing protection against discrimination, it is not surprising that they are disproportionately uninsured. Therefore, the United States must make efforts to reduce the uninsured population a priority for ending all forms of racial discrimination. Furthermore, if women are not equally provided with vital health services, especially family planning, this will negatively impact society as whole, since so many pregnancies in the United States are unintended.

Unfortunately, the United States government is not currently inclined to recognize the right to health, as evidenced by its failure to

188. *See* OHCHR, ICESCR Ratification, *supra* note 19.

189. Paul Farmer, *Pathologies of Power: Rethinking Health and Human Rights*, 89 AM. J. PUB. HEALTH 1486, 1488 (1999).

190. *Id.*

ratify the ICESCR.[191] American politics surrounding health care policy have either focused entirely on improving what is already provided, or on groundless fears of a socialized health care system that takes choice away from those who currently have insurance.[192] Rather than react to the provision of insurance for male sexual dysfunction drugs with a reevaluation of the federal or state health insurance systems, states chose to keep these drugs covered by insurance and to "equalize" insurance plans by preventing discrimination against women who are more likely to already have access to family planning—the insured. Although the United States Supreme Court has upheld the accessibility of contraception,[193] contraceptive equity laws are not enough to ensure this right is fulfilled. Non-state actors and the general public can play a crucial role in changing the policy of the United States government. Holding the United States to its obligations in the ICCPR and CERD is a good place to begin to make a policy change.

Rather than leaving states to their own devices, which will concentrate unintended pregnancies amongst poor women of color, the United States must give serious consideration to a national health insurance policy or a contraceptive-specific health insurance program. Continuing along the current path will only deepen the institutionalized discrimination against uninsured women who wish to use contraceptives to prevent unintended pregnancies.

191. *See* OHCHR, ICESCR Ratification, *supra* note 19.

192. *See* HALVORSON & ISHAM, *supra* note 15, at xxv; Roger Stark, Editorial, *Solution to Health Care Crisis Needs Shot of Economic Reality*, SEATTLE POST-INTELLIGENCER, Feb. 1, 2008, at B7.

193. Carey v. Population Servs., Int'l, 431 U.S. 678, 686–87, 689, 697–99 (1977) (finding a law restricting the distribution and sale of contraceptives unconstitutional); *see also* Eisenstadt v. Baird, 405 U.S. 438, 453–54 (1972); Griswold v. Connecticut, 381 U.S. 479, 485 (1965).

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