

Comment

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Health Reform and the Plight of the Uninsured Pregnant Woman¹

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¹ The narratives of poor mothers about oversight by welfare officials are important not only because they tell of a world of need and oppression but also because they help us understand how poverty policy is no backwater of programs for marginal citizens but an integral part of the welfare state in an age when the rhetoric of policy connects all of its elements to the market and to globalization. Narratives of these regulated lives help us gain a better understanding of citizenship, identity, social participation—and the role of law—in contemporary society.

Frank Munger, *Poverty, Welfare, and the Affirmative State*, 37 *LAW & SOC’Y REV.* 659, 660 (2003) (reviewing JOHN GILLIOM, *OVERSEERS OF THE POOR: SURVEILLANCE, RESISTANCE, AND THE LIMITS OF PRIVACY* (2001); MICHAEL B. KATZ, *THE PRICE OF CITIZENSHIP: REDEFINING THE AMERICAN WELFARE STATE* (2001); and ALICE O’CONNOR, *POVERTY KNOWLEDGE: SOCIAL SCIENCE, SOCIAL POLICY, AND THE POOR IN TWENTIETH-CENTURY U.S. HISTORY* (2001)).

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INTRODUCTION

As a recent newlywed and a soon-to-be college graduate, I was embarking on the next chapter in my life and looking forward to the unknown journey that lay ahead. Despite the crumbling economy, I was optimistic. Like many twenty-year-olds, I believed I was invincible and in control; nothing could get in my way. However, my perception of reality quickly changed one pregnancy test later. This unexpected surprise sent my world tumbling. Over the next nine months, I would engage in a protracted and unsuccessful battle with both my employer and the State of California for maternity health insurance coverage.

Although insurance had previously been available through my parents' insurance and my undergraduate institution, as a recent newlywed and graduate, these avenues were no longer available to me. Having graduated college a semester early, I tried to reenroll in classes for the spring semester to qualify for the student health insurance plan. However, due to the economic downturn, the college had already distributed financial aid to other students that would have been allotted to me. Unable to get insurance through my parents or the college, I began searching for a job and quickly found a part-time position as a substitute preschool teacher. Unfortunately, I was not offered health insurance benefits, because in addition to only working part-time, I was also classified as an independent contractor.²

² Misclassifying employees as independent contractors is a growing problem across the country. Much of the misclassification is intentional because a business is not required to provide the traditional benefits of employment (for example, vacation pay, medical benefits, pensions, workers' compensation, and unemployment benefits) to an independent contractor. See *Leveling the Playing Field: Protecting Workers and Businesses Affected*

With a majority of jobs in the field of psychology requiring more than a bachelor's degree in psychology, my job pickings were slim to none, so I accepted the teaching position despite its lack of employee benefits. After a few weeks, the position became full time, and I began working in the same classroom every day. However, the preschool continued to classify me as an independent contractor, which meant it had no obligation of providing me with employee benefits.³ While I could purchase health insurance through my husband's employer, the \$360 per month cost to add a dependent was too expensive for our small budget.⁴ As a result, I still found myself uninsured and unable to afford prenatal care.

I began searching online for an insurance plan through the individual market. The vast number of plans was overwhelming. The more I researched, the more frustrated I became. With all of the technical jargon, I could not distinguish one plan from the next; nor was I able to determine to what extent the insurance plan would actually cover my prenatal care or my labor and delivery. However, one thing quickly became clear: The monthly payments and outrageously expensive deductibles exceeded the cost of my

by *Misclassification Before the S. Comm. on Health, Educ., Labor, and Pensions*, 111th Cong. 1 (2010) (“[M]uch worker misclassification is intentional. . . . Too many workers are being deprived of overtime premiums and minimum wages forced to pay taxes their employers are legally obligated to pay and are left with no recourse if they are injured or discriminated against in the workplace. Misclassification is no mere technical violation. It is a serious threat to workers and the fair application of the laws Congress has enacted to assure workers have good, safe jobs.” (statement of Seth D. Harris, Deputy Secretary, U.S. Department of Labor)); Christopher Buscaglia, *Crafting a Legislative Solution to the Economic Harm of Employee Misclassification*, 9 U.C. DAVIS BUS. L.J. 111, 111–12 (2010) (noting that misclassification of employees as independent contractors is a growing problem across the United States); Jenna Amato Moran, Comment, *Independent Contractor or Employee? Misclassification of Workers and Its Effect on the State*, 28 BUFF. PUB. INT. L.J. 105, 121–23 (2009) (discussing misclassification and the workers’ consequential loss of the social and economic benefits inherent in the employer-employee relationship). While the classification of the status as independent contractor can be difficult, the circumstances here indicate rather clearly that I was an employee. The preschool had behavioral and financial control. Additionally, the services I performed as a teacher were a key aspect of the regular business of the preschool. Internal Revenue Serv., *Independent Contractor vs. Employee*, <http://www.irs.gov/taxtopics/tc762.html> (last visited Oct. 20, 2011).

³ See sources cited *supra* note 2.

⁴ In a good month, if I worked full time and my husband worked overtime, our monthly net household income was \$2880. Expenses included rent: \$950; car payments: \$556; car insurance: \$80; gas: \$320; water and utilities: \$108; phone bill: \$95; loan payments: \$380; and food: \$200. Thus, at the most, we would have a surplus of \$221.

husband's employer-sponsored health insurance.⁵ Thus, individually purchased insurance joined the growing list of unfeasible health insurance options.

As a last resort, I finally succumbed to applying for Medi-Cal (California's Medicaid program).⁶ Several weeks later, I received a letter in the mail, approving me for Medi-Cal with a "share of cost"⁷ of \$2120 per month.⁸ After I met my monthly out-of-pocket cost, I

⁵ Although I did not write down the exact numbers of the varying individual insurance plans at the time of my pregnancy, a search in June 2011 revealed that the cost of insurance through the individual market remains similar. Of the eighty-one plans in the Los Angeles area, only thirteen claimed to offer maternity coverage. Of those thirteen plans, eleven were ambiguous as to the extent of maternity coverage and referred the consumer to the plan's membership agreement, which was not readily available online. Only two plans gave details as to the extent of maternity coverage. The first plan cost \$132 per month with a \$5000 deductible and a thirty percent co-pay after the deductible was met. This plan would have been clearly outside of our budget and reflects many of the options that were available to me in 2008 and 2009. Furthermore, after a nine-month pregnancy, the cost of this plan was equivalent to not having any insurance at all. See *infra* notes 103–12 and accompanying text. The second plan cost \$292 per month with a \$1500 deductible. A pregnant woman was required to pay \$40 for each prenatal and postnatal office visit. There would be no charge for labor and delivery after the \$1500 inpatient hospital care deductible was met. Although this plan's deductible was more reasonable, its higher monthly payment would have made it unaffordable for our meager budget. Furthermore, such a plan was not offered as an option at the time of my pregnancy. *Quotes for Individuals and Family Health Insurance Plans*, EHEALTHINSURANCE, <http://www.ehealthinsurance.com/individual-family-health-insurance?action=changeCensus> (enter zip code 90042) (last visited Oct. 20, 2011); see also NAT'L WOMEN'S LAW CTR., NOWHERE TO TURN 30, app. 3 (2008), available at <http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf>.

⁶ Medicaid is a state-administered federal program. All fifty states currently participate in the Medicaid program. Other states' programs include Massachusetts' MassHealth, Tennessee's TennCare, Colorado PEAK, and the Oregon Health Plan. See ANNETTE B. RAMÍREZ DE ARELLANO & SIDNEY M. WOLFE, UNSETTLING SCORES: A RANKING OF STATE MEDICAID PROGRAMS 40 (2007), available at <http://www.citizen.org/documents/2007UnsettlingScores.pdf>; *State Medicaid Programs*, MEDICAIDPROGRAM.NET, <http://www.medicaidprogram.net/articles/137720/State-Medicaid-Programs> (last visited Oct. 20, 2011).

⁷ "Share of cost" is a term that refers to the amount of medical expenses an individual must accrue each month before Medi-Cal offers assistance. Once the share of cost is achieved, Medi-Cal will pay for any additional health care expenses. CAL. HEALTHCARE FOUND., SHARE OF COST MEDI-CAL ISSUE BRIEF 1–2 (2010) <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20ShareOfCostMediCal2010.pdf>.

⁸ An individual's share of cost is a function of the difference between a person's or a family's gross monthly income after allowable deductions and the Maintenance Need Level (MNL). (For example, \$3054 – \$934 = \$2120.) The MNL is a fixed amount set by federal and state law that increases with family size. The amounts have not changed since 1989. HEALTH CONSUMER ALLIANCE, PRICED OUT: SHARE OF COST MAKES MEDI-CAL UNAFFORDABLE 1 (2007), available at <http://healthconsumer.org/ShareofCostRpt.pdf>; CAL. HEALTHCARE FOUND., *supra* note 7.

could then receive prenatal, delivery, and postpartum-related services free of charge.⁹ As I processed the information and did my own calculations, the numbers were not making sense.¹⁰ Somehow Medi-Cal's calculation was \$222 off.¹¹ I called my caseworker for an explanation of the numbers, but he was unable to provide me with a reasonable rationale for his calculation of our household income. Despite my protests, my caseworker insisted I was paid biweekly, which added several more paychecks to his calculation of my family's monthly income. Because our calculations were not matching up, I contacted his supervisor, hoping to have the situation clarified. Without asking for any identifying information to double check my caseworker's calculation, and without allowing me to provide her with the numbers, my caseworker's manager curtly told me my caseworker had correctly calculated my income and my share of cost. End of discussion.

Under Medi-Cal's overestimation of our gross monthly income, my husband and I were left with \$934 to live on each month before the State would help with any pregnancy-related medical expenses.¹² This amount did not even cover the \$950 monthly rent for our modest one-bedroom apartment in a run-down part of town, let alone the cost of other basic necessities like food, transportation to work, and utilities. With an unaffordable share of cost, I found myself forced into a situation where I had to choose between either foregoing prenatal care or quitting my job to meet the eligibility requirements for Medi-Cal. Given the cost of living and the additional expenses of bringing a new member into the family, the latter choice was an impossible option.¹³

⁹ L.A. Dept. of Pub. Soc. Servs., *Pregnant Only Medi-Cal Services*, http://www.ladpss.org/dpss/health_care/pregnant_women/pregnant_only_medical.cfm (last visited Oct. 20, 2011).

¹⁰ See *infra* Part I.C.1. While our gross monthly household income *prior* to Medi-Cal deductions was \$3012, Medi-Cal calculated our gross monthly household income *after* Medi-Cal deductions as \$3054. To qualify for Medi-Cal, we needed a monthly household income of \$3052. See *2009/2010 HHS Poverty Guidelines*, U.S. DEPT. OF HEALTH & HUMAN SERVS., <http://liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm> (last visited Oct. 20, 2011).

¹¹ Medi-Cal offers a basic deduction of \$90 per working adult. Assuming the minimal amount of deductions, our gross monthly household income *after* Medi-Cal deductions should have been \$2832. Medi-Cal calculated our gross monthly household income as \$3054 (a difference of \$222). See *supra* note 10.

¹² See *supra* notes 7–8. For example, \$3054 (gross income) – \$2120 (share of cost) = \$934 (“maintenance need”).

¹³ For many women who have husbands or significant others with adequate funds, quitting a job may be easy and is often done. See *generally* EDWARD J. MCCAFFERY,

Although the backside of the letter approving me for Medi-Cal with a share of cost indicated that I could appeal the agency's decision and ask for a hearing, it was unclear what this process entailed and the very concept of appealing was daunting. After speaking with my caseworker's supervisor, I was deterred from even entertaining the idea of appealing my miscalculated share of cost. I would have to take the day off work, and I could not see the point in investing the time and effort into appealing the decision when I had no reason to believe the appeals process would be fair and unbiased. It was clear the Department of Health Services did not want to listen to what I had to say—nor did it want to ensure its caseworkers were accurately calculating eligibility.¹⁴

Over the next five months, we worried about the health and safety of our baby. We wondered about our baby's gender and prayed to God I was not carrying twins. Finally, the hormones and the stress of my inability to obtain prenatal care overcame my worries about the financial barriers. I walked to the clinic down the street in tears and explained my predicament to the unsuspecting nurse behind the counter.¹⁵ He referred me to the on-site social worker. I proceeded

TAXING WOMEN (1997) (examining the tax system's large effect on marriages and working women).

¹⁴ My experience with Medi-Cal inaccurately calculating my eligibility is not unique. See *Sneede v. Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990) (finding that California improperly attributed income and resources to Medi-Cal applicants, and as a result, indigent individuals were denied the medical assistance to which they were otherwise entitled).

¹⁵ Crying is an atypical reaction for me. I had tried to remain strong throughout the process of seeking out affordable prenatal care. Despite my best efforts, I was unable to control my emotions at that time. Having failed at obtaining health care, I was frustrated, worn down, stressed out, and worried about the health of my baby and myself (not to mention hormonal from the pregnancy itself). In short, I was emotionally exhausted. Although some would argue crying is a feminist strategy women use to get what they want, such accusations are destructive and further stereotypes about women. Compare Lorena Fries & Verónica Matus, *Why Does the Method Matter?*, 7 AM. U.J. GENDER SOC. POL'Y & L. 291, 294 (1998–1999) (“During the oral exams, done at a podium before which the student feels tiny, there were two possibilities [for women]: to know the subject matter including the codes, doctrine, currents, and cases; or to cry and beg, using feminine strategies, which the evaluating committee usually displayed understanding and gave a passing grade.”) with Ann J. Gellis, *Great Expectations: Women in the Legal Profession, A Commentary on State Studies*, 66 IND. L.J. 941, 952 (1991) (“[P]rofessional relationships between men and women may be affected by male stereotyping of their female colleagues' behavior. For instance, some male lawyers complained that women lawyers are ‘too aggressive’ and ‘bitchy.’ They also complain that women lawyers unfairly use their feminine wiles. Such stereotyping is undoubtedly destructive of professional relationships and clouds men lawyers' perceptions of women lawyers' competence.”). The concept of “feminine wiles” is based on the idea that women use their behavior to manipulate men.

to fill out my financial information, and the social worker presumptively approved¹⁶ me for free Medi-Cal maternity coverage according to a matrix comparing our family income and size with 200% of the federal poverty level. Problem easily solved! A sense of relief flooded over me as the stress of my financial situation was lifted. Everything was going to be okay after all.

However, once the paperwork was processed by my assigned social worker at the Department of Human Services, I received a letter with the same unreasonable and unaffordable share of cost as before. Nothing had changed. Based on this letter, the clinic referred me to the Access for Infants and Mothers Program (AIM), a California program claiming to provide health insurance to middle-income pregnant women. Under the AIM Program, the cost of insurance coverage for my income bracket was a one-time fee of between \$549 and \$824¹⁷—a large discrepancy between the \$2120 monthly share of cost Medi-Cal imposed. The small fee would provide me with prenatal and postnatal services, as well as inpatient delivery.¹⁸

You can imagine my surprise when I received AIM's letter denying my application for health insurance because my "household income [was] less than the AIM program allows,"¹⁹ meaning I was too poor to qualify as a middle-income pregnant woman. This was

This strategy "reveals its own futility—if women really had effective power over men, such attempted deception would not be necessary." Jeanne L. Schroeder, *Abduction from the Seraglio: Feminist Methodologies and the Logic of Imagination*, 70 TEX. L. REV. 109, 205 (1991).

¹⁶ Presumptive Eligibility (PE) for Pregnant Women is a Medi-Cal program, which provides free, temporary, and immediate prenatal care coverage to low-income pregnant women pending a formal Medi-Cal application. The PE health care provider has the woman complete a Statement of California Residency and a "Presumptive Eligibility for Pregnancy Only" application. If eligible, the woman is given a pregnancy test. If the pregnancy test is positive, the provider issues the pregnant woman a temporary Medi-Cal card for two months. The card is only for specific PE services and does not cover labor and delivery. The woman must then formally apply for Medi-Cal at the County Department of Social Service. Cal. Dept. of Health Care Servs., *Information for Women Interested in Presumptive Eligibility (PE) for Pregnant Women*, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_women.aspx (last visited Oct. 20, 2011).

¹⁷ The total cost of AIM is 1.5% of the household's "adjusted annual income." The adjusted annual household income is a function of family size and the household's gross annual income after AIM deductions. AIM allows a ninety-dollar deduction for each working adult, as well as deductions for alimony, child support, child care, and disabled dependent care. ACCESS FOR INFANTS & MOTHERS, APPLICATION AND HANDBOOK 14–16, 18 (2010), available at <http://www.aim.ca.gov/Downloads/Handbook.aspx>.

¹⁸ *Id.* at 3.

¹⁹ Letter from AIM program to author (Apr. 22, 2009) (on file with author).

the very opposite of Medi-Cal's reason for denying me access to affordable prenatal health care. At this point, the AIM program was kind enough to re-refer me to Medi-Cal. Upon receiving the information from AIM, Medi-Cal decided to impose an even higher share of cost of \$2316 per month. Confused by the contradicting information and my increased share of cost, I immediately contacted the AIM program for clarification. How could I make too little money, yet too much money at the same time? Well, for the most part, it came down to my employment status as an "independent contractor." While Medi-Cal accepted my pay stubs as income, AIM refused to acknowledge my pay stubs because taxes were not deducted from my paycheck. The AIM worker in the call center told me the problem would be solved with a form letter from my employer indicating my gross monthly income. My employer, however, refused to comply with the specific wording in AIM's form letter because my gross monthly income was not the same every month. Thus, AIM regarded my employer's letter as invalid, and I once again received a denial letter from AIM informing me that my household income was too low to qualify for the program.

All the while, the process of obtaining some form of health insurance was taking time and causing stress. By this point, I was desperate to receive prenatal care for my unborn child. My presumptive eligibility for Medi-Cal had expired, and I had not attended a prenatal doctor's appointment in months. To make my worries worse, the mellow fetus inside my womb often left me wondering if my baby was healthy and growing. Thus began my last trimester, a stressful, three-month cycle of endless phone calls, new and *different* requests from the AIM program, and additional coverage denial letters after doing the very things AIM asked of us. For example, in place of the employer letter, AIM instructed me to send in a copy of my 1040 tax form. This document was also denied because my household income was still too low to qualify for AIM's services. After contacting my Medi-Cal caseworker, who refused to accept my 1040, I once again called the AIM program in tears of frustration. This time I was told to write a self-affidavit letter regarding my household income. Despite following their explicit instructions, my affidavit was deemed invalid because of the previous pay stub I had sent in months earlier (the very same pay stub AIM refused to acknowledge when calculating my household income). So I called AIM for the fourth time. This time, I was instructed to write a different letter asking AIM to disregard the prior pay stub. Despite

my persistent efforts, I was once again denied insurance coverage for the fifth and final time on July 13, 2010—two weeks before my due date. The reasoning this time? Because I was now over thirty weeks into my pregnancy, I was no longer considered eligible to apply for AIM's services.²⁰ Despite my numerous contacts with the agency during the previous five months, AIM had successfully evaded my requests for insurance coverage until it was too late.²¹ Frustrated with the result and the conflicting information I received on numerous occasions from AIM personnel, I decided to utilize AIM's appeals process and challenge its decision to deny me health insurance coverage. Three weeks after the birth of my son, I received AIM's resounding response—"Appeal Denied."

Numerous phone calls, several letters, and one baby later, I still found myself uninsured. But now, in addition to my new little one, I also assumed an outstanding medical bill for labor and delivery that neither my husband nor I could afford. Despite my eligibility and best efforts to obtain health insurance coverage during my pregnancy, I was unable to prevail against the Machiavellian health insurance system. Fortunately, despite my lack of prenatal care, I delivered a happy, healthy, and thriving baby boy. However, not all are as lucky as I was.

According to the U.S. Department of Health and Human Services, mothers who receive no prenatal care are three times more likely to have babies with low birth weights.²² Low-birth-weight babies have an increased risk of serious health problems, ranging from breathing

²⁰ ACCESS FOR INFANTS & MOTHERS, *supra* note 17, at 13.

²¹ This is the epitome of the bureaucracy of poverty. Layers of red tape make it difficult for eligible families to obtain support from social service agencies. Although it is counterintuitive, the welfare system often operates to deny benefits to eligible welfare applicants. Jonathan Zasloff, *Children, Families, and Bureaucrats: A Prehistory of Welfare Reform*, 14 J.L. & POL. 225, 259 (1998). In theory, the hierarchy in bureaucracies should limit the influence of irrelevant factors in the decision-making process. In practice, these hierarchical controls are not perfect, and the criteria for decision making are ambiguous. See *infra* Part I.C.1. To varying degrees, decisions are negotiated with clients rather than unilaterally imposed. The potential arbitrariness of caseworker decisions is only increased by welfare recipients' lack of financial resources, political influence, and appropriate advocacy skills. Welfare programs presume poor mothers are morally suspect, and lower-level administrators do not hesitate to exercise their limited power over poor women who have few, if any, alternatives. Munger, *supra* note 1, at 660.

²² U.S. DEP'T OF HEALTH & HUMAN SERVS., A HEALTHY START: BEGIN BEFORE BABY'S BORN 1, available at <ftp://ftp.hrsa.gov/mchb/prenatal.pdf>.

difficulties,²³ bleeding in the brain,²⁴ heart failure,²⁵ and potentially dangerous intestinal problems.²⁶ With the increased risk of serious health problems comes the increased chance of infant mortality.²⁷ Babies whose mothers did not receive prenatal care are five times more likely to die than babies whose mothers did receive prenatal care.²⁸ Of further concern is the racial component intertwined in the statistics: Nearly twenty-five percent of African American women initiate prenatal care either late or not at all, a rate twice as high as their white counterparts.²⁹ Similarly, African American women are also twice as likely as white women to have a low-birth-weight baby or experience infant and maternal mortality.³⁰ Although the United States spends more money per birth than any other nation, its maternal mortality rate is higher than many other developed countries.³¹ Unfortunately, this number is only on the rise.³²

While access to health care is fundamental for everyone, it is especially crucial for the expectant mother. Prenatal care is more than just a routine checkup to prevent and cure complications that may otherwise arise.³³ Prenatal checkups provide the expectant mother with an opportunity to ask questions and voice any concerns she may have about her pregnancy. It is also an opportunity for doctors and nurses to educate and counsel her on how to handle different aspects

²³ E.g., March of Dimes, *Medical Resources: Low Birthweight*, http://www.marchofdimes.com/professionals/medicalresources_lowbirthweight.html (last visited Oct. 20, 2011).

²⁴ *Id.*

²⁵ E.g., *id.* (discussing *patent ductus arteriosus*).

²⁶ E.g., *id.* (discussing *necrotizing enterocolitis*).

²⁷ *Id.*

²⁸ U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 22.

²⁹ Adam Sonfield, *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*, 13 GUTTMACHER POL'Y REV. 13, 17 (2010), available at <http://www.guttmacher.org/pubs/gpr/13/3/gpr130313.pdf>.

³⁰ *Id.*

³¹ The U.S. maternal mortality rate is higher than forty other countries (including most of Europe) and has only grown worse in the past few years. Tiffany O'Callaghan, *Fewer Women Dying During Pregnancy, Childbirth*, TIME, Apr. 14, 2010, <http://healthland.time.com/2010/04/14/fewer-women-dying-during-pregnancy-childbirth/>; Shari Roan & Lisa Girion, *Rising Maternal Mortality Rate Causes Alarm, Calls for Action*, L.A. TIMES, May 22, 2010, <http://articles.latimes.com/2010/may/22/science/la-sci-maternal-deaths-20100523>.

³² Roan & Girion, *supra* note 31.

³³ Doctors conduct procedures, such as external cephalic version (turns fetus from breeched or side position), chorionic villus sampling (identifies chromosome abnormalities and other inherited disorders), and amniocentesis (diagnoses chromosome abnormalities and fetal infections).

of her pregnancy (for example, morning sickness, nutrition, physical activity, and breathing techniques), what to expect during birth, and what basic skills will be needed to care for her infant.³⁴ By monitoring the health of both a mother and her baby from an early stage in the pregnancy, the baby is given the best chance of arriving safely and beginning life with optimal health.³⁵ As a result, the child's risk of future health problems and the associated health care costs are reduced.³⁶ According to the Institute of Medicine, every dollar spent on prenatal care saves \$3.38 in health care costs for a low-birth-weight infant in the first year of his or her life alone³⁷—a savings that is even greater when one includes the potential lifetime medical expenses of a low-birth-weight baby with a mental or physical handicap.³⁸

In addition to prenatal care and delivery, postpartum care³⁹ for both the mother and her baby is also important. Postpartum checkups ensure the mother's body is healing properly from her pregnancy and delivery.⁴⁰ The checkups also give the mother an opportunity to ask questions about family planning and a successful feeding plan for the newborn infant.⁴¹ Most importantly, the checkups allow doctors and nurses the opportunity to monitor the mother's mental health, which can be in a vulnerable state in the days, weeks, and months following her pregnancy and childbirth.⁴² Whether the baby is her first or her last, the mother is experiencing dramatic changes in her body from pregnancy, birth, and the postpartum period; she must learn to adjust and to adapt her life to the new infant.⁴³ The stress of this adjustment

³⁴ *Care Before and During Pregnancy—Prenatal Care*, MAMA'S HEALTH.COM, <http://www.mamashealth.com/pregnancy/prenatal.asp> (last visited Oct. 20, 2011).

³⁵ *Policy Priorities: Uninsured Children*, CHILDREN'S DEF. FUND, <http://www.childrensdefense.org/policy-priorities/childrens-health/uninsured-children/> (last visited Oct. 20, 2011).

³⁶ See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 22, at 2.

³⁷ INST. OF MED., PREVENTING LOW BIRTHWEIGHT 117 (1985).

³⁸ L. Rachel Eisenstein, *Prenatal Health Care: Today's Solution to the Future's Loss*, 18 FLA. ST. U. L. REV. 467, 473 (1991).

³⁹ The postpartum period is defined as beginning one hour after birth of the placenta and continuing for approximately six weeks. Leah L. Albers, *Health Problems After Childbirth*, 45 J. OF MIDWIFERY AND WOMEN'S HEALTH 55, 55 (2000).

⁴⁰ See *id.* at 56.

⁴¹ Colleen Fogarty, *Postpartum Care: Breastfeeding and Mood Disorders*, in WOMEN-CENTERED CARE IN PREGNANCY AND CHILDBIRTH 35–37 (Sara G. Shields & Lucy M. Candib eds., 2010).

⁴² *Id.*

⁴³ *Id.*

is difficult for most mothers.⁴⁴ Recent statistics indicate postpartum depression (PPD)⁴⁵ affects between three and thirty percent of new mothers.⁴⁶ Clearly, a mother's mental health intimately impacts the health and the well-being of her newborn infant.⁴⁷ Mothers who struggle with PPD commonly think of harming their children, they exhibit more negative emotions and fewer positive emotions toward their children, they are less sensitive and responsive to the infants' cues, and they are less emotionally available.⁴⁸ Consequently, the infants are less securely attached to the mother, which may only exacerbate the feelings of inadequacy stemming from PPD.⁴⁹ Unfortunately, postpartum care is often neglected.⁵⁰ Despite the prevalent and pressing issues associated with the months immediately following pregnancy, postpartum care remains unaffordable and inaccessible for many women.⁵¹

With a clear consensus regarding the lifelong beneficial impact of prenatal, natal, and postpartum care, it should no longer be acceptable for a woman to be denied access to these services.⁵² Yet, thirteen

⁴⁴ *Id.*

⁴⁵ Postpartum depression "is characterized by sadness, crying, self-blame, loss of control, irritability, anxiety, tension, and sleep difficulties." Stacey A. Tovino, *Scientific Understandings of Postpartum Illness: Improving Health Law and Policy?*, 33 HARV. J.L. & GENDER 99, 102 (2010). These symptoms typically develop between two weeks and six months after giving birth and may last as long as six to twelve months after childbirth. *Id.*

⁴⁶ *Id.* Famous women who have publicly acknowledged their struggle with postpartum depression include Brooke Shields, Gwyneth Paltrow, Courtney Cox, Marie Osmond, and the late Princess Diana. 10 Celebrities Who Battled Postpartum Depression, CBSNEWS.COM, http://www.cbsnews.com/2300-204_162-10005857-11.html?tag=contentBody;mGalleryBottom (last visited Oct. 20, 2011); see also TINA BROWN, THE DIANA CHRONICLES 210–11, 357 (2007); MARIE OSMOND ET AL., BEHIND THE SMILE: MY JOURNEY OUT OF POSTPARTUM DEPRESSION (2001); BROOKE SHIELDS, DOWN CAME THE RAIN (2005).

⁴⁷ Fogarty, *supra* note 41, at 35–39.

⁴⁸ Edward H. Hagen, *The Functions of Postpartum Depression*, 20 EVOLUTION & HUM. BEHAV., 325, 325 (1999).

⁴⁹ *Id.*

⁵⁰ DEBBIE SINGH & MARY NEWBURN, WOMEN'S EXPERIENCES OF POSTNATAL CARE 2 (2000), available at http://www.nctpregnancyandbabycare.com/sites/default/files/related_documents/women%27sexperiencesofpostnatalcare.pdf.

⁵¹ See Whitney Morrill, *Pricey Therapy: The Downside of Making Postpartum Sexy*, SLATE (Aug. 30, 2005, 6:40 AM), <http://www.slate.com/id/2125233> (detailing one woman's attempt at obtaining health insurance coverage for postpartum depression).

⁵² U.S. DEP'T OF HEALTH & HUMAN SERVS., THE REPORT OF THE SELECT PANEL FOR THE PROMOTION OF CHILD HEALTH, BETTER HEALTH FOR OUR CHILDREN: A NATIONAL STRATEGY, 192 (1981), available at <http://www.eric.ed.gov/PDFS/ED198953.pdf>.

percent of pregnant women remain uninsured every year.⁵³ Many more are underinsured.⁵⁴ Each year, approximately 70,000 pregnant women do not receive any form of prenatal care.⁵⁵ These numbers are significant because a pregnant woman's access and ability to pay for health insurance affects her financial well-being and her access to prenatal and postnatal health care.⁵⁶ With the worry of unaffordable

⁵³ *Health Insurance for Pregnant Women*, AM. PREGNANCY ASS'N, <http://www.americanpregnancy.org/planningandpreparing/affordablehealthcare.html> (last visited Sept. 24, 2011).

⁵⁴ *See id.*

⁵⁵ LAURA PARISI & RACHEL KLEIN, COVERING PREGNANT WOMEN: CHIPRA OFFERS A NEW OPTION 2 (2010), available at <http://familiesusa2.org/assets/pdfs/chipra/Covering-Pregnant-Women.pdf>. No statistics were available on the number of women unable to receive postpartum care.

⁵⁶ KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED AND THE DIFFERENCE HEALTH INSURANCE MAKES 2 (2010), available at <http://www.kff.org/uninsured/upload/1420-12.pdf>; THE HENRY J. KAISER FAMILY FOUND., WOMEN'S FACT SHEET: WOMEN'S HEALTH INSURANCE COVERAGE 1 (2009), available at <http://www.kff.org/womenshealth/upload/6000-08.pdf>.

It is interesting to note the discrepancy between the number of women without prenatal, natal, or postnatal care and the amount of money expended on pro-natal causes (for example, infertility treatment and antiabortion). The infertility industry in the United States is estimated to bring in \$2 billion annually and the antiabortion movement raises approximately \$551 million annually. Catherine Winter, *The Fertility Industry*, in THE FERTILITY RACE (1998), http://news.minnesota.publicradio.org/features/1959711/20_smiths_fertility/part3/; Brian Clowes, *The Abortion Lobby's Deep Pockets*, HUM. LIFE REV. (2008), http://www.lifeissues.net/writers/clo/clo_07abortionpockets.html. Some critics argue this money could be better spent on meeting the unmet health care needs of pregnant women and their children. See ELIZABETH BARTHOLET, FAMILY BONDS: ADOPTION AND THE POLITICS OF PARENTING 203–05 (1993) (“A quick assessment of the costs and benefits involved in [In Vitro Fertilization (IVF)] raises serious questions about whether this new methodology for dealing with infertility should be seen as a net plus for women, for children or for the larger society. . . . For the society at large . . . it is the total cost of IVF that is relevant. . . . These resources could be devoted to serving some of the most basic health care needs of women and children, which now go unmet.”); JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM 137 (1993) (“Some will say that these reproductive technologies need not be pitted against access to basic health needs. Yet these technologies can only be defended in the interests of servicing the few, not the many others whose pressing needs go unmet because research and money are siphoned off in the quest for more profitable and high technologies of reproduction.”); Timothy Jost, *If You Are Pro-Life, You Should be Pro-Medicaid*, RICHMOND TIMES-DISPATCH, June 22, 2011, at A9 (“Medicaid is best understood as a pro-life program, and Virginians who are pro-life should be its strongest supporters. . . . The prenatal care and safe delivery promised by Medicaid is . . . a lifeline for children in the womb. . . . The Medicaid program is far from perfect, but it protects the lives of millions of Americans. Those of us who care about life and about the poor, Republicans and Democrats, must fight to protect it.”); Amanda Marcotte, *9 States Where Awful GOP Policies Will Actually Drive Up the Abortion Rate*, ALTERNET, June 23, 2011, http://www.alternet.org/reproductivejustice/151404/9_states_where_awful_gop_policies_will_actually_drive_up_the_abortion_rate/ (“Republicans who claim to hate abortion for

medical expenses looming, uninsured women are more than twice as likely as their insured counterparts to delay or forego needed medical care.⁵⁷

America's health and prosperity will depend on the health and prosperity of the future generation—a generation comprised of children. To ensure the health of America's tiniest citizens and the future leaders of tomorrow, the United States must take an interest in providing adequate prenatal, natal, and postnatal care to its mothers.⁵⁸ Part I of this Comment seeks to explain the barriers preventing pregnant women from obtaining adequate and affordable health insurance coverage. I examine the three health insurance options currently available to pregnant women—employer-sponsored insurance, individually purchased insurance, and government-funded insurance—and provide an overview of the legal history regarding the pregnant woman's access to health care coverage. Part II provides a discussion of the Patient Protection and Affordable Care Act (ACA) and analyzes whether Obama's 2010 health care reform made any significant progress toward improving the pregnant woman's ability to access affordable health care coverage. Part III concludes this Comment with further recommendations for reforming the new health insurance system, which include (1) updating the Federal Poverty Level (FPL) standard or adopting a new measurement to more accurately reflect the poverty level and economic need of families and individuals; (2) adopting a “fallback provision,” which extends affordable health insurance coverage to all pregnant women who do not otherwise have access to any means of affordable health insurance; and (3) instituting more outreach, transparency, and

itself should be embracing policies that secure women's access to health care, child care and financial stability—policies that actually reduce the abortion rate. Instead, they seem committed to policies that will do nothing but drive more women to seek abortion.”).

⁵⁷ KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 56.

⁵⁸ Raising healthy children should be a national priority. See Nancy Folbre, *Children as Public Goods*, 84 AM. ECON. REV. 86, 86 (1994) (“Economic development tends to increase [children's] costs to parents in general, and mothers in particular. Yet the growth of transfer payments and taxation of future generations ‘socialize’ many of the benefits of children. All citizens of the United States enjoy significant claims upon the earnings of future working-age adults through Social Security and public debt. But not all citizens contribute equally to the care of these future adults. Individuals who devote relatively little time or energy to child-rearing are free-riding on parental labor.”) See generally Paula England & Nancy Folbre, *The Silent Crisis in U.S. Child Care: Who Should Pay for the Kids?*, 563 ANNALS AM. ACAD. POL. & SOC. SCI. 194 (1999) (arguing that well-reared children are public goods because of their capacity to benefit society as a whole).

accountability within the government-funded health insurance systems.

I

PRE-HEALTH-REFORM STATE OF AFFAIRS FOR THE UNDERINSURED AND THE UNINSURED

As of yet, the federal government has not viewed women's health care—including prenatal, natal, and postnatal care—"as an unencumbered public right or universal entitlement for all women as a group."⁵⁹ Instead, the United States has adopted a model of personal responsibility.⁶⁰ In *Dandridge v. Williams*, the Supreme Court indicated that the Constitution imposes no obligation on states to pay medical- or pregnancy-related expenses of indigent women.⁶¹ In order to obtain health insurance coverage during pregnancy, a woman must first assume personal responsibility and make sure she has health insurance before becoming pregnant.⁶²

Despite the recognized benefits of prenatal, natal, and postnatal care, efforts to improve the pregnant woman's access to insurance coverage and affordable health care have fallen short. An in-depth look at the actual practices of obtaining health insurance reveals a societal trend of denying health insurance to pregnant women, which persists despite Congress's efforts to pass legislation to the contrary.⁶³ Currently, a pregnant woman has three options for attaining health care coverage: employer-sponsored health insurance, individually purchased health insurance, and Medicaid (government-funded health insurance).⁶⁴

⁵⁹ Susan L. Waysdorf, *Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 768 (1996).

⁶⁰ The epitome of this policy approach is the Personal Responsibility and Work Opportunity Act. Pub. L. No. 104-193, 110 Stat. 2105 (1996); *see also* Bill Clinton, Governor, Ark., Remarks to Students at Georgetown University, *The New Covenant: Responsibility and Rebuilding the American Community* (Oct. 23, 1991) ("[W]e're going to put an end to welfare as we have come to know it" by reasserting America's strong work ethic.), available at http://www.dlc.org/ndol_ci.cfm?contentid=2783&kaid=128&subid=174.

⁶¹ *See Dandridge v. Williams*, 397 U.S. 471, 485, 487 (1970).

⁶² *Pregnancy Complicates Health Insurance Options*, INSURE.COM, <http://www.insure.com/articles/healthinsurance/pregnancy.html> (last visited Oct. 20, 2011).

⁶³ *See Pregnancy Discrimination Act*, Pub. L. No. 95-555, 92 Stat. 2076 (1978); *infra* notes 75–79 and accompanying text.

⁶⁴ THE HENRY J. KAISER FAMILY FOUND., *supra* note 56.

A. Employer-Sponsored Health Insurance⁶⁵

Although employer-sponsored health insurance is the most common way for Americans to obtain health care coverage,⁶⁶ this was not always the case. Based on the idea that women belonged at home and not in the workplace, employers in the 1950s and 1960s commonly denied women coverage for their pregnancies while providing coverage for many other temporary disabilities not particular to women.⁶⁷ With the women's rights movement and the passing of Title VII of the Civil Rights Act, it became illegal for an employer to discriminate against an individual on the basis of sex.⁶⁸ On its face, the law seemed to forbid employers from engaging in the traditional conduct of refusing to insure pregnant women or refusing to offer disability benefits for pregnancy. However, in *General Electric Co. v. Gilbert*—a perplexing opinion passed down from the U.S. Supreme Court⁶⁹—the exclusion of pregnancy from an employee benefits package was held not to be sexual discrimination.⁷⁰ Although the Court acknowledged pregnancy as being exclusive to women, the exclusion of pregnancy from the list of covered diseases and disabilities was not an exclusion based on

⁶⁵ Preexisting conditions are not addressed because under the Health Insurance Patient Protection Act (HIPPA) group health plans may not consider pregnancy as a preexisting condition. 29 U.S.C. § 1181(d)(3) (2006).

⁶⁶ KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 56.

⁶⁷ Lisa Wilson, *Pregnancy Discrimination in the Workplace*, in THE HANDBOOK OF WOMEN, PSYCHOLOGY, AND THE LAW, 124, 125 (Andrea Barnes ed., 2005).

⁶⁸ Civil Rights Act, 42 U.S.C. § 2000e-2(a)(1) (2000).

⁶⁹ See *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 152 (Brennan, J., dissenting) (“[E]ven the Court’s principal argument for the plan’s supposed gender neutrality cannot withstand analysis. . . . In fostering the impression that it is faced with a mere underinclusive assignment of risks in a gender-neutral fashion—that is, all other disabilities are insured irrespective of gender—the Court’s analysis proves to be simplistic and misleading. . . . [P]regnancy affords the only disability, sex-specific or otherwise, that is excluded from coverage.”), *superseded by statute*, Pregnancy Discrimination Act, Pub. L. No. 95-555, 92 Stat. 2076 (1978), *as recognized in* *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *id.* at 161–62 (Stevens, J., dissenting) (“[T]he rule at issue places the risk of absence caused by pregnancy in a class by itself. By definition, such a rule discriminates on account of sex; for it is the capacity to become pregnant which primarily differentiates the female from the male.”); see also Lucinda M. Finley, *Transcending Equality Theory: A Way out of the Maternity and the Workplace Debate*, 86 COLUM. L. REV. 1118, 1121 (1986) (describing *Gilbert* as “the most egregious example of judicial blindness to the link between workplace pregnancy policies and the subordinate economic status of women”); Kenneth L. Karst, *Woman’s Constitution*, 1984 DUKE L.J. 447, 508 (1984) (noting that society’s duty to its members includes the responsibility of preventing harms that are dehumanizing, such as the decision passed down in *Gilbert*).

⁷⁰ *Gilbert*, 429 U.S. at 138.

gender.⁷¹ The Court classified pregnancy as a “physical condition with unique characteristics”⁷² that is “significantly different from the typical covered disease or disability.”⁷³ Thus, removal from the list of covered expenses was justified.⁷⁴ Because the employee benefits package covered the same categories of risks for nonpregnant male and nonpregnant female employees, the Court held the employee benefits package did not constitute sexual discrimination under Title VII.⁷⁵

In reaction to the illogical rationale provided in *Gilbert*, Congress passed the Pregnancy Discrimination Act (PDA), amending Title VII.⁷⁶ This amendment makes clear that pregnant women should be treated equally for employment purposes. It explicitly defines discrimination “on the basis of sex” as including discrimination based on “pregnancy, childbirth, or related medical conditions.”⁷⁷ Now, when employers with over fifteen employees offer employer-sponsored health insurance, the plan must cover pregnancy-related expenses to the same extent it covers other medical conditions.⁷⁸

While the PDA mandates equal health insurance for women and for men, there is no federal law requiring employers to actually provide health insurance to their employees.⁷⁹ As long as employers do not offer health insurance to their employees in general, they are not required to provide insurance coverage for pregnancy-related expenses. Thus, the PDA arguably grants employers a license to treat pregnant women badly, as long as the nonpregnant employees are treated the same way.⁸⁰

⁷¹ *Id.* at 136.

⁷² *Id.* at 134.

⁷³ *Id.* at 136.

⁷⁴ *Id.* at 134.

⁷⁵ *Id.* at 138.

⁷⁶ See Pregnancy Discrimination Act, Pub. L. No. 95-555, 92 Stat. 2076 (1978); see, e.g., Julie Manning Magid, *Pregnant with Possibility: Reexamining the Pregnancy Discrimination Act*, 38 AM. BUS. L.J. 819, 820–21 (2001) (indicating that Congress rejected the holding in *Gilbert* and responded by enacting the PDA as an amendment to the definitions section of Title VII).

⁷⁷ 42 U.S.C. § 2000e(k).

⁷⁸ *Id.*; 29 C.F.R. § 1604 (1990). There are two exceptions. First, employers can offer plans that exclude pregnancy-related expenses for “nonspouse” dependents, such as the employee’s daughter. Sonfield, *supra* note 29. The other exception is abortion. Employers are only required to cover abortion when medical complications arise from the abortion or if the mother’s life would be endangered if the fetus were carried to term. 29 C.F.R. § 1604.

⁷⁹ *Pregnancy Complicates Health Insurance Options*, *supra* note 62.

⁸⁰ Wilson, *supra* note 67.

Despite this cynical view, most large employers choose to offer some form of health insurance coverage to their employees.⁸¹ Yet, significant numbers of Americans still lack access to insurance through the employer-sponsored system.⁸² Eligibility for employer-sponsored health insurance is often conditioned upon the employee working full time and withstanding a waiting period after the commencement of employment.⁸³ As a result, working women in general are less likely than men to be eligible for employer-sponsored health insurance because women are more likely to work part time.⁸⁴ However, working full time and withstanding the waiting period do not guarantee access to employer-sponsored health insurance. If workers are classified as independent contractors, like I was while working as a preschool teacher, they will find that access to employer-sponsored health insurance is unavailable.⁸⁵

Furthermore, the increase in health care costs, insurance premiums, and employee contributions for health insurance pose additional challenges for employees considering whether to enroll in the health insurance plan offered by their employer.⁸⁶ Although I was eligible to obtain maternity coverage through my husband's employer, my husband and I opted out of this option because the employee contribution to enroll dependents in his employer-sponsored health insurance plan was beyond what we could afford.⁸⁷ Kaiser President and CEO Drew Altman notes, "[B]usinesses have been shifting more of the costs of health insurance to workers through premiums, deductibles, and other cost-sharing. . . . [This] means employer coverage is less comprehensive."⁸⁸ Additionally, the costs of health

⁸¹ Most employers choose to offer insurance because it attracts employees, and there are tax benefits for both employer and employee. Mark W. Stanton, *Employer-Sponsored Health Insurance: Trends in Cost and Access*, RES. IN ACTION (Agency for Healthcare Research and Quality, Rockville, Md.), Sept. 2004, at 2, available at <http://www.ahrq.gov/research/emspria/emspria.pdf>.

⁸² *Id.* at 7. In 2009, over 39.4 million women did not have employer sponsored insurance. See THE HENRY J. KAISER FAMILY FOUND., *supra* note 56. They were either uninsured or had to resort to government-funded health insurance or purchasing insurance through the individual market.

⁸³ THE HENRY J. KAISER FAMILY FOUND., *supra* note 56.

⁸⁴ *Id.*

⁸⁵ See sources cited *supra* note 2.

⁸⁶ Stanton, *supra* note 81, at 3.

⁸⁷ See *supra* note 4 and accompanying text.

⁸⁸ News Release, The Henry J. Kaiser Family Found., Employer Health (Sept. 2, 2010), <http://www.kff.org/insurance/090210nr.cfm>.

insurance are increasing faster than wages.⁸⁹ Since 2005, employees' contributions to their premiums increased forty-seven percent while wages only increased by eighteen percent.⁹⁰

An employee's ability to obtain employer-sponsored health insurance becomes more difficult for an employee working for a small employer. Small employers with predominantly low-wage workers are much less likely to offer health insurance for a variety of reasons, including their employees' inability to afford their share of the premiums⁹¹ and the employees' preferences to receive compensation in the form of wages rather than in the form of health insurance benefits.⁹² Pregnant women employed at small businesses face yet another hurdle: small businesses with less than fifteen employees are not governed by the PDA.⁹³ Thus, small-business employers that do offer health insurance are not mandated by federal law to provide health insurance coverage for pregnancy-related expenses.⁹⁴

B. Individually Purchased Insurance

For the unemployed, self-employed, or those unable to obtain employer-sponsored health insurance, health insurance can theoretically be purchased through the individual insurance market. Unfortunately, the federal and state laws providing consumer protection to individuals with employer-sponsored health insurance⁹⁵ do not apply to individuals with a plan purchased through the individual market.⁹⁶ Thus, premiums within the individual market can be based on gender.⁹⁷ Additionally, health insurance companies in the individual market can refuse to provide coverage for

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 56.

⁹² Other reasons include higher premiums caused by the greater cost of underwriting and administering in a small workforce, the lower likelihood employees will fulfill the waiting requirement for eligibility because of high rates of employee turnover, and incentives to keep business costs down because of higher rates of business failure compared to larger firms. Stanton, *supra* note 81.

⁹³ *See supra* note 78 and accompanying text.

⁹⁴ *See supra* notes 78–80 and accompanying text. Some states, however, have enacted their own version of the PDA, which applies to small employers. Sonfield, *supra* note 29.

⁹⁵ For example, HIPPA and the PDA.

⁹⁶ *Roadblocks to Healthcare: Why the Current Healthcare System Does Not Work for Women*, HEALTHREFORM.GOV, <http://www.healthreform.gov/reports/women/index.html> (last visited Oct. 20, 2011).

⁹⁷ *Id.*

pregnancy-related conditions by classifying pregnancy as a “pre-existing” condition, which automatically results in denial of health insurance coverage.⁹⁸ Thus, when a woman finds herself unexpectedly pregnant, as I did, she is effectively denied the opportunity to purchase insurance through the individual market. These practices place individually purchased insurance plans outside the reach of many women.⁹⁹

Furthermore, when a woman with an individually purchased insurance plan subsequently becomes pregnant, the plan’s coverage of her pregnancy-related expenses is often limited or nonexistent.¹⁰⁰ For example, the four largest for-profit insurance companies¹⁰¹ exclude coverage of most expenses related to a normal delivery,¹⁰² and a 2008 study conducted by the National Women’s Law Center found only twelve percent of individually purchased insurance plans included comprehensive maternity coverage.¹⁰³ While some individually purchased plans allow women to purchase a “rider”¹⁰⁴ to cover pregnancy, this costs thousands of dollars per year in the form of additional monthly premiums.¹⁰⁵ Even then, the rider may require a waiting period and limit the extent of coverage.¹⁰⁶ For example, after paying a \$110 monthly premium for a waiting period of ten months, one insurance company’s maternity option pays out \$3000 in benefits towards maternity health care expenses.¹⁰⁷ By the time the insured woman gives birth, she will have already paid out \$2090 in monthly premiums.¹⁰⁸ Furthermore, the benefits paid out under the maternity coverage (for example, \$3000) will not even cover half the estimated

⁹⁸ Currently, the four largest for-profit insurance companies—Aetna, Humana, UnitedHealth Group, and WellPoint—follow this practice. STAFF OF H. COMM. ON ENERGY & COMMERCE, 111TH CONG., MEMORANDUM ON MATERNITY COVERAGE IN THE INDIVIDUAL HEALTH INSURANCE MARKET 1 (Comm. Print 2010).

⁹⁹ See Sonfield, *supra* note 29, at 4; *Roadblocks to Healthcare*, *supra* note 96.

¹⁰⁰ STAFF OF H. COMM. ON ENERGY & COMMERCE, *supra* note 98, at 4.

¹⁰¹ *Id.* at 1.

¹⁰² *Id.* at 4.

¹⁰³ Sonfield, *supra* note 29, at 14.

¹⁰⁴ A “rider” is an additional benefits clause included in an insurance policy. MERRIAM-WEBSTER DICTIONARY (online ed.), <http://www.merriam-webster.com/dictionary/rider>.

¹⁰⁵ STAFF OF H. COMM. ON ENERGY & COMMERCE, *supra* note 98, at 5–6; Sonfield, *supra* note 29, at 14–15.

¹⁰⁶ See STAFF OF H. COMM. ON ENERGY & COMMERCE, *supra* note 98, at 5–6; Sonfield, *supra* note 29, at 14–15.

¹⁰⁷ NAT’L WOMEN’S LAW CTR., *supra* note 5.

¹⁰⁸ That is, \$110 x 19 months (ten-month waiting period plus nine months of pregnancy) = \$2090.

cost of delivery. On average, a low-risk delivery alone costs around \$7500—an amount that does not include any prenatal or postnatal care expenses.¹⁰⁹ If complications arise, the average cost of delivery can range between \$9600 and \$17,000.¹¹⁰ In addition to the delivery costs, hospitals also charge for use of the labor room and the nursery. If the newborn has health complications or is born premature, the cost of neonatal care can exceed \$3500 per day; the costs for a prolonged stay in the Neonatal Intensive Care Unit can easily exceed \$1,000,000.¹¹¹ Thus, the higher costs and inadequate coverage associated with an individually purchased insurance plan do not make this option feasible for pregnant women.¹¹²

C. Medicaid

The final insurance option is Medicaid, a state-administered federal program, which provides government-funded health insurance.¹¹³ Although Medicaid is a welfare program that bases eligibility for health insurance on economic need,¹¹⁴ “not all the poor are eligible and not all the eligible are poor.”¹¹⁵ As a matter of public policy, Medicaid favors certain groups among the needy (for example, pregnant women) known as the “deserving poor.”¹¹⁶

While federal laws and regulations provide the framework for determining who is eligible for Medicaid, states are given rather broad discretion in deciding the category of participants¹¹⁷ who may

¹⁰⁹ NAT’L WOMEN’S LAW CTR., *supra* note 5, at 11.

¹¹⁰ NAT’L WOMEN’S LAW CTR., *supra* note 5, at 12.

¹¹¹ Jonathan Muraskas & Kayhan Parsi, *The Cost of Saving the Tiniest Lives: NICUs Versus Prevention*, 10 VIRTUAL MENTOR 655, 655 (2008), available at <http://virtualmentor.ama-assn.org/2008/10/pdf/pfor1-0810.pdf>.

¹¹² Individually purchased insurance is only used by six percent of women. THE HENRY J. KAISER FAMILY FOUND., *supra* note 56.

¹¹³ BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 396 (6th ed. 2008).

¹¹⁴ *Id.*

¹¹⁵ RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 15 (citation omitted).

¹¹⁶ Currently, state Medicaid programs must cover over thirty-five discrete categories of the poor, and an additional two dozen discrete categories of the poor may be covered if the state so chooses. FURROW ET AL., *supra* note 113.

¹¹⁷ For example, low income children (age six and above) above 100% of the Federal Poverty Level (FPL), pregnant women with a household income over 133% of the FPL. KAISER COMM’N ON MEDICAID & THE UNINSURED, MEDICAID: AN OVERVIEW OF SPENDING ON “MANDATORY” VS. “OPTIONAL” POPULATIONS AND SERVICES 2 (June 2005), available at <http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf>.

be covered.¹¹⁸ Under current federal law, states are required to cover all pregnant women with family incomes up to 133% of the federal poverty level (FPL), and states have the option of covering pregnant women with family incomes up to 185% of the FPL.¹¹⁹ Many states have responded to their constituents' needs and used waivers or state funds to set their eligibility requirements above and beyond the federal government's optional requirements for Medicaid.¹²⁰ However, some states have obtained similar waivers to do the opposite: reduce participant benefits and increase the share of cost.¹²¹

Additionally, states have rather broad discretion in determining how eligibility will be calculated.¹²² Some states have expanded their eligibility requirements by using "less restrictive" methodologies when calculating a pregnant woman's household income.¹²³ For example, a certain portion of income may be excluded from the eligibility calculation for the first few months of employment.¹²⁴ A pregnant woman may also receive income deductions for being married and for childcare expenses.¹²⁵

Eligibility is the most difficult barrier to overcome for millions of uninsured Americans because it is uneven and complicated.¹²⁶ With each state varying in the criteria used to determine eligibility,¹²⁷ there are over fifty different pathways to attain the same government-funded health insurance.¹²⁸ California and Oregon, for example, emphasize the extent of these differences. Although these two West Coast states share a border, their Medicaid programs in general and their differing approaches to calculating Medicaid eligibility for pregnant women represent polar opposites of the Medicaid spectrum.

¹¹⁸ FURROW ET AL., *supra* note 113, at 397.

¹¹⁹ *Id.*

¹²⁰ RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 107; *see also* FURROW ET AL., *supra* note 113, at 399.

¹²¹ FURROW ET AL., *supra* note 113, at 397; BARRY R. FURROW ET AL., HEALTH CARE REFORM SUPPLEMENT TO HEALTH LAW: CASES, MATERIALS AND PROBLEMS 68 (6th ed. 2010) [hereinafter FURROW SUPPLEMENT].

¹²² FURROW ET AL., *supra* note 113.

¹²³ *Id.* at 397.

¹²⁴ RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 16.

¹²⁵ *Id.*

¹²⁶ *Id.* at 38, 108.

¹²⁷ Criteria for eligibility include but are not limited to: age, income, citizenship status, assets, work status, marital status, school enrollment, medical condition, and chance of improvement. *Id.* at 8.

¹²⁸ *Id.* at 15.

Although California and Oregon are on polar opposites of the Medicaid spectrum, they share some notable similarities. First, both programs require state residency,¹²⁹ categorize the pregnant woman as a family of two, and decline to consider assets in determining eligibility.¹³⁰ Second, both state Medicaid programs provide emergency benefits to pregnant noncitizens.¹³¹ However, the similarities between the two state Medicaid programs diverge from there. California's Medicaid program resembles a "traditional" Medicaid program. Only certain "categories" of individuals are eligible (e.g., women and children), and a myriad of income deductions are used to determine gross monthly household income.¹³² Oregon, on the other hand, was utilizing a waiver to create a "revolutionary" program based on prioritizing health benefits "from the most to the least important."¹³³ Additionally, while traditional Medicaid targets "categories" (for example, women and children), Oregon's Medicaid system covers "all people below poverty."¹³⁴ Furthermore, Oregon does not apply any income deductions when calculating gross monthly household income.¹³⁵

1. California's Medicaid Program: Medi-Cal

Once California state residency is established, Medi-Cal provides free prenatal health care coverage to all pregnant women with household incomes below 200% of the FPL.¹³⁶ Pregnant women with a household income above 200% of the FPL are assessed with a share of cost, leaving them with a minimal amount of their income to live on (e.g., \$934 for a family of three).¹³⁷

¹²⁹ Residency is not a difficult standard to prove. Generally, an individual must show she intends to stay in the state indefinitely. NAT'L HEALTH LAW PROGRAM, MEDI-CAL FLOWCHARTS 1 (2006), available at <http://healthconsumer.org/cs041Medi-CalFlowChart.pdf>; Oregon Health Plan Application for Oregon Health Plan and Healthy Kids, available at <https://apps.state.or.us/mbs/pdfHandler?action=show> (last visited Oct. 20, 2011).

¹³⁰ *Id.*; Telephone Interview with Sara, Caseworker, Or. Dep't of Human Servs., in Eugene, Or. (Mar. 17, 2011).

¹³¹ NAT'L HEALTH LAW PROGRAM, *supra* note 129; Telephone Interview with Sara, *supra* note 130.

¹³² *Infra* Part I.C.1.

¹³³ Ellen Pinney, *The Oregon Health Plan: Boon or Bust?*, ALTERNATIVES: RESOURCES FOR CULTURAL DIVERSITY (Winter 1997), <http://www.alternativesmagazine.com/04/pinney1.html>.

¹³⁴ *Id.*

¹³⁵ *Infra* Part I.C.2.

¹³⁶ NAT'L HEALTH LAW PROGRAM, *supra* note 129, at 4.

¹³⁷ *See supra* notes 7–8.

Medi-Cal determines household income after applying a long list of deductions to the pregnant woman's gross monthly household income. These deductions include: \$90 from the earned income of each member of the household;¹³⁸ child care costs;¹³⁹ court-ordered child or spousal support paid by the applicant;¹⁴⁰ \$50 in child support or alimony received by the applicant;¹⁴¹ certain student loans;¹⁴² educational expenses;¹⁴³ excluded child allocation;¹⁴⁴ income used to determine public assistance¹⁴⁵ eligibility of a spouse, parent, or child;¹⁴⁶ and self-employed business expenses (the applicant's choice of forty percent of her income or her actual expenses).¹⁴⁷ With the numerous income deductions available, actually calculating a pregnant woman's gross monthly household income is complicated.¹⁴⁸ The caseworker can easily determine gross monthly

¹³⁸ CAL. CODE REGS. tit. 22, § 50553.1 (2011); HEALTH CONSUMER ALLIANCE, *MEDI-CAL SUMMARY: PERCENTAGE OF POVERTY MEDI-CAL FOR PREGNANT WOMEN AND CHILDREN 1* (2007), available at <http://healthconsumer.org/cs027POP.pdf>.

¹³⁹ The maximum deduction is \$200 per child under two years old, and \$175 for older or disabled children. CAL. CODE REGS. tit. 22, § 50553.5; HEALTH CONSUMER ALLIANCE, *supra* note 138.

¹⁴⁰ CAL. CODE REGS. tit. 22, § 50554; HEALTH CONSUMER ALLIANCE, *supra* note 138.

¹⁴¹ CAL. CODE REGS. tit. 22, § 50554.5; HEALTH CONSUMER ALLIANCE, *supra* note 138.

¹⁴² These loans include: (1) loans made under Title III of the Federal Economic Opportunity Act, Special Program to Combat Poverty in Rural Areas; (2) loans or grants to an undergraduate student from the Federal Commissioner of Education with the expectation the money will be used for educational purposes; (3) educational loans or grants to an undergraduate student if they are awarded on the basis of the student's need; (4) educational scholarships; and (5) other loans, grants, scholarships, or fellowships to undergraduate or graduate students if they cannot be used for current living costs. CAL. CODE REGS. tit. 22, § 50533.

¹⁴³ Educational expenses include any of the following items necessary for school attendance: (1) tuition, (2) books, (3) fees, (4) equipment and supplies, (5) special clothing needs, (6) child care services, and (7) cost of transportation. Educational expenses will only be deducted from the gross monthly household income to the extent they exceed the applicant's income for educational purposes (for example, loans, grants, and fellowships). *Id.* § 50547.

¹⁴⁴ See *id.* § 50558(b). For a description on how to calculate the excluded child allocation see CAL. DEP'T OF HEALTH SERVS., ACWDL 04-25, *INCOME DEDUCTION FOR ALLOCATION TO EXCLUDED CHILD* (2004).

¹⁴⁵ For example, temporary financial assistance and employment services, free and low-cost health care insurance, food benefits, in-home services for the elderly and disabled, and financial assistance and advocacy for disabled individuals. See L.A. CNTY. DEP'T OF PUB. SOC. SERVS., <http://www.ladpss.org/> (last visited Oct. 20, 2011).

¹⁴⁶ CAL. CODE REGS. tit. 22, § 50555.1; HEALTH CONSUMER ALLIANCE, *supra* note 138.

¹⁴⁷ CAL. CODE REGS. tit. 22, § 50505; HEALTH CONSUMER ALLIANCE, *supra* note 138.

¹⁴⁸ CAL. HEALTHCARE FOUND., *supra* note 7, at 2.

household income inaccurately or overlook an applicable income deduction.¹⁴⁹

As the Medi-Cal application process is structured, the relevance of many of the applicable income deductions from gross monthly household income is rarely, if ever, investigated by the caseworker or explained to the applicant. Thus, many applicable income deductions escape the caseworker's attention. Throughout my nine-month battle with Medi-Cal, I was never asked about my student loans or about my self-employment status. It was not until two years later, while I was conducting research for this Comment, when I discovered student loans and a self-employment classification were sources of income deduction. A simple question about my tax status as a W-9 employee would have immediately informed my caseworker of the additional forty percent income deduction to which I was entitled for being self-employed. Yet, this question was never asked.

Thus, it falls on the Medi-Cal applicant to ensure the caseworker correctly computes the gross monthly household income. However, placing such an obligation on the applicant is unfair and problematic. Many of the deductions are vague (e.g., certain student loans and educational expenses) and complex (e.g., exempt child allocation), even for the caseworker.¹⁵⁰ Even if the information were readily available to the public, Medi-Cal applicants would have a difficult time understanding and applying the deductions themselves. As a result, the applicant, who has the most knowledge about her personal situation, is unable to review her caseworker's analysis to ensure her monthly household income is correctly calculated.

While California's Medicaid system, on its face, attempts to alleviate the plight of the low-income, uninsured pregnant woman by offering a variety of income deductions, not all of these deductions are actually applied in practice. As a result, eligible pregnant women are denied access to affordable health care and are forced to pay an exorbitant share of cost outside of their budget.¹⁵¹ Statistics indicate fewer than twenty percent of Medi-Cal beneficiaries are able to meet their share of cost each month; the remaining eighty percent are unable to access needed medical care because they cannot afford to pay their monthly share of cost.¹⁵²

¹⁴⁹ HEALTH CONSUMER ALLIANCE, *supra* note 8, at 2.

¹⁵⁰ *Id.* at 2.

¹⁵¹ See *supra* notes 7–8 and accompanying text.

¹⁵² HEALTH CONSUMER ALLIANCE, *supra* note 8.

2. Oregon's Medicaid Program: Oregon Health Plan (OHP)

Once Oregon state residency is established, OHP provides free prenatal health care coverage for all pregnant women with household incomes below 185% of the FPL.¹⁵³ In contrast to Medi-Cal, OHP's income determination is straightforward and uncomplicated. A pregnant woman's household income is simply her monthly household income before taxes.¹⁵⁴ No income deductions are applied unless a member of the woman's household is self-employed.¹⁵⁵ If a household member is self-employed, the self-employed individual receives an automatic fifty percent income deduction.¹⁵⁶ If the household income still exceeds 185% of the FPL, the pregnant woman may submit a profit-and-loss statement specifying the actual self-employment expenses.¹⁵⁷ These expenses are then deducted from the gross monthly household income to redetermine the pregnant woman's eligibility.¹⁵⁸ Unlike Medi-Cal, OHP's application for benefits specifically inquires whether the applicant is self-employed.¹⁵⁹ Thus, had I been living in Oregon at the time of my pregnancy, I would have received a fifty percent income deduction, and I would have qualified for OHP's no-cost maternity health care coverage. However, if my self-employed status went unnoticed, I would not have qualified for OHP. Our gross monthly household income of \$3012 exceeded 185% of the FPL.¹⁶⁰ In contrast to Medi-Cal, OHP does not offer a share-of-cost option for pregnant women whose household incomes exceed 185% of the FPL.¹⁶¹ These women must consider options outside of OHP.¹⁶² Therefore, rather than being given an exorbitant share of cost, I would have had to bear the even higher burden of paying the full cost of all my prenatal, natal, and postnatal health care expenses.

¹⁵³ OR. DEP'T OF HUMAN SERVS., OVERVIEW OF MEDICAL ASSISTANCE PROGRAMS 3 (2010), available at <http://apps.state.or.us/caf/fsm/pdf/08ma-a.pdf>.

¹⁵⁴ OR. ADMIN. R. 461-140-0040(4) (2010).

¹⁵⁵ Telephone Interview with Sara, *supra* note 130.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Supra* Part I.C.1.; Or. Healthy Kids, *supra* note 129.

¹⁶⁰ In 2009, 185% of the FPL was equivalent to \$2823 per month. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 10.

¹⁶¹ *Id.*

¹⁶² *Id.*

	California	Oregon
Possible Income Deductions for Pregnant Women	<ul style="list-style-type: none"> • \$90 from earned income of each household member • Child care costs • Court-ordered child support or alimony paid by the applicant • \$50 in child support or alimony received by the applicant • Certain student loans • Educational expenses • Excluded child allocation • Income used to determine public assistance for another family member • Self-employed business expenses (40% of self-employed household member's income or actual expenses) 	<ul style="list-style-type: none"> • Self-employed business expenses (automatic 50% of self employed household member's income with the possibility of a re-determination of income based on actual expenses)

Table 1. Medicaid Income Deductions for California and Oregon

Another distinction between OHP and Medi-Cal is OHP's Pre-Natal Citizen/Alien-Waived Emergent Medical (CAWEM) Expansion Pilot Program.¹⁶³ Rather than limiting pregnant noncitizens' health care coverage to emergency benefits only, Oregon's optional pilot program extends full prenatal benefits to noncitizen pregnant women

¹⁶³ See OR. DEP'T OF HUMAN SERVS., *supra* note 153; OR. DEP'T OF HUMAN SERVS., NONCITIZENS ELIGIBILITY FOR BCCM, CEC, CEM, EXT, MAA, MAF, OHP, OSIPM, AND SAC 5-6 (2011), available at <http://apps.state.or.us/caf/fsm/pdf/15nc-c.pdf>.

who otherwise meet the requirements for OHP.¹⁶⁴ Currently, seven counties in Oregon have opted to participate in the program.¹⁶⁵

3. *Conclusions About Medicaid as a Whole*

The demonstrable differences between California's and Oregon's Medicaid programs alone reveal a significant disparity between access to prenatal, natal, and postnatal health care based merely upon where the indigent pregnant woman lives.¹⁶⁶ However, the disparity is not restricted to California and Oregon; the problem extends nationwide. As a result of the minimal federal eligibility requirements for Medicaid, a pregnant woman's access to much-needed prenatal care can depend solely on whether she happens to live in the wrong state—one of the twenty-three states¹⁶⁷ whose restrictive eligibility requirements denies individuals access to government-funded health insurance—insurance for which those individuals would have otherwise been eligible had they lived in a state with more expansive eligibility requirements.¹⁶⁸ By implementing restrictive eligibility requirements or miscalculating the expansive eligibility requirements, many states fail to provide health insurance to otherwise eligible applicants.¹⁶⁹

Furthermore, inadequate outreach and complicated enrollment procedures for those who do qualify for Medicaid effectively prevent twenty to thirty-five percent of eligible individuals from obtaining government-funded health insurance.¹⁷⁰ With roots in the welfare system, Medicaid participation comes with a stigma attached.¹⁷¹ These persistent misperceptions about the people who Medicaid

¹⁶⁴ OR. DEP'T OF HUMAN SERVS., NONCITIZENS ELIGIBILITY, *supra* note 163.

¹⁶⁵ Participating counties include: Multnomah, Deschutes, Benton, Clackamas, Hood River, Jackson, and Lane. OR. DEP'T OF HUMAN SERVS., *supra* note 163.

¹⁶⁶ See RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 7.

¹⁶⁷ Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Illinois, Indiana, Kentucky, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wyoming. See *id.* at 38, 40. California is not one of the twenty-three states listed. On paper, the California program is ranked fifth in expansive eligibility requirements. *Id.* at 40. In practice, however, the complex income deductions result in a miscalculation of income and the exclusion of otherwise-eligible individuals. See *supra* Part I.C.1.

¹⁶⁸ RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 38, 107.

¹⁶⁹ See *id.* at 38–39; FURROW ET AL., *supra* note 113.

¹⁷⁰ RAMÍREZ DE ARELLANO & WOLFE, *supra* note 6, at 108.

¹⁷¹ KAISER COMM'N ON MEDICAID & THE UNINSURED, OPTIMIZING MEDICAID ENROLLMENT: PERSPECTIVES ON STRENGTHENING MEDICAID'S REACH UNDER HEALTH CARE REFORM 3, (2010), available at <http://www.kff.org/healthreform/upload/8068.pdf>.

covers prevent millions of uninsured pregnant women from realizing they qualify for government-funded health insurance.¹⁷² Furthermore, outreach to these pregnant women is deficient. Thirty-six states operate toll-free hotlines, twenty-six states use printed materials to inform pregnant women of their Medicaid program, and only ten states conduct outreach through the media (e.g., billboards, newspaper, TV, radio).¹⁷³ While some states utilize multiple outreach methods, there are other states with no outreach programs whatsoever.¹⁷⁴

For those pregnant women who are aware of their eligibility for Medicaid, the enrollment procedures can be cumbersome. Many states require applicants to enroll at the local social services office.¹⁷⁵ When the woman does appear in person to enroll, she often finds herself discouraged by further burdensome eligibility procedures and a disgruntled and often-overworked caseworker.¹⁷⁶ Rather than seeking to act as an agent and an advocate for the Medicaid applicant, caseworkers often view themselves as the gatekeepers to Medicaid.¹⁷⁷ Unfortunately, the inadequate outreach and the seemingly unending bureaucratic hurdles prevent a substantial number of pregnant women (and Americans in general) from obtaining desperately needed health care coverage and essential health care services.

¹⁷² *See id.*

¹⁷³ IAN HILL ET AL., MEDICAID OUTREACH AND ENROLLMENT FOR PREGNANT WOMEN: WHAT IS THE STATE OF THE ART? 37, 38 (2009), available at http://www.urban.org/UploadedPDF/411898_pregnant_women.pdf.

¹⁷⁴ *Id.* at 127 tbl.4.

¹⁷⁵ KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 171, at 6.

¹⁷⁶ *See* Richard Lichtenstein & Penni Johnson, *Breaking Down Barriers to Enrollment in Public Health Insurance: Eastside Access Partnership*, in INNOVATIVE STATE AND LOCAL APPROACHES TO HEALTH COVERAGE FOR CHILDREN 28, 29 (2003), available at http://www.familyimpactseminars.org/s_mifis07report.pdf (identifying poor customer service practices, such as “intrusive questions, lack of interest in customers as persons, and inadequate explanation of reasons for denials,” and negative characteristics of caseworkers, such as “rudeness, anger, feelings of being overworked,” as barriers to obtaining health care coverage); KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 171, at 6 (explaining that bureaucratic hurdles and demeaning treatment by caseworkers deters eligible individuals from ever applying for Medicaid benefits).

¹⁷⁷ *See* Lichtenstein & Johnson, *supra* note 176, at 30.

II

HEALTH REFORM AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law.¹⁷⁸ Described as “the most significant change in the American healthcare system in a generation,”¹⁷⁹ the ACA focuses primarily on increasing access to health care by providing access to affordable health insurance for all American citizens and legal residents regardless of their medical condition or ability to pay.¹⁸⁰

The increased benefits for both pregnant women and mothers are extensive. For instance, the ACA mandates that Medicaid cover smoking cessation programs for pregnant women.¹⁸¹ The ACA also increases the labor and delivery options of indigent pregnant women by requiring Medicaid to provide coverage for nonhospital birthing centers as well as the nurses, midwives, and birth attendants who staff the centers.¹⁸² In addition to physical health, the ACA also recognizes the importance of a mother’s mental health after giving birth. The ACA authorizes research regarding the mental-health consequences related to pregnancy and also provides funding for the education, treatment, and support for women, and the families of women, suffering from postpartum depression.¹⁸³ The ACA is not merely concerned with the health of pregnant women; it also mandates funding and community services to help indigent women be successful parents. The ACA creates state grants to provide support for pregnant and parenting teens and women.¹⁸⁴ These grants can be used for a wide range of services, including prenatal care, housing, baby clothes, education, and assistance for domestic violence victims.¹⁸⁵ The ACA also provides for a home visit program where nurses and other experts go to families’ homes to provide education and guidance about pregnancy and parenting, with a focus on “high-

¹⁷⁸ Brian Kopp et al., *New Federal Health Care Reform Legislation—Its Impact on Employers and Employee Benefits Plans*, 2010 EMERGING ISSUES 4954, Apr. 2010, at 1.

¹⁷⁹ FURROW SUPPLEMENT, *supra* note 121, at 1.

¹⁸⁰ *Id.*

¹⁸¹ Patient Protection and Affordable Care Act (ACA), H.R. 3590, 111th Cong. § 4107 (2010).

¹⁸² *Id.* § 2301.

¹⁸³ *Id.* § 2952.

¹⁸⁴ *Id.* §§ 10212–10214.

¹⁸⁵ *Id.*

risk” parents.¹⁸⁶ On its face, the ACA portends to decrease the plight of the pregnant woman by expanding the services available to her. However, it remains to be seen whether the ACA significantly changes the current insurance market in such a way that pregnant women are able to access these additional services at an affordable price. Furthermore, the fate of the ACA itself remains unknown. Despite any beneficial impact the health care reform may make on women’s access to affordable health care coverage, the Republican Party has started a movement to repeal the entire ACA on the grounds of unconstitutionality.¹⁸⁷

A. Employer-Sponsored Health Insurance

Although the ACA does not mandate that employers provide their employees with health insurance, it contains a number of penalties to encourage employers to provide affordable and adequate employer-sponsored health insurance.¹⁸⁸ For example, the “play-or-pay” provision gives employers with more than fifty employees the choice of either making health insurance available to full-time employees¹⁸⁹ or paying a penalty of \$2000 for every full-time employee who receives insurance through an exchange.¹⁹⁰ Furthermore, a penalty of \$3000 will be imposed on employers for every employee forced to purchase insurance through an exchange because employer-sponsored health care is either unaffordable¹⁹¹ or inadequate.¹⁹²

¹⁸⁶ *Id.* § 2951.

¹⁸⁷ See *Florida v. U.S. Dep’t of Health & Human Servs.*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011), *aff’d in part, rev’d in part*, 648 F.2d 1235 (2011), *cert. granted*, No. 11-400 (U.S. Nov. 14, 2011); David M. Herszenhorn & Robert Pear, *As Vowed, House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES, Jan. 20, 2011, at A1; Andrea Stone, *Repealing “Obamacare” Will Define Republicans in 2011*, AOL NEWS, Dec. 11, 2010, <http://www.aolnews.com/2010/12/11/repealing-obamacare-will-define-republicans-in-2011/>.

¹⁸⁸ FURROW SUPPLEMENT, *supra* note 121, at 80.

¹⁸⁹ The ACA defines full-time employee as an employee who works at least thirty hours per week. H.R. 3590, 111th Cong. § 1513(d)(4)(A) (2010).

¹⁹⁰ See *id.* §§ 1512–13; FURROW SUPPLEMENT, *supra* note 121, at 80–81. An “exchange” is an entity created by the ACA, which is supposed to provide a place for consumers to shop for an affordable and adequate insurance plan to meet the needs of themselves and their families. See *infra* Part II.B.

¹⁹¹ For example, when the health insurance premium is over 9.5% of the employees income. FURROW SUPPLEMENT, *supra* note 121, at 80.

¹⁹² For example, when the health insurance plan does not cover sixty percent of the allowable plan expenses. *Id.*

While the Congressional Budget Office predicts that the number of employees offered and covered by employer-sponsored health insurance under the ACA will increase, it is unclear how large employers will respond to the penalties imposed.¹⁹³ The ACA provides many loopholes with the potential to undermine the intended increase in availability and access to employer-sponsored health insurance. For instance, rather than making health insurance available to full-time employees, employers may choose to hire more seasonal and part-time employees or begin contracting their low-wage positions to independent contractors.¹⁹⁴ Additionally, the relatively small size of the penalties may actually incentivize employers to pay the penalty rather than provide their employees with insurance.¹⁹⁵ Thus, employers have no incentive under the ACA to provide affordable health care coverage to their employees. It is easy and much more profitable to avoid the obligation either by hiring more part-time employees and independent contractors or by simply paying the relatively small penalty. As a result, the current climate of unaffordable, employer-sponsored health insurance may remain intact. Thus, pregnant women, and women in general, may still be less likely than men to be eligible for employer-sponsored health insurance because they are still more likely to work part time and have lower incomes.¹⁹⁶

The ACA also aims to increase the availability of health insurance to employees of small businesses by requiring states to create Small Business Health Option Program (SHOP) exchanges.¹⁹⁷ Similar to the individual exchanges,¹⁹⁸ the SHOP exchanges are intended to assist small business employers in purchasing group health insurance coverage for their employees.¹⁹⁹ In contrast to the penalties imposed on large employers, however, small employers²⁰⁰ are offered a tax

¹⁹³ *Id.* at 81.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* Compared to the \$2000 fee for every noncovered employee, an employer paid \$13,375 for an average family policy in 2009. *Id.*

¹⁹⁶ THE HENRY J. KAISER FAMILY FOUND., *supra* note 56.

¹⁹⁷ ACA, H.R. 3590, 111th Cong. § 1311(b)(1)(B) (2010).

¹⁹⁸ *See infra* Part II.B.

¹⁹⁹ Kopp et al., *supra* note 178, at 4.

²⁰⁰ For the purposes of the tax credit, a small employer is defined as (1) having fewer than twenty-five employees, and (2) paying an average annual wage below \$50,000. ACA, H.R. 3590 § 1421(d)(1).

credit²⁰¹ if they contribute more than fifty percent toward the cost of their employees' premiums on health plans purchased through the SHOP Exchange.²⁰² This tax credit is expected to incentivize small-business owners to contribute to the health insurance premiums of their employees by reducing the overall cost to the employer. If small businesses choose to utilize the tax credit and offer employer-sponsored health insurance, pregnant women employed by small businesses will be able to access affordable health care coverage through their employer—an insurance option widely unavailable under the pre-ACA insurance regime. However, the tax credit gradually phases out for small businesses with either ten to twenty-five full-time employees or an average wage between \$25,000 and \$50,000.²⁰³

B. Individually Purchased Insurance

The biggest step in creating affordable health insurance for pregnant women, and the American public in general, comes in the form of regulating the individual health insurance market. Starting January 1, 2014, the ACA prohibits individual and small-group health insurance plans from increasing insurance premiums based on gender²⁰⁴ and also bars the plans from excluding individuals from coverage based on preexisting conditions.²⁰⁵ The benefits for pregnant women under the ACA do not end there. For the first time, federal law has set forth an “essential benefits package,” specifying ten benefits new individual insurance plans will be required to cover starting January 1, 2014; maternity and newborn care are included among the list.²⁰⁶ While the specific details of the extent of coverage required still remain to be determined, the ACA regulations have specified a list of important prenatal services for which co-payments

²⁰¹ Starting in 2010, a small business can be reimbursed up to thirty-five percent in the form of a tax credit. This amount increases to fifty percent on January 1, 2014. *Small Business Health Care Tax Credit for Small Employers*, INTERNAL REVENUE SERV., <http://www.irs.gov/newsroom/article/0,,id=223666,00.html> (last visited Oct. 20, 2011).

²⁰² ACA, H.R. 3590 § 1421.

²⁰³ INTERNAL REVENUE SERV., *supra* note 201.

²⁰⁴ ACA, H.R. 3590, § 2701.

²⁰⁵ *Id.* § 2704.

²⁰⁶ *Id.* § 1302. However, while States may elect to include abortion services in maternity care, federal funding will not pay for the procedure. *Id.* §§ 1302, 10104; see also Adam Sonfield, *The New Health Care Reform Legislation: Pros and Cons for Reproductive Health*, 13 GUTTMACHER POL'Y REV. 25, 25 (2010), available at <http://www.guttmacher.org/pubs/gpr/13/2/gpr130225.pdf>.

will not be required.²⁰⁷ These services include folic acid supplements, sexually transmitted infection (STI) testing, smoking cessation, and a variety of other screenings and vaccinations critical to prenatal care.²⁰⁸

In an attempt to further remove the significant barriers to coverage for independent contractors, self-employed, and otherwise-uninsured Americans, the ACA also requires states to establish an individual exchange²⁰⁹ —“a consumer-friendly market for health insurance, resembling a farmer’s market, stock market, or on-line travel service.”²¹⁰ Individual exchanges will be open for use by all U.S. citizens and legal residents who (1) are not incarcerated and (2) do not have access to affordable employer coverage.²¹¹ The purpose of the individual exchange is five-fold. First, individual exchanges will offer consumers a choice of health plans organized in a standardized way to make comparing different insurance plans much easier.²¹² By requiring insurance plans to cover the same benefits with a different percentage of cost sharing,²¹³ individual exchanges “focus competition among plans on the price of [health insurance] and minimize the tendency for plans to vary benefits.”²¹⁴ Second, individual exchanges are supposed to provide consumers with transparent information about the covered benefits and cost of premiums in the varying insurance plans.²¹⁵ Third, individual exchanges could potentially play a facilitating role, serving a similar function as a group employer who enrolls employees in a health insurance plan and pays the premium.²¹⁶ Fourth, individual exchanges will coordinate shifts between Medicaid and subsidized

²⁰⁷ Sonfield, *supra* note 29.

²⁰⁸ *Id.*

²⁰⁹ ACA, H.R. 3590 § 1311(b). A state may elect to provide only one exchange, merging the individual exchange and the SHOP exchange, if the merged exchange will have adequate resources to assist individuals and employers. *Id.* § 1311(b)(1)(C)(2).

²¹⁰ FURROW SUPPLEMENT, *supra* note 121, at 114–15.

²¹¹ THE HENRY J. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: WHAT ARE HEALTH INSURANCE EXCHANGES? 1 (2009), available at <http://www.kff.org/healthreform/upload/7908.pdf>.

²¹² *Id.*

²¹³ See FURROW SUPPLEMENT, *supra* note 121, at 68.

²¹⁴ THE HENRY J. KAISER FAMILY FOUND., *supra* note 211; see ALLIANCE FOR HEALTH REFORM & THE COMMONWEALTH FUND, Transcript of *Webcast: Health Insurance Exchanges: See How They Run*, (May 11, 2009), <http://www.allhealth.org/briefingmaterials/Transcript5-11-1482.pdf>.

²¹⁵ THE HENRY J. KAISER FAMILY FOUND., *supra* note 211.

²¹⁶ See *id.*

insurance purchased through the exchanges for low-income individuals and for those with fluctuating incomes.²¹⁷ Lastly, individual exchanges are intended to reform the current individual health insurance market by monitoring market practices and implementing a uniform system for enrolling participants in health insurance plans.²¹⁸

Before a health insurance plan can be offered through an individual exchange, it must meet statutory requirements (for example, an essential benefits package).²¹⁹ Additionally, individual exchanges may refuse to include an insurance plan if the plan has a history of excessively increasing premiums without justification.²²⁰ In short, individual exchanges are supposed to help consumers make better-informed decisions regarding their health insurance plans. Americans can browse through the various insurance plans available through individual exchanges and pick the option best suited to meet the needs of their families and themselves.²²¹ In addition to forming individual exchanges, the ACA also offers two subsidies to further reduce the cost of health insurance for families with low-to-moderate incomes who purchase insurance through an exchange.²²²

Thus, individual exchanges appear to positively impact the plight of the uninsured pregnant woman. First, individual exchanges offer an alternative medium through which to purchase affordable health care coverage—filling in the current gap between employer-sponsored health insurance and Medicaid. Second, exchanges are intended to provide the consumer with transparent information. This should allow pregnant women to easily find the best health insurance plan to cover all their prenatal, natal, postnatal, and other health care needs. As a result of individual exchanges, many pregnant women will no longer have to resort to purchasing inadequate and unaffordable health care plans through the individual market. However, incarcerated individuals and undocumented immigrants are prohibited from utilizing the individual exchanges to purchase

²¹⁷ *See id.*

²¹⁸ *Id.* at 2.

²¹⁹ ACA, H.R. 3590, 111th Cong. § 1311(c)–(d) (2010); FURROW SUPPLEMENT, *supra* note 121, at 115.

²²⁰ FURROW SUPPLEMENT, *supra* note 121, at 115.

²²¹ *Id.*

²²² ACA, H.R. 3590 § 1401 (premium tax credit); *Id.* § 1402 (cost sharing reduction payment). *See generally* THE HENRY J. KAISER FAMILY FOUND., *supra* note 211 (premium tax credit); FURROW SUPPLEMENT, *supra* note 121, at 66–67 (premium tax credit); *id.* at 68 (cost sharing reduction payment).

insurance.²²³ These pregnant women must still rely on resources other than the individual exchanges for prenatal, natal, and postnatal health care coverage.²²⁴

While the ACA makes numerous changes and regulations to the individual insurance market, much like the employer-sponsored health insurance regulations, it is unclear exactly what role individual exchanges will take in the insurance market. While individual exchanges are intended to guarantee consumers actually receive quality and affordable health insurance, some critics note the possibility that individual exchanges may simply become passive markets for displaying the “wares of insurers.”²²⁵ Furthermore, a Kaiser Family Foundation analysis estimates no significant change between individual exchanges and the individual insurance market as it exists now.²²⁶ The deductible amounts for some plans are “roughly comparable.”²²⁷ Although the out-of-pocket costs for an individual with a household income between 150% and 200% of the FPL is capped at \$2100, individuals with a household income between 200% and 250% of the FPL may have a deductible ranging between \$1750 and \$3200.²²⁸ Family deductibles will be twice this amount.²²⁹ Thus, a married pregnant woman may have to pay a deductible of \$6400—a price similar to what a pregnant woman would pay for a low-risk delivery if insured through the individual market today.²³⁰

C. Medicaid

The ACA is described as “the biggest change in [Medicaid history].”²³¹ Similar to Oregon’s approach, the ACA creates a “newly eligible” category, which mandates Medicaid insurance coverage be provided to all adults with household incomes below

²²³ ACA, H.R. 3590 § 1312(f)(1)(B), (f)(3).

²²⁴ See *infra* Part II.D.

²²⁵ FURROW SUPPLEMENT, *supra* note 121, at 115; see also Robert Pear, *Health Care Overhaul Depends on States’ Insurance Exchanges*, N.Y. TIMES, Oct. 24, 2010, at A3, available at <http://www.nytimes.com/2010/10/24/health/policy/24exchange.html> (discussing various state models for exchanges that are already in place).

²²⁶ THE HENRY J. KAISER FAMILY FOUND., WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN 5 (Apr. 2011), available at <http://www.kff.org/healthreform/upload/8177.pdf>.

²²⁷ *Id.*

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Supra* Part I.B.

²³¹ FURROW SUPPLEMENT, *supra* note 121, at 145.

133% of the FPL and who do not fit within any other eligibility category.²³² However, under current federal law, pregnant women are already eligible for government-funded health insurance if their household income is within 133% of the FPL.²³³

Although pregnant women do not benefit from the creation of the “newly eligible” category, the ACA largely resolves the most pressing problems with the current state Medicaid programs. For instance, income eligibility is now standardized to reduce the discrepancies in access to government-funded health insurance coverage among the states. Starting January 1, 2014, all states will be required to calculate a pregnant woman’s household income using the modified adjusted gross income (MAGI) as defined by the federal tax code.²³⁴ A MAGI is calculated by taking an applicant’s adjusted gross income on his or her tax form²³⁵ and adding back in foreign income and tax-exempt interest received by the taxpayer.²³⁶ Although the process may appear complex, many of these deductions are unlikely to apply to applicants who are eligible for Medicaid. After an applicant’s MAGI is calculated, a five percent income deduction will be applied.²³⁷ However, any other income deductions and asset tests are now prohibited, making the formula relatively simple and straightforward.²³⁸ Thus, rather than attempting to compute a myriad of complex deductions from an applicant’s gross household income, caseworkers can simply rely on well-established tax principles.

Furthermore, the ACA addresses the inadequate outreach and complicated enrollment procedures of the current Medicaid systems, which currently prevent many eligible individuals from obtaining

²³² ACA, H.R. 3590, 111th Cong. § 2001 (2010).

²³³ FURROW ET AL., *supra* note 113, at 397.

²³⁴ ACA, H.R. 3590 § 2002.

²³⁵ See, for example, line 38 of Form 1040, line 22 of Form 1040A, and line 36 of Form 1040NR.

²³⁶ The deductions that will be added back in include: (1) traditional IRA contributions, (2) student loan interest amounts, (3) tuition and fees, (4) domestic production activities, (5) foreign income costs excluded on Form 2555, (6) foreign housing costs deducted or excluded on Form 2555, (7) savings bond interest excluded on Form 8815, and (8) adoption benefits from an employer excluded on Form 8839. I.R.C. § 36B(d)(2) (1986); KAISER COMM’N ON MEDICAID AND THE UNINSURED, EXPLAINING HEALTH REFORM: THE NEW RULES FOR DETERMINING INCOME UNDER MEDICAID IN 2014 2 (2011), available at <http://www.kff.org/healthreform/upload/8194.pdf>.

²³⁷ KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 236, at 2 n.2.

²³⁸ ACA, H.R. 3590 § 2002; KAISER COMM’N ON MEDICAID & THE UNINSURED, *supra* note 236.

government-funded health insurance.²³⁹ Starting January 1, 2014, state Medicaid programs must allow individuals to apply and to renew their enrollment online.²⁴⁰ Additionally, state Medicaid and state exchanges will be streamlined so individuals identified by an exchange as eligible for Medicaid will be enrolled without further determination by the state.²⁴¹ Likewise, individuals found ineligible for Medicaid must be screened to determine whether they are eligible to enroll in an insurance plan offered through the state exchange.²⁴²

In addition to these convenient and coordinated enrollment procedures, the ACA requires each state to report its outreach and enrollment process to the Secretary of Health and Human Services (the Secretary), as well as any other data the Secretary may require to monitor enrollment and retention in Medicaid.²⁴³ Beginning in April 2015, the Secretary will be required to submit an annual report to the appropriate congressional committees.²⁴⁴ The report must contain each state's total new enrollment in Medicaid as well as recommendations for improving Medicaid enrollment.²⁴⁵

D. Future Impacts of the ACA on Women's Access to Health Care

Most of the ACA provisions do not go into effect until January 1, 2014, and even then they still leave much to be decided by administrators and regulators. Thus, it is too early to tell if the health care reform will indeed be beneficial to the American people in general and pregnant women in particular. In response to an accusation that the health care bill was "timid," President Barack Obama defended the Act, saying, "[The ACA] is what, I think most people would say, is as significant a piece of legislation as we've seen in this country's history."²⁴⁶

²³⁹ See RAMIREZ DE ARELLANO & WOLFE, *supra* note 6, at 112.

²⁴⁰ ACA, H.R. 3590 § 2201(b)(1)(A).

²⁴¹ *Id.* § 2201(b)(1)(B).

²⁴² *Id.* § 2201(b)(1)(C).

²⁴³ JULIE STONE ET AL., CONG. RESEARCH SERV., R41210, MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PROVISIONS IN PPACA 17 (2010), available at http://www.arkleg.state.ar.us/healthcare/medicaid/Documents/CRS%20Report%204_28_10.pdf.

²⁴⁴ *Id.* at 17.

²⁴⁵ *Id.*

²⁴⁶ *The Daily Show with Jon Stewart: Barack Obama Pt. 2* (Comedy Central broadcast Oct. 27, 2010), available at <http://www.thedailyshow.com/watch/wed-october-27-2010/barack-obama-pt--2>.

Not only has the ACA extended health insurance to approximately thirty million people,²⁴⁷ it appears to have made great strides for the advancement of women's rights to health care. Incentives will be put in place to encourage employers to provide affordable health care coverage to their employees,²⁴⁸ the current inequalities of the individual insurance market will be largely resolved by implementing regulations and creating a medium of transparency via the individual exchanges,²⁴⁹ and government-funded health insurance will be improved as the Secretary coordinates enrollment and enacts a standardized formula for calculating income eligibility.²⁵⁰

While health care reform may have taken some significant steps forward, it retains several aspects of the pre-ACA health insurance system. For instance, the ACA continues to maintain a strict model of personal responsibility. Starting in 2014, the ACA will impose a "financial penalty"²⁵¹ on legal residents and U.S. citizens who are uninsured.²⁵² While the law does exempt certain categories of individuals from paying the mandate (for example, individuals with household incomes below 100% of the FPL, and individuals whose lowest cost health plan exceeds 8% of their household income),²⁵³ it offers no means for these uninsured individuals to obtain affordable health insurance.

Estimates predict 23 million people will be uninsured by 2019.²⁵⁴ Undocumented immigrants will make up one-third of the uninsured.²⁵⁵ These immigrants remain ineligible for Medicaid, and

²⁴⁷ See *id.*

²⁴⁸ See *supra* Part II.A.

²⁴⁹ See *supra* Part II.B.

²⁵⁰ See *supra* Part II.C.

²⁵¹ The penalty will be phased in. Beginning in 2016, it will be the greater of (1) \$695 per adult and half the amount per minor (with a household cap of \$2085) or (2) 2.5% of the income above 100% of the FPL. See ACA, H.R. 3590, 111th Cong. §1501 (2010); THE HENRY J. KAISER FAMILY FOUND., SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2011), available at <http://www.kff.org/healthreform/upload/8023-R.pdf>.

²⁵² ACA, H.R. 3590 §1501; THE HENRY J. KAISER FAMILY FOUND., *supra* note 251.

²⁵³ Other categories of individuals excluded from paying the individual mandate include: Native Americans, inmates, individuals with financial hardships or religious objections, and people who have been uninsured for less than three months. ACA, H.R. 3590 § 1501; FURROW SUPPLEMENT, *supra* note 121, at 74; THE HENRY J. KAISER FAMILY FOUND., *supra* note 251.

²⁵⁴ FURROW SUPPLEMENT, *supra* note 121, at 63.

²⁵⁵ Ezra Klein, *Who is Left Uninsured by the Health-Care Reform Bill?*, WASH. POST (Mar. 22, 2010), http://voices.washingtonpost.com/ezra-klein/2010/03/who_is_left_uninsured_by_the_h.html.

the ACA prohibits any undocumented immigrants from using the exchanges, even if they wish to purchase health insurance with their own money rather than through a government subsidy.²⁵⁶ Although legal immigrants are eligible for Medicaid, they must first satisfy a five-year waiting period requirement.²⁵⁷ While legal immigrants who do not meet all the eligibility requirements for Medicaid will be able to use the exchanges to purchase subsidized health insurance,²⁵⁸ many immigrants have incomes at or below the FPL.²⁵⁹ Thus, they will not be able to afford the cost-sharing portion of any insurance plan they are able to purchase through an exchange.²⁶⁰

The remainder of the uninsured will be comprised of individuals who pay the individual mandate fee rather than obtain health insurance, those eligible for Medicaid but who have not applied, and the working poor—those who cannot afford insurance but do not qualify for Medicaid or a subsidy through an exchange.²⁶¹ The latter two categories are most worrisome because they are the same impediments and financial barriers to affordable health insurance prevalent in the pre-ACA health insurance system, albeit in smaller numbers. Several commentators noted, “[The ACA] is neither the panacea its supporters claim nor the radical break from the past its detractors assert. The Act modifies the existing system of employer-[sponsored health insurance] and [individually purchased] insurance but essentially leaves the system intact.”²⁶² President Obama attempted to alleviate these worries, as he explained:

If the point . . . is that overnight we did not transform the healthcare system, that point is true. . . . When Social Security was passed, it applied to widows and orphans, and it was a very restrictive program, and over time that structure that was built ended up developing into the most important social safety net that we have in our country We’d created a structure; we’d put a framework in place that allowed us then to continue to make progress. That’s

²⁵⁶ Maria C. Abascal, *Reform’s Mixed Impact on Immigrants*, AM. PROSPECT, Aug. 2, 2010, http://www.prospect.org/cs/articles?article=reforms_mixed_impact_on_immigrants.

²⁵⁷ In February 2009, President Obama enacted the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which is a federal law allowing states to cover pregnancy-related care for recent immigrants. *See* Pub. L. No. 111-3, 123 Stat. 8. However, only eighteen states have actually chosen to utilize this option. *See id.*; Abascal, *supra* note 256.

²⁵⁸ Abascal, *supra* note 256.

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ Klein, *supra* note 255.

²⁶² Kopp et al., *supra* note 178, at 2.

what we've done over the last eighteen months [with the health care bill]."²⁶³

President Obama asserted that the ACA is merely the first step on the long road toward health care reform, remarking, "Is it enough? No!"²⁶⁴

III

SUGGESTIONS FOR CHANGE

While health care for the masses is important, health care for pregnant women is even more important. Much more can be done to ensure pregnant women have access to quality health care at an affordable price. In the spirit of future change aimed at reforming the health insurance system, I recommend: (1) modifying the FPL to accurately reflect an individual's and a family's need for government-funded health insurance; (2) adopting a fallback provision, which extends affordable health insurance coverage to pregnant women who do not otherwise have access to affordable insurance through an employer, a state exchange, or a state Medicaid program; and (3) instituting more outreach, transparency, and accountability within the state health insurance systems.

First, in order to close the gap of uninsured individuals, the FPL must be revised to reflect the actual poverty levels in America. The FPL is a "one-third for food formula" based on consumption patterns from the 1950s.²⁶⁵ In the sixty years since the FPL was developed, America's consumption patterns have changed dramatically,²⁶⁶ and the FPL should reflect those changes. Furthermore, the FPL does not reflect the geographic variation in cost of living.²⁶⁷ The government itself has recognized that the FPL formulation is too low to accurately reflect a family's need for government-funded health insurance.²⁶⁸ Yet, the FPL measurement has not changed because no federal administration wants to be remembered or blamed for "increas[ing]"

²⁶³ *The Daily Show with John Stewart*, *supra* note 245.

²⁶⁴ *The Daily Show with Jon Stewart: Barack Obama Pt. 1* (Comedy Central broadcast Oct. 27, 2010), available at <http://www.thedailyshow.com/watch/wed-october-27-2010/barack-obama-pt-1>.

²⁶⁵ Juliet M. Brodie, *Post-Welfare Lawyering: Clinical Legal Education and a New Poverty Law Agenda*, 20 WASH. U. J.L. & POL'Y 201, 208 (2006).

²⁶⁶ *Id.* at 209.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

poverty.²⁶⁹ To avoid the predicament of “increasing” poverty, the government should adopt a measurement for family economic hardship that is slightly higher than the FPL, such as the “Family Economic Self-Sufficiency” (FESS) standard.²⁷⁰ This standard provides a more realistic assessment of poverty by taking into consideration the local costs of housing, childcare, and health care.²⁷¹ With local organizations in over thirty states already collecting data, imposing this standard appears to be a more feasible means of measuring economic need.²⁷²

However, poverty cannot be described simply by the annual income limits set by the federal government.²⁷³ In reality, poverty encompasses a broader continuum than society usually recognizes—with many individuals well above 100% of the FPL struggling with the troubles associated with poverty (for example, affordable health insurance coverage).²⁷⁴ Therefore, in addition to revising the FPL, I also recommend instituting a fallback provision, which will provide affordable health care coverage to all pregnant women who do not otherwise have access to affordable health insurance through an employer, state exchange, or state Medicaid program.²⁷⁵ This provision would allow pregnant women who do not have affordable health insurance coverage to pay a percentage of their MAGI in return for comprehensive prenatal, natal, and postnatal health care coverage. Similar to the AIM program, this one-time fee could be paid over the period of twelve months.²⁷⁶

The difficulty with this recommendation is selecting the appropriate percentage of household income a pregnant woman must pay to obtain maternity health care coverage. Following the definition of “affordable” implied by the ACA, the fallback provision could impose a one-time deductible equivalent to eight percent of the

²⁶⁹ *Id.*

²⁷⁰ *Id.* at 210.

²⁷¹ *Id.* at 210–11.

²⁷² *Id.* at 211.

²⁷³ DAVID K. SHIPLER, *THE WORKING POOR: INVISIBLE IN AMERICA*, x (2004).

²⁷⁴ *Id.* at xi.

²⁷⁵ This idea was inspired by the Breast and Cervical Cancer Prevention and Treatment Act of 2000. Under this Act, states have the option of allowing women to be eligible for Medicaid if: (1) the woman has been diagnosed with breast or cervical cancer after being screened by the National Breast and Cervical Cancer Early Detection Program, (2) the woman is under the age of sixty-five, and (3) the woman is uninsured and not otherwise eligible for Medicaid. Pub. L. No. 106-354, 114 Stat. 1381.

²⁷⁶ ACCESS FOR INFANTS & MOTHERS PROGRAM, *supra* note 17, at 18–19.

pregnant woman's annual household income.²⁷⁷ However, for many individuals and families, eight percent of the annual household income still makes access to health care unaffordable. For instance, if such a program existed at the time of my pregnancy, I would have been required to pay a lump sum of \$2765. This total would have provided me with access to prenatal, natal and postnatal care—a luxury I was denied under the pre-ACA insurance system. However, my husband and I struggled to save up enough money to cover one month's worth of our Medi-Cal share of cost (\$2300) so I could obtain prenatal care for the final month of my pregnancy. Despite our frugality and the fundraiser organized by generous parents at the preschool at which I worked, we failed to meet the share of cost; we were still \$600 short. Thus, a deductible equivalent to eight percent of a pregnant woman's annual household income is likely to be financially unattainable for a large majority of low- and middle-class pregnant women.

Alternatively, rather than following the guidelines of the ACA, the fallback provision could impose a one-time deductible equivalent to 1.5% of a pregnant woman's annual household income. This percentage has been adopted by the AIM program, and my experience indicates that this amount is feasible for working poor pregnant women to achieve. However, with the current economic struggles and budget cuts, a deductible equivalent to 1.5% of a pregnant woman's annual household income is largely unrealistic because it would leave near-bankrupt states with the burden of covering a large portion of pregnant women's prenatal, natal, and postnatal health care.²⁷⁸

²⁷⁷ See ACA, H.R. 3590, 111th Cong. § 5000A(e)(1)(a) (2010).

²⁷⁸ Many states are struggling financially and are already worried about the ACA's expansion of Medicaid eligibility, which is scheduled to take place in 2014. In an attempt to save money, House Republicans are pushing to transform Medicaid into block grants. Under this plan, the federal government will pay out an annual lump sum amount to each state. Over the next decade, it is estimated this plan will save the federal government \$180 billion in expenditures toward Medicaid while also giving each state the flexibility to run its Medicaid program as it sees fit. However, critics are skeptical. With the states' newfound flexibility comes the states' responsibility of covering all Medicaid costs that exceed the federal allotment. Unfortunately, with the struggling economy, there is no guarantee that the beneficiaries who are now covered will continue to be covered and there is no guarantee that the states will not cut back on their Medicaid programs. See Mary Agnes Carey & Marilyn Werber Serafini, *How Medicaid Block Grants Would Work*, KAISER HEALTH NEWS, Mar. 6, 2011, <http://www.kaiserhealthnews.org/Stories/2011/March/07/block-grants-medicaid-faq.aspx> ("Lately, Republican governors have more aggressively pursued the block-grant idea, partly because they're worried about the cost of adding millions more people to the [Medicaid] program beginning in 2014. . . . Critics of

The percentage imposed must strike a balance between the desire for personal responsibility and the importance of pregnant women accessing prenatal, natal, and postnatal health care. A majority of individuals living in poverty are not looking for a free ride; they want to pay their own way but are simply unable to afford it.²⁷⁹ Thus, the percentage selected must be a reasonable amount, so even the poorest of the poor can afford their one-time deductible. This ensures women with low and moderate incomes have access to the maternity coverage and health care that is critical to the health of a woman and her baby. By extending affordable health insurance coverage to all uninsured pregnant women, men and women alike will have the peace of mind that mother and fetus will receive the needed medical care, resulting in the delivery of a healthy baby nine months down the road.

I also recommend instituting more outreach, accountability, and transparency within the government-funded health insurance system. States should create multidimensional outreach programs, which strive to raise awareness about the availability of health insurance coverage. State outreach programs should also provide “hands-on, one-on-one assistance” to interested applicants who have questions about their eligibility or the enrollment process.²⁸⁰ State policy makers should be encouraged to develop an ongoing media campaign that consistently reminds the general public about the availability of health insurance coverage and the importance of prenatal care.²⁸¹ Outreach cannot be a one-time occurrence; the messages must remain “fresh and in the public eye.”²⁸² Furthermore, the messages should be multilingual and cater to the cultural and ethnic mix of the community.²⁸³ Additionally, the campaign should be complemented with community-based outreach programs.²⁸⁴ These community-based programs can provide hands-on assistance to potential applicants and increase the enrollment of “hard-to-reach” populations of people who either ignore or do not have access to the media

block granting argue it wouldn't solve states' fiscal woes.”); Editorial, *Preserving Health Coverage for the Poor*, N.Y. TIMES, July 6, 2011, at A20 (“In tough economic times, Medicaid enrollments typically soar as government revenues shrink, adding budget woes. . . . For cash-strapped states, program cuts may be necessary right now.”).

²⁷⁹ See Munger, *supra* note 1, at 662.

²⁸⁰ HILL ET AL., *supra* note 173, at 104.

²⁸¹ *Id.*

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ *Id.*

campaign.²⁸⁵ States should also be encouraged to maintain a toll-free hotline available twenty-four hours a day, seven days a week. This hotline should be advertised on all promotional materials.²⁸⁶ This will enable women and families to contact someone at any time and ask questions about available programs.²⁸⁷ For working women, it is difficult to access a hotline that is only available Monday through Friday from eight a.m. to five p.m. Finally, states should consider building a partnership with Managed Care Organizations (MCOs).²⁸⁸ By doing so, states could utilize the business and marketing expertise of the MCO staff, share the MCO's resources for promoting coverage and preventive care, and broaden the overall reach of the state's outreach effort.²⁸⁹

Research indicates that the most successful state outreach programs combine broad media campaigns with community-based assistance.²⁹⁰ The options available for reaching out to and enrolling pregnant women are numerous and interchangeable.²⁹¹ With different challenges facing each state's unique constituency, a "right" combination of outreach procedures does not necessarily exist.²⁹² Rather, each state should analyze the various options and develop a combination of outreach procedures that best suits the demographics of its community.²⁹³

Furthermore, government-funded health insurance programs need increased accountability and transparency. Caseworkers and applicants alike should be trained thoroughly on how to correctly calculate income and determine eligibility.²⁹⁴ Additionally, quality control measures should be put in place to ensure that applicants are not denied health care benefits without being fully and properly

²⁸⁵ *Id.*

²⁸⁶ *Id.*

²⁸⁷ *Id.*

²⁸⁸ MCOs manage care by (1) providing a list of particular providers available for members to use, (2) conducting case-by-case evaluations to determine whether the recommended treatment is necessary and appropriate, and (3) creating incentives to reduce the cost of care. Some MCOs also oversee the quality of care their members receive. Common types of MCOs include: Health Maintenance Organizations (HMOs), Point-of-Service Plans (POSs), Preferred Provider Organization (PPOs), and Provider-Sponsored Organizations (PSOs). See FURROW ET AL., *supra* note 113, at 301–02, 314.

²⁸⁹ HILL ET AL., *supra* note 173, at 104.

²⁹⁰ *Id.* at 103.

²⁹¹ *Id.* at 102.

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ HEALTH CONSUMER ALLIANCE, *supra* note 8, at 3.

evaluated for eligibility. Such measures should include supervisory reviews²⁹⁵ and regular audits of each caseworker's calculations of gross monthly household income and determinations of applicants' Medicaid eligibility.

Lastly, the appeal process should be more transparent. With the power imbalance between the applicant and the agency, in combination with the applicant's unfamiliarity with the system, navigating the appeals process can be intimidating and daunting, even for the educated.²⁹⁶ A letter informing the applicant that her claim has been denied, even with an address or phone number to contact if she wishes to appeal, is insufficient.²⁹⁷ To increase the transparency of the appeals process, the applicant should be informed of what she can expect from the appeals process and what steps to take next.²⁹⁸ The letter should inform the denied applicant about whether she should appear in person or send in a written statement, whether there is an impartial decision maker, whether she needs an attorney, what to do if she cannot afford an attorney, how long the appeals process generally takes, etc. The letter denying the applicant access to affordable health insurance should also refer the applicant to Medicaid consumer assistance programs in the community. These programs have the expertise to determine whether a hearing is the best course of action or whether there is a quicker or better way for the applicant to achieve her desired result.²⁹⁹ The applicant, herself, often does not have this knowledge and is unable to navigate the appeals process. These community programs can also help the applicant file the appeal and prepare for the hearing.³⁰⁰ Some community programs may even represent the applicant at the hearing.³⁰¹ By increasing outreach, accountability, and transparency in the government-funded health insurance system itself, fewer eligible pregnant women will be denied access to their only avenue for obtaining affordable health insurance coverage.

²⁹⁵ *Id.*

²⁹⁶ FAMILIES USA, *Tips for Assisting Consumers with Medicaid Appeals and Fair Hearings*, <http://www.familiesusa.org/issues/medicaid/making-it-work-for-consumers/tips-consumers.html> (last visited Oct. 20, 2011).

²⁹⁷ Letter from Baghdassar Sukiassians, Caseworker, Cal. Dep't of Health Servs. to author (May 5, 2009) (on file with author).

²⁹⁸ FAMILIES USA, *supra* note 296.

²⁹⁹ *Id.*

³⁰⁰ *Id.*

³⁰¹ *Id.*

CONCLUSION

Raising healthy children should be a national priority.³⁰² Whether the pregnant woman is an inmate, an undocumented immigrant, or an American citizen, the tiny being growing inside of her womb will be an American citizen. As such, Americans should take an interest in the health of both a mother and her child. After all, “healthy women create healthy families, and healthy families create healthy communities.”³⁰³ From the perspective of our capitalist society, babies are a public good—not only are they the future employees and leaders of America, but also, they are the future of America’s economy and success.³⁰⁴ The Children’s Leadership Council succinctly states the importance of the next generation: “There is no greater investment we can make than in our children because investing in children is investing in America. Improving children’s health, . . . and well-being is not just the right thing to do; it is one of the smartest investments we can make for our nation’s future.”³⁰⁵ As a nation, we should be striving for affordable health care for expectant mothers, regardless of class. While the Patient Protection and Affordable Care Act provides a good first step, there is still a long road ahead—a road full of advocacy, reform, and policy changes before prenatal, natal, and postnatal health care become a universal entitlement for women as a group.

³⁰² See *supra* note 58.

³⁰³ Giovanna Rossi Pressley, *Exclusive: How to Get the Best out of Health Care Reform*, THE WOMEN’S MEDIA CENTER (Sept. 13, 2010, 9:15 AM), <http://womensmediacenter.com/blog/2010/09/exclusive-how-to-get-the-best-out-of-health-care-reform/>.

³⁰⁴ See *supra* note 58.

³⁰⁵ CHILDREN’S LEADERSHIP COUNCIL, *Economic Recovery*, <http://www.childrensleadershipcouncil.org/node/7> (last visited Oct. 20, 2011).

