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Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 St. Louis U. J. HEALTH L. & POL'y 303 (2018).

ALWD 7th ed.

Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 St. Louis U. J. Health L. & Pol'y 303 (2018).

APA 7th ed.

McCuskey, E. Y. (2018). *The body politic: federalism as feminism in health reform*. Saint Louis University Journal of Health Law & Policy, 11(2), 303-[iii].

Chicago 17th ed.

Elizabeth Y. McCuskey, "The Body Politic: Federalism as Feminism in Health Reform," Saint Louis University Journal of Health Law & Policy 11, no. 2 (2018): 303-[iii]

McGill Guide 9th ed.

Elizabeth Y. McCuskey, "The Body Politic: Federalism as Feminism in Health Reform" (2018) 11:2 St Louis U J Health L & Pol'y 303.

AGLC 4th ed.

Elizabeth Y. McCuskey, 'The Body Politic: Federalism as Feminism in Health Reform' (2018) 11(2) Saint Louis University Journal of Health Law & Policy 303

MLA 9th ed.

McCuskey, Elizabeth Y. "The Body Politic: Federalism as Feminism in Health Reform." Saint Louis University Journal of Health Law & Policy, vol. 11, no. 2, 2018, pp. 303-[iii]. HeinOnline.

OSCOLA 4th ed.

Elizabeth Y. McCuskey, 'The Body Politic: Federalism as Feminism in Health Reform' (2018) 11 St Louis U J Health L & Pol'y 303
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THE BODY POLITIC: FEDERALISM AS FEMINISM IN HEALTH REFORM

ELIZABETH Y. MCCUSKEY*

ABSTRACT

This essay illuminates how modern health law has been mainstreaming feminism under the auspices of health equity and social determinants research. Feminism shares with public health and health policy both the empirical impulse to identify inequality and the normative value of pursuing equity in treatment. Using the Affordable Care Act's federal health insurance reforms as a case study of health equity in action, the essay exposes the feminist undercurrents of health insurance reform and the impulse toward mutuality in a body politic. The essay concludes by revisiting—from a feminist perspective—scholars' arguments that equity in health insurance is essential for human flourishing.

* ©2018 Elizabeth Y. McCuskey. This essay is the product of the *Mainstreaming Feminism* project launched at the American Association of Law Schools 2018 Annual Meeting. It owes its impulse to the founders of that project, Brooke Coleman and Liz Porter, and to my co-panelists, Anastasia Boles and Linda Malone. Elizabeth Pendo and Nicole Porter also generously provided input. I dedicate this essay to the memory of my mother, Anne T. McCuskey—a warrior for human flourishing.

I. INTRODUCTION

Health reform in the United States has slowly and tentatively come to embrace a normative foundation of equity and equality. As this slow-motion embrace has unfolded, feminism has been hiding in plain sight. This essay aims to illuminate some feminist principles at work in the federalism of health insurance reform.

Initially, this essay traces feminist principles through the empiricism, doctrine, and federalism of modern health law, revealing parallels in the empirical observations of disparity and normative arguments for eliminating them. Public health research on the social determinants of health has focused health policy on eliminating health disparities at their social sources.¹ This empirical demonstration of disparities has catalyzed health law scholarship on “health equity” and health care as social justice.² While the health equity movement does not routinely claim the mantle of feminism,³ its core focus on eradicating the social structures of inequality in bodily health fits within feminism’s intellectual lineage and embraces the pivot toward intersectionality.⁴

Data on health disparities have informed recent legal reforms. The most comprehensive health reform law to-date—the Affordable Care Act (ACA)—in many ways embodies the health equity ethos, approaching equality in access to care via health insurance.⁵ In the ongoing debate about health reform and the ACA, feminism and health insurance regulation have converged in subtle but

1. E.g., Harry J. Heiman & Samantha Artiga, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. 4 (Nov. 4, 2015), <http://files.kff.org/attachment/issue-brief-beyond-health-care>.

2. See, e.g., DANIEL DAWES, 150 YEARS OF OBAMACARE (2016); JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE (2010); Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 LOY. L. REV. 655, 665–66 (2012); Michael Marmot et al., *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, 372 LANCET 1661, 1661 (2008); Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL’Y 47, 65–66 (2014).

3. See, e.g., Joanna N. Erdman, *Human Rights in Health Equity: Cervical Cancer and HPV Vaccines*, 35 AM. J.L. & MED. 365, 367–70 (2009) (considering health equity as a policy outcome for human rights and focusing on cervical cancer disparities, without discussing feminism). Feminism and bioethics, however, have a well-recognized history of cross-pollination. See, e.g., Raghavi Ravi Kasthuri & Sathyaraj Venkatesan, *From Diaries to Virtual Narratives: Breast Cancer and Feminism*, 6 LITERARIA 30, 39 (2016) (illustrating that “feminist movements have always served as catalysts in shaping the ideologies of breast cancer movement”); Susan M. Wolf, *Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia*, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 282, 297–98 (Susan M. Wolf ed., 1st ed. 1996).

4. See Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, U. CHI. LEGAL F., 1989, at 139, 140 (launching the intersectionality strain of feminism); cf. Kristin Kalsem & Verna L. Williams, *Social Justice Feminism*, 18 UCLA WOMEN’S L.J. 131, 158 (2010); Leti Volpp, Essay, *Feminism Versus Multiculturalism*, 101 COLUM. L. REV. 1181, 1202 (2001).

5. See generally, e.g., DAWES, *supra* note 2.

consequential ways, explored in this essay. For example, under most states' laws predating the ACA, health insurers could charge higher premiums to women than men, and could exclude coverage for contraception, maternity and prenatal care, and fertility treatments, while covering drugs to treat erectile dysfunction in men.⁶ By federalizing a set of "essential health benefits"⁷ for insurance sold on the exchanges and enacting a nationwide prohibition on sex-based underwriting,⁸ the ACA brought a modicum of equality to health insurance sold to individuals.

Data exposing disparities and their consequences drove this shift, which was a long time in the making, and not irrevocably made. As but one example from 2017, Congress considered repealing the ACA's mandate for essential health benefits, including insurance coverage of women's preventive care without a co-pay, in all plans sold on the exchanges.⁹ A male member of Congress who supported the repeal quipped sarcastically, "I wouldn't want to lose my mammograms."¹⁰ Other male senators supporting repeal expressed similar sentiments about having insurance policies cover essential health benefits for prenatal and maternity care.¹¹ Focusing national debate on the tensions between the collective good of risk pooling¹² versus perceptions of the individual good in health insurance¹³ has highlighted feminist principles of equality, without identifying them as such.

6. See Anne Adams Lang, *For Infertility Treatments, Now You're Covered, Now You're Not*, N.Y. TIMES, June 21, 1998, at 12.

7. See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *Info. on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last visited Apr. 2, 2018).

8. 42 U.S.C. § 300gg(a)(1) (2012); cf. Robert J. Carney & Donald W. Hardgree, *The Economic Impact of Gender-Neutral Insurance Rating on Women*, 13 J. INS. ISSUES & PRAC. 1, 1 (1990) (noting that sex-based underwriting was prohibited in the employer-sponsored group insurance market).

9. Timothy Jost, *Essential Health Benefits: What Could Their Elimination Mean?*, HEALTH AFF.: BLOG (Mar. 23, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170323.059343/full/> (last visited Mar. 20, 2018).

10. Amber Phillips, *'I Wouldn't Want to Lose My Mammograms,' Male GOP Senator Says – Then Immediately Regrets*, WASH. POST (Mar. 23, 2017), https://www.washingtonpost.com/news/the-fix/wp/2017/03/23/i-wouldnt-want-to-lose-my-mammograms-snipes-gop-male-lawmaker/?utm_term=.7d5385489197 (last visited Mar. 20, 2018).

11. *Id.*

12. See, e.g., Nancy Metcalf, *Why Should a Childless Man Have to Buy Maternity Coverage? It's All About Sharing the Risk*, CONSUMER REP. (Nov. 5, 2013), https://www.washingtonpost.com/news/the-fix/wp/2017/03/23/i-wouldnt-want-to-lose-my-mammograms-snipes-gop-male-lawmaker/?utm_term=.7d5385489197 (last visited Mar. 20, 2018).

13. See Jost, *supra* note 9.

By federalizing a notion of uniform baseline insurance protections,¹⁴ the ACA addressed some demonstrable disparities in access to care, including disparities based on sex. This essay makes a case for federalism as feminism in the ACA's health insurance regulatory infrastructure. Comprehensive federal baseline regulations for health care access promote equity and address some forms of discrimination in health care access and finance. This relatively new federalism relationship¹⁵ in health insurance regulation also incorporates feminist principles by making the data-driven case for eliminating some of the health care costs of discrimination.¹⁶ Infusing health insurance with greater equality at the federal level reflects the metaphor of the body politic—that just as the parts of a human body are mutually necessary for physical health, so too are all members of a corporate body essential to its flourishing.

Ultimately, this essay illuminates how modern health law has been mainstreaming feminism¹⁷ under the auspices of health equity and social determinants research. First, the essay explores the empirical impulses and equality norms that bind feminism, public health, and health policy. Next, it explains some ways the equality norm has translated into the health equity framework for health reform. Then, it uses the ACA's federal health insurance reforms as a case study of equity in action, exposing the feminist undercurrents of health insurance reform and the impulse toward mutuality in a body politic. The essay concludes by revisiting—from a feminist perspective—scholars' arguments that equality in health insurance is essential for human flourishing.¹⁸

14. See Amy B. Monahan, *The ACA, the Large Group Market, and Content Regulation: What's a State To Do?*, 5 ST. LOUIS J. HEALTH L. & POL'Y 83, 83 (2011) ("One of the primary, and overarching, changes made by the ACA is to regulate health insurance at the federal, rather than state, level.").

15. Cf. Abbe Gluck & Nicole Huberfeld, *What is Federalism in Health Care For?*, 70 STAN. L. REV. (forthcoming 2018) (manuscript at 8).

16. See generally Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J.L. & SOC. JUST. 235, 275–76 (2016).

17. See generally Catharine A. MacKinnon, *Mainstreaming Feminism in Legal Education*, 53 J. LEGAL EDUC. 199, 205 (2003); cf. *112th Annual Meeting Program*, ASS'N AM. LAW SCHOOLS 21 (Jan. 3–6, 2018), https://www.aals.org/wp-content/uploads/2017/09/AM18_regBrochure.pdf ("The goal of the program is to de-compartmentalize feminism from other strains of legal scholarship ... Stated differently, the goal is to begin normalizing the consideration of intersectionality—including, but not limited to, feminism—within traditional legal scholarship to create a scholarly environment where this kind of inquiry is the norm and not just the panel regarding 'other.'").

18. See Jennifer Prah Ruger, *Normative Foundations of Global Health Law*, 96 GEO. L.J. 423, 424–25 (2008); Jennifer Prah Ruger, *Commentary, The Moral Foundations of Health Insurance*, 100 Q. J. MED. 53, 53 (2007) [hereinafter Ruger, *The Moral Foundations*].

II. EQUALITY & EMPIRICISM

Health reform and feminism have often shared an empirically-informed philosophy of equality. At first glance, feminism's commitment to empiricism and health law's commitment to equality may seem less obvious than feminism's focus on equality and health law's empiricism. But closer inspection reveals the essential relationship between equality and empiricism in feminist philosophy and in modern health care regulation.

Equality offers a unifying principle in feminism. Feminism resists male domination and female subordination in all forms: legal and political rights, civic participation, social structure, cultural content, and consciousness.¹⁹ Feminist thought has many branches²⁰ from the same roots. Feminism, at its core, is a philosophy of equality, dissecting inequalities in these spheres both normatively and descriptively.²¹ Descriptively, feminism identifies ways in which beliefs about and treatment of women reflect and perpetuate subordination.²² Normatively, feminism claims that these forms of subordination "[are] in some way illegitimate or unjustified."²³ The descriptive informs the normative and vice versa.²⁴

Public health and health reform exhibit a strikingly similar feedback loop of doctrine and empiricism on inequalities. Public health and health law are distinct but increasingly linked disciplines. Health law typically concerns regulation of the health care delivery system and access to it, while public health concerns influence over health at the population level. Public health traditionally is known as "the science and art of preventing disease, prolonging life, and promoting physical health ... through organized community efforts" aimed at sanitation, health and hygiene education, medical intervention, disease prevention, and development of "social machinery, which will ensure to every individual in the community a standard of living adequate for the maintenance of health."²⁵ The

19. E.g., Sally Haslanger et al., *Topics in Feminism*, STAN. ENCYCLOPEDIA PHIL. (2012), <https://plato.stanford.edu/entries/feminism-topics/> (last visited Apr. 7, 2018).

20. See, e.g., *id.*

21. *Id.*

22. This descriptive critique aligns in many places with the Critical Legal Studies approach. See Carrie Menkel-Meadow, *Feminist Legal Theory, Critical Legal Studies, and Legal Education or "The Fem-Crits Go to Law School"*, 38 J. LEGAL EDUC. 61, 61 (1988).

23. Susan James, *Feminism*, in 10 ROUTLEDGE ENCYCLOPEDIA OF PHILOSOPHY 576, 576 (Edward Craig ed., 1998) ("Feminism is grounded on the belief that women are oppressed or disadvantaged by comparison with men, and that their oppression is in some way illegitimate or unjustified.").

24. Haslanger et al., *supra* note 19 (defining descriptive and normative feminism which belies the considerable intellectual diversity within feminism, the details of which remain just beyond the parameters of this essay).

25. Charles Edward Avery Winslow, *The Untilled Fields of Public Health*, 51 SCIENCE 23, 30 (1920).

“prevention of chronic conditions, environmental hazards, and policy and regulations” have come to define public health concerns in the 21st century.²⁶

These two disciplines inform each other, with public health often supplying the empirical perspective and health law injecting regulation as an intervention or “reform” of empirically-identified problems. This essay refers to “health law” as the wide field of regulation dealing with the health care access and delivery systems, and “health reform” as the sub-category of health laws designed to address one or more major failures (actual or perceived) in those systems.²⁷ Over the last two decades, public health research demonstrating the “social determinants of health” has infused most facets of health reform with both a critical perspective on health disparities and a range of normative claims about addressing those disparities.²⁸

Social determinants of health are “the structural determinants and conditions in which people are born, grow, live, work and age,”²⁹ including socioeconomic status, education, the physical environment, employment, social support, stress, and access to health care. Visually,³⁰ Dahlgren and Whitehead illustrated the main determinants of health as a wheel of factors surrounding an individual’s core biological features:³¹

26. David Rosner & Linda P. Fried, *Traditions, Transition, and Transfats: New Directions for Public Health*, PUB. HEALTH REP., Jan.–Feb. 2010, at 3, 3.

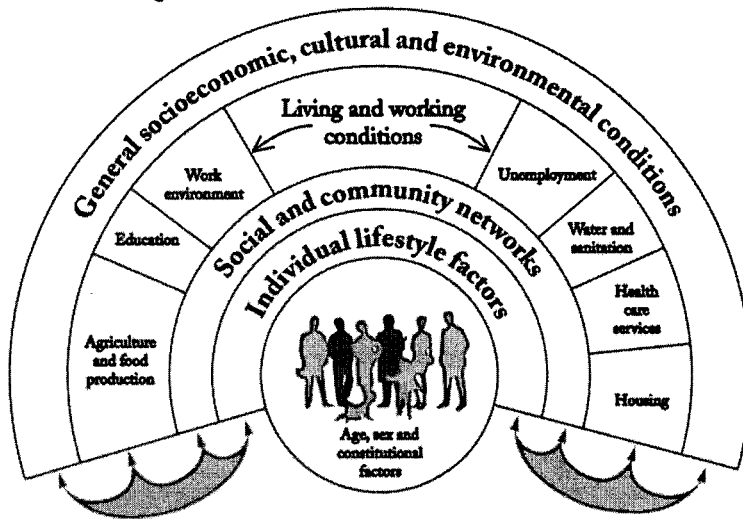
27. See, e.g., Victor R. Fuchs & Ezekiel J. Emanuel, *Health Care Reform: Why? What? When?*, 24 HEALTH AFF. 1399, 1399–1400 (2005) (discussing “health care reform” as a range of possible responses to system failures and widespread dissatisfaction).

28. E.g., Elizabeth Tobin Tyler, “*Small Places Close to Home*”: *Toward a Health and Human Rights Strategy for the US*, 15 HEALTH & HUMAN RTS. 80, 84 (2013) (“At the core of health inequity in the US are the political and social systems which drive socioeconomic status and income inequality.”); Wiley, *supra* note 2, at 50–51.

29. Marmot et al., *supra* note 2, at 1661.

30. Elizabeth G. Porter, *Taking Images Seriously*, 114 COLUM. L. REV. 1687, 1781 (2014).

31. Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1656 fig. 2 (2011) (citing Göran Dahlgren & Margaret Whitehead, *Policies and Strategies to Promote Social Equity in Health* 11 fig.1 (Inst. for Future Studies, Working Paper No. 2007:14, 1991)).



This complex web of external influences *determines* how individuals' and groups' inherent physical characteristics (like age, sex, and genetics) express themselves. These social determinants create inequalities in health outcomes among individuals with similar inherent physical characteristics.³² According to current research, nearly one-third of premature deaths result from social determinants, rather than individual behavior or genetics.³³ The most powerful determinant is wealth: life expectancy positively correlates with income on a gradient.³⁴ In terms of income, the gender pay gap reveals that women on average make less than men, and that the gap is even wider for Black and Hispanic women.³⁵ While sex is an individual physical characteristic, gender is a population-wide social determinant of health that intersects with other factors.³⁶

Public health research has found that discrimination—gender and otherwise—also is a powerful determinant of health.³⁷ According to the U.S. Department of Health and Human Services' *Healthy People 2020* research initiative, "health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on" social

32. See *id.* at 1653.

33. Sandro Galea et al., *Estimated Deaths Attributable to Social Factors in the United States*, 101 AM. J. PUB. HEALTH 1456, 1462 (2011).

34. *Id.* at 1462–63.

35. See ARIANNE HEGEWISCH & EMMA WILLIAMS-BARON, *THE GENDER WAGE GAP: 2016 EARNINGS DIFFERENCES BY GENDER, RACE, AND ETHNICITY 2* (2017).

36. See U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, *Health Disparities Data*, HEALTHYPEOPLE.GOV (2018), <https://www.healthypeople.gov/2020/data-search/health-disparities-data> (last visited Apr. 10, 2018).

37. Heiman & Artiga, *supra* note 1, at 3.

determinants such as gender, race, disability, geography, and “other characteristics historically linked to discrimination or exclusion.”³⁸ Further, the cumulative effects of multiple social determinants of health, such as sex and race, painfully and powerfully illustrate the concerns of intersectionality in feminism.³⁹

Public health research provides empirical evidence of inequality as a social disease with physical consequences. Health disparities research from the field of public health thereby performs a descriptive function and serves an inherently critical objective—identifying the constructs that produce disparities. Health reform supplies the normative half of the descriptive-normative relationship, as modeled by feminism.

III. HEALTH REFORM’S EQUITY FRAMEWORK

Health reform has evolved to embrace social determinants of health doctrinally, philosophically, and actuarially. With the recognition of quality, cost, access, and ethical issues in health care, “health law” has expanded from medical liability and bioethics into a diverse field encompassing regulation of all aspects of human health and the health care system.⁴⁰ Health law has been plagued by theoretical tensions between market-based individualism and social solidarity.⁴¹ Health reform movements of late suffer from that tension, but tilt definitively toward social solidarity and recognition of social determinants.⁴²

With this expanded recognition of the complexity in social determinants and in the U.S. health care system, health law scholars have proposed normative values of justice and equity to supplant the traditional patient rights and market-

38. *Id.*

39. See Crenshaw, *supra* note 4, at 151–52; cf. DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 33, 116–17 (2015) (describing encounters of gender- and race-based discrimination faced by African American women in health care); Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53, 60–62 (2016) (stating that race- and gender-based bias strongly contributes to health disparities); Wiley, *supra* note 2, at 48–49, 61 (describing how the women’s reproductive justice movement now includes analysis of race and other social determinants as they contribute towards health disparity).

40. See Wiley, *supra* note 2, at 50–51 (defining “health law broadly to encompass the law of health care financing and delivery as well as public health law”); Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 113–23, 123 fig. 1 (2016) (illustrating “health law’s diversity, density, and diffusion across regulatory authorities”). Health law’s expansive nature has prompted some to question the field’s coherence. See Elizabeth Y. McCuskey, *The Space Between Two Words: Foreword to the Health Law Symposium*, 46 U. TOL. L. REV. vii, viii (2015).

41. See Gluck & Huberfeld, *supra* note 15, at 8 (noting how, despite the ACA’s compromises, health law “remains caught in centuries-old, unresolved tension between the so-called ‘social solidarity’ model . . . and the ‘individual responsibility’ model . . .”).

42. See *id.*

based competition paradigms.⁴³ In *Health Law as Social Justice*, for example, Lindsay Wiley chronicled this evolution and outlined the health justice framework through which to examine the role of law in reducing health disparities.⁴⁴

“Health equity” has emerged as a guiding principle in public health research, health care regulation, and health law scholarship.⁴⁵ “Health equity” seeks “attainment of the highest level of health for all people” and “requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”⁴⁶ Health equity values, at the very least, equality in the *conditions* for optimal individual health—the conditions for flourishing.

Actuarially, the constructed disparities underlying health equity contribute to health care costs in an already overburdened and uneven health care economy. Health care services which treat symptoms of disparity—the socially-imposed determinants—are largely avoidable by addressing underlying social causes. Addressing the social determinants may in some circumstances even cost less than dealing with the medical consequences of inequality.⁴⁷ Yet the political debate over whether laws should address inequality and whether we should devote government resources to help the neediest among us persists, and even is amplified.⁴⁸

The law’s embrace of health equity has come slowly, in piecemeal progression, and incompletely over time. While a handful of states have become leaders in enacting health equity-based legal reforms, the momentum behind

43. See Wiley, *supra* note 2, at 50–51; see generally RUGER, *supra* note 2.

44. See Wiley, *supra* note 2, at 51–53.

45. See, e.g., COMM’N ON SOC. DETERMINANTS OF HEALTH & WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 26 (2008), http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

46. U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 36.

47. See, e.g., Tom McKay, *Study Reveals It Costs Less to Give the Homeless Housing Than to Leave Them on the Street*, MIC (Mar. 26, 2014), <https://mic.com/articles/86251/study-reveals-it-costs-less-to-give-the-homeless-housing-than-to-leave-them-on-the-street#.wGSliqB9> (last visited Mar. 23, 2018); Matthew Yglesias, *Giving Housing to the Homeless Is Three Times Cheaper Than Leaving Them on the Streets*, VOX (Feb. 4, 2015), <https://www.vox.com/2014/5/30/5764096/its-three-times-cheaper-to-give-housing-to-the-homeless-than-to-keep> (last visited Mar. 23, 2018). But see Aaron E. Carroll, *Preventive Care Saves Money? Sorry, It’s Too Good to Be True*, N.Y. TIMES (Jan. 29, 2018), <https://www.nytimes.com/2018/01/29/upshot/preventive-health-care-costs.html> (last visited Mar. 22, 2018) (explaining that, “Contrary to conventional wisdom, [preventive care] tends to cost money, but it improves quality of life at a very reasonable price.”).

48. See Gluck & Huberfeld, *supra* note 15, at 6 (“The field remains caught in centuries-old, unresolved tension between the so-called ‘social solidarity’ model—every person should be guaranteed some minimal level of health care; and the ‘individual responsibility’ model—a person gets only the health care she can pay for.”).

equity reforms has largely come from federal statutes.⁴⁹ Medicare, Medicaid, the Emergency Medical Treatment and Labor Act, the Employee Retirement Income Security Act (ERISA), the Family and Medical Leave Act, the Supplemental Nutrition Assistance Program, and the Americans with Disabilities Act all address disparities at some level, though not expressly those based on sex.⁵⁰ Antidiscrimination laws are applied to health care providers and health insurance programs.⁵¹ But the effects of those applications have been limited.⁵² Despite gains in small ways, before the ACA insurers were allowed under state law to charge higher premiums to women versus men and to account for individual health status.⁵³ Health law scholarship and policy have largely embraced equity, but health insurance regulation has lagged in most states.

Through the health justice lens and normative focus on disparities, laws regulating *access* to health care become most crucial.⁵⁴ In part, the ascendance of health equity and health care access helps explain the fact that the vast majority of regulatory work in the past decade has targeted health insurance—the financial and pragmatic point of access to care for most people.⁵⁵

IV. THE BODY POLITIC: EQUITY & EQUALITY IN HEALTH REFORM

Health insurance is the new field on which equity's resistance against the forces of disparity is being waged. Health *reform* is by now nearly synonymous with health *insurance reform*, owing to the increasingly unbearable costs of

49. See DAWES, *supra* note 2, at 10–90 (tracing the historical development of health reform); cf. McCuskey, *supra* note 40, at 93 (sketching the role of states vis-a-vis federal health laws).

50. See, e.g., Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 15, 17, 23 (2008).

51. See, e.g., *Alexander v. Choate*, 469 U.S. 287 (1985) (applying the Rehabilitation Act to providers participating in state Medicaid programs); *Henderson v. Bodine Aluminum*, 70 F.3d 958 (8th Cir. 1995) (applying the ADA to private health insurance); *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983) (applying anti-discrimination statutes to employer-sponsored health insurance).

52. See, e.g., Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 302 (2005); Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 UCLA L. REV. 17, 18 (2002); Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 UCLA L. REV. 17, 18 (2002);

53. Theresa Joux Neisen, Comment, *A Liberal Feminist Perspective on Gender Rating and the Patient Protection and Affordable Care Act – Is Limited Protection Enough?*, 11 LOY. J. PUB. INT. L. 469, 470 (2010); NAT'L WOMEN'S LAW CTR., STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION 3 (2009), <https://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf>; Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 20 (2016).

54. See Monahan, *supra* note 14, at 92.

55. See, e.g., Huberfeld & Roberts, *supra* note 53; Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 279–82 (2015).

health care in the United States.⁵⁶ The third-party payment mechanism that health insurance offers almost entirely dictates access to medical care in the United States because the overwhelming majority of Americans cannot afford to pay out-of-pocket for needed care.⁵⁷ It is this financial access dimension that has catalyzed federal health reform.

Health insurance regulation, at least at the federal level, has evolved in a large piecemeal fashion since 1965, when Congress established the Medicare and Medicaid programs. This piecemeal progress produced single-issue patches, many of which aimed to correct small parts of pervasive income- and gender-based disparities in health care and coverage. A federal statute in the 1970s, for example, required that hospitals participating in Medicare accept all patients in active labor at their emergency rooms, who had routinely been “dumped” or shut out based on doctors’ and administrators’ perceptions that labor and delivery were too risky and low-income patients were not worth the risk.⁵⁸ Similarly, federal Medicaid law added a patch that allows state Medicaid programs to add coverage for breast and cervical cancer screenings, and ERISA amendments added patches to private coverage for hospital stays after childbirth and for breast reconstruction after mastectomy.⁵⁹

Particularly for insurance regulation, this issue-by-issue process resembled a game of whack-a-mole with gender-based health care and access disparities based on sex. Health insurers in the private market routinely underwrote policies with different (always higher) premiums for women, which then made coverage less affordable for women.⁶⁰ Women were less likely than men to have employer-sponsored health insurance and women who had to buy insurance in the individual market were charged up to 1.5 times more than men for health insurance, resulting in gender rating costs of approximately \$1 billion each year.⁶¹ This gender-based underwriting, permitted by most states’ insurance

56. E.g., Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES, June 2, 2013, at A1.

57. See *id.*

58. Decanda M. Faulk, *EMTALA: The Real Deal*, 16 A.B.A. HEALTH L. SEC. HEALTH LAW., Dec. 2003, at 10, 10.

59. Breast and Cervical Cancer Prevention and Treatment Act of 2000, 42 U.S.C. § 1396a (2012); Newborns’ and Mothers’ Health Protection Act, 29 U.S.C. § 1185, 42 U.S.C. §§ 300gg-4, 300gg-51 (1996); Women’s Health and Cancer Rights Act, 29 U.S.C. § 1185b (1998).

60. See, e.g., NAT’L WOMEN’S LAW CTR., NOWHERE TO TURN: HOW THE INDIVIDUAL HEALTH INSURANCE MARKET FAILS WOMEN 9–10 (2008) (detailing gender rating in individual insurance); Jenny Gold, *Fight Erupts over Health Insurance Rates for Businesses with More Women*, KAISER HEALTH NEWS (Oct. 25, 2009), <https://khn.org/news/gender-discrimination-health-insurance/> (last visited Apr. 10, 2018) (explaining how gender rating increased employer-sponsored premiums, too).

61. Samantha Kahn, *The End of Gender Rating: Women’s Insurance Under the ACA*, U. PA. WHARTON PUB. POL’Y INITIATIVE: NEWS (Aug. 4, 2015), <https://publicpolicy.wharton.upenn.edu/live/news/819-the-end-of-gender-rating-womens-insurance-under> (last visited Apr. 11, 2018); see,

laws, contributed not just to costs, but exacerbated health disparities as women's policies often excluded important conditions—like maternity care—and women who were priced out of insurance developed preventable conditions, incurring the enormous social and individual costs of dealing with disease and disability.⁶²

Before the ACA, state laws supplied the majority of health insurance regulation, beyond the thin patchwork of federal provisions and Medicare.⁶³ The ACA stands as the first successful, comprehensive federal health reform statute in the United States.⁶⁴ The ACA made health law broadly across all segments of the health care system, focused mostly on reforming health insurance.⁶⁵ Among the ACA's federal insurance reforms were several provisions that directly address gender disparities: explicit prohibition of sex discrimination by any recipient of federal health care funds (including insurance companies, providers, and assistance programs),⁶⁶ prohibition of gender rating,⁶⁷ federalizing "essential health benefits" to include women's preventive care without cost-sharing and maternity and newborn care,⁶⁸ and prohibiting pre-existing

e.g., *Women's Health Insurance Coverage*, KAISER FAM. FOUND. 1 fig.1 (Oct. 2017), <http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage>.

62. See, e.g., Elizabeth M. Patchias & Judy Waxman, *Women and Health Coverage: The Affordability Gap*, COMMONWEALTH FUND (Apr. 2007), http://www.commonwealthfund.org/usr_doc/1020_Patchias_women_hlt_coverage_affordability_gap.pdf; see also *Essential Health Benefits: Individual Market Coverage*, U.S. DEP'T OF HEALTH & HUMAN SERVS. 1 (2011), <https://aspe.hhs.gov/system/files/pdf/76356/ib.pdf> (highlighting that sixty-two percent of those enrolled in individual market plans in 2011 did not have maternity coverage).

63. See Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L.J. 1099, 1111–12 (2017).

64. See *id.* at 1115. Medicare and Medicaid's passage in 1965 certainly revolutionized access to care, but only for defined segments of the population: those over sixty-five and low-income populations with qualifying disabilities and other medical conditions. Dora Hughes, *New Offices of Minority Health at FDA and CMS: Will They Help Eliminate Disparities in Health?*, HEALTH AFF.: BLOG (June 19, 2014), <https://www.healthaffairs.org/do/10.1377/hblog20140619.039703/full/> (last visited Apr. 11, 2018).

65. See McCuskey, *supra* note 63, at 1115.

66. 42 U.S.C. § 18116(a) (2012) ("[A]n individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency" on the basis of membership in a protected class, age, sex, or disability); see Blake, *supra* note 16, at 236.

67. 42 U.S.C. § 300gg(a)(1) ("prohibiting discriminatory premium rates" based on any factors other than household size, geographic rating area, age, and tobacco use).

68. *Id.* §§ 300gg–13(a), 18022(b).

condition penalties or exclusions,⁶⁹ which disproportionately disadvantaged women.⁷⁰

Establishing preemptive federal protections against health insurance discrimination represented a departure from the traditional state-based regulation⁷¹ and an embrace of feminism through federalism. The shift of health insurance regulation from an individualized, piecemeal, state-by-state approach to a population-wide, federal regime was supposed to benefit health care expenditures by reducing the economic drain of preventable conditions and reliance on emergency, rather than preventive care. But this economic focus on *population* health and access to health care—this goal of *universal* coverage under meaningful insurance—belies an inherently feminist commitment to health equity best served on the scale of nationwide protections.

The body politic offers a longstanding metaphor for civil society⁷² with relevance to the feminism of health insurance regulation. The thrust of this concept is “that as all parts of the human body have their own function and are mutually necessary for its proper performance, so all members of a corporate body are essential for its health and well-being.”⁷³ Health insurance regulation that sets equality protections at the federal level serves the entire body politic and acknowledges the mutuality inherent in public health and the pooling of risk. It also wields feminism as federalism in the quest for health equity by establishing a national baseline of equal treatment.

V. CONCLUSION

The empiricism and equity concerns advanced by feminism have thus quietly taken root in health insurance reform. The ACA, reacting to data-driven evidence of disparity in women’s access to health care via insurance, creates federal baseline rules that bring some gender equity to health insurance.⁷⁴ The federalization of these risk-pooling rules, however, neither achieves full equality nor entirely safeguards partial equality—even if the statute itself survives further

69. *Id.* § 300gg-3(a).

70. See Marcia Greenberger & Lisa Codisoti, *What Health Reform Means for Women*, 37 HUM. RTS., Summer 2010, at 5, 6–7 (surveying insurance premium penalties based on classifying cesarean sections, IVF, rape, and domestic abuse as pre-existing conditions).

71. See, e.g., McCuskey, *supra* note 40, at 113–139, 123 fig.1.

72. See Ruth Ilesley Hicks, *The Body Political and the Body Ecclesiastical*, 31 J. BIBLE & RELIGION 29, 29–30 (1963); cf. Tracy E. Higgins, *Democracy and Feminism*, 110 HARV. L. REV. 1657, 1686 (1997); Ruth Gavison, *Feminism and the Private/Public Distinction*, 45 STAN. L. REV. 1, 1–2 (1992).

73. Hicks, *supra* note 72.

74. The ACA also reaffirmed the health equity commitment to empiricism and intersectionality by elevating the National Institute on Minority Health and Health Disparities. See Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 HASTINGS RACE & POVERTY L.J. 69, 80–95 (2013); DAWES, *supra* note 2, at 49.

legislative appeal attempts and administrative sabotage.⁷⁵ States may apply for waivers of some of these baseline rules and supplant them with their own versions.⁷⁶ While the ACA's waiver provision contemplates state substitute rules that have equivalent protections, the danger that states will water down protections lurks in the waiver process's fuzzy standards.⁷⁷

But the health equity paradigm and the data-norm feedback loop have embedded themselves in the structure of health insurance reform. Perhaps one of the most important revelations of the health equity and social determinants role in health reform is just how essential access to care is to the conditions for human flourishing.⁷⁸

Jennifer Prah Ruger has long argued that universal health insurance "is essential for human flourishing," applying Aristotelian theory of the "supreme good," as well as the capability approach.⁷⁹ Ruger poses that "[u]niversal health insurance is [] morally justified because it ensures (some of) the conditions for human flourishing, by reducing, mitigating and coping with the risks of ill health and the resulting financial insecurity."⁸⁰ This view of health insurance offers a communitarian alternative to the neo-classical economic approach frequently applied to health insurance questions.⁸¹

The health insurance reforms the ACA ultimately produced do not fully realize equity or universality in coverage. But they do take a necessary first step toward securing equal conditions for human flourishing by eroding some socially-constructed gender disparities in health insurance—a salubrious step for the body politic.

75. See Elizabeth Y. McCuskey, *Health Reform: Sabotage Edition*, PRAWFSBLAWG (Sept. 29, 2017, 5:21 PM), <http://prawfsblawg.blogs.com/prawfsblawg/2017/week39/> (last visited Apr. 3, 2018).

76. See McCuskey *supra* note 63, at 1129–33.

77. See *id.* at 1164–67.

78. See, e.g., Ruger, *The Moral Foundations*, *supra* note 18, at 53.

79. *Id.* at 53, 55.

80. *Id.* at 55.

81. *Id.* at 53, 57.

STUDENT COMMENTS

