

**Gender-rating in the United States Health Insurance Industry:**

**A Human Rights Violation**

Heidi Bramson, MPH, JD Candidate  
Third-Year Evening Student  
Rutgers School of Law – Newark  
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## **Introduction**

Health insurance is an essential aspect to the physical, emotional, psychological, and financial security of people residing in the United States (U.S.). “Health insurance coverage is the most important means for assuring that individuals have access to expensive health care services.”<sup>1</sup> Sixty percent of the U.S. population under age 65 accesses health insurance through an employer-sponsored plan.<sup>2</sup> In addition, five percent, or approximately 13.1 million of those under age 65 purchase private health insurance policies in the individual health care market.<sup>3</sup> In particular, six percent or approximately 5.7 million women aged 18-64 purchase health insurance in the individual market.<sup>4</sup> It is important to note there also exist over 17 million women aged 18-64 who are uninsured.<sup>5</sup> Such women do not have access to an employer-based health care plan, and earn too little to afford individual health insurance and too much to qualify for public assistance, such as Medicaid or a state equivalent.<sup>6</sup> The above statistics indicate there are nearly 23 million or 24 percent of women in the U.S. aged 18-64 whom at one point or another may seek to secure health insurance from the individual market.

The individual health insurance market is fraught with barriers for women. As reported in the groundbreaking 2008 study conducted by the National Women’s Law Center (NWLC), “*Nowhere to Turn: How the Individual Health Insurance Market Fails Women*”,<sup>7</sup> the individual health insurance market participates in a phenomenon known as “gender-rating”, where “insurance carriers are free to charge women and men different premiums for individually-

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<sup>1</sup> Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 Rutgers L. Rev. 335, 356 (2008).

<sup>2</sup> Kaiser Commission On Medicaid and the Uninsured, *The Uninsured, A Primer: Key Facts About Americans Without Health Insurance*, at 2 (October 2009), <http://www.kff.org/uninsured/7451.pdf>.

<sup>3</sup> *Id.* at 1.

<sup>4</sup> The Henry J. Kaiser Family Foundation, *Women’s Health Insurance Coverage, Fact Sheet*, at 1 (October 2009).

<sup>5</sup> *Id.* at 1.

<sup>6</sup> *Id.*

<sup>7</sup> National Women’s Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), <http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf>.

purchased insurance.”<sup>8</sup> Premiums may be higher, and applicant rejections and the insurance plan’s coverage conditions may differ solely because of the applicant’s sex, or for conditions related to the applicant’s sex, such as a history of domestic violence or sexual assault, and maternity-related conditions, such as pregnancy, previous Cesarean sections (C-sections), and fertility treatment.<sup>9</sup> This discrimination presents difficulties to health insurance affordability for women, creating an obstacle to the achievement of “health”, termed by the World Health Organization as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”.<sup>10</sup> The U.S. legal system has shirked its responsibilities in protecting women from sex discrimination in the health insurance market. This paper will explore ways in which the international human rights legal framework can contribute towards the protection of women from such discrimination. The first section of this paper will explain the weaknesses of the U.S. legal system particular to gender-rating, and the second section will explore the obligations the U.S. has to be beholden to international human rights law. The third section of this paper will explicate the ways gender-rating occurs and the human rights principles it violates. Lastly, the fourth section will present a recommendation for health care reform that is inclusive of a human rights framework particular to gender-rating that can fit neatly within the confines of U.S. law.

## **I. US Law**

Title VII of the Civil Rights Act of 1964<sup>11</sup> “prohibits discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of

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<sup>8</sup> *Id.* at 8.

<sup>9</sup> *See generally* National Women’s Law Center, *supra* note 7.

<sup>10</sup> Office of the United Nations High Commissioner for Human Rights and World Health Organization, The Right to Health, Fact Sheet No. 31, at 1, [www.ohchr.org/Documents/Publications/Factsheet31.pdf](http://www.ohchr.org/Documents/Publications/Factsheet31.pdf).

<sup>11</sup> Civil Rights Act of 1964, Title VII, 42 U.S.C. §2000e (1964).

employment, on the basis of race, color, religion, sex or national origin.”<sup>12</sup> In 1976 the Supreme Court ruled in *General Electric v. Gilbert*<sup>13</sup> that sex discrimination as prohibited by Title VII, was not inclusive of pregnancy related conditions. Congress responded by passing “the Pregnancy Discrimination Act of 1978<sup>14</sup> (PDA) clarifying the meaning of the phrases ‘on the basis of sex’ or ‘because of sex’ as inclusive of ‘pregnancy, childbirth and related medical conditions’ in relation to Title VII of the Civil Rights Act of 1964.”<sup>15</sup> While Title VII and the PDA are both important aspects of protecting women from sex discrimination in employment, the federal legislation’s main aim was to prevent employment discrimination.<sup>16</sup> Insurance companies were primarily regulated so they would not assist *employers* in discriminating; the aim was not necessarily to prevent *insurers* from discriminating.<sup>17</sup> While insurers cannot provide group health insurance plans that discriminate on the basis of sex to employers, federal legislation does nothing to prevent sex discrimination in individual health insurance plans sold in the private market directly to consumers.<sup>18</sup> An analysis that locates sex discrimination legislation in the employment realm, rather than in the health realm makes clear that “as a society we are more concerned about sex-based inequality in employment than we are about pursuing a social solidarity vision of insurance more broadly.”<sup>19</sup> Congress’ aim was to control employment discrimination, the vehicle was health insurance, but the focus was not to prioritize the health of women.

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<sup>12</sup> Ethnic/National Origin, Color, Race, Religion & Sex Discrimination, U.S. Department of Labor, <http://www.dol.gov/dol/topic/discrimination/ethnicdisc.htm>.

<sup>13</sup> *General Electric v. Gilbert*, 429 U.S. 125 (1976), reh’g denied, 429 U.S. 1079 (1977).

<sup>14</sup> Pub. L. No. 95-555, 92 Stat. 2076 (1978).

<sup>15</sup> Kandace Engle, *Pregnancy Discrimination in the Insurance Industry 1994*, 34 U. of Louisville J. of Fam. L. 177, 181 (Winter 1995/1996).

<sup>16</sup> *Id.* at 183.

<sup>17</sup> *Id.*

<sup>18</sup> *See Id.*

<sup>19</sup> Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 Kan. L. Rev. 73, 91 (2005) (Crossley defines “social solidarity” as a “vision of health coverage (by which insurance permits the risk of medical costs to be spread broadly across society, so that healthy persons subsidize the care received by healthy persons).”).

Individual states are responsible for regulating the individual health insurance industry. After the Supreme Court found in 1944 in *United States v. South-Eastern Underwriters Association*<sup>20</sup> that the business of the insurance industry qualifies as commerce under the regulatory power of Congress' Commerce Clause,<sup>21</sup> Congress quickly enacted the *McCarran-Ferguson Act of 1945* to grant states the authority to continue regulating insurance, unless Congress specifies otherwise.<sup>22</sup> States have followed suit in enacting legislation similar to Title VII and the PDA, as well as state Equal Rights Amendments.<sup>23</sup> However, these statutes also fall short in protecting women who do not have access to employer-based health insurance and who must purchase from the individual health insurance market.<sup>24</sup>

## **II. U.S. Obligations Under International Law**

It is clear that gender equity was on the agenda of those participating in the creation of human rights norms after World War II. The preamble of the Charter of the United Nations (U.N.) reads “We the Peoples of the United Nations Determined . . . to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small”.<sup>25</sup> In addition, Article 55(c) calls for “universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.”<sup>26</sup> Although the U.S. signed the U.N. Charter, the general interpretation in the U.S. court system is “that the Charter provisions lacked the necessary mandatory quality and definiteness that would indicate an intent to create enforceable

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<sup>20</sup> *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533 (1944).

<sup>21</sup> *Id.* at 533.

<sup>22</sup> 15 U.S.C. §§ 1011-1015 (1945). ; *see also* Engle, *supra* note 15, at 192.

<sup>23</sup> National Women's Law Center, *supra* note 7, at 14.

<sup>24</sup> *Id.* at 6-7.

<sup>25</sup> U.N. Charter, pmbl.

<sup>26</sup> *Id.*

rights in the United States.”<sup>27</sup> The U.N. moved forward and wrote the 1948 Universal Declaration of Human Rights (UDHR), and yet again in the preamble appears an acknowledgement of the U.N. Charter’s “reaffirm[ation] . . . in the equal rights of men and women . . . .”<sup>28</sup> Indeed, the UDHR is not a “binding legal instrument”<sup>29</sup> but it is written with the spirit of encouraging Member States, including the U.S., and their citizens’ observance of the principles so espoused.<sup>30</sup> Additionally, such “soft” law can evolve into “international legal obligation.”<sup>31</sup> According to David J. Bederman, “virtually all of the provisions of the Universal Declaration concerning civil and political rights have come to be recognized as human rights norms in customary international law or in other multilateral instruments.”<sup>32</sup> In particular, the International Covenant on Civil and Political Rights (ICCPR)<sup>33</sup> and the International Covenant on Economic, Social and Cultural Rights (ICESCR)<sup>34</sup> served to “turn the aspirations of the Universal Declaration into ‘real’ and ‘binding’” law.<sup>35</sup>

The ICCPR and the ICESCR are two of numerous international human rights treaties that address the multiple human rights violations implicated in the phenomenon of gender-rating and its subsequent deleterious effects. The U.S. signed and ratified both the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)<sup>36</sup> and the ICCPR.<sup>37</sup> Ratification is a significant act whereby a state “indicates its consent to be bound to a treaty . .

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<sup>27</sup> David J. Bederman, *International Law Frameworks*, 99 (2d ed. 2006).

<sup>28</sup> Universal Declaration of Human Rights, pmbl, Dec. 10, 1948, G.A. res. 217A (III), U.N. Doc A/810 [hereinafter UDHR].

<sup>29</sup> Bederman, *supra* note 27, at 100.

<sup>30</sup> UDHR, *supra* note 28, pmbl.

<sup>31</sup> Bederman, *supra* note 27, at 100.

<sup>32</sup> *Id.*

<sup>33</sup> International Covenant on Civil and Political Rights, opened for signature Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR].

<sup>34</sup> International Covenant on Economic, Social, and Cultural Rights, opened for signature Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

<sup>35</sup> Bederman, *supra* note 27, at 101.

<sup>36</sup> International Convention on the Elimination of All Forms of Racial Discrimination, opened for signature Mar. 7, 1966, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969) [hereinafter ICERD].

<sup>37</sup> Kinney, *supra* note 1, at 337.

.”,<sup>38</sup> and in the case of human rights treaties, Congress is imparted with the responsibility of then passing legislation according to the treaty contents.<sup>39</sup> The U.S. is also a signatory to the ICESCR, the Convention on the Rights of the Child (CRC),<sup>40</sup> and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>41</sup>.<sup>42</sup> “The signature . . . creates an obligation to refrain, in good faith, from acts that would defeat the object and the purpose of the treaty.”<sup>43</sup>

### **III. Gender-rating and Human Rights**

#### **Right to Health**

The right to health is a right that is both foundational to the achievement of other human rights and is a right itself buoyed by the successful implementation of human rights norms.<sup>44</sup> “Health, among all the other forms of disadvantage, is special and foundational, in that its effects on human capacities impact one's opportunities in the world and, therefore, health must be preserved to ensure equality of opportunity.”<sup>45</sup> It is a right integral to non-discrimination, gender equality, a person's right to life, the right to reproductive services, and the right to be free from violence, not to mention various other human rights. The strongest declaration to the right to health can be found in the ICESCR, Article 12, whereby it is declared: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable

<sup>38</sup> Susan Deller Ross, *Women's Human Rights: The International and Comparative Law Casebook*, 23 (2008) (quoting Treaty Reference Guide, U.N. Treaty Collection (Treaty Guide)).

<sup>39</sup> Bederman, *supra* note 27, at 172-73 (Bederman discusses how human rights treaties are not self-executing; self-executing treaties have “immediate application without the necessity of implementing legislation by Congress.”)

<sup>40</sup> Convention on the Rights of the Child, opened for signature Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990) [hereinafter CRC].

<sup>41</sup> Convention on the Elimination of all Forms of Discrimination Against Women, opened for signature Mar. 1, 1980, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW].

<sup>42</sup> Kinney, *supra* note 1, at 337.

<sup>43</sup> Ross, *supra* note 38, at 22.

<sup>44</sup> U.N. Econ. & Soc. Council, Comm. On Econ., Soc. & Cultural Rights, Substantive Issues Arising in the Implementation of the International Convention on Economic, Social and Cultural Rights, General Comment 14, Article 9, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter ICESCR General Comment 14].

<sup>45</sup> Lawrence O. Gostin, *Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health*, 15 Geo. J. Poverty Law & Pol'y 571, 576-77 (2008).

standard of physical and mental health.”<sup>46</sup> The right to health can also be found in Article 25 of the UDHR “as part of the right to an adequate standard of living,”<sup>47</sup> in various CEDAW Articles, as well as in the CRC and the ICERD.

The right to health as defined in the ICESCR is a broad entitlement that encompasses the right to have access to health insurance. In the U.S., “[h]ealth insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately how healthy people are.”<sup>48</sup> Often people without health insurance do not receive the preventive care they need to stave off disease, infection, and ultimately death.<sup>49</sup> Indeed health insurance is a “service” that is “necessary for the realization of the highest attainable standard of health.”<sup>50</sup> Without health insurance, one cannot fulfill the aspirations of the ICESCR’s Article 12(d) that calls for “conditions which would assure to all medical service and medical attention in the event of sickness.”<sup>51</sup> In fact, General Comment 14 to the ICESCR expounds upon this principle and calls for increasing the participation of a state’s population in the insurance system.<sup>52</sup>

### **Sex Discrimination**

Women are unable to equally participate in the individual health insurance system, and are thereby discriminated against by the insurance industry on the basis of sex. Gender-rating in the individual health insurance market prevents or severely limits women’s abilities to access health insurance. Among the “best-selling plans”<sup>53</sup> in each state capital, 95 percent charge

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<sup>46</sup> ICESCR, *supra* note 34, at art. 12.

<sup>47</sup> Office of the United Nations High Commissioner for Human Rights and World Health Organization, *supra* note 10, at 1.

<sup>48</sup> The Kaiser Commission on Medicaid and the Uninsured, *supra* note 2, at 7.

<sup>49</sup> *Id.* at 1.

<sup>50</sup> See ICESCR General Comment 14, *supra* note 44, at art. 3.

<sup>51</sup> ICESCR, *supra* note 34, at art.12(d).

<sup>52</sup> ICESCR General Comment 14, *supra* note 44, at art. 17.

<sup>53</sup> National Women’s Law Center, *Still Nowhere to Turn*, Notes and Methodology, Table 1.a. (2009), <http://www.nwlc.org/pdf/stillnowheretoturn.pdf> (“‘Best-selling’ status is assigned by eHealthInsurance.com, based on the number of applications submitted through eHealthInsurance.com and approved by the insurance company during the most recent calendar quarter.”).

women and men of the same age and health status differently, with women under age 55 charged more.<sup>54</sup> This difference in cost occurs when men and women have the same exact coverage plan,<sup>55</sup> and even when the plan does not include maternity care.<sup>56</sup> The cost differential is ubiquitous in the U.S. with only eleven states legislating a complete ban on gender-rating,<sup>57</sup> and another two states implementing provisions to limit gender-rating.<sup>58</sup> In addition, NWLC found the differential in gender premiums to vary dramatically across states and within states. For example, in plans compared across states, “at age 25, women were charged between 6% and 45% more than men for individual market health plans; at 40-years-old, women’s monthly premiums ranged between 4% and 48% higher than men’s . . . ; and at age 55, women were charged 22% less to 8% more than the rates men were charged.”<sup>59</sup> Vast variations continued to be found within states, for example, insurers in Missouri ranged from charging 40-year-old women 140 percent more than men versus another plan charging 15 percent more.<sup>60</sup> Such examples show that actuarial justifications for charging women more than men are quite arbitrary.<sup>61</sup>

Discrimination is “any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms.”<sup>62</sup> Article 1 of the CEDAW adapts this definition applying it particularly to “discrimination against women”.<sup>63</sup> Greater premiums and other fees charged to women by virtue of their sex have the *effect* of limiting women’s access to

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<sup>54</sup> *Id.* at 1.

<sup>55</sup> National Women’s Law Center, *supra* note 7, at 4.

<sup>56</sup> *Id.* at 9.

<sup>57</sup> National Women’s Law Center, *supra* note 53, at 4.

<sup>58</sup> *Id.* at Notes and Methodology, Table 1.f.

<sup>59</sup> National Women’s Law Center, *supra* note 7, at 10.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Office of the High Commissioner for Human Rights and World Health Organization (WHO), *supra* note 10, at 7; *see also* General Comment 14, *supra* note 44, at art. 18.

<sup>63</sup> CEDAW, *supra* note 41, at art. 1.

health insurance, and thereby their access to services that support their right to health. This violates the principle of “formal equality” because women and men are not treated “in a neutral manner”, and the principle of “substantive equality” because the tolerance of such policies by the state “maintain . . . the inherent disadvantage” women experience.<sup>64</sup> As mentioned in General Comment 16 to the ICESCR, Articles 2 and 3 of the ICESCR work hand in hand.<sup>65</sup> In the attainment of economic, social, and cultural rights, Article 2 asserts there shall be no discrimination, including on the basis of sex,<sup>66</sup> and Article 3 asserts the equal rights of men and women to such human rights.<sup>67</sup> General Comment 14 to the ICESCR determines that “accessibility” is an essential element to the right to health and includes the principle of “non-discrimination”, specifically mentioning women as a vulnerable or marginalized group.<sup>68</sup>

Importantly, because of its ratification status, the ICCPR, while not declaring a right to health, declares in Article 26 that “the law shall prohibit any discrimination and guarantee equal and effective protection against discrimination on any ground such as . . . sex.”<sup>69</sup> This prohibition extends to the discrimination women are subjected to in the individual health insurance market. In relation to Article 26, General Comment 28 to the ICCPR maintains that States should act to change policies that discriminate against women, including “by private actors in areas such as employment, education, political activities and the provision of accommodation, goods and services.”<sup>70</sup> In *Broeks v. The Netherlands*,<sup>71</sup> the Human Rights Commission (HRC) ruled that

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<sup>64</sup> U.N. Econ. & Soc. Council, Comm. On Econ., Soc. & Cultural Rights, Substantive Issues Arising in the Implementation of the International Convention on Economic, Social and Cultural Rights, General Comment 16, Article 7, U.N. Doc. E/C.12/2005/4 (Aug. 11, 2005) [hereinafter ICESCR General Comment 16].

<sup>65</sup> *See Id.* at para. 2-3.

<sup>66</sup> ICESCR, *supra* note 34, at art. 2.

<sup>67</sup> *Id.* at art. 3.

<sup>68</sup> ICESCR General Comment 14, *supra* note 44, at para. 12(a); *see also* ICESCR General Comment No. 14, *supra* note 44, at para. 18.

<sup>69</sup> ICCPR, *supra* note 33, at art. 26.

<sup>70</sup> Human Rights Committee, General Comments Adopted By the Human Rights Committee Under Article 40, Paragraph 4, of the International Covenant on Civil and Political Rights, General Comment 28, Article 31, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000) [hereinafter ICCPR General Comment 28].

social security legislation once enacted, although only a right secured in the ICESCR, must not discriminate on the basis of sex according to Article 26 of the ICCPR.<sup>72</sup> The court determined Article 26 “derives from the principle of equal protection of the law without discrimination, as contained in Article 7 of the [UDHR], which prohibits discrimination in law or in practice in any field regulated and protected by public authorities.”<sup>73</sup> As noted earlier, health insurance is regulated and protected by public authorities; as such, although the right to health is not secured in the ICCPR, the accessibility to a publicly regulated service must not be discriminatory.

Another important attribute to accessing the right to health is that of “economic accessibility (affordability)” as mentioned in General Comment 14.<sup>74</sup> The right to health encompasses this “essential element”<sup>75</sup> that ensures health expenses, even those provided privately, are affordable to everyone.<sup>76</sup> CEDAW’s General Recommendation 24 on women and health consider “high fees” a “barrier” to health care access.<sup>77</sup> A woman’s earning power is still less than a man’s, with women earning only 78 cents on a man’s dollar.<sup>78</sup> It is apparent that the right to equality, especially relevant to women’s economic rights, particularly as workers, is integral to the right to health. Not only does CEDAW call for “equal remuneration” in regards to equal pay for “work of equal value”, but it also includes benefits as a part of such remuneration.<sup>79</sup> Women workers are positioned to be even more affected by the unequal benefits offered in the individual insurance market. Uninsured women are more likely to be part-time

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<sup>71</sup> *S. W. M. Broeks v. The Netherlands*, Communication No. 172/1984, U.N. Doc. CCPR/C/OP/2 at 196 (1990).

<sup>72</sup> *Id.* at para. 12.4.

<sup>73</sup> *Id.* at para. 12.3.

<sup>74</sup> ICESCR General Comment 14, *supra* note 44, at para. 12(b).

<sup>75</sup> *Id.* at para. 12.

<sup>76</sup> *Id.* at para. 12(b).

<sup>77</sup> U.N. Econ. & Soc. Council, Comm. on the Elimination of Discrimination Against Women, Report of the Committee on the Elimination of Discrimination Against Women, General Recommendation 24, Article 21, U.N. Doc. A/54/38/Rev.1 (Feb. 5, 1999) [hereinafter CEDAW General Rec. 24].

<sup>78</sup> National Women’s Law Center, *supra* note 7, at 9,

<sup>79</sup> CEDAW, *supra* note 41, at art. 11.1(d).

workers than uninsured men.<sup>80</sup> Part-time workers either cannot afford the coverage offered to them or are not offered any coverage at all.<sup>81</sup> Women are also more likely “to work for smaller employers who do not offer health insurance”.<sup>82</sup> Increasingly employers in general are not offering benefits,<sup>83</sup> much of which is a response to the high costs insurance companies charge the employer.<sup>84</sup> This is particularly relevant to industries with a mostly female workforce because insurers are free to charge the entire group more if their workforce is predominately female, such as found in the fields of health care, non-profit and community service organizations.<sup>85</sup> Employers instead choose high-deductible plans that shift costs to employees,<sup>86</sup> or employers provide fixed sums for workers to buy individual health insurance.<sup>87</sup> Either way, because of policies that tolerate unequal pay and unequal benefit distribution to women, women encounter significant barriers to accessing health insurance and their equal right to health.

### **Reproductive Health**

Maternity care is hard to come by in the individual health insurance market. According to NWLC, most of the individual plans studied did not include maternity care. “Of the over 3,500 individual insurance market policies that NWLC analyzed . . . just 12% include comprehensive maternity coverage, and these are available in less than half of the capital cities examined (23 of 47 states . . .).”<sup>88</sup> Non-comprehensive coverage, such as coverage that only includes certain aspects of maternity care, for example only labor and delivery, or only pre-natal care,<sup>89</sup> was

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<sup>80</sup> National Women’s Law Center, *supra* note 7, at 18.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. Times, June 1, 2008, [www.nytimes.com/2008/06/01/health/01insure.html](http://www.nytimes.com/2008/06/01/health/01insure.html).

<sup>84</sup> See National Women’s Law Center, *supra* note 53, at 9; see also The Kaiser Commission on Medicaid and the Uninsured, *supra* note 2, at 15.

<sup>85</sup> National Women’s Law Center, *supra* note 53, at 7.

<sup>86</sup> See *Id.* at 9.

<sup>87</sup> National Women’s Law Center, *supra* note 7, at 3.

<sup>88</sup> *Id.* at 10.

<sup>89</sup> *Id.* at FN 42.

available in 9 percent of the plans.<sup>90</sup> For plans that do not offer maternity care as a part of the individual plan, a “rider” or a supplemental policy, can be bought for an additional fee.<sup>91</sup> Riders are not the optimal choice, as they are expensive, sometimes costing more than the monthly premium.<sup>92</sup> They can entail a waiting period before coverage, even if a woman is already pregnant, and they can cover minimal services, or provide benefits only up to a certain amount.<sup>93</sup> Sometimes riders may even cost a woman more than paying for the cost of care without insurance.<sup>94</sup> For example, if a woman must pay \$300 a month for a rider for a year prior to pregnancy (\$3,600), and then with a hypothetically \$3,000 limit to her benefits, she will pay out more for insurance than what she will get back in coverage.

Other conditions related to reproductive health that become cause for the rejection of an individual insurance applicant include pregnancy, usually classified as a pre-existing condition, and a history of fertility treatment.<sup>95</sup> History of a C-section may give grounds for an insurance company to refuse an applicant, refuse to cover additional C-sections for a designated period, or the insurer may charge higher premiums.<sup>96</sup> For example, Blue Cross Blue Shield of Florida charged a 25 percent higher premium for 5 years in order to cover “repeat Caesareans”.<sup>97</sup> More so, after 5 years women only achieve a lower premium if “there is not a complication of pregnancy, another C-section, or if they get their tubes tied, and are no longer in that risk situation . . . .”<sup>98</sup> Not only are women’s reproductive choices, and the unpredictable outcomes of pregnancy subject to the whims and invoices of the insurance companies, at times women are

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<sup>90</sup> *Id.* at 10.

<sup>91</sup> *Id.* at 11.

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.* at 10.

<sup>96</sup> *Id.*

<sup>97</sup> Grady, *supra* note 83.

<sup>98</sup> *Id.*

also pushed into getting C-sections.<sup>99</sup> Obstetricians and hospitals often pressure women who have already undergone a C-section to have another one,<sup>100</sup> contributing to the fact that the Cesarean rate “is at an all-time high of 31.1 percent.”<sup>101</sup>

The barriers to maternal coverage for women who need individual health insurance are dangerous to the mother, the fetus, and the child once born. Pre-natal care is a recognized way of reducing both infant and maternal mortality and morbidity, and as such Healthy People 2010 included these reductions in their objectives.<sup>102</sup> “Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care.”<sup>103</sup> In addition, as of 2005, forty-two states had higher maternal mortality rates than found in 2004,<sup>104</sup> although maternal mortality is quite preventable.<sup>105</sup>

Gender-rating violates numerous international human rights treaties when it comes to reproductive health care. The UDHR set the tone for providing access to maternity services via Article 25.2 that declares “[m]otherhood and childhood are entitled to special care and assistance.”<sup>106</sup> A mother’s right to life, and that of her newborn child is protected via Article 6.1 of the ICCPR.<sup>107</sup> In General Comment 28 to the ICCPR, it is stated that reports submitted to the HRC on the right to life “should provide data on birth rates and on pregnancy- and childbirth-

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<sup>99</sup> Sylvia A. Law, *Childbirth: An Opportunity For Choice That Should Be Supported*, 32 N.Y.U. Rev. L. & Soc. Change 345, 359 (2008).

<sup>100</sup> Grady, *supra* note 83.

<sup>101</sup> *Id.*

<sup>102</sup> Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA), *Healthy People 2010, Maternal, Infant, and Child Health*, Vol.2, Ch. 16, (accessed Dec. 1, 2009), <http://www.healthypeople.gov/Document/HTML/volume2/16MICH.htm> [hereinafter CDC and HRSA].

<sup>103</sup> HRSA, Maternal and Child Health Bureau, *A Healthy Start: Begin Before Baby's Born*, (accessed Dec. 1, 2009), <http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.htm>.

<sup>104</sup> National Women’s Law Center and Oregon Health and Science University, *National Report Card on Women’s Health, Key Findings*, (2007), <http://hrc.nwlc.org/Key-Findings.aspx>.

<sup>105</sup> CDC and HRSA, *supra* note 102.

<sup>106</sup> UDHR, *supra* note 28, at art. 25.2.

<sup>107</sup> ICCPR, *supra* note 33, at art. 6.1.

related deaths of women.”<sup>108</sup> A request for such statistics implies that preventing infant and maternal mortality is a priority under the ICCPR. The way to achieve this priority is to ensure that individual health insurance plans provide affordable access to reproductive care during and after pregnancy.

As per Article 17 of the ICCPR, women have the right to not “be subjected to arbitrary or unlawful interference with his [or her] privacy, [and] family . . . .”<sup>109</sup> The conditions insurance companies impose upon women, such as in the previous Blue Cross Blue Shield example, obstruct a women’s choice to have (or not have) a C-section, or a sterilization procedure. This is especially so when insurance companies offer a lower premium to women struggling financially in return for meeting these conditions. This unnecessary pressure crosses into the realms of privacy and family, both protected by Article 17.<sup>110</sup> General Comment 28 makes it clear that private actors, not just the state, must be prohibited from interfering with a women’s privacy.<sup>111</sup> The family is supposed to be protected by both state and society,<sup>112</sup> and this entails ensuring pregnant women do not suffer from discrimination. Article 26 prohibits discrimination on the basis of “sex” and “other status”<sup>113</sup> and therefore pregnancy, as it is used in the PDA where pregnancy is included within the definition of “sex”, or pregnancy as a physical state on its own, cannot be cause for discrimination in individual health insurance coverage or eligibility.

The Committee of the ICESCR (CESCR) has encountered the matter of women paying more for health insurance in the case of Chile, where the Chilean Courts ruled gender-rating was not discriminatory because “women’s statistical risk of maternity” is cause for insurance

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<sup>108</sup> ICCPR General Comment 28, *supra* note 70, at para. 10.

<sup>109</sup> ICCPR, *supra* note 33, at art. 17.

<sup>110</sup> *Id.*

<sup>111</sup> ICCPR General Comment 28, *supra* note 70, at para. 20.

<sup>112</sup> ICCPR, *supra* note 33, at art. 23.

<sup>113</sup> *Id.* at art. 26.

companies to charge women more than men.<sup>114</sup> The CESCR subsequently determined that Chile's "[p]rivate system is beset with obstacles and limitations impeding women's access to healthcare coverage and thereby detracts from the principle of equal opportunities for men and women."<sup>115</sup> Implicit in this finding is that a woman's equal access to healthcare is essential to the enjoyment of economic, social, and cultural rights. This access must be available, non-discriminatory, and affordable.<sup>116</sup> The ICESCR explicitly details that the right to health includes steps necessary to reduce infant mortality and the stillborn rate, and to provide for healthy child development.<sup>117</sup> It is further clarified that this goal entails "access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."<sup>118</sup> Women in the individual health insurance market must be able to access maternity coverage in order to attain such goals.

The CEDAW's preamble declares "the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole."<sup>119</sup> This principle stands in direct contradiction to the practice of gender-rating, as the preamble prohibits discriminating on the basis of pregnancy or the eventual need for maternity coverage. More so, it declares that the responsibilities for children should be shared, providing a way to think about insurance coverage where all persons share risk equally, rather than individually.<sup>120</sup> General Recommendation 24 to the CEDAW clarifies that women's health must be secured by access to non-discriminatory health care services. Such services must be available "throughout the life cycle, particularly in

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<sup>114</sup> Center for Reproductive Rights, Trends in Reproductive Rights Jurisprudence in Latin America, July 1, 2003, <http://reproductiverights.org/en/document/trends-in-reproductive-rights-jurisprudence-in-latin-america>.

<sup>115</sup> CESCR - Chile - E/1994/104/Add.26 (2003); *see* ICESCR, *supra* note 34, at art. 3.

<sup>116</sup> ICESCR General Comment 14, *supra* note 44, at para. 12.

<sup>117</sup> ICESCR, *supra* note 34, at art. 12.2(a).

<sup>118</sup> ICESCR General Comment 14, *supra* note 44, at para. 14.

<sup>119</sup> CEDAW, *supra* note 41, pmb1.

<sup>120</sup> *See* Crossley, *supra* note 19, at 91.

the areas of family planning, pregnancy, confinement and during the post-natal period.”<sup>121</sup> The CRC also makes it clear that reproductive services are integral to many human rights, including those of the child, as it too calls for achieving reductions in infant and child mortality, and increasing pre-and-post natal care for women and family planning.<sup>122</sup>

### **Health Disparities**

Sex discrimination does not exist in a vacuum and women who suffer racial/ethnic discrimination have to bear the multiplied effects of injustice, often times resulting in great health disparities. This is particularly relevant when looking at women who do not have access to health insurance. “Women of color are much less likely than white women to be insured through employers or to be able to afford private insurance.”<sup>123</sup> In particular, “41% of Latinas, 36% of indigenous women, and 24% of African-American women are uninsured.”<sup>124</sup> The inability to afford health insurance is “a critical element contributing to these disparities . . . .”<sup>125</sup> The U.S. sees health disparities in infant mortality, “cancer mortality, diabetes, heart disease, and overall life expectancy”, among others, between communities of color and whites.<sup>126</sup> Reproductive health disparities are particularly egregious with rates of maternal mortality in African American women quadruple those of white women.<sup>127</sup> African American children are also “2.5 times more likely than white children to die in the first year of life.”<sup>128</sup>

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<sup>121</sup> CEDAW General Rec. 24, *supra* note 77, at para. 2.

<sup>122</sup> CRC, *supra* note 40, at art. 12.

<sup>123</sup> CERD Working Group on Health and Environmental Health, *Unequal Health Outcomes in the United States: Racial and Ethnic Disparities in Health Care Treatment and Access, The Role of Social and Environmental Determinants of Health, And the Responsibility of the State, A Report to the Committee on the Elimination of Racial Discrimination*, at 8, January 2008, <http://www.prrac.org/pdf/FinalHealthEJShadowReport12-6-07.pdf> [hereinafter *Unequal*].

<sup>124</sup> Center for Reproductive Rights, *Women’s Reproductive Rights in the United States: A Shadow Report*, at 14, (2000), <http://www.reproductiverights.org/sites/crr.net/.../Romania%20CEDAW%202000.pdf> [hereinafter *Shadow Report*].

<sup>125</sup> *Unequal*, *supra* note 123, at 3.

<sup>126</sup> *Id.*

<sup>127</sup> *Shadow Report*, *supra* note 124, at 7.

<sup>128</sup> *Id.*

The two treaties the U.S. ratified, the ICERD and the ICCPR, both prohibit discrimination on the basis of race, color, or nationality.<sup>129</sup> Specifically, Article 5 of the ICERD obligates States to “guarantee” without racial discrimination “[t]he right to public health, medical care, social security and social services.”<sup>130</sup> Although the U.S. refuses to ratify the ICESCR, where the right to health is primarily located, the U.S. did commit their willingness to acknowledge the right to health in the ICERD via ratification. More so, General Recommendation 25 to the ICERD recognizes the importance of having States address the way gender and race intersect to affect women of color.<sup>131</sup> Similarly, General Comment 28 to the ICCPR acknowledged that “[d]iscrimination against women is often intertwined with discrimination on other grounds such as race . . . “ and requested States work to put an end to such discrimination.<sup>132</sup> It seems only apparent, with these recommendations coming from the two treaties the U.S. ratified, that the U.S. must not only make provisions for the right to health that prevent race discrimination, but must bring a plan of action that takes into consideration the way sex and race function together when it comes to the right to health. CEDAW’s preamble speaks to this issue of intersecting oppressions, clarifying that gender equality cannot be achieved without addressing racial/ethnic inequality: “Emphasizing that the eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women.”<sup>133</sup>

### **Violence Against Women**

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<sup>129</sup> See ICERD, *supra* note 36, pmbl; see ICCPR, *supra* note 33, at art. 2.1.

<sup>130</sup> ICERD, *supra* note 36, at art. 5.

<sup>131</sup> See generally Committee on the Elimination of Racial Discrimination, Gender Related Dimensions of Racial Discrimination, General Recommendation 25, U.N. Doc. A/55/18, annex. V (Mar. 20, 2000) [hereinafter ICERD General Rec. 25].

<sup>132</sup> ICCPR General Comment 28, *supra* note 70, at para. 30.

<sup>133</sup> CEDAW, *supra* note 41, pmbl.

Survivors of domestic violence may be denied access to individual health insurance in eight states.<sup>134</sup> This is quite problematic given that domestic violence is rampant in the U.S. where “one-third of American women (31 percent) report being physically or sexually abused by a husband or boyfriend at some point in their lives.”<sup>135</sup> Health care is important to survivors of domestic violence for numerous reasons. Women must first have access to treatment for their immediate injuries, as well as access to treatment for the multitude of health effects linked to abuse, “including arthritis, chronic neck or back pain, migraine and other frequent headaches”.<sup>136</sup> Furthermore, abuse increases during pregnancy,<sup>137</sup> with 324,000 pregnant women reporting domestic violence annually.<sup>138</sup> Health care providers can serve as a means to assisting women in getting help. In one study of women who reached out to someone to speak with about their abuse, 37 percent of the people approached were health care providers.<sup>139</sup>

Domestic violence is an issue that clearly displays how the violation of one human right means the violation of many. “Violence against women is both a consequence and a cause of gender inequality.”<sup>140</sup> The right to health is understood in General Comment 14 to be “related to and dependent upon the realization of other human rights.”<sup>141</sup> Women who suffer from abuse are often dependent on their abuser for food, housing, protection, and financial resources.<sup>142</sup> Therefore women’s access to education and economic independence, and the guaranteed protection of the State is vital to women’s health. General Comment 14 continues to say that “the

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<sup>134</sup> National Women’s Law Center, *supra* note 53, at 4.

<sup>135</sup> Family Violence Prevention Fund, *The Facts on Health Care and Domestic Violence*, (accessed Dec. 1, 2009), [http://www.endabuse.org/userfiles/file/Children\\_and\\_Families/HealthCare.pdf](http://www.endabuse.org/userfiles/file/Children_and_Families/HealthCare.pdf).

<sup>136</sup> *Id.*

<sup>137</sup> Sheri A. Mullikin, *A Cost Analysis Approach to Determining the Reasonableness of Using Domestic Violence as an Insurance Classification*, 25 J. Legis. 195, 225 (1999).

<sup>138</sup> Family Violence Prevention Fund, *supra* note 135.

<sup>139</sup> *Id.*

<sup>140</sup> Joy Phumaphi, *Foreward* to WHO Multi-country Study on Women’s Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women’s responses vi, viii (2005).

<sup>141</sup> ICESCR General Comment 14, *supra* note 44, at para. 3.

<sup>142</sup> See generally Ellen J. Morrison, *Insurance Discrimination Against Battered Women: Proposed Legislative Protections*, 72 Ind. L.J. 259, 261-263 (1996).

right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health . . . .”<sup>143</sup> Women’s independent access to health insurance is one such determinant of health. States are required under General Recommendation 19 to CEDAW to “eliminate discrimination by any person, organization or enterprise.”<sup>144</sup> Therefore, States have a responsibility to prevent insurance companies from discriminating against survivors of gender violence and must ensure their “equal access to health care”.<sup>145</sup>

Discrimination against women who are survivors of gender violence is a violation of Article 26 of the ICCPR, which “prohibit[s] any discrimination and guarantee[s] to all persons equal and effective protection against discrimination on any ground such as sex . . . or other status.”<sup>146</sup> Individual insurance companies are discriminating against women because of their status as survivors of gender violence. General Recommendation 14 incorporates “protecting women from domestic violence” as a way to improve the health of women and eliminate gender discrimination.<sup>147</sup> CEDAW’s General Recommendation 19 on violence against women underscores that discrimination against women “includes gender-based violence . . . that affects women disproportionately”,<sup>148</sup> as seen in 2001, where “85 percent of victimizations by intimate partners were against women (588,490).”<sup>149</sup> Article 12.2(c) declares steps to ensure the right to health must include “[t]he prevention, treatment and control of epidemic, endemic, occupational

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<sup>143</sup> ICESCR General Comment 14, *supra* note 44, at para. 4.

<sup>144</sup> U.N. Econ. & Soc. Council, Comm. on the Elimination of Discrimination Against Women, Report of the Committee on the Elimination of Discrimination Against Women, CEDAW, General Recommendation 19, para.9, UN GAOR, 1992, Doc. No. A/47/38 (11<sup>th</sup> Session 1992) [hereinafter CEDAW General Rec. 19].

<sup>145</sup> *Id.* at para. 19.

<sup>146</sup> ICCPR, *supra* note 33, at art. 26.

<sup>147</sup> ICESCR General Comment 14, *supra* note 44, at para. 21.

<sup>148</sup> CEDAW General Rec. 19, *supra* note 144, at para. 6.

<sup>149</sup> Family Violence Prevention Fund, *supra* note 135.

and other diseases”.<sup>150</sup> WHO recently reported violence against women is “common, wide-spread, and far-reaching in its impact . . . part of everyday life for millions of women.”<sup>151</sup>

Violence against women is an epidemic<sup>152</sup> that calls for women’s guaranteed access to health services through insurance availability. Of particular note, this violence epidemic cannot be treated or controlled if women are discouraged from seeking medical treatment or protective services because they fear their insurance company will find out they are a survivor of domestic violence by looking through their medical records or credit reports.<sup>153</sup>

### **Duties of the State to Regulate the Insurance Industry**

General Comment 28 to the ICCPR determines that States should “take the lead” in changing legislation and policy that discriminates against women.<sup>154</sup> This is specific to discrimination against women “in all fields, for example by prohibiting discrimination by private actors in areas such as employment, education, political activities and the provision of accommodation, goods and services.”<sup>155</sup> Individual insurance is a service provided by private actors and falls under this responsibility. Indeed, international treaties have traditionally requested that States regulate industries in their countries, including under the ICCPR. Regulating industries such as the “[l]abour market, commercial and agricultural sectors . . . logging and mining concessions and media” have been targeted in the concluding observations of the HRC.<sup>156</sup> The CESCR also identified the private health-care system as an industry that

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<sup>150</sup> ICESCR, *supra* note 34, at art. 12.2(c).

<sup>151</sup> Phumaphi, *supra* note 140, at vii.

<sup>152</sup> Charles Montaldo, *Domestic Violence an 'Epidemic' Researchers Report: Harms Women's Physical, Mental Health*, May 16, 2006, [http://crime.about.com/od/v\\_domviolence/a/ipv\\_rates.htm](http://crime.about.com/od/v_domviolence/a/ipv_rates.htm).

<sup>153</sup> Crossley, *supra* note 19, at 104; Mullikin, *supra* note 137, at 199.

<sup>154</sup> ICCPR General Comment 28, *supra* note 70, at para. 33.

<sup>155</sup> *Id.*

<sup>156</sup> Human Rights Council, Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled “Human Rights Council”, Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, Addendum, State responsibilities to regulate and adjudicate corporate activities under the United Nations core human rights treaties: an overview of treaty body commentaries, para. 30, U.N. Doc. A/HRC/4/35/Add.1, (Feb.13, 2007).

needs to be regulated by the State in order for the State to fulfill its obligations under the ICESCR.<sup>157</sup> The ICERD too demonstrates an expectation that states will take an active role in reforming legislation or regulations that are racially discriminatory.<sup>158</sup> The harmful impact gender-rating has on women is surely a sign the U.S. must assert its role under both the ICCPR and the ICERD to regulate and reform the individual insurance industry.

The ICESCR and the CEDAW clearly provide for the State's role in regulating private industry. General Comment 14 clarifies how States must "respect, protect, and fulfill" their obligations set forth in the ICESCR.<sup>159</sup> In particular, the duty "to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees."<sup>160</sup> This can be established by "fulfil[ling]" the obligations of the State by enacting "legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of health."<sup>161</sup> General Recommendation 24 to the CEDAW specifically advised on the current trend that finds governments privatizing their health sectors, and warned that "State parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies."<sup>162</sup> In addition, General Comment 14 mentions the State's duties to ensure "equal access" to privately provided health care and services, paying heed to the fact that "privatization of the health sector" must not endanger people's "availability, accessibility, acceptability and quality of health facilities, goods, and services . . .", particularly among women, and more so women who suffer from violence.<sup>163</sup> The State will be held responsible for

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<sup>157</sup> *Id.*

<sup>158</sup> ICERD, *supra* note 36, at art. 2.1(c).

<sup>159</sup> ICESCR General Comment 14, *supra* note 44, at para. 33.

<sup>160</sup> *Id.*

<sup>161</sup> *Id.*

<sup>162</sup> CEDAW General Rec. 24, *supra* note 77, at para. 17.

<sup>163</sup> ICESCR General Comment 14, *supra* note 44, at para. 35.

industries that violate the right to health who are not properly regulated by the State.<sup>164</sup> It is clear the U.S. should not do anything to offend such principles put forth in the ICESCR and the CEDAW. It would be prudent for the U.S. to federally regulate the individual health insurance industry in a way that protects the availability, accessibility, and affordability of health insurance for women.

### **The Insurance Industry**

The private health insurance industry is a for-profit industry that makes its money by taking into account a person's health risk factors, collecting and investing premiums determined by those factors, and aggregating people of similar risk in the same group plan.<sup>165</sup> People assumed to have too much risk are too much of a liability, and as reflected in the gender-rating phenomenon, are often refused insurance or are charged prohibitive premiums.<sup>166</sup> The insurance industry argues that classifications "based on a statistically significant relationship to risk of loss ensure fairness."<sup>167</sup> While NWLC found premium differentials subject to arbitrary calculations,<sup>168</sup> courts tend to accept this argument.<sup>169</sup> However, the courts and federal and state legislatures have also determined that despite increased risk, sometimes it is not good public policy to refuse to insure people.<sup>170</sup> This "antidiscrimination" argument suggests, "when social costs of using a classification outweigh industry costs of not using a classification, social welfare should govern insurers' decisions."<sup>171</sup>

Internationally it is becoming ever more apparent that cultural norms can no longer justify the denial of women's human rights, especially as people understand the negative effects

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<sup>164</sup> *Id.* at para. 48.

<sup>165</sup> Mullikin, *supra* note 137, at 200.

<sup>166</sup> *See generally* National Women's Law Center, *supra* note 7.

<sup>167</sup> Mullikin, *supra* note 137, at 200.

<sup>168</sup> National Women's Law Center, *supra* note 7, at 10.

<sup>169</sup> Mullikin, *supra* note 137, at 203.

<sup>170</sup> *Id.* at 203.

<sup>171</sup> *Id.*

such norms have on women.<sup>172</sup> In the same sense, the U.S. must begin to look at its economic system as a cultural norm that can no longer justify the harms it perpetrates on women and other oppressed communities. Paul Farmer writes in his book *Pathologies of Power*, that the new trend that terms health a “commodity”, where insurance industries push healthcare for profit, “has, of course, deep cultural resonance with the affluent, inegalitarian society from which it springs.”<sup>173</sup> In particular, gender and race have been used to denigrate, segregate, keep poor, and thereby unhealthy; historically oppressed communities should not have to pay more for the effects of their discrimination.<sup>174</sup> Farmer sees such social inequality as the “motor force behind most human rights violations.”<sup>175</sup> The insurance industry, even as a private actor, has “responsibilities regarding the realization of the right to health”<sup>176</sup> including accountability<sup>177</sup> to the consumer and the state. Our profit-based economic system is no longer enough of a reason to justify withholding access to health insurance and human rights.

#### **IV. Recommendation**

Strict Constitutionalists may argue the U.S. government is hesitant to abide by international human rights treaties particularly because our Constitution was designed to “insulate and protect people from government power” rather than mandate that the government provide benefits.<sup>178</sup> Despite such resistance, the U.S. is accountable to the ICCPR and the ICERD by way of ratification. The equal treatment and non-discrimination principles espoused in those treaties are

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<sup>172</sup> Sarah R. Hamilton, *The Status of Women in Chile: Violations of Human Rights and Recourse Under International Law*, 25 Women’s Rights L. Rep. 111, 122 (2004).

<sup>173</sup> Paul Farmer, *Pathologies of Power*, 163 (2005).

<sup>174</sup> *See Id.* at 219.

<sup>175</sup> *Id.* at 219.

<sup>176</sup> ICESCR General Comment 14, *supra* note 44, at para. 42.

<sup>177</sup> Human Rights Council, Promotion and Protection of All Human Rights, Civil, Political, Economic, Social, and Cultural Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, para. 99-102, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008).

<sup>178</sup> Bederman, *supra* note 27, at 101.

enough to legally persuade Congress to pass legislation that prevents the multiple ways the individual insurance industry discriminates against women, and disproportionately women of color. Additionally, while advocates of the CEDAW differ in their belief as to whether the U.S. legal apparatus is already equipped to deal with gender discrimination,<sup>179</sup> ratification of the CEDAW would certainly serve to bring women's issues to the national conversation on health care. Even more so, it seems the ratification of the ICESCR would bring a better understanding to the general public about the right to health.

Yet ratification is not necessary to address the human rights violations attributed to gender-rating. In fact, signatories cannot act to defeat the object and purpose of a signed treaty.<sup>180</sup>

Women's rights advocates need only understand "state action" differently and more broadly, as Rosa Ehrenreich Brooks wrote: "If we use a more nuanced and expanded definition of state action - one that recognizes that willful blindness or deliberate inaction is just as much a state choice - many injuries that affect women in particular suddenly appear on our maps with startling clarity."<sup>181</sup> The world community must recognize that doing nothing is equivalent to inflicting harm. The "inaction" of the U.S. in securing non-discriminatory health insurance for women in the individual market is both a direct violation of their responsibilities in observing their State obligations to the ICCPR and the ICERD, as well as an act that violates their State signatory obligations under the ICESCR, the CEDAW, and the CRC.

The injuries women face from gender-rating in the individual health insurance market are many. With sustained government inaction women will not be guaranteed non-discriminatory options. As per General Recommendation 14 to the ICESCR, the U.S. must "develop and

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<sup>179</sup> Elizabeth M. Schneider, *Anna Hirsch Lecture: Transnational Law as a Domestic Resource: Thoughts on the Case of Women's Rights*, 38 New Eng. L. Rev. 689, 715-716 (2004).

<sup>180</sup> Ross, *supra* note 38, at 22.

<sup>181</sup> Rosa Ehrenreich Brooks, *Feminist Justice, At Home and Abroad: Feminism and International Law: An Opportunity for Transformation*, 14 Yale J.L. & Feminism 345, 352 (2002).

implement a comprehensive national strategy for promoting women’s right to health” that includes affordable health care, access to reproductive services, and services that assist women suffering from domestic violence.<sup>182</sup> There are currently eleven states that ban gender-rating in the individual health insurance market,<sup>183</sup> forty-two states ban health insurers from refusing to insure women who suffer from domestic violence,<sup>184</sup> and eighteen states mandate coverage for maternity care.<sup>185</sup> These results are dismal and embarrassing. State reform has only served to create a “patchwork” of protections that leave loopholes allowing insurers to continue to deny or limit coverage to women.<sup>186</sup> A comprehensive federal law must be passed that respects a women’s right to equality, health, life, reproductive care, and freedom from violence. This law must ban insurers from rejecting applicants or allowing for premium and coverage differentials on the basis of gender or sex, including conditions related to a person’s gender or sex, such as pregnancy and domestic violence. Additionally, comprehensive reproductive care across a woman’s life span must be mandatory. With a new U.S. Administration that prioritizes health, the renewed buzz about the CEDAW, and a changing ethos in the way the Supreme Court has begun to utilize international law,<sup>187</sup> the time is ripe for a health care reform that champions the international human rights of women.

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<sup>182</sup> ICESCR General Comment 14, *supra* note 44, at para. 21.

<sup>183</sup> National Women’s Law Center, *supra* note 53, at 4.

<sup>184</sup> *Id.*

<sup>185</sup> See National Women’s Law Center, *supra* note 53; Kaiser Family Foundation, Mandated Coverage of Maternity Care, January 2009, <http://www.statehealthfacts.org/comparetable.jsp?cat=10&ind=687&typ=5&gsa=1>.

<sup>186</sup> National Women’s Law Center, *supra* note 7, at 7; see also Grady, *supra* note 83.

<sup>187</sup> Schneider, *supra* note 179, at 691-696.