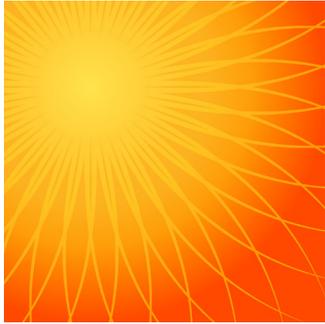
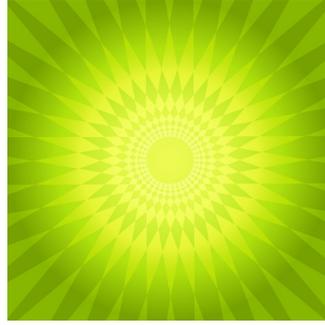




# Through the Lens of **EQUALITY**



## Eliminating Sex Bias to Improve the Health of Pennsylvania's Women



**Women's Law Project  
Pennsylvania  
April 2012**





# **THROUGH THE LENS OF EQUALITY: Eliminating Sex Bias to Improve the Health of Pennsylvania's Women**

Terry L. Fromson, Amal Bass, Carol E. Tracy, Susan Frietsche  
The Women's Law Project

*The Women's Law Project is a legal advocacy organization based in Pennsylvania. Founded in 1974, its mission is to create a more just and equitable society by advancing the rights and status of all women throughout their lives. To this end, the Law Project engages in high-impact litigation, public policy advocacy, and community education.*

125 South 9<sup>th</sup> Street  
Suite 300  
Philadelphia, PA 19107  
215-928-9801  
info@womenslawproject.org

401 Wood Street  
Suite 1020  
Pittsburgh, PA 15222  
412-281-2892  
infopitt@womenslawproject.org

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## **ACKNOWLEDGMENTS**

### **Authors**

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### **Disclaimer**

While text, citations, and data are, to the best of the authors’ knowledge, current as this report was prepared, there may well be subsequent developments, including recent legislative actions, that could alter the information provided herein. This report does not constitute legal advice; individuals and organizations considering legal action should consult with their own legal counsel before deciding on a course of action. In addition, this report does not constitute medical advice. Individuals with health problems should consult an appropriate health care provider.

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# FOREWORD

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Sometimes life comes full circle — by place and circumstance. Pennsylvania, for me, became both. The circle began in pain and ended in pain — with one bright spot.

My own story about the indignities of trying to gain access to necessary health care began years ago when I was the victim of the state’s medieval treatment of women seeking an abortion. My first husband had abandoned me and my three small daughters. Pregnant and sinking into poverty, the only way to obtain a medically safe procedure was to be diagnosed unfit as a potential parent by a hospital panel of all-male doctors. I was also required to obtain my estranged husband’s written permission. It was a harsh lesson on the frustration and humiliation borne by women in desperate need of basic health care.

As personally devastating and thoroughly degrading as my experience was, my procedure was at least safe and legal. That was not the experience of the vast majority of women at that time, whose only options were to put their lives on the line — as well as their dignity — and seek unsafe illegal abortions. The scope of this reality and its overwhelmingly harmful effects on women became the force and the pedestal for *Roe v. Wade*, the very reasons that legal protection be given to abortion. But it was more; its broader effect was to begin to shine a public light on the inferior health care given women.

For many years, I lived in Washington, DC and commuted on weekends to my home in central Pennsylvania. In Washington, as President of NARAL Pro-Choice America, I took up the struggle for a woman’s right to full reproductive health care and personal liberty. Twenty-five years later, this work came to a grinding halt for me when life’s circumstances required me to become the caregiver for my late husband who, already living with Parkinson’s disease, had taken a catastrophic fall and suffered life-threatening injuries. I returned to Pennsylvania — a different place and different circumstance — but, ironically no less in need of adequate and accessible health care from the powers that be than when I was a single mother. While overwhelmed with the care of my husband, my life was overtaken by the inadequacies of the health care system.

Coming full circle, I once again found myself trapped by the inexorable web of health care dilemmas — this time paying enormous medical bills for my uninsured daughter, who had been seriously injured in a tragic horse accident and care for my husband. What insurance coverage we had was far less than adequate to cover my husband's growing needs. What savings we had were wiped out to pay both for my daughter's medical bills and to cover the gap between what our insurance covered and the actual cost of my husband's care. I gave up my job to care for my husband because we could not afford outside help. Once again I faced the quagmire of health care and the emotional and physical toll exacted by inadequate or inaccessible health care, a toll borne disproportionately by women.

The one bright spot in this painful time?

Having returned to Pennsylvania, I decided to focus my energies on improving the health care system. I spoke with Governor Rendell and Donna Cooper, his Secretary of Policy and Planning and an architect of his health reform package. They recommended I contact my friends at the Women's Law Project, who had recently held a forum about women's health care needs in Pennsylvania. As both a Pennsylvania resident and former national director of the NARAL Pro-Choice America, I was quite familiar with the WLP's legal work to advance reproductive rights. It was not until I began my weekly treks to Philadelphia that I learned about the full range and depth of work they do on a broad range of issues affecting women's legal, health, and social status.

For months we met; we researched; we analyzed; we finally decided that the public needed to know more about the intersection of health and law, and in particular about the huge impact that bias against women has on women's overall health and the health of their families. For all of the years that I have been involved in women's rights and in women's health care, I have never seen the connections between health and equality more dramatically demonstrated than it is in this report, *Through the Lens of Equality: Eliminating Sex Bias To Improve The Health of Pennsylvania's Women*. While it paints a sobering picture of the health consequences of inequality, it also provides hope as it lays out a series of recommendations for policy makers, legislators, and advocates that frame the issues that must propel the next wave of activism for women's equality.

It has been a great honor to collaborate with the Women's Law Project. Their work with local issues and direct contact with women keeps them grounded on needs and trends. Their insight is a true beacon about unmet needs. Their exceptional legal skills, policy analysis, and keen understanding of operational issues facing government and health and social service providers has no parallel in any other organization with which I am familiar.

This publication is a blueprint for improving women's health through the elimination of sex bias. While its focus is Pennsylvania, the findings and recommendations have nationwide application. It should be required reading for policymakers and advocates and should generate a deep commitment to making changes not just to policy but to the underlying attitudes that have allowed bad policy — policy detrimental to over half the population — to persist.

*Kate Michelman*

Gettysburg, Pennsylvania  
March 30, 2012



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# INTRODUCTION

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The Women’s Law Project (WLP) is one of only a few public interest law centers in the nation devoted to women’s rights — and the only one in Pennsylvania. Our vigorous advocacy to protect women’s rights and opportunities in Pennsylvania is crucial to the women and families in our state. Moreover, because our populous and diverse state is often a bellwether of what happens nationally, our success — or failure — has consequences for women and children across the country.

Since our founding in 1974, WLP has worked at the vanguard of the battle against sex bias, violence and injustice. Combining high impact litigation, public policy advocacy and community education, we have forged an extensive track record of legal precedents, policy reforms, direct services and collaborations to improve the rights, safety and security of women and their families — particularly those who have few resources and little political power. Our expertise is broad, because women’s lives are multi-dimensional, and sex bias persists in all dimensions of private and public life. Working across the range of issues that interact in women’s lives empowers WLP to identify cross cutting issues, and creates opportunities to change law and policy in ways that affect large numbers of women and families.

Inspired by the public debate on health care, WLP embarked on an examination of the relationship between the sex bias women experience and their health. The goal was to build a state and federal policy agenda tailored to both overcoming sex bias and improving women’s health.

We knew that discrimination and bias exist. We also knew that women do not fare well on critical health measures. Although we recognized the connection between women’s health and some aspects of societal bias and unlawful discrimination, we did not fully understand the extent to which sex bias and women’s health outcomes are linked. Nor had we developed a comprehensive advocacy strategy that focused on both the legal and health inequities.

As familiar as we were with women’s health-related issues, our more in-depth examination of the health consequences of inequality truly shocked us. Despite decades of incremental progress on women’s rights, the inextricable link between women’s health and their legal status

cannot be denied. As discrimination, bias, and violence against women persist, women have — and will continue to have — significant, inequitable, and avoidable health problems.

In *Through the Lens of Equality: Eliminating Sex Bias to Improve the Health of Pennsylvania's Women*, WLP examines four realms of women's lives with a total of 10 discrete and overlapping spheres in which profound connections between sex bias and health exist and in which legislative and policy improvements are needed:

#### Home and Community

- A. Sexual Assault
- B. Intimate Partner Violence
- C. Poverty
- D. Caretaking

#### II. Workplace

#### III. School

- A. Athletic Opportunity and Treatment
- B. Sexual Victimization

#### IV. Health Care System

- A. Reproductive Health
- B. Insurance
- C. Drug Treatment Trials

This introduction summarizes the historical context for and the present day status of women's equality in the legal, social, and health arenas. Each chapter of the report provides a thorough discussion of the relevant national and Pennsylvania laws and data and offers suggestions about how to best make use of this report. The connections made between sex bias and women's health and suggestions for reform are of national significance and apply to all states.

## Equality and Health: The Context

### Historical Sex Bias

The legal and social status of American women has changed dramatically in the last fifty years. Half a century ago, it was legal to segregate jobs by sex, to refuse to hire or promote on the basis of a person's sex, to fire women who became pregnant, and to limit the number of women admitted to professional schools such as law and medicine. Sexual and domestic violence were hidden from public view and public policy. Abortion was illegal and the birth control pill was not yet on the market. Today, women have taken their place in the working world and educational opportunities for women have expanded exponentially. Sexual and domestic violence are recognized as crimes and some resources are available to its victims. Abortion is legal and birth control is available.

Despite these advances, deeply embedded cultural biases and stereotypes about women's place in society continue to impede women's equal participation in society. In our homes and communities women are subjected to violence, poverty, and the burden of caretaking responsibilities. In the workplace, women are paid less than men for the same work, remain concentrated in stereotypically female low-paying occupations, are subjected to sexual harassment and discrimination on the basis of pregnancy and caregiving, and are denied advancement to managerial and higher paying positions. In school, young women are denied their fair share of sports opportunities and are sexually harassed and violated. Women are denied essential reproductive health care and subjected to discrimination in access to insurance coverage. Women pay more than men for the same coverage, and pregnancy is a pre-existing condition that often denies pregnant women access to insurance coverage and therefore maternity care. Access to abortion

has been limited by burdensome legislative requirements, and providers and patients have been terrorized by an increasingly violent opposition. Attacks on access to contraceptive services have grown.

While many laws have been adopted to eliminate sex discrimination at work and at school, gaps persist that must be filled and enforcement needs to be strengthened. This is particularly true in Pennsylvania. While some Pennsylvania cities have outlawed employment discrimination on the basis of caregiving responsibilities and provide other accommodations for women who work, the Pennsylvania legislature has failed to adopt a statewide prohibition on discrimination on the basis of caregiver status or to provide family leave for caregivers. In Pennsylvania, the law permits insurers to price the cost of health insurance higher for women than for men, resulting in women paying more for individual health insurance policies and small employers paying more for health insurance for a predominantly female workforce. Pennsylvania's sexual assault laws have for the most part eliminated discriminatory provisions, but the myths and stereotypes that continue to infect the criminal justice system hinder the investigation and prosecution of these crimes. The health care perspective on domestic violence and sexual assault is far too limited. Sexual assault is treated as a health care matter primarily in the immediate aftermath of a rape, even though the physical and emotional health consequences can be long lasting. Although a number of health care providers recognize that domestic violence is also a health issue, screening for domestic violence in health care settings is not universal. Poverty, which disproportionately impacts women, exacerbates the impact of sex bias in all of these realms.

### **Women's Health Status: Nationally and in Pennsylvania**

As bias and discrimination against women persist, women experience significant health problems. Recent reports on women's health status by the Kaiser Foundation and the National Women's Law Center and Oregon Health & Science University present stark findings on the extent to which women's health suffers.

The most recent national Kaiser Women's Health Survey reveals that one in five women between the ages of 18 and 64 are in fair or poor health, a figure that increases to one in four when limited to women between 50 and 64.<sup>1</sup> The Kaiser survey also found that one-third of women live with a chronic health problem requiring ongoing medical attention. Poor women are three times as likely as higher income women to report fair to poor health and African American women have higher rates of several chronic conditions.<sup>2</sup> The chronic conditions most frequently experienced include arthritis, hypertension, and high cholesterol, with asthma and diabetes increasing in recent years.<sup>3</sup> Mental health conditions are prevalent among women, with one in four of all surveyed women suffering from depression or anxiety, a number that increases with age, poverty level, and physical health problems.<sup>4</sup>

Pennsylvania, with 6.5 million women, has consistently been found deficient in national studies on women's health care measures. In their 2010 health report card, the National Women's Law Center and Oregon Health & Science University placed Pennsylvania 32 among the 50 states and graded it unsatisfactory with respect to the status of women's health.<sup>5</sup> Pennsylvania earned grades of failing or unsatisfactory in the following critical areas related to women's health, which are listed with Pennsylvania's ranking in relation to other states:

- Breast cancer death rate (44)
- High blood pressure (41)
- Diabetes (38)
- No leisure-time physical activity (37)
- Smoking (36)
- Infant mortality (32)
- Coronary heart disease death rate (32)
- Obesity (29)
- Binge drinking (29)
- Life expectancy (28)
- Lung Cancer death rate (24)
- Stroke death rate (17)

To alleviate women’s health problems, it is necessary to eliminate adverse experiences — discrimination and bias — early in life and throughout life — and to improve access to health care, with an emphasis on care essential to women.

## Advocating for a Better Future

We need to reform both the delivery of health care and the underlying sex bias in society to improve the legal and health status of women.

### Health Care Reform

Repeatedly raised throughout this report is the anticipated full implementation of the Patient Protection and Affordable Care Act (ACA) to expand access to better health care for women.<sup>6</sup> Signed into law by President Obama in March 2010, the ACA has the ability to transform health insurance in the United States, making it more accessible and more affordable for everyone, including women. If the ACA is fully implemented, it has the potential to provide comprehensive quality health insurance for all U.S. citizens through mandatory coverage of preventive and essential aspects of health care, Medicaid expansion, and subsidies. If fully implemented, the ACA will eliminate discrimination that has historically denied access to health insurance for women and will mandate coverage of most essential elements of women’s health care.

The ACA, however, contains gaps in coverage for health care essential to women. Most importantly, it does not mandate that insurers cover abortion care. To the contrary, it prohibits federal funding of abortion care except in cases of rape, incest, and life endangerment,<sup>7</sup> and permits states to ban the sale of insurance covering abortion care in the health insurance marketplace to be created by 2014. In addition, most ACA provisions will not be implemented until 2014 and will not apply to all segments of the employer sponsored health insurance market. The scope of benefits, cost of insurance and accessibility of insurance under the ACA will not be known until federal and state actors define these elements. We still do not know, for example, how maternity care will be defined in the benefit package. Will it cover prenatal care and postpartum care or be more limited?

Moreover, threats to ACA implementation exist. The Supreme Court is reviewing the constitutionality of the law in response to multiple legal challenges to essential provisions of the law.<sup>8</sup> The provisions the Court is reviewing include the individual mandate, which requires residents who can afford it to purchase qualified health plans or pay a fine, and the Medicaid expansion program, which expands Medicaid eligibility for residents to 133 percent of the federal poverty level.<sup>9</sup>

## Eliminating Sex Bias

The underlying inequality tolerated by society perpetuates discrimination and bias that have a deleterious impact on women's health. Deep seated cultural bias about women's role in society must be exposed and eliminated. Numerous targeted interventions — well beyond improving access to insurance through the ACA — are necessary to cure institutional and individual prejudices about women. Eliminating barriers to equality requires targeted policy responses to provide essential services, policy changes, educational initiatives, and effective monitoring systems to address ongoing sex bias.

## Conclusion

*Through the Lens of Equality* demands that we look past the impressive strides that have been made in women's rights over the past fifty years. Those incremental victories were hard won and took enormous courage and coordination, but past victories are not enough. Looking to the future requires us to insist on equal treatment, equal access, and equal opportunity to achieve — not just healthy women — but a healthy society.

## A Guide to Using this Report

Each chapter of this report provides in-depth research, analysis, and specific and extensive recommendations. Following this introduction is an Executive Summary of the analysis and recommendations from each chapter. For complete analysis and policy recommendations, please review each chapter in its entirety. This report is available on WLP's website, [www.womens-lawproject.org](http://www.womens-lawproject.org), and links to new research relevant to this report will be posted periodically.

This report focuses on the intersection of law and health primarily in the context of legal, legislative, and policy work in which WLP has experience and expertise. Our overall objective is to provide research and recommendations that will assist reform efforts by policy makers and advocates, as well as health care providers, employers, and educators.

As comprehensive as this report is, it is not an exhaustive account of all legal and health issues affecting women and girls. We appreciate that women are impacted by many societal challenges that have significant health consequences that we were unable to address as thoroughly as they deserved, such as immigration laws that deprive women of accessing the most minimal health care, or the health consequences of inadequate housing. Similarly, the health, legal and financial challenges associated with depriving lesbian and gay couples of marriage, and the multitude of challenges faced by transgendered individuals are beyond the scope of this report. We encourage readers to use this report as a foundation for ongoing research and advocacy that will better inform and guide efforts to improve the health, legal, and social status of women and girls.

## NOTES

<sup>1</sup> Usha Ranji & Alina Salganicoff, Kaiser Family Found., Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey 10 (2011), *available at* <http://www.kff.org/womenshealth/upload/8164.pdf>.

<sup>2</sup> *Id.* at 6-7.

<sup>3</sup> *Id.* at 7.

<sup>4</sup> *Id.* at 8.

<sup>5</sup> National Women's Law Center & Oregon Health & Science University, *Making the Grade on Women's Health: A National and State-by-State Report Card* (2011) <http://hrc.nwlc.org/>.

<sup>6</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>7</sup> See Susan A. Cohen, *Insurance Coverage of Abortion: The Battle to Date and the Battle to Come*, 13 *Guttmacher Policy Rev.* 2 (2010), *available at* <http://www.guttmacher.org/pubs/gpr/13/4/gpr130402.html>.

<sup>8</sup> *Florida v. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011) (upholding the Medicaid expansion program but striking down the individual mandate), cert. granted by *Dep't of Health & Human Servs. v. Florida*, 2011 U.S. LEXIS 8094 (U.S. Nov. 14, 2011), *Florida v. Dep't of Health & Human Servs.*, 2011 U.S. LEXIS 8248 (U.S. Nov. 14, 2011), and *Florida v. Dep't of Health & Human Servs.*, 2011 U.S. LEXIS 8225 (U.S. Nov. 14, 2011).

<sup>9</sup> WLP believes that both of these provisions are constitutional. The individual mandate is constitutional because the decision not to purchase health insurance is an economic activity subject to congressional regulation under the Commerce Clause that will, over time, impose costs on taxpayers and others when they inevitably utilize healthcare during the course of their lives. As one court held, the individual mandate "is no more [an encroachment on individual liberty] than a command that restaurants or hotels are obliged to serve all customers regardless of race, that gravely ill individuals cannot use a substance their doctors described as the only effective palliative for excruciating pain, or that a farmer cannot grow enough wheat to support his own family." *Seven-Sky v. Holder*, 661 F.3d 1, 54, 55 (D.C. Cir. 2011). The Medicaid expansion program is constitutional under the Spending Clause because the Medicaid program remains, as it has been since its inception, a voluntary Federal-State partnership, the federal government will pay nearly all the costs of the expansion, and states retain the power to establish their own healthcare programs if they so choose. See *Florida v. U.S. HHS*, 648 F.3d 1235 at 1267, 1268.

# executive summary

## KEY FINDINGS & Key Recommendations

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### CHAPTER 1: THE IMPACT OF SEX BIAS IN THE HOME AND COMMUNITY ON WOMEN'S HEALTH

#### Section A. The Impact of Sexual Violence on Women's Health

In the United States, sexual assault of women is rampant in the home and in the community, and has serious and long-lasting health consequences. In addition to the rape itself and immediate trauma, the consequences include physical injuries, chronic pain, sexually transmitted infections (STIs), gynecological problems, unwanted pregnancies, post-traumatic stress disorder (PTSD), suicide attempts, substance abuse, and eating disorders. The vast majority of rape victims suffer from chronic physical or psychological conditions. Yet, in spite of the significant physical and psychological ramifications of sexual assault, most of the public policy initiatives exist in law enforcement, not in health care. Sexual assault is a crime, and the criminal justice system needs to be more responsive and needs to rid itself of practices that are victim blaming and deter women from seeking police assistance. Only a minority of victims report to police; many of those who do suffer what they describe as “secondary victimization” by police officers, prosecutors, judges, and juries, who, infected by systemic bias, do not believe them. Such treatment reinforces the low reporting rates, and deters some victims from seeking health services. In addition, women are not receiving sufficient or adequate health care to treat the impact of sexual assault. Eliminating the threat to women's health from sexual assault requires improving the response of both the law enforcement and health care systems.

#### Recommendations for Reform

- Include screening for sexual assault in health care;
- Provide trauma-informed counseling;

- Require insurance coverage of health care for conditions resulting from sexual assault;
- Increase funding for immediate and long term supportive services for victims of sexual assault;
- Increase research-based prevention programs; and
- Eliminate victim-blaming and gender bias from the criminal justice system.

## **Section B. The Impact of Intimate Partner Violence on Women's Health**

Intimate Partner Violence (IPV) is physical, sexual, or psychological harm committed by a current or former spouse, partner, or dating partner in order to gain power and control. While IPV victims and perpetrators may be male or female, the majority of victims are women who endure abuse perpetrated by men. Research has shown connections between IPV, particularly coercive control by one intimate partner against the other, and traditional gender-based stereotypes and hostility towards women. IPV impacts women far beyond the immediate injuries they receive when physically and/or psychologically abused, affecting women's short and long term physical and mental health. Women may be killed or suffer from chronic neurological, gastrointestinal, gynecological, cardiac, and mental health problems, while children exposed to IPV also bear long term psychological and developmental consequences. Although laws have been reformed and services have been developed to address IPV, the locus for addressing IPV remains in law enforcement. While law enforcement has a role in addressing IPV, it should not be the only remedy. A coordinated community response is necessary to protect victims from abuse and promote their health and well-being.

### **Recommendations for Reform**

- Create community responses that include coordination between law enforcement and health and social services;
- Provide health interventions that include IPV screening and are trauma-informed;
- Provide insurance coverage for treatment of conditions resulting from IPV.
- Expand accommodations for IPV victims in employment, housing, and public assistance programs;
- Increase capacity and quality of victim and batterer services;
- Increase access to legal assistance and self-help legal resources to IPV victims; and
- Train and educate the public, law enforcement, and the courts about IPV and the importance of addressing victim and child safety in PFA and custody determinations;

### **Section C. The Impact of Poverty on Women's Health**

Women are disproportionately burdened by poverty and the health risks and conditions associated with poverty. This is due in large part to the persistence of discriminatory practices and stereotypes in the workplace, home, and society at large. In the workplace, women are paid less than men for the same work and are also sidelined into lower paying jobs. Pregnancy, caretaking, and the impact of domestic violence and sexual assault can remove women partially or completely from gainful employment. Once out of the paid employment economy, women are consigned to the U.S. welfare system that has been gender-based from the outset. Poverty has led many Pennsylvanians, especially women and children, to suffer from a host of physical and mental health problems. These conditions include obesity, malnutrition, diabetes, coronary heart disease, asthma, HIV, cervical cancer, and high blood pressure. Poverty is also associated with low breastfeeding rates, poor health outcomes from treatable illnesses, and post-traumatic stress disorder (PTSD). The safety net of public and private programs has not alleviated either poverty or its negative impact on health.

#### **Recommendations for Reform**

- Eliminate sex discrimination in employment;
- Expand access to affordable health care;
- Improve access to cash, food, medical, and housing assistance programs;
- Increase cash, food, and child care assistance to cover basic needs; and
- Increase domestic violence shelters and services.

### **Section D. The Impact of Sex Bias in Caregiving on Women's Health**

Gendered stereotypes of women as homemakers and mothers underlie the disproportionate share of family caregiving placed on women. Women comprise the majority of family caregivers for older persons, adults with disabilities, and children, including children with special needs. This burden is exacerbated by the failure of society to develop adequate legal, social, and economic supports for caring for aging and disabled adults and for children. Caregivers are more likely than non-caregivers to experience heart disease, depression, lower back and neck pain, and lower resistance against infection. Legal reform, increased work flexibility, and expansion of social services will alleviate the negative impact of caregiving on women.

#### **Recommendations for Reform**

- Prohibit employment discrimination on the basis of caregiving responsibilities;
- Make paid family and sick leave universally available;
- Provide tax credits for caregiving;
- Increase work flexibility; and
- Expand high quality child, elder, and respite care.

## **CHAPTER II. THE IMPACT OF SEX BIAS IN THE WORKPLACE ON WOMEN'S HEALTH**

Women comprise a large segment of the workforce in the United States and in Pennsylvania. Anti-discrimination laws opened the doors for women to enter the workforce in greater numbers, including jobs traditionally reserved for men. Women work for the same reason men do: they have to work in order to support their families. The societal perception that sex bias in the workplace has disappeared because of the advances in law and legal protection is, unfortunately, erroneous. Despite its illegality and the growing numbers of women joining the workforce, sex bias continues, manifesting itself in a variety of ways. Women are paid less than men for comparable or equal work, are concentrated in stereotypically female low-paying occupations, are subjected to sexual harassment, are discriminated against on the basis of pregnancy and caregiving, and are denied advancement to managerial and higher paying positions. The intersection of gender, race, and ethnicity compounds the sex bias experienced by women in the workplace. While work can be good for women, employment sex bias leads to physical and psychological health problems and reduced access to health care.

### **Recommendations for Reform**

- Expand and enforce federal, state, and local laws prohibiting discrimination based on sex, including pregnancy and caregiving;
- Require employers to accommodate employees with temporary conditions affecting their ability to perform job duties, including temporary conditions related to pregnancy;
- Require employers to provide sick, family, domestic violence, and sexual assault paid leave; and
- Require breastfeeding accommodations in employment.

## **CHAPTER III. THE IMPACT OF SEX BIAS IN SCHOOL ON WOMEN'S AND GIRLS' HEALTH**

### **Section A. The Impact of Sex Bias in Athletic Opportunity and Treatment on Women's and Girls' Health**

Physical activity is key to the health of girls and women. Girls today are participating in organized sports in record numbers, thanks in large part to Title IX of the Education Amendments of 1972, a federal law prohibiting sex discrimination in educational programs receiving federal financial assistance.<sup>1</sup> Research demonstrates, however, that girls are not exercising enough and remain less physically active than boys. This lack of physical exercise places young women at risk for obesity, major health problems, and risky behavior. Sex bias and school non-compliance with Title IX deprive young women of equal opportunities to participate in sports and to acquire the health benefits of physical activity. Advocacy to bring schools into full compliance with Title IX is necessary to improve the health of young women.

### Recommendations for Reform

- Achieve full compliance with Title IX through ongoing self-assessment and voluntary reform;
- Aggressively monitor and enforce Title IX requirements;
- Adopt mandatory annual public reporting of athletic participation and treatment by Pennsylvania schools; and
- Audit and expand the provision of physical education instruction in schools.

### **Section B. The Impact of Sexual Victimization in Education on Women’s and Girls’ Health**

Young women are subjected to sexual victimization in school from elementary school through college. “Sexual victimization” encompasses both sexual assault and sexual harassment and includes behavior ranging from sexual comments and inappropriate touching to criminal acts of sexual assault. Young women are at greatest risk of being raped between the ages of sixteen and twenty-four and at higher risk if they are in college. Such victimization not only deprives young women of an education but also causes physical, emotional, and mental health problems that may follow them through life. In some cases, the victim is so distraught that she becomes suicidal. Increased prevention efforts and enforcement of laws that prohibit such conduct in our schools are necessary to protect the health, well-being, and lives of students.

### Recommendations for Reform

- Increase sexual victimization prevention efforts;
- Expand and fully enforce federal and state laws that prohibit such conduct in our schools;
- Adopt and enforce an NCAA policy that sets forth guidelines, corrective actions, and sanctions for violations;
- Adopt protections for individuals who testify in school discipline proceedings to eliminate barriers to reporting and participating in such proceedings; and
- Undertake significant educational efforts to protect the health, well-being, and lives of female students.

## **CHAPTER 4: THE IMPACT OF SEX BIAS IN THE HEALTH CARE SYSTEM ON WOMEN’S HEALTH**

### **Section A. The Impact of Sex Bias in Reproductive Health Care on Women’s Health**

Reproductive health care provides enormous benefits for women’s health. Contraception enables childbearing to be limited and timed, averting unwanted pregnancies and improving the health of women and babies. Some contraceptive methods also prevent transmission of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs). Abortion, which is safe, le-

gal, and one of the most common surgical procedures in the United States, saves lives and is an essential component of women's health care. Maternity care, including prenatal, obstetric, and postpartum care, prevents loss of maternal and child life and markedly improves health outcomes for both women and children. Reproductive health care, however, has been under attack for decades, despite the clear health benefits it confers upon women, and despite the constitutional protection afforded to women seeking reproductive health services. Politically motivated restrictions, cutbacks or outright bans in governmental subsidies, and concerted campaigns of harassment and violence against health care providers have chipped away at reproductive health services and rights. Over the years, these tactics have limited access to abortion for the poor<sup>2</sup> and the young,<sup>3</sup> as courts have weakened the applicable constitutional standards.<sup>4</sup> While the core right remains intact, the legal, political, and economic barriers impeding access to reproductive health care place women's health at risk. Significant public policy initiatives are necessary to nurture and support women's reproductive health.

### Recommendations for Reform

- Expand access to affordable and timely contraceptive and family planning services, emergency contraception, and maternity and abortion care;
- Implement comprehensive, evidence-based sexuality education;
- Ensure women receive accurate and complete information about their reproductive health option;
- Eliminate laws that impede access to reproductive health care;
- Protect patients and healthworkers from clinic violence through enforcement of FACE and adoption of statewide clinic buffer zone legislation; and
- Expand financial support for abortion through expansion of Medicaid funding of abortion and elimination of differential treatment of abortion under the Affordable Care Act.

### **Section B. The Impact of Sex Bias in Commercial Insurance on Women's Health**

The discrimination that women experience in access to and cost of health insurance obtained from employers (the commercial group market) or directly from insurers (the commercial individual market), negatively affects their access to health care and consequently, their health. Women who obtain health insurance through the commercial group and individual markets experience gaps in insurance coverage with respect to pregnancy and maternity care, contraceptive services, and abortion care. Furthermore sex discriminatory pricing of insurance deprives women access to insurance altogether. These gaps cause a broad range of negative health outcomes for women, including increased risk of maternal illness, low birth rate, premature birth, and infant mortality, delayed diagnoses, chronic illnesses, premature death, exposure to medical negligence, and mental health conditions.

### Recommendations for Reform

- Fully implement the Patient Protection and Affordable Care Act, providing maximum coverage of essential benefits for women; and
- Immediately adopt state legislation providing comprehensive pregnancy, maternity, and contraceptive coverage as well as equitable pricing.

### **Section C. The Impact of Sex Bias in Drug Trials on Women's Health**

Until 1993, the Food and Drug Administration (FDA) excluded women from participating in drug treatment trials. Although women are no longer explicitly excluded from clinical drug trials, the sex breakdown of subjects paints an incomplete picture about how much is known (or unknown) about a drug's effects on women. Pregnant women especially lack information about how FDA-approved drugs will affect them or the fetus. The exclusion of women from clinical drug trials has had major repercussions throughout the years. Women have suffered severe health consequences when drugs such as DES, oral contraceptives, and others are approved for use and prescribed without appropriate testing.

### Recommendations for Reform

- Require pools of trial participants to reflect the prevalence of health conditions by sex;
- Eliminate barriers to participation of women in drug trials;
- Enforce and monitor analysis of drug trials by sex;
- Eliminate politics from drug treatment trials and base decisions about drug trials and availability on scientific data; and
- Inform the public about differences in side effects by sex, including in particular with respect to pregnancy exposure.

## NOTES

<sup>1</sup> 20 U.S.C. § 1681(a) (2010).

<sup>2</sup> *See, e.g.*, *Williams v. Zbaraz*, 448 U.S. 358 (1980) (upholding state funding restrictions on abortion similar to those in the Hyde Amendment); *Harris v. McRae*, 448 U.S. 297 (1980) (upholding constitutionality of Hyde Amendment, restricting Medicaid funding for medically necessary abortions); *Maher v. Roe*, 432 U.S. 464 (1977) (holding that U.S. Constitution does not require government funding programs such as Medicaid to subsidize abortion care).

<sup>3</sup> *See, e.g.*, *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502 (1990) (upholding one-parent notification for minors' abortions with judicial bypass); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (striking down two-parent notification for minors' abortions); *Bellotti v. Baird*, 443 U.S. 622 (1979) (upholding mandatory parental consent requirement for minors who seek abortions provided that state offers expeditious and confidential alternative such as judicial bypass).

<sup>4</sup> *See, e.g.*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992) (preserving core of abortion right while changing constitutional standard from strict scrutiny to undue burden test: restrictions on abortion are unconstitutional if their purpose or effect is to impose substantial obstacle in path of woman seeking pre-viability abortion).

## Section A. The Impact of **SEXUAL VIOLENCE** on Women's Health

### INTRODUCTION

*Sexual assault of women is rampant in the United States and has serious and long-lasting health consequences.<sup>1</sup> In addition to the rape itself and immediate trauma, the consequences include physical injuries, chronic pain, sexually transmitted infections (STIs), gynecological problems, unwanted pregnancies, post-traumatic stress disorder (PTSD), suicide attempts, substance abuse, and eating disorders. The vast majority of rape victims suffer from chronic physical or psychological conditions.<sup>2</sup> Yet, in spite of the significant physical and psychological ramifications of sexual assault, most of the public policy initiatives exist in law enforcement, not in health care. Sexual assault is a crime, and the criminal justice system needs to be more responsive and needs to rid itself of practices that are victim blaming and deter women from seeking police assistance. Only a minority of victims report sexual assault to police; those who do often suffer what they describe as “secondary victimization” by police officers, prosecutors, judges, and juries who, infected by systemic bias, do not believe them. Such treatment reinforces the low reporting rates,<sup>3</sup> and deters some victims from seeking health services.<sup>4</sup> In addition, women are not receiving sufficient or adequate health care to treat the impact of sexual assault. Eliminating the threat to women’s health from sexual assault requires improving the response of both the law enforcement and health care systems.*



## Definition

The terminology and definitions of sexual assault and sexual violence vary in different settings. Crime definitions vary from state to state and from crime to crime, and from federal crime reporting definitions, leading to a lack of clarity in publicly reported crime rates. In health and other fields, broad definitions have been adopted. The National Institute of Justice defines sexual violence as including rape, sexual assault, and sexual harassment. Rape encompasses nonconsensual oral, anal, or vaginal penetration of the victim by body parts or objects. Sexual assault includes a wide range of “unwanted behaviors — up to but not including penetration,” and may include intentional touching of the victim’s genitals, groin, anus, or breasts, voyeurism, exposure to exhibitionism, unwanted exposure to pornography, and public display of images that were taken without the victim’s knowledge or in a private context. Sexual harassment includes a range of unwelcome behavior, including sexual advances, requests for sexual favors, and other verbal or physical sexual conduct.<sup>5</sup>

## Prevalence National Data

Currently, the most reliable data on sexual violence is drawn from telephone surveys that collect data on all forcible rapes of adult women, not just those reported to police.<sup>6</sup> These major national surveys, published in 1992, 2000, 2007, and 2011, demonstrate that women are raped in epidemic numbers, the risk of rape is not being reduced, and, in raw numbers, more women are being raped than ever before.

Based on questions answered by thousands of women, the 1992 National Women’s Survey estimated a 12.6 percent lifetime prevalence of completed forcible rape;<sup>7</sup> the 2000 National Violence Against Women Survey estimated a 14.8 percent lifetime prevalence;<sup>8</sup> and the 2007 Drug-facilitated,

Incapacitated, and Forcible Rape study estimated a 16.1 percent lifetime prevalence.<sup>9</sup> The three surveys estimated annual prevalence of completed forcible rape at: 0.71% (1992), 0.3% (2000), and 0.74% (2007).<sup>10</sup> In raw numbers for the years in which the data was collected, and taking into account U.S. population growth, the number of women estimated to be forcibly raped each year rose from 683,000 in 1991 to 829,000 in 2006.<sup>11</sup> In addition to the forcible annual rapes, the 2007 study also found that 303,000 women are raped while incapacitated, and 179,000 women experience drug-facilitated rape annually.<sup>12</sup> That brings the total number of completed forcible rapes each year to over one million.

The National Intimate Partner and Sexual Violence Survey (NISVS), which was conducted by the Centers for Disease Control and published in November 2011, produced extensive data on rape and other sexual assaults. Counting both completed and attempted forcible and alcohol/drug facilitated rape, the NISVS study found that 1 in 5, or 18.3 percent of U.S. women were forcibly raped at some time in their lives and estimated that nearly 1.3 million were raped annually.<sup>13</sup> The NISVS study also found that 1 in 2, or 44.6 percent of women experienced sexual violence other than rape (sexual coercion, unwanted sexual contact and non-contact unwanted sexual experiences) in their lifetime, while 1 in 20 or 5.6 percent of women experienced sexual violence in a 12 month period.<sup>14</sup>

Research has also found:

- Rape is often accompanied by physical assault, but many victims are not physically assaulted in addition to the rape.<sup>15</sup>
- Many victims are raped multiple times.<sup>16</sup>
- Most victims are women and most perpetrators are men.<sup>17</sup>

- Women are more likely than men to be raped by an intimate partner.<sup>18</sup>
- Most victims know the perpetrator.<sup>19</sup>
- Almost half of victims are raped before their 18<sup>th</sup> birthday.<sup>20</sup>
- Almost one-third of drug-facilitated and incapacitated rapes occurred when the victims were between ages 12 and 17 and two-thirds among women 18 and older.<sup>21</sup>

Decades of research has documented that only about 15-20 percent of rape victims report the crime to police.<sup>22</sup> As a consequence, in contrast to the survey results described above, data reported to the Federal Bureau of Investigation (FBI) by local police annually show many fewer rapes: in 2009, the FBI data lists only 88,097 reported forcible rapes in the United States, or 28.7 per 100,000 inhabitants.<sup>23</sup>

The low reporting rate is disturbing — but understandable. Victims are faced with the decision to contact the police in the immediate aftermath of a rape, when they may be traumatized and trying to make sense of what happened. Most are afraid, unsure whom to tell, fearful of retaliation from the rapist, and wary of exposing themselves to a system that they do not trust and that may further invade their privacy and cause additional trauma.<sup>24</sup> Victims also refrain from reporting to police because they are ashamed or embarrassed, or fear that the police will blame or disbelieve them. Victims might not understand that their experience is a police matter, or they may think the police cannot do anything.<sup>25</sup> A significant number of victims of drug-facilitated/incapacitated rape do not classify what happened to them as a crime or as the crime of rape.<sup>26</sup>

Once in the law enforcement system, the number of convictions is alarmingly low.

Studies suggest that 82-86 percent of all reported rape cases are dropped, most during the investigation.<sup>27</sup> Of those rapes in which the accused is arrested and prosecuted, 54 percent of the prosecutions end in either dismissal or acquittal.<sup>28</sup> More than one-fifth of convicted rapists are never sentenced to jail or prison time, and nearly a quarter of them receive time in local jail, which means that they spend an average of less than 11 months behind bars.<sup>29</sup>



### Pennsylvania Data

Until recently, no surveys reported the prevalence of rape in Pennsylvania. The NISVS report estimates that in Pennsylvania 18.8 percent or 960,000 women were raped, and that 45.3 percent or 2.3 million women are subjected to sexual violence other than rape.<sup>30</sup> The only other available Pennsylvania-specific data relate to those who report to police or who seek counseling services from Pennsylvania's sexual assault service providers.

Under the federal Uniform Crime Reporting (UCR) system, police reporting of crime data is voluntary.<sup>31</sup> However, in 2004, Pennsylvania created the Pennsylvania UCR Program, which requires local, county, and state police authorities to submit monthly crime statistics to the Pennsylvania State Police (PSP), and requires the PSP to publicly report such data on an annual basis.<sup>32</sup> In 2010, the Pennsylvania UCR Program

received data for 1,759 jurisdictions, although some of these jurisdictions did not fully report.<sup>33</sup> For 2010, Pennsylvania's reported data shows that Pennsylvania police authorities reported receiving 3,455 forcible rape complaints;<sup>34</sup> from those complaints, 989 charges were brought,<sup>35</sup> 894 arrests were made,<sup>36</sup> defendants were found guilty as charged in 137, defendants were found guilty of a lesser offense in 58,<sup>37</sup> and the courts acquitted or dismissed charges in 49.<sup>38</sup> With respect to sexual offenses other than rape, the reported data shows that in 2010, 7,821 complaints of

sexual offenses other than rape were made to police authorities;<sup>39</sup> 2,693 charges were brought, 1,901 arrests were made, 656 defendants were found guilty as charged, 116 defendants were found guilty of lesser offenses, and courts acquitted defendants or dismissed charges in 97.<sup>40</sup>

From April 2005 through May 2006, Pennsylvania's sexual assault service providers aided 13,867 adult victims, 10,247 child victims, and 13,838 significant others.<sup>41</sup>

## Impact on Women's Health

Sexual assault impacts women's health, both physically and mentally, sometimes seriously, and often for the long-term.

### Physical and Mental Health Consequences

The physical consequences of sexual assault may include:

- Physical injuries: 31.5 percent of women victims incur an injury; in addition to the rape itself and the associated genital trauma, victims also suffer minor scratches, bruises and welts, broken bones, dislocated joints, sore muscles, sprains, strains, chipped or broken teeth, knife wounds, internal injuries, and loss of consciousness.<sup>42</sup>
- STIs: Studies find an elevated prevalence of STIs among survivors of sexual violence.<sup>43</sup>
- Chronic pain, headaches, and stomach problems.<sup>44</sup>
- Gynecological problems: Common consequences of forced sex include vaginal bleeding, genital irritation, pain during menstruation, and sexual dysfunction.<sup>45</sup>

- Unwanted Pregnancy: 5.0 percent of rape victims of reproductive age (12 to 45) become pregnant as a result of a rape, resulting in an estimated 32,101 pregnancies each year, most occurring among adolescents and resulting from assault by a known, often related perpetrator.<sup>46</sup> The risk of pregnancy may increase when the assailant is an intimate partner.<sup>47</sup> There is a risk of poor pregnancy outcomes when a woman is pregnant at the time of the rape.<sup>48</sup>

The mental health consequences of sexual assault may be severe and long-lasting:

- PTSD, Depression, and Other Mental Health Problems: Nearly one-third of rape victims develop PTSD;<sup>49</sup> the rate of PTSD is three times greater among women who were raped as children.<sup>50</sup> One-third of victims experience major depression in their lifetime.<sup>51</sup> Victims of sexual assault by someone they know tend to experience more severe psychological stress due to self-blame.<sup>52</sup> Victims of drug and alcohol facilitated rape also have an increased risk of PTSD, major depression, and substance use disorders.<sup>53</sup>



- Family members also experience trauma as a result of the victimization of a loved one.<sup>61</sup>
- Access to Health Care**
- The health consequences of sexual assault require the provision of health services. When a victim reports a sex crime to the police, the police often direct her to an emergency department and to community rape crisis services.<sup>62</sup> The police can only make these referrals to victims who make a report to the police. Thus, barriers to reporting to the police also serve as barriers to health care.
- Only about one-fifth of rape victims receive post-rape medical care.<sup>63</sup> Research also shows that only 11.7 percent of women who got pregnant as a result of rape received immediate medical attention, while 47.1 percent received no rape-related medical attention.<sup>64</sup>
- To the extent that someone reports the crime, her first source of medical care may be the emergency department to which she is transported by the police after they respond to a call for assistance. In some cities, there may be a specific forensic unit established for sexual assault victims; Philadelphia has established such a unit to save traumatized victims from the long waits for treatment they would experience in busy urban emergency departments.<sup>65</sup> Other cities, like Doylestown, instruct police to take victims of sexual assault to designated hospital emergency departments.<sup>66</sup> At the medical facility, survivors receive treatment for injuries, a forensic exam, treatment for STIs, and emergency contraception. Sometimes, this care is provided by a Sexual Assault Nurse Examiner (SANE Nurse), who is specially trained.<sup>67</sup> If a SANE nurse is not on staff, a hospital may call one to come in and perform the exam. In addition, the emergency department may have a relationship with a local sexual assault
- Suicide: 13 percent of rape victims attempt suicide.<sup>54</sup>
  - Substance Use Disorders: Sexual abuse is significantly associated with the development of addictions in women.<sup>55</sup> Research suggests that some survivors of sexual assault may self-medicate to deal with the depression or anxiety resulting from the assault.<sup>56</sup> Rape victims are more likely to use illicit drugs and prescription drugs for non-medical reasons than non-victims.<sup>57</sup> One study found that 35 percent of adolescent girls in nine inpatient substance abuse treatment programs reported a history of sexual victimization;<sup>58</sup> another found that 73 percent of the sixty women interviewed in a residential substance abuse treatment facility had been raped, and 45 percent had been raped more than once.<sup>59</sup>
  - Eating Disorders: 26.6 percent of women with bulimia nervosa were raped at some point in their lives.<sup>60</sup>

advocacy agency, which may provide an advocate to assist the survivor, at her request.<sup>68</sup>

This initial emergency department visit can be difficult for a sexual assault victim. Because it is associated with law enforcement's evidence collection objective, and the forensic exam is an intrusive experience, it can be traumatizing. In addition, not all hospitals provide emergency contraception and the victim may have to be transported to another health facility or pharmacy in order to obtain EC. Being transported to another health facility or pharmacy for EC after having been sexually assaulted and then subjected to police intervention and medical treatment is onerous for the victim. Problematically, not all pharmacies supply emergency contraception, posing another obstacle to treatment.<sup>69</sup>

Following the initial interaction with the health care system, subsequent care is often available from a number of services, including medical, mental health, and rape crisis centers. Many victims do not seek assistance; studies show that only 14-43 percent of survivors seek help from such services.<sup>70</sup>

Many of those who seek assistance receive counseling from a mental health professional as a direct result of his or her most recent rape.<sup>71</sup> Available counseling is not always trauma-informed, an essential component of care for sexual assault victims.<sup>72</sup>

Lack of treatment may prolong the health consequences of rape. According to a recent study, victims do not seek help because they:

- are unable to tolerate being touched;
- feel unworthy of help as a result of self-blame or shame;
- believe they do not qualify for help, because their rape did not fit the stereotype of brutal rape by a stranger;
- believe the service will not help; or
- fear that seeking help would require the involvement of other systems (law enforcement or social services), which they believe will cause additional pain by forcing them to relive their experience or by subjecting them to mistreatment or blame.<sup>73</sup>

## Applicable Law

Pennsylvania's crime code criminalizes forcible rape, sexual assault, sexual intercourse or deviate sexual intercourse without consent, involuntary deviate sexual intercourse, public indecency, statutory sexual assault, aggravated indecent assault, indecent exposure, and attempts to commit such crimes.<sup>74</sup> These crimes are punishable by incarceration and other penalties, and are enforced by the Pennsylvania State Police and local law enforcement. Furthermore, the civil justice system provides an opportunity for a victim to seek damages from the perpetrator for injuries suffered during the crime in addition to or instead of pursu-

ing justice through the criminal system.<sup>75</sup> If the criminal system fails to respond appropriately to a complaint of sexual violence, the civil system may provide a remedy for the victim.<sup>76</sup>

In a series of reforms that started in the early 1970s, the Pennsylvania General Assembly dramatically changed Pennsylvania's sex offense laws. The legislature eliminated the requirements of resistance, corroboration, and prompt complaint so that a victim's lack of active resistance, lack of physical injuries, or delay in reporting the crime would not bar prosecution.<sup>77</sup> The legislature also recognized that spousal rape

is a crime, although it continued to treat it differently from non-spousal rape; abolished consideration of the victim's prior sexual history, except in limited circumstances; and eliminated cautionary jury instructions requiring special care in evaluating the testimony of rape victims.<sup>78</sup>

In 1995, the legislature revamped Pennsylvania's sex offense laws again, after the Pennsylvania Supreme Court upheld the reversal of a conviction for rape due to the absence of sufficient "forcible compulsion." Although the victim, a female college student, clearly said "no," the law at that time did not criminalize penetration without consent. The case, *Commonwealth v. Berkowitz*, generated a public outcry.<sup>79</sup> Recognizing the complexity of sexual assault, particularly in situations in which the parties know each other, the Pennsylvania General Assembly adopted a broader definition of forcible compulsion, eliminated differential treatment of spousal rape, and recognized the crime of non-consensual sexual penetration.<sup>80</sup> The creation of a new offense titled "Sexual Assault," which criminalized "engag[ing] in sexual intercourse or deviate sexual intercourse with a complainant without the complainant's consent" as a second degree felony, was a major step forward for sexual assault victims.<sup>81</sup>

Questions remain whether these reforms have resulted in actual change in the courtroom. For example, while clarifying that a victim's delay in reporting a sexual offense

to police is not "conclusive evidence that the act did not occur," the standard jury instructions continue to permit jurors to consider a delay in reporting to the police with regard to the reliability of the victim, despite the repeal of the prompt complaint statutory requirement and research on victim behavior in the aftermath of an assault that explains any delay.<sup>82</sup>

A number of laws aim to improve access to social and health services for victims of sexual assault.<sup>83</sup> The federal Violence Against Women Act, for example, provides funding to sexual assault service provider organizations to expand their capacity to provide services.<sup>84</sup> It also requires states to provide forensic exams free of charge to sexual assault victims without forcing victims to "participate in the criminal justice system or cooperate with law enforcement."<sup>85</sup> Pennsylvania law requires a hospital providing emergency medical care to survivors of sexual assault to give survivors written and oral information about EC and to administer EC if the survivor requests it, unless it claims a religious or moral exemption.<sup>86</sup> Thirteen Pennsylvania hospitals have informed the Department of Health that they will not provide EC based on the exemption.<sup>87</sup> Hospitals claiming an exemption must transport survivors, at no cost, to facilities that provide EC, or, if a survivor no longer requires in-patient treatment, transport her to a health clinic or pharmacy for EC.<sup>88</sup>

## **Sexual Assault Victim Arrested While Perpetrator Went Free**

Sara Reedy was sexually assaulted at gunpoint during a robbery of her workplace in Western Pennsylvania. Instead of investigating her complaint, Cranberry Township police disbelieved Reedy, arrested her, and charged her with theft, receiving stolen property, and falsely reporting a crime. Based on misconceptions of how a “real” rape victim acts, the police erroneously concluded that Ms. Reedy was uncooperative in the immediate aftermath of the attack, based on her failure to resist the assault (during which the perpetrator held a knife to her neck) and her apparent lack of interest in seeking counseling. Ms. Reedy sat in jail for five days and awaited a criminal trial for eight months. Finally, a serial rapist confessed to sexually assaulting her and two other victims. Ms. Reedy ultimately sued the police authorities for violating her civil rights. Applying the same long discredited rape myths that had improperly influenced the police, the trial court held that the detective’s conduct in arresting Ms. Reedy was reasonable and dismissed Ms. Reedy’s lawsuit. On appeal, the Third Circuit Court of Appeals reinstated the lawsuit, finding that the detective chose to “disregard plainly exculpatory evidence” and that “no reasonably competent officer could have concluded at the time of Reedy’s arrest that there was probable cause for the arrest.”<sup>i</sup> In doing so, the Third Circuit concluded that the trial court had erroneously and repeatedly adopted the least favorable interpretation of the facts for Reedy, made judgments about how victims ought to respond to sexual assault and trauma unsupported by the record or the law, and ignored the impact of the investigating police detective’s predisposition against Reedy and his “aggressive and insulting accusations” in evaluating her behavior.<sup>ii</sup> The Women’s Law Project submitted an *amicus* (friend of the court) brief on behalf of 39 non-profit organizations to the Third Circuit in support of Ms. Reedy.<sup>iii</sup>

<sup>i</sup> Reedy v. Evanson, 615 F.3d 197 (2010), *cert denied*, 2011 U.S. LEXIS 1893 (U.S. Feb. 28, 2011), at 232.

<sup>ii</sup> *Id.* at 216-20.

<sup>iii</sup> See Brief of *Amici Curiae* of Thirty-Nine Organizations Dedicated to Improving the Criminal Justice System’s Response to Violence Against Women in Support of Appellant and Requesting Reversal, Reedy v. Evanson, No. 2:06-cv-1080, 615 F.3d 197 (3d Cir. 2010), available at [http://www.womenslawproject.org/Briefs/Reedy\\_Amici\\_Spt\\_Appellant.pdf](http://www.womenslawproject.org/Briefs/Reedy_Amici_Spt_Appellant.pdf) [hereinafter Brief of *Amici Curiae* of Thirty-Nine Organizations, Reedy v. Evanson].

## **Barriers to Rape Prevention and Treatment**

### **Law Enforcement Response**

If law enforcement fails to respond appropriately to rape complaints, this failure is likely to prevent them from identifying, arresting, and prosecuting rapists. By failing to believe victims, law enforcement revictimizes them, and in so doing, deters victims from other help-seeking activities, including obtaining health and mental health care.<sup>89</sup>

Law enforcement responses can be tainted by “attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women.”<sup>90</sup> These myths establish expectations about “real” rape victims that defy reality. Contrary to the widely held belief that the typical victim is raped by a stranger through use of force or weapon, victims more often than not are

assaulted by people they know,<sup>91</sup> are raped in their own home or the home of a relative or friend,<sup>92</sup> are not likely to face an armed offender,<sup>93</sup> and are not necessarily physically injured.<sup>94</sup> In addition, the expectation that a victim will be upset and crying is not always met; victims commonly have a flat affect when describing what happened to them, possibly from having repeated the account to many people or because they feel a need to control their emotions.<sup>95</sup> Finally, the myths that many allegations of rape are false<sup>96</sup> or that rape only happens to “bad” people are untrue.<sup>97</sup> The consequences of these misconceptions are that rape victims are blamed and disbelieved, sexual assault is trivialized, particularly if the victim is assaulted by someone she knows, and assailants are excused.<sup>98</sup>

Critically, the police officers who adhere to rape myths handle rape cases differently from the way they handle other types of crimes.<sup>99</sup> They interrogate victims as if they are the suspects, and subject them to polygraph exams and arrests or threats of arrest for false reporting. They doubt and revictimize victims by closely scrutinizing their lives in search of evidence to charge the victim, without even investigating the rape allegations. Studies show that about one half of rape victims report being revictimized by police; one study that interviewed police officers as well as victims found that police themselves labeled their own behavior as revictimizing, consistent with the victims’ assessment of police behavior.<sup>100</sup>

The manner in which detectives interview complainants has an effect on the extent to which the complainant discloses what happened and potentially on the successful prosecution of the case.<sup>101</sup> Complainants whose cases were prosecuted described detectives as consoling, questioning them at a gentle pace, and giving them an overall feeling of being believed; complainants

## ***The Philadelphia Experience***

The 1999 *Inquirer* series uncovered a police scandal of epic proportions. Almost one-third of all sex crime complaints from the mid-1980’s through 1998 were buried in a non-crime code – 2701 – Investigation of Person.<sup>i</sup> Following City Council hearings and a strong response from the advocacy community led by the Women’s Law Project, the Philadelphia Police Department (PPD) eliminated the 2701 code for sex crimes, and reviewed all cases coded 2701 for the previous five years, finding 681 cases that should have been classified and investigated as rape – a first degree felony – and over 1700 additional cases that should have been classified and investigated as other sex crimes. The PPD reinvestigated these cases and were able to make some arrests. The PPD also instituted reforms in the Special Victims Unit (the PPD unit that investigates sex crimes) and invited WLP and other advocacy groups to conduct an unprecedented annual review of its sex crime files.

<sup>i</sup>Mark Fazlollah et al., *Women Victimized Twice in Police Game of Numbers*, *Phila. Inquirer*, Oct. 17, 1999, at A1.

whose cases were not prosecuted describe police as engaging in rapid and forceful questioning, victim blaming, and implicit or explicit communication of disbelief.<sup>102</sup> To the extent that a negative experience with a detective results in an inadequate victim statement, it may impact whether a case is prosecuted and whether prosecution ultimately results in a conviction.<sup>103</sup>

An emerging body of research finds that police treatment is a critical element in both advancing and impeding victim recovery. Given police power and authority, and the extreme vulnerability of and trauma experienced by sexual assault victims, the way the police treat the victim will either be an empowering first step toward her safety and healing or a devastating betrayal of trust, a second trauma. Two independent studies of rape victims' experiences in the police reporting process — in England and New Zealand — reported strikingly similar findings and conclusions.<sup>104</sup> Both studies found a strong polarity in victims' experiences, with many feeling either well-treated or profoundly mistreated by police.<sup>105</sup> Both found that, when police demonstrate respect and concern for the victim and belief in her story, it has a powerfully positive impact; women who felt well-treated were empowered by their police interactions.<sup>106</sup> Conversely, both studies found that, when police lack empathy, challenge a victim's credibility or judge her behavior, they re-traumatize her. Women who felt ill-treated by police were devastated by their interactions.<sup>107</sup>

Research shows that not only an alarmingly high number of perpetrators of sexual assault reoffend, but also that repeat offenders commit the vast majority of rapes.<sup>108</sup> In their 2002 study, David Lisak and Paul H. Miller found that 120 rapists were responsible for 1,225 separate acts of interpersonal violence, including rape, battery, and child physical and sexual abuse, and that repeat rapists averaged 5.8 rapes each.<sup>109</sup> Police mishandling of sexual assault complaints has allowed serial rapists like those in Lisak and Miller's research to perpetrate again and again without detection.

In the fall of 1999, the *Philadelphia Inquirer* published an investigative report revealing that for almost two decades, the Philadelph-

ia Police Department (PPD) had downgraded thousands of rapes and other sex crimes to a non-criminal category, thereby precluding a full and complete investigation of the crime.<sup>110</sup> During this time, one perpetrator assaulted six women in Center City Philadelphia between 1997 and 1999, while police investigators disbelieved and doubted the victims' complaints. Not until the rapist assaulted and murdered Shannon Schieber in 1998, did the police link the assaults and begin to believe there was a serial rapist attacking women in Center City. Five years and six victims later, the police arrested the perpetrator in 2002 in Fort Collins, Colorado.

In city after city, starting with Philadelphia in 1999, journalists have published accounts of police making sexual assault complaints disappear without investigating and prosecuting them. In St. Louis, New Orleans, Baltimore, New York, Cleveland, Milwaukee, and New York City, the number of reported rapes has declined,<sup>111</sup> and the number of unfounded rapes has grown.<sup>112</sup> Police place rapes in non-crime categories<sup>113</sup> or do not bother to write up formal complaints.<sup>114</sup> Horrendous sexual assaults and murders occurred in Cleveland,<sup>115</sup> Milwaukee,<sup>116</sup> and Baltimore,<sup>117</sup> which could have been stopped if only police had believed the repeated complaints by prior victims.

This mishandling of rape and other sex crimes puts victims at a unique disadvantage in the criminal justice system, decreasing the rate of reporting rape and other sex crimes and increasing the rate of claims withdrawn by victims.<sup>118</sup> Further, distrust of police and interrogation of victims of rape and other sex crimes create seemingly uncooperative victims, feed the misperception that uncooperative victims are lying, and discourage future victims from reporting to police.<sup>119</sup>

After reporters from cities across the U.S. contacted the Women’s Law Project (WLP), WLP asked Senator Specter to schedule a hearing on the subject before the U.S. Senate Judiciary Subcommittee on Crime and Drugs. On September 14, 2010, Carol E. Tracy, Executive Director of WLP, testified about the chronic and systemic failure of police departments in many cities to properly investigate sex crimes and asked that Congress take steps to hold police departments accountable.<sup>120</sup>

On March 16, 2011, the Civil Rights Division of the U.S. Department of Justice (Civil Rights Division) made a landmark finding that the mishandling of sex crimes by the New Orleans Police Department (NOPD) constituted widespread and pervasive gender bias against women, stating in its report:

We find that NOPD has systematically misclassified large numbers of possible sexual assaults, resulting in a sweeping failure to properly investigate many potential cases of rape, attempted rape, and other sex crimes. We find that in situations where the Department pursues sexual assault complaints, the investigations are seriously deficient, marked by poor victim interviewing skills, missing or inadequate documentation, and minimal efforts to contact witnesses or interrogate suspects. The documentation we reviewed was replete with stereotypical assumptions and judgments about sex crimes and victims of sex crimes, including misguided commentary about the victims’ perceived credibility, sexual history, or delay in contacting the police.<sup>121</sup>

The Civil Rights Division conducted a similar investigation of the Puerto Rico Police Department (PRPD), uncovering “troubling evidence that PRPD frequently fails to police sex crimes and incidents of domestic violence” that “may rise to the

level of a pattern and practice of violations of the Fourteenth Amendment and the Safe Streets Act.”<sup>122</sup>

### Court Response

Participants in the judicial process are not immune from bias in their handling of sexual assault. In the past few decades, researchers, state task forces, and judicial organizations have studied and made findings about gender bias in the court system.<sup>123</sup> The Pennsylvania Supreme Court

## ***Judge Labels Rape “Theft of Services”***

In the fall of 2007, Philadelphia Municipal Court Judge Teresa Carr Deni reduced rape and sexual assault charges against a man accused of raping a prostitute at gunpoint to robbery charges for “theft of services.” The victim, who had agreed to have protected sex with one man for \$150, was threatened with a gun and subjected to a demand for unprotected sex with at least three additional men.<sup>i</sup> The judge’s decision prompted public outrage, with then-Philadelphia Bar Association Chancellor Jane Dalton decrying Deni’s ruling as biased: “Her decision in this case was based on pre-existing bias as to when sex can be consented to, and as to when that consent can be withdrawn, and reflects, in my opinion, a clear disregard of the legal definition of rape and the rule of law in this case.”<sup>ii</sup>

<sup>i</sup> Jill Porter, *Hooker Raped and Robbed – By Justice System?*, Phila. Daily News, Oct. 12, 2007, <http://forums.civfanatics.com/archive/index.php/t-253216.html> (last visited Sept. 20, 2011).

<sup>ii</sup> Scott Michels, *Philly Judge Criticized for Rape Decision*, ABC News, Oct. 31, 2007, <http://abcnews.go.com/TheLaw/story?id=3801167&page=1> (last visited Sept. 20, 2011).

## ***Outcry Over Lenient Sentence for "Mistake in Judgment" by University Professor Who Pled No Contest to Sexual Assault***

Tracy McIntosh, a University of Pennsylvania professor who was head of Penn's Head Injury Research Center, pled *nolo condere* to sexually assaulting his college roommate's 23-year-old niece in his office.<sup>i</sup> Despite sentencing guidelines that recommended a minimum sentence of 24 to 66 months of imprisonment, Philadelphia Common Pleas Judge Rayford Means sentenced McIntosh to fines, probation, and house arrest in a plea deal that allowed McIntosh to avoid serving time in prison.<sup>ii</sup>

The sentence was met with outrage by women's and victims' groups, and the prosecutor appealed the sentence.<sup>iii</sup> Reversing the trial court's sentence for departing from sentencing guidelines without adequate reasons, the Pennsylvania Superior Court found that the judge relied on impermissible factors and mischaracterization of the record to justify the light sentence given, including: (i) stating that incarceration would be a hardship on McIntosh's family, (ii) characterizing McIntosh's conduct as inappropriate or a mistake in judgment rather than criminal, and (iii) acting more concerned about McIntosh than the victim or society.<sup>iv</sup> Based on the judge's failure to appreciate the seriousness of the crime and his disregard of the psychological harm suffered by the victim, the Superior Court also instructed that the case be reassigned to another judge for sentencing.<sup>v</sup> On remand, McIntosh was sentenced to three and a half to seven years in prison.<sup>vi</sup>

<sup>i</sup> *Pennsylvania v. McIntosh*, 911 A.2d 513, 516-17 (Pa. Super. Ct. 2006); Associated Press, *Penn Ex-Professor Sentenced in Sex Assault*, Feb. 13, 2008, [http://www.pennlive.com/midstate/index.ssf/2008/02/penn\\_exprofessor\\_sentenced\\_in.html](http://www.pennlive.com/midstate/index.ssf/2008/02/penn_exprofessor_sentenced_in.html) (last visited Sept. 20, 2011).

<sup>ii</sup> *McIntosh*, 911 A.2d 513 at 516-517, 521.

<sup>iii</sup> Associated Press, *supra* note i.

<sup>iv</sup> *McIntosh*, 911 A. 2d 513 at 519-22.

<sup>v</sup> *Id.* at 521-22.

<sup>vi</sup> Associated Press, *supra* note i.

Committee on Racial and Gender Bias in the Justice System reported evidence of judges, court officers, prosecutors, and juries who displayed stereotypical views, insensitivity to, and ignorance about victims of sexual assault, and disbelieved and blamed victims. This bias was reported as most prevalent when the victim knew the perpetrator — a circumstance that is true of the vast majority of sexual assaults.<sup>124</sup> In those cases, victim-blaming and inadequate sentencing was observed.<sup>125</sup> Researchers have found that jurors have inaccurate understandings of rape victim behavior

which influence their decisions.<sup>126</sup> Many judges and jurors expect proof of resistance and injury to overcome a consent defense, even though the law requires neither resistance nor corroboration.<sup>127</sup> As a result of this bias, jurors often fail to convict intimate partner rapists.<sup>128</sup> In one case, a Pennsylvania judge refused to permit the prosecution of the victim's husband for sexual assault because he would be imprisoned and the wife and children would have no one to care for them.<sup>129</sup>

Facing judges and juries with the same biases held by police, prosecutors face a daunting task in achieving a conviction, compounded by the fact that Pennsylvania is the only state in the country to prohibit expert testimony to explain victim behavior.<sup>130</sup> Many cases can be difficult; alcohol and drug-facilitated rapes may involve impaired memory and observation as well as biases against intoxicated victims.<sup>131</sup> Rather than try to overcome the misconceptions and challenges, prosecutors often decide not to prosecute.<sup>132</sup>

### The FBI's Uniform Crime Reporting System

The UCR system was created by the International Association of Chiefs of Police in 1929 to provide reliable uniform crimes statistics. Each year *Crime in the United States* is published with data reported to the UCR program from approximately 17,000 law enforcement agencies throughout the nation.<sup>133</sup> The UCR fails to provide accurate data on sex crimes to inform the public or to develop policies, strategies, and resources to assist victims. The UCR is limited at the outset because it reports only those sex crimes reported to police. It has been further limited by a definition of rape that includes only vaginal-penile penetration by force; all other sex crimes are consigned to a single undifferentiated category.<sup>134</sup> This definition, which dates back to 1929, is inconsistent with the broader statutory definitions of serious sex crimes promulgated by state legislatures. The UCR's anti-

quoted definition of rape left out many sex crimes considered serious by the public, regardless of gender, relationship, or mode of penetration.

The limited UCR definition has impacted society's response to sex crimes on a number of levels. First, by minimizing what crimes count as rape, the UCR definition can powerfully influence police perception of serious sex crimes and the resulting police response. Second, inadequate police response leads to diminished public confidence in the handling of sex crimes by police within a particular community, further undermining trust in the police and the likelihood of victim reporting. Third, by diminishing the scope of the problem, the narrow definition of rape has misled the public regarding the prevalence and incidence of the crime and reduced our ability to develop programs and policies that appropriately respond to the problem, thus hampering law enforcement and victim assistance efforts.

Efforts initiated by WLP in 2000 resulted in the FBI's expanding the definition of rape in 2011. The new definition defines rape as, "Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."<sup>135</sup> The new definition will be more consistent with state crime laws and public understanding of rape and will more accurately represent the incidence of serious sex crimes reported to law enforcement.

## ***Success After a Decade of Advocacy***

In 2000, during its work with the Philadelphia Police Department, WLP researched the UCR definition and concluded that it needed to be expanded. On September 20, 2001, WLP wrote to FBI Director Mueller on behalf of 80 state-based sexual assault coalitions and national organizations concerned with violence against women, requesting that the definition be changed.<sup>i</sup> WLP argued that the change was necessary because the current definition was narrow, outmoded, steeped in gender-based stereotypes, and seriously understated the true incidence of sex crimes. WLP did not receive a response. As the letter coincided with the tragedy of September 11, 2001, WLP assumed the FBI was otherwise engaged.

The campaign to change the definition was revived in 2010. WLP testified before the U.S. Senate Judiciary Subcommittee on Crime and Drugs that sexual stereotypes and bias is a root cause of police mishandling of sex crimes but also that less visible, but no less responsible, is the manner in which the FBI's UCR system defines, analyzes, and publicizes the incidence of sex crimes. The combination of bias and an unrealistic definition result in highly unreliable data on the incidence of sex crime in America.<sup>ii</sup> Senators attending the hearing sent letters to the FBI supporting a change in the definition. With the assistance of the Feminist Majority Foundation and its division, the National Center for Women & Policing, WLP met with FBI personnel who oversee the UCR Program to discuss further efforts to change the definition.

As a result of these discussions, on May 7, 2011, WLP renewed its request to the FBI's CJIS advisory process. The Department of Justice, Office of Violence Against Women (OVW), whose Director, Susan Carbon, had also testified before the Senate Judiciary Subcommittee, also made a request. A series of three meetings took place in which police chiefs and other high ranking law enforcement personnel considered and ultimately supported this request. A *Ms. Magazine*/Feminist Majority initiative that resulted in over 160,000 emails' being sent to the FBI bolstered WLP's campaign.

The Senate hearings also led to collaboration between WLP and the Police Executive Research Forum (PERF). This collaboration led to a Critical Issues Forum on "Improving Police Practices in Sexual Assault," which took place in September 2011. Police chiefs and other senior police officials from virtually every major city attended this landmark session,<sup>iii</sup> and expressed widespread support for changing the UCR.

In January 2012, Attorney General Eric Holder announced that FBI Director Robert Mueller agreed to update the definition of rape.<sup>iv</sup>

<sup>i</sup> Letter from Carol E. Tracy & Terry L. Fromson to Robert S. Mueller, III (Sept. 20, 2001), available at [http://www.womenslawproject.org/testimony/FBI\\_Letter\\_2001.pdf](http://www.womenslawproject.org/testimony/FBI_Letter_2001.pdf).

<sup>ii</sup> Carol E. Tracy, Women's Law Project, *Rape in the United States: The Chronic Failure to Report and Investigate Rape Cases* (Testimony Before the Senate Committee on the Judiciary Subcommittee on Crime and Drugs) (Sept. 14, 2010), available at [http://www.womenslawproject.org/testimony/UCR\\_Rape\\_Testimony091410.pdf](http://www.womenslawproject.org/testimony/UCR_Rape_Testimony091410.pdf).

<sup>iii</sup> Erica Goode, *Rape Definition Too Narrow in Federal Statistics, Critics Say*, N.Y. Times, Sept. 28, 2011, [http://www.nytimes.com/2011/09/29/us/federal-rules-on-rape-statistics-criticized.html?pagewanted=1&\\_r=1](http://www.nytimes.com/2011/09/29/us/federal-rules-on-rape-statistics-criticized.html?pagewanted=1&_r=1) (last visited Mar. 12, 2012).

<sup>iv</sup> FBI, *Attorney General Eric Holder Announces Revisions to the Uniform Crime Report's Definition of Rape*, Jan. 6, 2012, <http://www.fbi.gov/news/pressrel/press-releases/attorney-general-eric-holder-announces-revisions-to-the-uniform-crime-reports-definition-of-rape> (last visited Mar. 6, 2012).

## RECOMMENDATIONS FOR REFORM

### Health Care

- Health care providers must screen for sexual assault.<sup>136</sup>
- Services should be trauma-informed (respectful of patients as survivors, maximizing survivor control over recovery, respecting need for safety, emphasizing strengths, minimizing re-traumatization, and providing culturally competent services).<sup>137</sup>
- Funding for sexual assault programs should be increased to provide more immediate and long-term support for victims of sexual assault.
- Services must be provided on a long-term basis, since the consequences of sexual assault may be long-lasting.<sup>138</sup>
- Public health prevention programs must be adopted that include risk factor research, program data collection and analysis, development, evaluation, and dissemination of best practices for stopping deviant behavior before it starts and containing it afterwards.<sup>139</sup>
- Insurers should be required to cover treatment of sexual trauma as a reimbursable mental health service.

### Law Enforcement

- The FBI should proceed with all deliberate speed to implement the change in the definition of rape in the Uniform Crime Report so that accurate data about the true incidence of serious sex crimes can be reported to the public and appropriate resources directed to combat this violent crime.
- Local, state and federal police authorities must ensure public reporting of sex crime data based on clear definitions of reporting categories, and including comprehensive case tracking from complaint to disposition.
- Leadership organizations such as the Police Executive Research Forum (PERF), the International Association of Chiefs of Police (IACP), and the National Sheriffs' Association must identify systemic gender bias in the handling of sex crimes and take steps to ensure local police authorities have effective policies, procedures, and training programs to improve their response to sex crimes.
- The leadership of local, state, and federal police departments should demonstrate a commitment to improving police response to sexual assault by implementing proper management and supervision.
- Local, state and federal police authorities should adopt policies that require full documentation and investigation of sex crime complaints, prohibit polygraphs, and require supervisory review for proper crime classification and unfounding.

- Local, state and federal police authorities should implement training programs on victim behavior, interview techniques, and how to respond to victims of sexual assault.
- Police and community collaborations should be formed to identify and analyze problems, implement solutions, and monitor reforms in police procedure and culture over the long-term.
- Police should communicate with the public about the level of sex crimes in the community and the police response to it.
- Police should issue public notifications of sex offenders at large in order to increase public confidence in law enforcement and increase the likelihood of stopping serial sex offenders.

### **Prosecutors**

- Rather than decline to prosecute, prosecutors should educate judges and juries and prepare their cases with the goal of dispelling mistaken understandings about sexual assault through jury selection, opening and closing arguments, expert witnesses, and direct examination.

### **Courts**

- Judges and court personnel should receive continuing education about sex crimes, the myths and stereotypes associated with them, and recent research about the traumatic impact of sexual assault on the victims. Judges themselves have expressed a desire for judicial education.<sup>140</sup> Many resources exist for judicial education on sexual assault.<sup>141</sup>
- The Pennsylvania Suggested Standard Jury Instructions (Crim.) § 4.13A permitting jurors to consider delay in reporting a rape in determining the credibility of a rape victim should be revised to prohibit consideration of delayed reporting in determining the credibility of a rape victim.

### **Pennsylvania General Assembly**

- The Pennsylvania General Assembly should adopt House Bill 1264,<sup>142</sup> which allows experts to testify regarding common behaviors of sexual assault victims so that juries do not improperly acquit rapists based on victim behavior that they find counterintuitive but is typical victim behavior.
- More resources must be allocated to victim services to increase the availability of counseling and advocacy services, free pregnancy counseling, and confidential testing for HIV/AIDs and STIs.<sup>143</sup>

### **Advocates**

- Public education about sexual victimization should be expanded in order to increase reporting of sexual assault to police. The public must understand what constitutes a sex

crime, including in particular drug-facilitated/incapacitated rape, how to report a crime, and available services.

- Advocates should document and analyze problems with police response to sexual assault, develop collaborations with police to craft solutions to problems, such as case reviews of sexual assault files and Sexual Assault Response Teams (SART), and develop tools to monitor reforms.

### **Researchers**

- Researchers should adopt uniform definitions of sex crimes and affected populations for the collection and analysis of data so that the true incidence of sex crimes is communicated to the public, policy makers can properly allocate resources, and service providers can craft effective responses.
- Research on sex crimes should be expanded to all types of sexual assault and not limited to forcible rape and should be extended to the development of effective treatment and prevention strategies.

## ENDNOTES

<sup>1</sup> While men are also subjected to sexual assault, this chapter focuses on sexual assault as it affects women. Sexual assault disproportionately affects women and this publication is intended to address women's health care needs. However, the Women's Law Project recognizes the importance of addressing the particular needs of male victims of sexual assault. Sexual assault on college campuses is the subject of another chapter.

<sup>2</sup> See Lisabeth Saunders Medlock, South Carolina Coal. Against Domestic Violence & Assault, *Against Their Will: An Assessment of Sexual Assault Services in South Carolina* 3 (2008), available at <http://www.peedee-coalition.org/resources/against.pdf>.

<sup>3</sup> See Debra Patterson, *The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes*, 26 J. Interpersonal Violence 328, 341 (2010).

<sup>4</sup> Debra Patterson et al., *Understanding Rape Survivors' Decision Not to Seek Help from Formal Social Systems*, 34 Health & Social Work 127 (2009); see also Patricia Tjaden & Nancy Thoennes, Nat'l Inst. of Justice and Ctr. for Disease Control and Prevention, Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women Survey 54 (2000), available at <http://www.ncjrs.gov/pdffiles1/nij/183781.pdf> (finding that only one-third of victims with physical injuries obtained medical care).

<sup>5</sup> Nat'l Inst. of Justice, Rape and Sexual Violence, Oct. 26, 2010, <http://www.ojp.usdoj.gov/nij/topics/crime/rape-sexual-violence/> (last visited Mar. 12, 2012). The Center for Disease Control's more specific definition of sexual violence is "[n]onconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse." See also Kathleen C. Basile & Linda E. Saltzman, Ctr. for Disease Control and Prevention, *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements* (2009), available at [http://www.cdc.gov/violenceprevention/pdf/SV\\_Surveillance\\_Definitions1-2009-a.pdf](http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitions1-2009-a.pdf).

<sup>6</sup> See *infra* text accompanying notes 133-135 for a discussion of flaws in FBI system of collecting data on rape and other sex crimes.

<sup>7</sup> Dean G. Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape: A National Study* 26 (2007), available at <http://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf> [hereinafter Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*].

<sup>8</sup> Tjaden & Thoennes, *supra* note 4, at 13. While the survey was also administered to men, this report only addresses sexual assault of women.

<sup>9</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 26.

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

<sup>11</sup> *Id.* at 57.

<sup>12</sup> *Id.* at 23.

<sup>13</sup> M.C. Black, et al., *The National Intimate Partner and Sexual Violence Survey* 18 (2011) (hereinafter NISVS Survey), available at [http://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Report2010-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf).

<sup>14</sup> *Id.* at 18-19.

<sup>15</sup> Tjaden & Thoennes, *supra* note 4, at 17.

<sup>16</sup> *Id.* at 13.

<sup>17</sup> *Id.* at 13-15, 36.

<sup>18</sup> *Id.* at 25.

<sup>19</sup> *Id.* at 45.

<sup>20</sup> *Id.* at 35; NISVS Study, *supra* note 13, at 25.

<sup>21</sup> Kilpatrick et al., Drug-facilitated, Incapacitated, and Forcible Rape, *supra* note 7, at 29.

<sup>22</sup> *Id.* at 43; Tjaden & Thoennes, Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey 33 (2006), available at <http://www.ncjrs.gov/pdffiles1/nij/210346.pdf>; Dean G. Kilpatrick et al., Nat'l Victim Ctr., Rape in America: A Report to the Nation 5-6 (1992), available at [http://www.musc.edu/ncvc/resources\\_prof/rape\\_in\\_america.pdf](http://www.musc.edu/ncvc/resources_prof/rape_in_america.pdf).

<sup>23</sup> Crime in the United States by Volume and Rate per 100,000 Inhabitants, 1990-2009, [http://www2.fbi.gov/ucr/cius2009/data/table\\_01.html](http://www2.fbi.gov/ucr/cius2009/data/table_01.html) (last visited Mar. 12, 2012).

<sup>24</sup> *Rape in the United States: The Chronic Failure to Report and Investigate Rape Cases: Hearing Before the Senate Committee on the Judiciary Subcommittee on Crime and Drugs*, 111th Cong. 7 (2010) (testimony of Dean G. Kilpatrick) [hereinafter *Rape in the United States*], available at <http://judiciary.senate.gov/pdf/10-09-14KilpatrickTestimony.pdf>; Kimberly Lonsway, & Joanne Archambault, *The Earthquake in Sexual Assault Response: Police Leadership Can Increase Victim Reporting to Hold More Perpetrators Accountable*, 77 *The Police Chief* 50 (2010), available at [http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article\\_id=2201&issue\\_id=92010](http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article_id=2201&issue_id=92010); Tjaden & Thoennes, *supra* note 22, at 33.

<sup>25</sup> Tjaden & Thoennes, *supra* note 22, at 35.

<sup>26</sup> Kilpatrick et al., Drug-facilitated, Incapacitated, and Forcible Rape, *supra* note 7, at 41.

<sup>27</sup> Debra Patterson, *The Impact of Detectives' Manner of Questioning on Rape Victims' Disclosure*, 17 *Violence Against Women*, 1349, 1349-50 (2011) (summarizing research).

<sup>28</sup> Majority Staff of the S. Judiciary Comm., 103rd Cong., *The Response to Rape: Detours on the Road to Equal Justice* (1993), available at <http://www.mith2.umd.edu/WomensStudies/GenderIssues/Violence+Women/ResponsetoRape/full-text>.

<sup>29</sup> *Id.*

<sup>30</sup> NISVS Study, *supra* note 13, at 69, Table 7.1.

<sup>31</sup> 28 U.S.C. § 534 (2011); UCR General FAQs, [http://www.fbi.gov/about-us/cjis/ucr/frequently-asked-questions/ucr\\_faqs](http://www.fbi.gov/about-us/cjis/ucr/frequently-asked-questions/ucr_faqs) (last visited Mar. 12, 2012).

<sup>32</sup> Uniform Crime Reporting Act, 18 P.S. §§ 20.501-20.509 (2010).

<sup>33</sup> Pennsylvania Uniform Crime Reporting System, *Crime in Pennsylvania: Annual Uniform Crime Report, Introduction and Contributing Jurisdictions*, available at <http://ucr.psp.state.pa.us/UCR/Reporting/Annual/AnnualFrames.asp?year=2010>.

<sup>34</sup> *Id.* at Table 1; Federal Bureau of Investigation (FBI), *Crime in the United States: Forcible Rape, Crime in the United States* (2010), available at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/violent-crime/rapemain> (defining forcible rape as “the carnal knowledge of a female forcibly and against her will,” including attempts and assaults to commit rape by force or threat of force, but excluding statutory rape).

<sup>35</sup> Pennsylvania Uniform Crime Reporting System, *Persons Charged and Dispositions of Persons Charged by Police*, Table 15, *supra* note 33.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> Pennsylvania Uniform Crime Reporting System, Offenses Reported in Pennsylvania, Table 1, *supra* note 33.

<sup>40</sup> Pennsylvania Uniform Crime Reporting System, Persons Charged and Dispositions of Persons Charged by Police 2010, Table 15, *supra* note 33.

<sup>41</sup> Pa. Coal. Against Rape, Quarterly Service Report for All Subcontractors: Unverified Sexual Assault Services FY 2004/2005, *available at* [www.jrsa.org/dvsa-drc/pennsylvania/PCAR\\_quarterly\\_Stats.xls](http://www.jrsa.org/dvsa-drc/pennsylvania/PCAR_quarterly_Stats.xls).

<sup>42</sup> Tjaden & Thoennes, *supra* note 4, at 49-50.

<sup>43</sup> Sandra L. Martin & Rebecca J. Macy, *Sexual Violence Against Women: Impact on High-Risk Health Behaviors and Reproductive Health* 3 (2009), *available at* [http://snow.vawnet.org/Assoc\\_Files\\_VAWnet/AR\\_SV\\_ReproConsequences.pdf](http://snow.vawnet.org/Assoc_Files_VAWnet/AR_SV_ReproConsequences.pdf).

<sup>44</sup> Ctrs. For Disease Control, Understanding Sexual Violence Fact Sheet (2009), *available at* [http://www.cdc.gov/violenceprevention/pdf/SV\\_factsheet-a.pdf](http://www.cdc.gov/violenceprevention/pdf/SV_factsheet-a.pdf).

<sup>45</sup> Martin & Macy, *supra* note 43, at 3-4.

<sup>46</sup> Melisa Holmes, et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 *Am. J. Obstetrics & Gynecology* 320, 320-25 (1996).

<sup>47</sup> Judith McFarlane et al., *Intimate Partner Assault Against Women: Frequency, Health Consequences and Treatment Outcomes*, 105 *Obstetrics & Gynecology* 99 (2005).

<sup>48</sup> Martin & Macy, *supra* note 43, at 4.

<sup>49</sup> Nat'l Ctr. for Victims of Crime, *Acquaintance Rape*, <http://www.ncvc.org/NCVC/main.aspx?dbName=DocumentViewer&DocumentID=32306#references> (last visited Mar. 12, 2012).

<sup>50</sup> Benjamin E. Sanders, et al., *Prevalence, Case Characteristics, and Long-Term Psychological Correlates of Child Rape Among Women: A National Survey*, 4 *Child Maltreatment* 187, 193 (1999).

<sup>51</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 51-52.

<sup>52</sup> Bonnie Katz, *The Psychological Impact of Stranger Versus Nonstranger Rape on Victims' Recovery*, in *Acquaintance Rape: The Hidden Crimes* 251, 267 (Andrea Parrot & Laurie Bechhofer eds., 1991); Susan Roth et al., *Victimization History and Victim-Assailant Relationship as Factors in Recovery from Sexual Assault*, 3 *J. Traumatic Stress* 169, 178 (1990).

<sup>53</sup> *Rape in the United States*, *supra* note 24, at 7-8.

<sup>54</sup> Nat'l Ctr. for Victims of Crime, *Rape-Related Posttraumatic Stress Disorder* (2009), <http://www.ncvc.org/NCVC/main.aspx?dbName=DocumentViewer&DocumentID=32366> (last visited Mar. 12, 2012).

<sup>55</sup> U.S. Dep't of Health & Human Servs., *Substance Abuse Treatment: Addressing the Specific Needs of Women* 22 (2009), *available at* <http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP51.pdf>.

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

<sup>57</sup> Sarah Dawgert, Pa. Coal. Against Rape, *Substance Use and Sexual Violence: Building Prevention and Intervention Responses* 1 (2009), *available at* <http://www.pcar.org/sites/default/files/file/TA/SubstanceUseandSexualViolenceBuildingPreventionandInterventionResponses.pdf>.

- <sup>58</sup> Sandra L. Bloom, Women's Law Project, *The PVS Disaster: Poverty, Violence and Substance Abuse in the Lives of Women and Children* 43 (2002) (citing Glenance Edwall et al., *Psychological Correlates of Sexual Abuse In Adolescent Girls in Chemical Dependency Treatment*, 24 *Adolescence* 279 (1989)).
- <sup>59</sup> *Id.* at 60.
- <sup>60</sup> Bonnie S. Dansky et al., *The National Women's Study: Relationship of Victimization and PTSD to Bulimia Nervosa*, 21 *Int'l J. Eating Disorders* 213, 220 (1997).
- <sup>61</sup> Carolyn Moore Newberger et al., *Mothers of Sexually Abused Children: Trauma and Repair in Longitudinal Perspective*, 63 *Am. J Orthopsychiatry* 92 (1993); Ian G. Manion et al., *Secondary Traumatization in Parents following the Disclosure of Extrafamilial Child Abuse: Initial Effects*, 20 *Child Abuse & Neglect* 1095 (1996).
- <sup>62</sup> Lonsway & Archambault, *supra* note 24.
- <sup>63</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 37.
- <sup>64</sup> Holmes et al., *supra* note 46, at 324.
- <sup>65</sup> Carole Johnson, Executive Director, Women Organized Against Rape, Announcement at Philadelphia Domestic Violence Law Enforcement Committee Meeting (Apr. 26, 2011).
- <sup>66</sup> Mary-Helen Scales et al., *An Informal Discussion of Emergency Nurses' Current Clinical Practice: What's New and What Works*, 33 *J. Emergency Nurses* 480 (2007).
- <sup>67</sup> Stacy B. Plichta et al., *Why SANEs Matter: Models of Care for Sexual Violence Victims in the Emergency Department*, 3 *J. Forensic Nursing* 15, 22 (2007) (evaluating different models of care and concluding that "it is necessary for [emergency departments] to have trained nursing personnel (ideally SANE/forensic nurses) available to all victims in a timely manner.").
- <sup>68</sup> *See, e.g.*, Rape, Abuse, & Incest Nat'l Network, *Receiving Medical Attention*, <http://www.rainn.org/get-information/aftermath-of-sexual-assault/receiving-medical-attention> (last visited Mar. 12, 2012); Women Organized Against Rape, *What to Do if You Are Raped*, <http://www.woar.org/what-to-do-if-youre-raped.php> (last visited Mar. 12, 2012).
- <sup>69</sup> *See* Cynthia H. Chuang & Laura D. Shank, *Availability of Emergency Contraception at Rural and Urban Pharmacies in Pennsylvania*, 73 *Contraception* 382 (2006); Women's Law Project, Summer 2009 Plan B Access Project Narrative (2009) (on file with authors).
- <sup>70</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 3 (reporting that medical care was received following 19 percent of forcible rape incidents and 21 percent of drug-facilitated or incapacitated rape incidents while injury was reported for 52 percent of forcible rape and 30 percent of DF or incapacitated incidents); Patterson, *supra* note 3, at 127.
- <sup>71</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 56 (finding that 38 percent of those surveyed sought help for emotional problems, with more women with forcible rape history seeking help than women without forcible rape history).
- <sup>72</sup> *See* Dean G. Kilpatrick et al., *Rape-related PTSD: Issues and Interventions*, *Psychiatric Times*, June 1, 2007, at 50.
- <sup>73</sup> Patterson, *supra* note 3, at 130-33.
- <sup>74</sup> 18 Pa. Cons. Stat. Ann. §§ 3121-27 (2010).
- <sup>75</sup> In Pennsylvania, a victim can sue an individual for damages for intentionally assaulting her. *See, e.g.*, *C.C.H. v. Phila. Phillies, Inc.*, 596 Pa. 23 (2008) (plaintiff brought a civil action seeking damages against the perpetrators and the Philadelphia Phillies after she had been sexually assaulted at a Phillies game.)

<sup>76</sup> Police misconduct may be challenged under federal civil rights laws, which make it unlawful for anyone acting under the authority of state law to deprive another person of his or her rights under the U.S. Constitution or federal law. Common claims brought against police officers include false arrest, false imprisonment, malicious prosecution, and use of excessive or unreasonable force. *See, e.g.,* Reedy v. Evanson, 615 F.3d 197 (2010), *cert denied*, 2011 U.S. LEXIS 1893 (U.S. Feb. 28, 2011).

<sup>77</sup> *See* Act of May 18, 1976, Pub. L. 120, No. 53, §§ 1-2 (codified at 18 Pa. Cons. Stat. §§ 3107, 3106, and 3105 respectively).

<sup>78</sup> *Id.* (codified at 18 Pa. Cons. Stat. § 3104 (a)); *id.* (codified at 18 Pa. Cons. Stat. § 3106).

<sup>79</sup> Commonwealth v. Berkowitz, 537 Pa. 143, 641 A.2d 1161 (1994).

<sup>80</sup> *See* Act 1995 Special Session-10 (S.B. 2), P.L. 985, § 3, approved Mar. 31, 1995; Section 10 of Act 1995-10 (Sp. Sess. 1) repealed 18 Pa.C.S. § 3128 on March 31, 1995; 18 Pa. Cons. Stat. § 3124.1.

<sup>81</sup> 18 Pa. Cons. Stat. § 3124.1; *see* Commonwealth v. Kelley, 569 Pa. 179, 189 n. 6, 801 A.2d 551, 557 n.6 (2002) (noting how *Berkowitz* provided the impetus for legislative rape reform).

<sup>82</sup> *See* PA. Suggested Standard Jury Instructions (Crim.) § 4.13A; Tara Murtha, *Reality Check: Pennsylvania's Rape Laws Perpetuate the Myths*, Phila. Weekly, Jun. 22, 2011, <http://www.phila-delphiaweekly.com/news-and-opinion/cover-story/Reality-Check-Pennsylvanias-Rape-Laws-Perpetuate-the-Myths.html> (last visited Sept. 20, 2011); Patricia L. Fanflik, Am. Prosecutors Research Inst., Nat'l Dist. Attorneys Ass'n, *Victim Responses to Sexual Assault: Counterintuitive or Simply Adaptive?* 10 (2007).

<sup>83</sup> *See, e.g.,* Violence Against Women Act (VAWA), 42 U.S.C. § 13981 (2011); Victims of Crime Act (VOCA), 42 U.S.C. § 10601 (2011).

<sup>84</sup> 42 USCS § 14043g (2012).

<sup>85</sup> 42 U.S.C. § 3796gg-4 (2011).

<sup>86</sup> 28 Pa. Code § 117.57 (2011).

<sup>87</sup> Pa. Bulletin, Sexual Assault Victim Emergency Services Regulation, <http://www.pabulletin.com/secure/data/vol40/40-26/1173.html> (last visited Mar. 12, 2012).

<sup>88</sup> 28 Pa. Code § 117.57 (2011).

<sup>89</sup> Patterson, *supra* note 3, at 343.

<sup>90</sup> Kimberly A. Lonsway & Louise F. Fitzgerald, *Rape Myths in Review*, 18 Psychol. of Women Q. 133, 134 (1994).

<sup>91</sup> Callie Marie Rennison, Bureau of Justice Statistics, National Crime Victimization Survey: Criminal Victimization 2000, Changes 1999-2000 with Trends 1993-2000, *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/cv00.pdf>; Tjaden & Thoennes, *supra* note 22, at 21-22.

<sup>92</sup> Lawrence A. Greenfeld, Bureau of Justice Statistics, Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault 3 (1997), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/SOO.PDF>.

<sup>93</sup> Rennison, *supra* note 91.

<sup>94</sup> Tjaden & Thoennes, *supra* note 4, at 49-50.

<sup>95</sup> Nat'l Judicial Educ. Program, Judges Tell: What I Wish I had Known Before I Presided in an Adult Victim Sexual Assault Case 9 (2010), *available at* <http://jec.unm.edu/manuals-resources/manuals/Judges%20Tell.pdf> view; *see also* Lynn Hecht Schafran, *Maiming the Soul: Judges, Sentencing and the Myth of the Nonviolent Rapist*, 20 Fordham Urb. L.J. 439, 450-51 (1993).

<sup>96</sup> David Lisak et al., *False Allegations of Sexual Assault: An Analysis of Ten Years of Reported Cases*, 16 *Violence Against Women* 1318 (2010) (reporting the findings of the most methodologically sound studies on false allegations, which found that false allegations are made in only 2.1 percent to 10.9 percent of cases, as well as the results of the author's new study, which found that only 5.9 percent of cases were false).

<sup>97</sup> Tammy Garland, *An Overview of Sexual Assault and Sexual Assault Myths*, in *Sexual Assault: The Victims, the Perpetrators, and the Criminal Justice System* 3, 15-16 (Frances P. Reddington & Betsy Wright Kreisel eds., 2009).

<sup>98</sup> Martha R. Burt, *Rape Myths and Acquaintance Rape*, in *Acquaintance Rape: The Hidden Crime* 26, 27 (Andrea Parrot & Laurie Bechhofer eds., 1991); David Lisak, *Understanding the Predatory Nature of Sexual Violence*, 14 *Sexual Assault Rep.* 1, 2 (2011).

<sup>99</sup> See Susan Caringella, *Addressing Rape Reform in Law and Practice* 115 (2009).

<sup>100</sup> Patterson, *supra* note 3, at 329.

<sup>101</sup> Patterson, *supra* note 27 at 1355-1364.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> Jan Jordan, *Worlds Apart? Women, Rape, and the Police Reporting Process*, 41 *British J. of Criminology* 679 (2001); Jennifer Temkin, *Plus ça change: Reporting Rape in the 1990s*, 37 *British J. of Criminology* 507 (1997).

<sup>105</sup> Jordan, *supra* note 104, at 694; Temkin, *supra* note 104, at 513-514.

<sup>106</sup> Jordan, *supra* note 104, at 694-697; Temkin, *supra* note 104, at 519.

<sup>107</sup> Jordan, *supra* note 104, at 694-697; Temkin, *supra* note 104, at 522.

<sup>108</sup> See generally David Lisak & Paul M. Miller, *Repeat Rape and Multiple Offending among Undetected Rapists*, 17 *Violence and Victims* 73 (2002).

<sup>109</sup> *Id.* at 78.

<sup>110</sup> *Id.*; Fazlollah et al., *After FBI Questioned One Tactic, Another Was Found*, *Phila. Inquirer*, Oct. 18, 1999, at A8; Fazlollah et al., *How Police Use a New Code When Sex Cases Are Unclear*, *Phila. Inquirer*, Oct. 18, 1999, at A1; Michael Matza & Craig R. McCoy, *Police Used 'Throwaway Categories' Since 1960's*, *Phila. Inquirer*, Oct. 18, 1999, at A8. These articles, as well as those describing Philadelphia's response to the reports and continuing reverberations from this scandal through March 2004, can be found on The Philadelphia Inquirer's website, *Down With Crime: The Rape Squad Files*, <http://inquirer.philly.com/packages/crime/> (last visited Mar. 12, 2012).

<sup>111</sup> John Eligon, *Panel Seeks More Police Training on Sex Crimes*, *N.Y. Times*, June 2, 2010, at A26, <http://www.nytimes.com/2010/06/03/nyregion/03rape.html> (last visited Mar. 12, 2012); Justin Fenton, *City Rape Statistics, Investigations Draw Concern*, *Balt. Sun*, Jun. 27, 2010, at 1A, [http://articles.baltimoresun.com/2010-06-27/news/bs-md-ci-rapes-20100519\\_1\\_fbi-data-mayor-orders-review-detectives](http://articles.baltimoresun.com/2010-06-27/news/bs-md-ci-rapes-20100519_1_fbi-data-mayor-orders-review-detectives) (last visited Mar. 12, 2012); Jeremy Kohler, *What Rape?: Abused by the System*, *St. Louis Dispatch*, Aug. 28, 2005, <http://dartcenter.org/content/what-rape-0> (last visited Mar. 12, 2012); Laura Maggi, *NOPD Downgrading of Rape Reports Raises Questions*, *Times-Picayune*, July 11, 2009, [http://www.nola.com/news/index.ssf/2009/07/nopd\\_downgrading\\_of\\_rape\\_repor.html](http://www.nola.com/news/index.ssf/2009/07/nopd_downgrading_of_rape_repor.html) (last visited Mar. 12, 2012).

<sup>112</sup> Eligon, *supra* note 111; Fenton, *supra* note 111.

<sup>113</sup> Maggi, *supra* note 111.

<sup>114</sup> Fenton, *supra* note 111; Kohler, *supra* note 111.

<sup>115</sup> See Rachel Dissell, *History Shows Sexual-Assault Cases Have Not Been a Priority for Cleveland's City Leaders, Law Enforcement*, Plain Dealer, Mar. 28, 2010, [http://blog.cleveland.com/metro/2010/03/history\\_shows\\_sexual\\_assault\\_c.html](http://blog.cleveland.com/metro/2010/03/history_shows_sexual_assault_c.html) (last visited Mar. 12, 2012); Rachel Dissell, *Mayor Frank Jackson Creates Commission to Examine Response to Sexual Assault and Missing Person Cases*, Plain Dealer, Dec. 9, 2009, [http://blog.cleveland.com/metro/2009/12/mayor\\_frank\\_jackson\\_creates\\_co.html](http://blog.cleveland.com/metro/2009/12/mayor_frank_jackson_creates_co.html) (last visited Mar. 12, 2012); Rachel Dissell, *Sowell's Arrest, Release in 2008 Leaves Lingering Questions About Handling of Case*, Plain Dealer, Nov. 13, 2009, [http://blog.cleveland.com/metro/2009/11/sowells\\_arrest\\_release\\_in\\_2008.html](http://blog.cleveland.com/metro/2009/11/sowells_arrest_release_in_2008.html) (last visited Mar. 12, 2012).

<sup>116</sup> Gina Barton & Becky Vevea, *Police Launch Investigation into Inaction Complaints*, J. Sentinel, July 7, 2010, <http://www.jsonline.com/news/crime/97995519.html> (last visited Mar. 12, 2012); Gina Barton & Becky Vevea, *Rape Victims Say Police Failed Them*, J. Sentinel, July 6, 2010, <http://www.jsonline.com/news/milwaukee/97848834.html> (last visited Mar. 12, 2012).

<sup>117</sup> Fenton, *supra* note 111.

<sup>118</sup> See Tjaden & Thoennes, *supra* note 22, at 35.

<sup>119</sup> See Brief of *Amici Curiae* of Thirty-Nine Organizations Dedicated to Improving the Criminal Justice System's Response to Violence Against Women in Support of Appellant and Requesting Reversal, *Reedy v. Evanson*, No. 2:06-cv-1080, 615 F.3d 197 (3d Cir. 2010), available at [http://www.womenslawproject.org/Briefs/Reedy\\_Amici\\_Spt\\_Appellant.pdf](http://www.womenslawproject.org/Briefs/Reedy_Amici_Spt_Appellant.pdf) [hereinafter Brief of *Amici Curiae* of Thirty-Nine Organizations, *Reedy v. Evanson*].

<sup>120</sup> *Reporting and Investigation of Rape Cases: Hearing Before the Senate Comm. on Crime and Drugs*, 111th Cong. (2010) (testimony of Carol Tracy, Exec. Dir., Women's Law Project), available at <http://www.c-spanvideo.org/program/id/232817>.

<sup>121</sup> U.S. Dep't of Justice, Civil Rights Div., *Investigation of the New Orleans Police Department*, xi (2011), available at [http://www.justice.gov/crt/about/spl/nopd\\_report.pdf](http://www.justice.gov/crt/about/spl/nopd_report.pdf).

<sup>122</sup> U.S. Dep't of Justice, Civil Rights Div., *Investigation of the Puerto Rico Police Department*, 5, 58 (2011), available at [http://www.justice.gov/crt/about/spl/documents/prpd\\_letter.pdf](http://www.justice.gov/crt/about/spl/documents/prpd_letter.pdf).

<sup>123</sup> See Legal Momentum, *Addressing Gender Bias in the Courts*, <http://www.legalmomentum.org/our-work/njep/njep-task-forces.html> (last visited Mar. 12, 2012).

<sup>124</sup> Tjaden & Thoennes, *supra* note 22, at 21-22.

<sup>125</sup> *Final Report of the Pennsylvania Supreme Court Committee on Racial and Gender Bias in the Justice System* 422-52 (2003), available at <http://origin-www.aopc.org/NR/rdonlyres/EC162941-F233-4FC6-9247-54BFE3D2840D/0/FinalReport.pdf>.

<sup>126</sup> See Louise Ellison & Vanessa E. Munroe, *Turning Mirrors into Windows? Assessing the Impact of (Mock) Juror Education in Rape Trials*, 49 *Brit. J. Criminology* 363 (2009); Louise Ellison & Vanessa E. Munroe, *Reacting to Rape: Exploring Mock Jurors' Assessments of Complainant Credibility*, 49 *Brit. J. Criminology* 202 (2009).

<sup>127</sup> Patterson *supra* note 27 at 1350; see e.g., *Commonwealth v. Claybrook*, Clay & Lewis, Nos. 1926, 1835, 1762 EDA 210 (Pennsylvania Superior Court non-precedential opinion overturning convictions for sexual assault and indecent assault based on lack of sufficient resistance and injury and other misconceptions about victim behavior).

<sup>128</sup> Jennifer Gentile Long, *Prosecuting Intimate Partner Sexual Assault*, 3 *Family & Intimate Partner Violence* 353, 354 (2011).

<sup>129</sup> *Final Report of the Pennsylvania Supreme Court Committee on Racial and Gender Bias in the Justice System* 437 (2003), available at <http://origin-www.aopc.org/NR/rdonlyres/EC162941-F233-4FC6-9247-54BFE3D2840D/0/FinalReport.pdf>.

<sup>130</sup> See, e.g., *Commonwealth v. Emge*, 381 Pa. Super. 139, 144 (1988); Christopher Mallios, *Landmark MN Decision on Expert Testimony*, 15 Sexual Assault Rep. 1 (Sept./Oct. 2011).

<sup>131</sup> Teresa Scalzo, Nat'l Dist. Attorney's Ass'n, *Prosecuting Alcohol Facilitated Sexual Assault 1* (2007), available at [http://www.ndaa.org/pdf/pub\\_prosecuting\\_alcohol\\_facilitated\\_sexual\\_assault.pdf](http://www.ndaa.org/pdf/pub_prosecuting_alcohol_facilitated_sexual_assault.pdf).

<sup>132</sup> Julia Dahl, *Is Rape a "Crime Without Consequence?"*, The Crime Report, Nov. 7, 2010, <http://www.thecrimereport.org/archive/is-rape-a-crime-without-consequence/> (last visited Sept. 20, 2011); Christopher Mallios & Toolsi Meisner, *Educating Juries in Sexual Assault Cases*, Strategies: The Prosecutors' Newsletter on Violence Against Women, July 2010, available at <http://www.vaw.umn.edu/documents/educatingjuriessexualassault/educatingjuriessexualassault.pdf>.

<sup>133</sup> FBI, *Uniform Crime Reports*, <http://www.fbi.gov/about-us/cjis/ucr/ucr> (last visited Mar. 6, 2012).

<sup>134</sup> FBI, *Unified Crime Reporting Handbook* 19 (2004).

<sup>135</sup> *Id.*

<sup>136</sup> Am. Cong. Obstetricians & Gynecologists, *Screening Tools – Sexual Assault*, [http://www.acog.org/departments/dept\\_notice.cfm?bulletin=1477&recno=17](http://www.acog.org/departments/dept_notice.cfm?bulletin=1477&recno=17) (last visited June 15, 2011).

<sup>137</sup> Martin & Macy, *supra* note 43, at 6.

<sup>138</sup> *Id.*

<sup>139</sup> Ass'n for Treatment of Sexual Abusers, *Multi-disciplinary Approach to Public Health: Sexual Abuse as a Public Health Problem*, 5 Research & Advocacy Digest 74 (2003).

<sup>140</sup> See Nat'l Judicial Educ. Program, *supra* note 95.

<sup>141</sup> See, e.g., Legal Momentum, <http://www.legalmomentum.org/our-work/vaw/njep.html> (last visited June 24, 2011); Pennsylvania Coalition Against Rape, *Sexual Violence Benchbook*, available at <http://www.pcar.org/sites/default/files/file/minor-judicial-benchbook.pdf>.

<sup>142</sup> H.B. 1264, Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>143</sup> Kilpatrick et al., *Drug-facilitated, Incapacitated, and Forcible Rape*, *supra* note 7, at 42, 49.



## Section B. The Impact of **INTIMATE PARTNER VIOLENCE** on Women's Health

### INTRODUCTION

*Intimate Partner Violence (IPV) is physical, sexual, or psychological harm directed at a current or former spouse, partner, or dating partner, in order to gain power and control.<sup>1</sup> While IPV victims and perpetrators may be male or female, the majority of victims are women who endure abuse perpetrated by men.<sup>2</sup> Research has shown connections between IPV, particularly coercive control of one intimate partner by the other, and traditional gender-based stereotypes<sup>3</sup> and hostility towards women.<sup>4</sup> IPV impacts women far beyond the immediate injuries they suffer when physically and/or psychologically abused, affecting women's short and long-term physical and mental health. Women suffer death and chronic neurological, gastrointestinal, gynecological, cardiac, and mental health problems, while children exposed to IPV also bear long-term psychological and developmental consequences. Although laws have been reformed and services have been developed to address IPV, the locus for addressing IPV remains in law enforcement. While law enforcement has a role in addressing IPV, it should not be the only remedy. A coordinated community response is necessary to protect victims from abuse and promote their health and well-being.*



## Prevalence

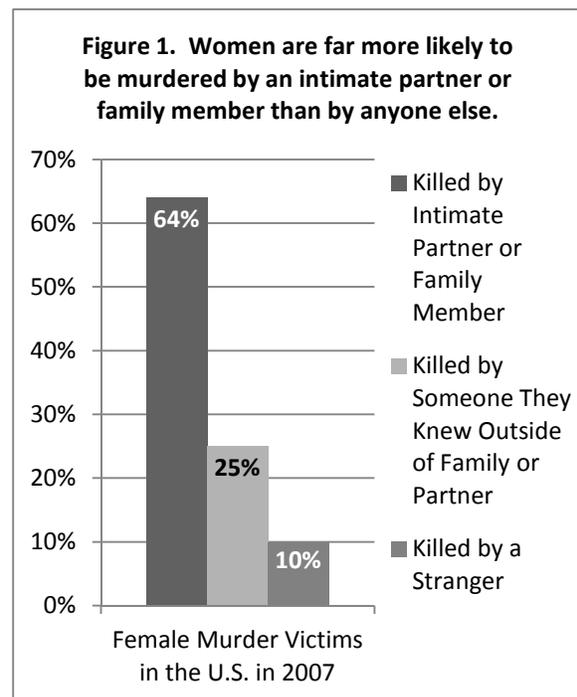
IPV is widespread in the United States and in Pennsylvania at all socioeconomic levels. It is impossible to know the exact number of IPV victims because many victims do not tell anyone about it; they do not report to police, seek medical or other help, or tell their family and friends. There are many reasons victims do not disclose abuse. Many of those affected by IPV view it as a private family matter, believe the situation will improve without intervention, fear retaliation if they seek intervention, are concerned that the police will not believe them or protect them, fear loss of custody of their children, and/or are unaware of services available to them. Others do not report because they feel shame and blame themselves. Immigrant women in particular may have difficulty reporting abuse, because they may have little support in their communities, face language and cultural barriers to accessing services, and, in the event they are undocumented, fear deportation if they access services.<sup>5</sup>

### National Data

The most recent data on IPV is from the National Intimate Partner and Sexual Violence Survey (NISVS), which was conducted by the Centers for Disease Control (CDC) and published in November 2011. The NISVS study found that more than one-third of women aged 18 and over in the United States (35.6 percent or approximately 42.4 million) were subjected to physical violence, sexual violence, and/or stalking by a current or former intimate partner at some point in their lifetime.<sup>6</sup> Over the course of their lives, 32.9 percent of individuals experienced physical violence, 9.4 percent had been raped, and 10 percent had been stalked.<sup>7</sup> Over 12 percent of women were subjected to all three forms of IPV.<sup>8</sup> In the 12 months preceding the survey, approximately 5.9 percent of U.S.

women, almost 7.0 million, experienced one or more of these forms of IPV.<sup>9</sup>

IPV is often fatal. For example, stalking, which involves a course of unwanted repeated harassing or threatening conduct that causes fear in a reasonable person, often escalates over time and may become violent and ultimately lethal.<sup>10</sup> There were 2,340 intimate partner homicides in 2007, with 70 percent of the victims female.<sup>11</sup> Women are more often killed by someone they know; in 2007, 64 percent of the female homicide victims were killed by a family member or intimate partner.<sup>12</sup> An additional 25 percent of the female homicide victims were killed by other individuals they knew, and approximately 10 percent were murdered by a stranger.<sup>13</sup>



IPV often spills beyond the home, for example, by directly affecting victims in their workplaces. According to various studies, between 35 and 56 percent of employed IPV victims were abused or

harassed at work by their partners, sometimes leading to workplace deaths of victims, perpetrators, and bystanders.<sup>14</sup>

Although law enforcement and health care providers receive reports of IPV, no national data on IPV is collected from these sources. The FBI's Uniform Crime Reporting (UCR) Summary Data System, does not collect relationship data. Although the National Incident Based Reporting System (NIBRS), another UCR data reporting system which the FBI launched in 1988 with the goal of addressing inadequacies in the UCR summary data system, collects such data, most law enforcement agencies do not participate in NIBRS.<sup>15</sup> While the medical system may see more victims than the law enforcement system, health care providers do not always find out that IPV is the cause of a health problem they are treating,<sup>16</sup> nor do they collect and maintain data on the numbers of IPV victims they treat.

### **Pennsylvania Data**

The NISVS study estimated that 37.7 percent of Pennsylvania women, or 1.9 million women, have experienced IPV.<sup>17</sup> Almost 20 percent of Pennsylvania women (977,000) are estimated to be victims of stalking.<sup>18</sup>

The Commonwealth does not collect data on the number of Pennsylvania individuals victimized by IPV. Three very limited sources provide information about IPV prevalence in Pennsylvania. One is the number of individuals who have sought assistance from community service agencies. The second is the number of individuals who seek court protection. The third is the number of IPV homicides that can be identified from media reports.

Data on the number of individuals who obtain assistance from IPV programs does not accurately reflect the number of abused

women in Pennsylvania. It is estimated that only one in six victims of IPV receives services from a domestic violence service provider.<sup>19</sup> Many victims are not aware of the existence of free services and many are hindered from seeking assistance for all the reasons previously cited for not reporting abuse. Nonetheless, in one 24-hour period in September 2010, 61 IPV programs in Pennsylvania served 2,321 victims by providing shelter, transitional housing, counseling, legal advocacy, or other non-residential services.<sup>20</sup> In 2009-10, Pennsylvania's 92 community-based domestic violence servers assisted 91,999 survivors of domestic violence and their children.<sup>21</sup> These numbers may decrease as funding cuts reduce service capacity of community organizations.

The court system data shows that in 2010, individuals in Pennsylvania filed 41,204 petitions seeking Protection From Abuse (PFA) Orders.<sup>22</sup> This is less than half the number of individuals who sought services from community providers and far short of the number one would expect, given the NISVS estimate that more than 37.7 percent of Pennsylvania women will be abused in their lifetimes.

In Pennsylvania, the police do not collect data on IPV. Domestic violence itself is not a crime, but may be involved in many crimes, ranging from homicide to assault to harassment. The Philadelphia Police Department (PPD) has been attempting to track police complaints based on domestic violence. In 2010, the PPD received 155,776 calls to 911 for emergency police assistance for a domestic violence incident; these calls included 30 domestic murders and 187 domestic rapes and attempted rapes.<sup>23</sup>

In the absence of any systematic tracking of IPV related crime in Pennsylvania, the Pennsylvania Coalition Against Domestic

Violence (PCADV) has for over a decade counted domestic homicides in which an arrest has occurred. PCADV identifies these deaths through reviews of media reports and publishes its finding annually. Including in its count of homicides by current or former intimate partners as well as blood relatives and deaths of perpetrators and bystanders, PCADV has determined that at least 1,532 Pennsylvania

women, men, and children lost their lives to domestic violence between 2001 and 2010.<sup>24</sup> For the year 2010, PCADV found 169 domestic deaths.<sup>25</sup> The majority of victims were women and most of the perpetrators were male.<sup>26</sup> Sixty-one victims were killed by a gun, 24 were stabbed, and others were beaten, strangled, run over, set on fire, smothered, poisoned, tortured, or drowned.<sup>27</sup>

## Impact on Women's Health

IPV impacts the physical and mental health of women and children in a variety of ways, causing short and long-term physical and emotional repercussions, including death. Research suggests that increasing frequency and severity of abuse causes increasingly severe health effects.<sup>28</sup>

### Health of Women

IPV is reported to be one of the most common causes of injury to women, with injuries to the “head, face, neck, thorax, breasts, and abdomen” occurring more often in battered women than in other women.<sup>29</sup> Hospital emergency rooms see many of the short term effects, though patients often do not identify the injuries as due to domestic violence and medical professionals often do not adequately screen for domestic violence.<sup>30</sup>

Research based on a World Health Organization international sample shows that women who had been abused by their partners reported overall poorer health than non-abused women, as well as specific problems such as trouble walking and difficulty with daily activities, pain, memory loss, dizziness, and vaginal discharge.<sup>31</sup> Furthermore, long-term health concerns such as chronic pain, gastro-intestinal problems, cardiac symptoms, and central nervous system symptoms such as fainting and seizures are reported by victims of

domestic violence more often than by non-victims.<sup>32</sup>

Abuse negatively affects women's reproductive health. A report of findings from several reviews concluded:

[g]ynaecological problems are the most consistent, longest lasting and largest physical health difference between battered and non-battered women. Differential symptoms and conditions include sexually transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, and urinary-tract infections. In one of the best-sampled . . . US population-based studies of self-reported data, the odds of having a gynaecological problem were three times greater than average for victims of spouse abuse.<sup>33</sup>

Women who experience sexual assault as well as physical abuse experience 40 – 45 percent more health problems than women who experience physical abuse alone.<sup>34</sup> Forced sex also may produce vaginal, anal, and urethral injuries, sexually transmitted infection (STI), and unintended pregnancy.<sup>35</sup>

IPV victims are also subjected to reproductive coercion, in which an abusive partner

“uses power and control in a relationship related to reproductive health,” including forcing a partner to engage in unwanted sexual acts, intentionally transmitting STIs, sabotaging birth control to impregnate a partner against her will, and controlling the outcomes of a partner’s pregnancy.<sup>36</sup> In one study, 19 percent of women reported pregnancy coercion, defined as being forced by a partner to become pregnant, 15 percent reported birth control sabotage, and 40.9 percent reported experiencing at least one unintended pregnancy.<sup>37</sup>

Research has found that abuse during pregnancy “is more common than some maternal health conditions routinely screened for in antenatal care.”<sup>38</sup> Studies have found that 3.9 – 8.3 percent of pregnant women are abused during their pregnancies.<sup>39</sup> The consequences of abuse during pregnancy include death of the mother, fetus, or both; low weight gain by the mother; and low birth weight of the newborn.<sup>40</sup>

In addition to physical injuries and reproductive consequences, women may also experience life-long psychological trauma stemming from abuse. Numerous studies have found significant links between IPV and depression and post-traumatic stress disorder (PTSD) in subjects worldwide.<sup>41</sup> PTSD occurs at much higher rates in battered women than in the general population. PTSD in victims of IPV is associated with severity of abuse, previous trauma, and a dominating partner.<sup>42</sup> Studies have found that women who have been abused are more likely to experience anxiety, insomnia, and social dysfunction, and to misuse alcohol and drugs.<sup>43</sup>

IPV causes ongoing stress and trauma for everyone living in the home. There is not only the abuse itself, but ongoing encounters with the civil and criminal justice systems, difficulties parenting and holding

jobs, and isolation from social support systems.

Ultimately, IPV may end in the death of the abuse victim; sometimes, friends and family members caught in the middle or directly targeted by abusers also die. Strangulation, frequently mischaracterized as choking, is particularly deadly and often goes unrecognized as the serious threat that it is.<sup>44</sup> Many victims lack immediate visible injuries and do not inform police or medical personnel that they were strangled.<sup>45</sup> Strangulation-related injuries may appear minor in the initial aftermath of an assault, but could lead to the victim’s death from airway obstruction due to swelling, bleeding, vocal cord immobility, and/or displaced fractures of the larynx.<sup>46</sup> Multiple studies also report that battered women are more likely to commit suicide than women who have not experienced domestic abuse.<sup>47</sup>

The NISVS study examined the magnitude and severity of the impact of abuse on victims and reported state-by-state findings. It found that 28.3 percent, or almost 1.5 million Pennsylvania women, experienced IPV and also experienced at least one of the following impacts:

[B]eing fearful, concerned for safety, any PTSD symptoms, need for healthcare, injury, crisis hotline, need for housing services, need for victim’s advocate services, need for legal services, missed at least one day of work/school. For those who reported being raped, it also includes having contracted a sexually transmitted disease or having become pregnant.<sup>48</sup>

Twenty-five percent (1.28 million women) experienced fear or concern for safety, 22.8 percent (1.16 million women), experienced PTSD symptoms and 17.3 percent

(884,000) were injured and/or needed medical care.<sup>49</sup>

### Health of Children

More than 50 percent of households affected by violence between intimate partners include children under the age of twelve.<sup>50</sup> Children who witness IPV are more likely to be abused themselves. They may be physically injured in the course of violence directed toward their mothers,<sup>51</sup> and they may experience life-long trauma.<sup>52</sup> Witnessing IPV causes emotional distress, behavioral problems, and physical health problems for children.<sup>53</sup> Studies show strong correlations between childhood exposure to violence at home and post-traumatic stress symptoms,<sup>54</sup> as well as various health problems, such as asthma<sup>55</sup> and gastrointestinal problems.<sup>56</sup>

According to the National Resource Center on Domestic Violence,

the list of physical, emotional, psychological, and behavioral responses experienced by children witnessing domestic violence is strikingly similar to responses found in children who were physically abused and neglected, as well as children who had experienced sexual abuse.<sup>57</sup>

Even children as young as toddlers live in constant fear and stress when living in an abusive household, and as a result, experience sleep disturbances,<sup>58</sup> eating disorders,<sup>59</sup> stomach aches,<sup>60</sup> headaches,<sup>61</sup> and developmental delays.<sup>62</sup> These children may also have difficulty developing appropriate peer relationships.<sup>63</sup> If there is no adequate intervention, research shows that these children are at risk of repeating the violence in their intimate relationships as adults.<sup>64</sup>

The Adverse Childhood Experiences Study (ACES) evaluated the relationship between specified negative childhood experiences and the presence of medical and mental health problems later in adulthood. Psychological, physical, or sexual abuse of a child and violence against a child's mother were two of the eight categories the study examined.<sup>65</sup> Overall, the more negative childhood experiences a child had, the greater the likelihood that the person, as an adult, would smoke, have chronic obstructive pulmonary disease (COPD), use intravenous drugs, attempt suicide, or be diagnosed with depression.<sup>66</sup> This study supports the conclusion that exposure to violence, including being raised in a household with IPV, carries long-term negative health consequences.

## SOCIETAL RESPONSE TO DOMESTIC VIOLENCE

Since the 1970's, when domestic violence emerged from the secrecy of the home and became a public concern, society has undertaken to protect victims and deter abusers by adopting a variety of community, law enforcement, and legal remedies. The earliest efforts focused on the criminal and civil justice systems. Community services have grown alongside justice system initiatives but are restricted in what they can accomplish because available funding is

limited. More recently, advocates have encouraged strategies to address and prevent IPV in the medical and government sponsored behavioral health systems. While these initiatives have been substantial and their impact significant, IPV persists. Insufficient funding and inherent bias against and disbelief of women have impeded society's efforts to protect women from IPV.

## RESPONSE OF THE CIVIL AND CRIMINAL JUSTICE SYSTEMS

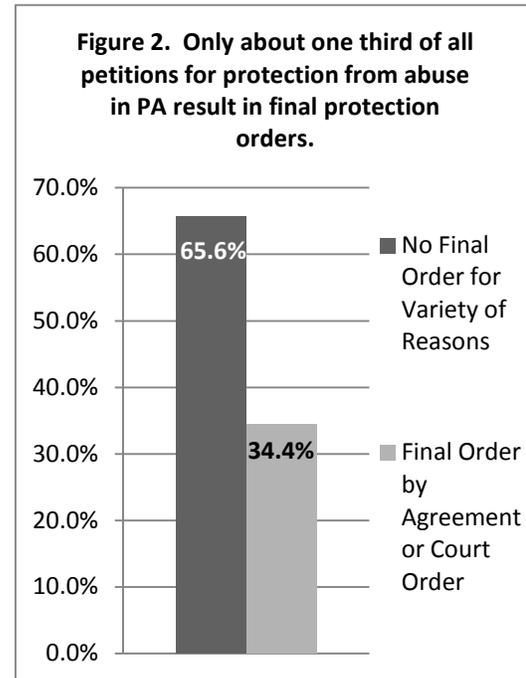
### Civil Protection

Pennsylvania was one of the first states to adopt legal protection from abuse under civil law, when it adopted the Protection From Abuse Act (PFA Act) in 1976. The PFA Act authorizes courts to issue enforceable orders that direct the defendant (abuser) to refrain from abusing the plaintiff or minor children,<sup>67</sup> stay out of the plaintiff's home,<sup>68</sup> pay financial support,<sup>69</sup> refrain from contacting the plaintiff or minor children,<sup>70</sup> relinquish weapons that were used or threatened to be used against the plaintiff or the minor children,<sup>71</sup> refrain from acquiring or possessing a firearm for the duration of the order, relinquish any firearm license,<sup>72</sup> and compensate the victim for reasonable losses.<sup>73</sup> The PFA Act also permits the court to award exclusive possession of the home to the victim<sup>74</sup> and to provide for temporary custody and visitation of the children.<sup>75</sup> Domestic violence is also frequently an issue in custody proceedings. Pennsylvania's custody law, as amended effective January 24, 2011, prioritizes the consideration of domestic violence when determining custody.<sup>76</sup> Domestic violence is also often present in child welfare proceedings.<sup>77</sup>

Firearms kill and cause significant, life-long physical injuries. Firearm removal from perpetrators of abuse has been shown to reduce the rate of intimate partner homicide.<sup>78</sup> While there is no Pennsylvania data as to the frequency with which judges include firearm restrictions in PFA orders, research from cities in other states has shown that judges are infrequently ordering the removal of weapons.<sup>79</sup>

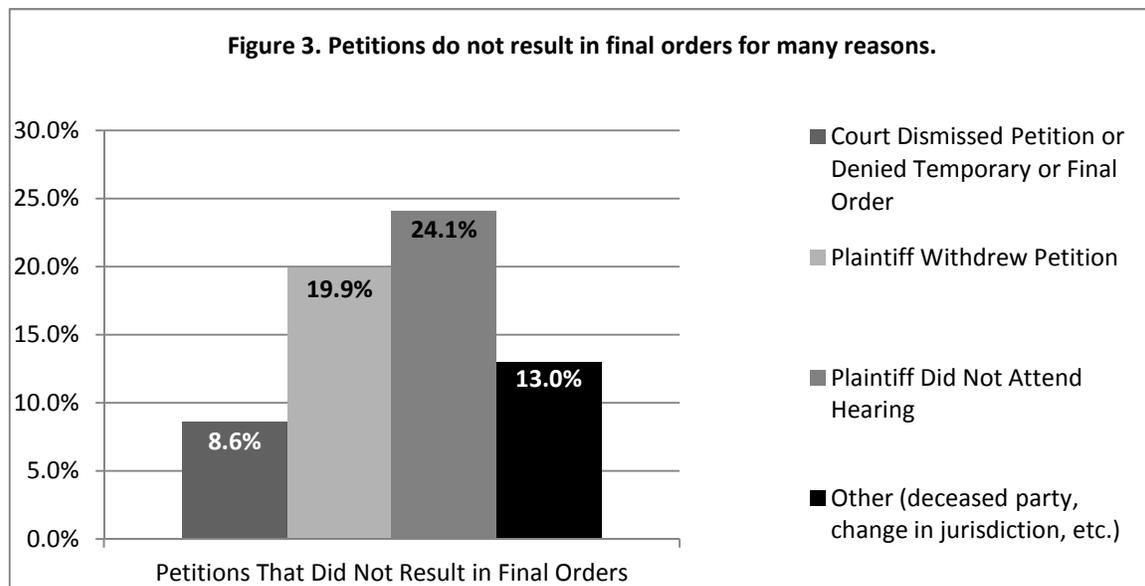
Domestic violence victims seeking protection orders face a number of obstacles in doing so. Of the 44,526 PFA cases processed in Pennsylvania in 2010, only 6,092

(13.7 percent) received final orders from a judge after a hearing, and 9,204 (20.7 percent) received a final order by stipulation or by agreement where there is no admission



of abuse by the defendant.<sup>80</sup> This means that only 15,296 or 34.4 percent of petitions for protection from abuse led to a final order. A high portion of cases — 19,607 or 44 percent — were either withdrawn by the plaintiff or dismissed because the plaintiff did not appear for the hearing.<sup>81</sup> According to court data, reasons petitions do not result in final orders include court dismissal of the petition or denial of temporary or final order (8.6 percent), plaintiff withdrawal of petition (19.9 percent), plaintiff's failure to appear at the hearing (24.1 percent), and other reasons (13.0 percent).

This low rate of orders and high rate of dismissals/withdrawals may be a result of barriers litigants face, including:



- Lack of available and affordable legal representation: Most PFA petitioners lack legal representation.<sup>82</sup> Existing pro bono legal services, which research has shown to be effective at reducing the incidence of reported IPV,<sup>83</sup> lack sufficient funding to provide representation to all who need it.
- A complex process: To obtain a PFA, the typically unrepresented plaintiff must negotiate a maze of proceedings, often without court assistance or information. If she needs to file an emergency petition when the court is closed, she must go to the emergency PFA site or a magistrate, return to court during the day for a temporary order, and return again for the hearing on her final order. Before the hearing, the plaintiff must serve the legal papers on the defendant, sometimes with the help of local police, sometimes by herself. This can be a frightening and dangerous experience. In addition, plaintiffs may not understand what is required of them and how to complete all the required procedures; this can lead to the dismissal of their petition.
- A time consuming process: Court proceedings involve long waits for brief, often incomplete hearings, requiring multiple appearances over a lengthy period of time.<sup>84</sup> Hearings are conducted during day time hours, when work and child-related demands may make it impossible for a plaintiff to appear in court, especially if she must appear repeatedly.<sup>85</sup> Although Philadelphia has adopted an ordinance that requires some employers to provide leave time for court activities related to abuse, neither Pennsylvania nor any other locality in Pennsylvania requires employers to provide such leave time.
- Judicial bias: Battered women and their advocates and lawyers have observed the disbelief with which the testimony of domestic violence victims is met in Philadelphia's Domestic Relations courtrooms.<sup>86</sup> A gender and race bias study performed by the Pennsylvania Supreme Court in 2003 confirmed ongoing concern that Pennsylvania courts improperly fail to believe victims of domestic violence.<sup>87</sup> This bias and disbelief results in denial of PFAs and inappropriate custody determinations, in

which batterers are given custodial rights without appropriate restrictions to protect the safety of the child. It also leads to issuance of PFAs that fail to address custody, placing both the mother and children at risk of further abuse.<sup>88</sup>

- Fear of reprisal and economic dependence on the batterer: Some individuals withdraw petitions or do not actively pursue them because of economic or emotional dependence on the batterer or fear that their involvement with the judicial system will place them or their children at risk of further violence.<sup>89</sup>
- Lack of confidence in the judicial system: Some litigants may drop out of the PFA process because their experience has been difficult or bad.<sup>90</sup> Judges and court staff may treat litigants rudely and fail to give them an opportunity to adequately present their cases.<sup>91</sup> Litigants may not feel safe in courthouses where there are insufficient security personnel or they must wait in the same room as the abuser, and they fear attack after leaving court.<sup>92</sup>

Judges would benefit from education designed to help them understand the complexities involved in a victim's participation in the judicial system, including the impact of coercion, the need to prioritize victim safety, and risk assessment. Although there is a reluctance to mandate judicial training, in part due to lack of authority to do so, the need is urgent. The improper denial of a PFA can have drastic consequences to a victim who lives with a batterer. There are existing resources for obtaining this training.<sup>93</sup>

### **Criminal Justice System**

**Law Enforcement:** Police are frequently called upon to respond to IPV. Although there is no specific crime of either IPV or

## **Gonzales v. U.S.A.**

In 1999, the estranged husband of Jessica Lenahan (formerly Gonzales) kidnapped and killed their three children after the local police department refused to enforce a restraining order against him. Lenahan sued the local police, but the U.S. Supreme Court ruled that she did not have a constitutional right to demand enforcement of the restraining order. Lenahan brought a petition to the Inter-American Commission on Human Rights (the Commission), claiming international human rights violations by the United States. In 2011, the Commission held that the United States failed to meet its duty to protect Lenahan and her children from domestic violence when it failed to enforce her restraining order. The Commission also recognized a systematic failure that disproportionately affects women and racial and ethnic minorities.<sup>i</sup>

<sup>i</sup> *Jessica Gonzales v. United States*, Case 12.626, Inter-Am. C.H.R., Report No. 80/11 ¶¶ 160-61 (2011), <http://www.cidh.oas.org/Comunicados/English/2011/92-11eng.htm> (last visited Sept. 6, 2011).

domestic violence in Pennsylvania, abuse can involve violations of many criminal laws for which abusers may be arrested, prosecuted, and penalized. Some of these crimes include homicide, simple or aggravated assault, rape or other sexual assault, false imprisonment, stalking, threats, arson, vandalism and property offenses, theft, burglary, violation of PFAs, fraud, endangering the welfare of children, and interference with the custody of children.

As stated at the beginning of this chapter, however, many victims do not report domestic violence to police. Reasons for the underreporting of domestic violence to law

## **Law Enforcement Response to Domestic Violence in Philadelphia**

The Women's Law Project and Women Against Abuse have drafted proposals on behalf of the City of Philadelphia for DOJ/OVW grants to improve law enforcement response to domestic violence in Philadelphia, three of which have been awarded, bringing a total of \$3 million dollars to Philadelphia. The Domestic Violence Law Enforcement Committee, which monitors implementation of grant activities, is jointly led by WLP and the District Attorney's Office. This committee brings together all of the relevant parties, including prosecution, police, probation, and court leadership. Advocates from the public interest legal and domestic violence communities also participate. The grant has provided training for over 1,600 police supervisors, patrol officers, and dispatchers and has provided additional resources for prosecution, probation, and domestic violence legal agencies.

The committee is also a forum where issues are discussed, policies are reviewed, and collaboration occurs. A significant outcome resulting from this coordination is the PPD's reorganization of its response to domestic violence incidents. In 2011, the PPD adopted a comprehensive police incident form to be used for domestic violence incidents. The form requires police to fully record all details of the incident in a checklist format. Collecting this information is intended to improve investigation and prosecution of domestic violence cases. In non-arrestable repeat calls, the PPD instituted procedures for follow up by Victim Assistance Officers and detectives. In addition, domestic violence advocates make follow up contacts in certain high risk and repeat cases to provide appropriate social service and civil legal referrals.<sup>1</sup>

<sup>1</sup> Ian Urbina, *Philadelphia to Handle Abuse Calls Differently*, N.Y. Times, Dec. 30, 2009, <http://www.nytimes.com/2009/12/31/us/31philadelphia.html>; Troy Graham, *Domestic-abuse Reports Get Specific in Pa. Police Pilot Program*, Phila. Inquirer, Sept. 6, 2010, <http://www.policeone.com/police-products/communications/articles/2603386-Domestic-abuse-reports-get-specific-in-Pa-police-pilot-program/>.

enforcement authorities include victims' fear that police will not believe them or protect them from the abuse.<sup>94</sup> Law enforcement personnel may adhere to myths and stereotypes about IPV, including blaming the victim for the abuse and assuming that the victim is lying; these attitudes erode any trust between the victim and law enforcement.<sup>95</sup> Women's past negative experiences with police contribute to their underreporting.<sup>96</sup> Negative experiences with the police may include their trivializing the abuse, responding slowly to a call for help, and bonding with the batterer; some women have also found the system as a whole to be too lenient on batterers.<sup>97</sup>

It does not help that victims of IPV have no constitutionally-protected right to have the police enforce orders for protection. There have been high profile examples in which the police failed to enforce restraining orders against abusers, leading to the deaths of the victim and/or minor children.<sup>98</sup>

Efforts are being made to improve police response in some parts of Pennsylvania. For years, Pennsylvania has received funding under the VAWA STOP program, federal funding dedicated to the elimination of violence against women.<sup>99</sup> The current Pennsylvania STOP goals include: reducing violence against women in Pennsylvania through a coordinated response among law

enforcement, prosecution, and victim services that holds offenders accountable; increasing understanding of the dynamics of sexual assault and domestic violence; promoting a vigorous and effective response to violence against women among law enforcement, prosecution, and victim services by providing appropriate training and technical assistance, mandating protocol development, and funding county and statewide initiatives that enhance service providers' capacity to respond effectively; and enhancing the capacity of victim service agencies to provide expanded and culturally relevant services.<sup>100</sup> Pennsylvania seeks to accomplish all this on only \$4.3 million annually.<sup>101</sup> In addition, PCADV regularly trains law enforcement. The Philadelphia Police Department has participated in three sequential Department of Justice Office of Violence Against Women (DOJ/OVW) grants aimed at improving the law enforcement response to domestic violence, working cooperatively with domestic violence groups, the courts, and the prosecutor's office, and training significant portions of its policing staff in understanding and properly responding to domestic violence.

The U.S. Department of Justice (DOJ) has authority to investigate and correct police response to domestic and sexual violence. In its recent investigation of the practices of the New Orleans Police Department, the DOJ found that "the Department fails to adequately investigate violence against women, including sexual assaults and domestic violence" and that such failure constitutes gender biased policing."<sup>102</sup> Specifically, the investigation found that the department's lack of "protocols for 911 operators taking domestic violence calls; initial entry and preliminary investigation of domestic violence scenes; identifying and documenting victim injuries; or procedures for follow-up investigations... impedes effective response and investigation, but also creates potentially dangerous condi-

## **Federal Laws Protecting IPV Victims**

Federal criminal law provides some protection for IPV victims. Under the Violence Against Women Act (VAWA), it is a felony to cross state lines to violate a protective order or to physically injure an intimate partner.<sup>i</sup> Individuals who believe they have been harmed by a possible VAWA violation may call their local Federal Bureau of Investigation (FBI) Office.<sup>ii</sup>

In addition, the federal Gun Control Act makes it a crime for anyone subject to a protection order that meets certain conditions to possess a firearm or ammunition and to receive or ship firearms or ammunition in interstate or foreign commerce, whether the order expressly prohibits possession or not.<sup>iii</sup> The Gun Control Act also prohibits the sale or transfer of firearms or ammunition to a person, "knowing or having reasonable cause to believe that such person" is subject to a protection order;<sup>iv</sup> and prohibits people convicted of misdemeanor domestic assault from purchasing or possessing firearms<sup>v</sup> when the misdemeanor crime for which the individual was convicted specifically prohibits the use or attempted use of physical force, or threatened use of a deadly weapon against an intimate partner.<sup>vi</sup> The extent to which the protection order provisions of the federal Gun Control Act are enforced in Pennsylvania is unknown.

<sup>i</sup> 18 U.S.C. § 2261 (2010); 18 U.S.C. § 2262 (2010).

<sup>ii</sup> See U.S. Dep't of Justice, Federal Domestic Violence Laws, available at <http://www.justice.gov/usao/gan/documents/federallaws.pdf>.

<sup>iii</sup> 18 U.S.C. § 922(g)(8); Darren Mitchell & Susan B. Carbon, *Firearms and Domestic Violence: A Primer for Judges*, 39 Court Rev. 32, \*35 (2002).

<sup>iv</sup> 18 U.S.C. § 922(d)(8) (2010).

<sup>v</sup> 18 U.S.C. § 922(g)(9) (2010).

<sup>vi</sup> 18 U.S.C. § 921(a)(33) (2010).

tions for victims.”<sup>103</sup> The DOJ also found serious inadequacies in investigations, including failure “to solicit or document key facts regarding past history of domestic violence or assault, or include sufficient information to identify the primary aggressor in a situation... to note symptoms of strangulation or ask appropriate follow-up questions related to strangulation... to find and interview witnesses.”<sup>104</sup>

### **The Medical System**

Women who are victims of violence frequently seek medical treatment for the wide range of health consequences stemming from abuse, even though the medical personnel who help them often do not know that they have been abused. Evidence suggests that health care providers may see more domestic violence victims than do law enforcement personnel.<sup>105</sup> Many studies show that abused women seek medical care at a higher rate than women who are not abused, including obtaining prescriptions and admissions to hospitals.<sup>106</sup> In a Canadian population-based study, battered women sought care from accident and emergency departments and saw a medical professional about three times more often than non-battered women.<sup>107</sup>

Medical providers are in a position to provide many services to battered women. It is critical, therefore, that abuse victims' access to medical care be assured. It is also essential to ensure that the privacy of IPV victims be protected when they seek medical help. This will create a sense of safety that may make more IPV victims willing to reach out for help. Pennsylvania has undertaken significant efforts on all of these fronts, but there is room for improvement.

**Trauma Informed Care:** Extensive research has focused on the process of recovery from trauma-inducing experiences such as physical and sexual abuse, which lead to mental health and other co-

occurring disorders. This work has led to the development of a “trauma-informed” treatment model.<sup>108</sup> A service program is trauma-informed when “every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.”<sup>109</sup> Trauma-informed services “are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”<sup>110</sup> To facilitate recovery, treatment is provided with the recognition that (1) the survivor needs to be respected, informed, connected, and hopeful regarding their own recovery; (2) there is a relationship between trauma and conditions which are symptoms of trauma; and (3) there is a “need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers.”<sup>111</sup>

**Routine Assessment for IPV:** Routine assessment for IPV in health care settings and referral of patients to local domestic violence programs connects victims to available services, provides information about safety planning, and helps assure that they receive any additional medical follow-up they may need related to the violence. Guidelines, policies, and protocols developed by national health care associations<sup>112</sup> and national standards established by the Joint Commission on the Accreditation of Healthcare Organizations call for hospitals to have criteria in place to assess patients who may be victims of abuse, neglect or exploitation.<sup>113</sup> Nonetheless, health care providers do not consistently and adequately identify IPV victims, assess their safety, or provide intervention.<sup>114</sup> Routine assessment for IPV is rarely done.<sup>115</sup> Re-

search shows that the majority of domestic violence victims who seek emergency room treatment are not identified as domestic violence victims.<sup>116</sup>

There are many reasons health care providers do not routinely assess patients for IPV. For physicians, part of the problem stems from gaps in medical school and in the residency training that follows medical school. For example, one study found that program directors of primary care residency programs across the country did not believe their residents had gained the knowledge necessary to assess for domestic violence or satisfy other core clinical competencies in women's health.<sup>117</sup> Even if a health care facility has an IPV protocol, medical providers may not know about it.<sup>118</sup>

Lack of insurance reimbursement for routine IPV assessment and follow-up care also may inhibit such assessment. Health care providers might be more likely to assess patients for IPV and provide counseling, safety planning, and other services beyond the treatment of physical injuries if they were adequately reimbursed for their services. This could be accomplished by developing a Current Procedural Terminology (CPT) billing code for domestic violence for use in private practices.<sup>119</sup> The problems with coding and reimbursement will likely improve following the implementation of the Department of Health and Human Services (HHS) guidelines requiring insurance plans to cover, without any cost sharing, domestic violence screening and counseling.<sup>120</sup>

Wisely, Pennsylvania has not adopted any mandatory reporting requirements that might deter routine assessment for IPV. Although Pennsylvania law requires hospitals to report to police when they see patients who have suffered serious bodily injury inflicted by their own act or the act of another person, injury as a result of use

of a deadly weapon, or injuries inflicted in violation of any penal law, the statute specifically exempts bodily injury resulting from IPV from this reporting requirement.<sup>121</sup> This exemption recognizes that IPV victims may be subject to retaliatory abuse if they report to police and respects the right of IPV victims to decide themselves whether to make a police report.<sup>122</sup>

In an attempt to improve the response of the health care system to domestic violence, Pennsylvania adopted the Health Care Response Act of 1998, which established a program within the Department of Public Public Welfare (DPW) to facilitate domestic violence medical advocacy projects.<sup>123</sup>

These programs, administered by PCADV, provide domestic violence-related services in health care settings and train health care providers in order to facilitate the "identification of [domestic violence] victims seeking health care-based services and the provision of support, information, education, resources and follow-up services within the health care setting."<sup>124</sup> While these programs and laws are a start, they have not resulted in consistent routine assessment for IPV in all Pennsylvania hospitals. For example, many of Pennsylvania's 67 counties do not have medical advocacy programs.<sup>125</sup> Furthermore, a 2005 study of the state's programs found varying performances across the program sites. The researchers recommended the establishment of domestic violence task forces at the hospital level, ongoing staff training on domestic violence, improved screening and safety assessment, and standardized intervention checklists for hospital staff to use when domestic violence advocates are not present.<sup>126</sup>

Additionally, studies of domestic violence assessment practices at Pennsylvania hospitals have found them wanting. A study of the emergency department at one major hospital in Philadelphia found that health

## **Insurance Discrimination Against IPV Victims**

In 1994, the Women's Law Project (WLP) and Pennsylvania Coalition Against Domestic Violence (PCADV) started a nationwide effort to stop insurance discrimination against IPV victims after a Pennsylvania woman reported that two insurance companies had denied her health, life, and mortgage disability insurance because she had reported to her doctor that her husband abused her. Insurers justified their discrimination on the grounds that domestic violence victims voluntarily engaged in risky behavior, analogizing them to individuals who ride motorcycles or parachute recreationally. WLP analyzed insurance practices, developed model legislation, collected stories of women impacted by this type of discrimination, and provided technical assistance to legislators, insurance regulators, and advocates. WLP became a consumer representative to the National Association of Insurance Commissioners and contributed to the development of model legislation for state adoption. These efforts contributed to nationwide reform with 43 states adopting legislation to prevent discrimination on the basis of IPV in insurance.

care professionals resisted routine domestic violence assessment.<sup>127</sup> Another study found deficits in the way the emergency departments in four Philadelphia hospitals assess and provide intervention for IPV victims.<sup>128</sup> For example, only one hospital has a written protocol, and one of the hospitals automatically informs police when an IPV screen is positive, even if the victim does not want to speak with police and

even though hospitals are under no legal obligation to report domestic violence to law enforcement authorities when there is no serious bodily injury. Importantly, however, this researcher also found that emergency departments are willing to work with domestic violence advocates to better serve patients, opening a door to improvements in the future.<sup>129</sup>

The Patient Protection and Affordable Care Act (ACA), passed by Congress and signed into law by President Obama in March 2010, may improve IPV assessment practices.<sup>130</sup> Effective August 2012, the ACA requires insurers to cover domestic violence screening and counseling with no co-payments or cost sharing as a component of preventive health care.<sup>131</sup>

**Insurance Coverage:** Insurance companies have a long history of using domestic abuse as a reason to deny women insurance coverage in all types of insurance or as the basis for determining premium payments. The result for victims is denial of insurance altogether or incomplete coverage that excludes or denies claims related to abuse. Such denials both penalize victims for their victimization and deny them access to the means for fleeing abuse: without insurance to enable them to house their families, obtain health care, and otherwise function in society independently, an IPV victim may remain with a batterer for financial security for herself and her children.

In response to the problems of insurance discrimination against victims of IPV, Pennsylvania amended its Unfair Insurance Practices Act to prohibit insurers from denying coverage, cancelling or terminating coverage, charging more for coverage, excluding benefits, and refusing to pay claims in all types of insurance – health, life, disability, and property insurance – on the basis of their status as IPV victims.<sup>132</sup> This protection extends to prohibiting insurers

from denying a property and casualty insurance claim if the loss is caused by the intentional act of another insured, thus protecting individuals whose homes or automobiles are damaged or destroyed by a co-insured partner.

As of 2014, the ACA will implement similar health insurance protection nationwide.<sup>133</sup> The ACA will prohibit individual and group health plans and issuers from denying coverage to women based on many factors (pre-existing conditions), including domestic abuse or sexual violence, and it will prohibit premium rate discrimination.<sup>134</sup>

**Medical Privacy Protection:** Pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), women who seek medical care have confidentiality protection for their written and oral, individually identifiable health information.<sup>135</sup> In the absence of written authorization by the patient, HIPAA protects the patient's

identity and address if the disclosure reveals or is likely to reveal individually identifiable health information, including medical status and diagnosis.<sup>136</sup> This protection permits a woman to safely obtain health care without worrying that her abuser may be able to discover her location, which she may have carefully concealed. While permitting health care providers to make reports required by law of "abuse, neglect, or domestic violence," without written authorization,<sup>137</sup> HIPAA also requires that the provider, health care clearinghouse, or health plan disclosing the protected health information must promptly inform the individual about the report, unless they "believe informing the individual would place the individual at risk of serious harm"<sup>138</sup> or the individual who would be informed is a personal representative believed to have caused the abuse or neglect and therefore should not be informed.<sup>139</sup>

## Response of Community and Governmental Services

### Domestic Violence Victim Services

Pennsylvania has 61 local county-based domestic violence agencies that provide a range of services, including legal and non-legal counseling, shelter, and hotlines that IPV victims may call 24-7 to obtain safety information and learn about services in their area.<sup>140</sup> Research suggests that these types of services help some women escape abuse and that women view them as central to their ability to leave abusive relationships.<sup>141</sup> For example, women who experience severe violence and have access to shelter services leave those abusive relationships sooner than women who do not have access to shelter services.<sup>142</sup> Research has also shown that access to legal services reduces the reported incidence of IPV because "legal services help women with practical matters (such as protective orders,

custody, and child support)... actually present[ing] women with real, long-term alternatives to their relationships."<sup>143</sup>

While these agencies provide significant assistance to IPV victims, they are inadequately funded by a combination of federal and state sources, including the Marriage License Surcharge,<sup>144</sup> VAWA,<sup>145</sup> Family Violence Prevention and Services Act (FVPSA),<sup>146</sup> and Victims of Crime Act (VOCA).<sup>147</sup> As a result of shortages in funding, clients needing services are turned away. For example, Philadelphia's only overnight shelter for domestic violence victims, Women Against Abuse, has a 100 bed capacity and is consistently forced to turn away requests for shelter; in fiscal year 2010-11, the shelter turned away 7,705 requests for shelter.<sup>148</sup> In addition, cut-backs in funding streams are forcing reduc-

tions in services throughout Pennsylvania.<sup>149</sup> Ninety percent of Pennsylvania's domestic violence service programs reported decreased funding in 2010.<sup>150</sup>

### **Abuse and Batterer Intervention Services**

Rehabilitative treatment for people who abuse their intimate partners is an essential part of community response to IPV. Through counseling services, intervention programs for perpetrators of IPV seek to reduce their propensity to abuse.<sup>151</sup> A number of models exist. Some programs do a careful lethality assessment, take in-depth background histories on the use of violence, and conduct separate confidential partner interviews.<sup>152</sup> Since many abusive partners do not have a history of explosive or violent behavior outside of their homes, intervention should include but not be limited to anger management, which usually does not address the power dynamics and gender bias involved in IPV, among other shortcomings.<sup>153</sup> Regardless of the model used, communications with the victim should include clear warnings on the limits of treatment and the offer of a connection to domestic violence counseling and legal services, as research has shown that abused women are more likely to return to an abusive partner when that partner has sought counseling.<sup>154</sup> Current research on intervention with IPV perpetrators suggests that, similar to treatment of other adult populations, the expected success rate will be small and will not impact all participants equally.<sup>155</sup>

In Pennsylvania there are approximately 36 programs affiliated with the Domestic Abuse and Battering Intervention Network of Pennsylvania, a non-accrediting body that promulgates recommended standards for IPV perpetrator intervention.<sup>156</sup> Some of the programs are court referral programs and some also provide stand alone counsel-

ing.<sup>157</sup> Nationally and in Pennsylvania, these services are underutilized and are not taken advantage of early enough in the perpetrator's involvement in the judicial process.

### **Housing**

Some IPV victims face eviction by landlords and public housing authorities as a result of the violence they experience at home. Eviction occurs for a variety of reasons, including complaints from other tenants and property damage. As a result, IPV victims may find themselves homeless through no fault of their own. Laws provide some protection for these victims, but do not go far enough. The 2005 VAWA prohibits public housing and voucher and Section 8 programs from denying housing or terminating assistance.<sup>158</sup> VAWA's shortcomings include its failure to provide a private cause of action for IPV victims who have been wrongfully evicted, lack of protection for IPV victims in private housing, and failure to provide for damages.<sup>159</sup>

The Fair Housing Act (FHA) may also provide some protection for IPV victims. It prohibits discrimination in housing on the basis of sex, in addition to other protected classes.<sup>160</sup> While some courts have extended this protection to include an individual's status as a domestic violence victim, most do not.<sup>161</sup>

At the local level, the Philadelphia Fair Practices Ordinance prohibits owners of commercial housing or any other real property from discriminating against domestic or sexual violence victims.<sup>162</sup> The Philadelphia Fair Practices Ordinance also prohibits discrimination against individuals based on their status as a domestic or sexual violence victim in public accommodations. The Philadelphia Commission on Human Relations enforces this ordinance.<sup>163</sup>

### Public Assistance

While IPV affects individuals of all socio-economic levels, a high number of women living in poverty are abused.<sup>164</sup> For these women, the abuse may hinder their ability to reach financial security, for example, by affecting their ability to stay employed. Low income women who are subjected to abuse may seek cash assistance from the Temporary Assistance for Needy Families (TANF), a federally-funded welfare program administered through the states, and General Assistance (GA), a state-funded welfare program. Pennsylvania's GA program permits domestic violence victims who are receiving IPV-related services to receive nine months of GA during the course of their lives.<sup>165</sup> In addition, to better enable IPV victims to access cash assistance, Pennsylvania adopted the Family Violence Option (FVO), which Congress enacted in 1996 as part of its welfare reform legislation.<sup>166</sup> By adopting the FVO, Pennsylvania certified that it will screen for domestic violence, maintain victims' confidentiality, refer victims to domestic violence-related services, and waive any TANF or GA requirements, such as work requirements, cooperation with child support enforcement, and time limits on the receipt of benefits, if the program requirement would hinder a family or household member from escaping IPV; place a family or household member at risk of more violence; or unfairly penalize a family or household member because of IPV.<sup>167</sup> DPW has established uniform policies and procedures for waivers of TANF or GA program requirements.<sup>168</sup> In March 2011, 1,231 TANF recipients had FVO waivers of work requirements and 3,291 recipients had FVO waivers of child support cooperation requirements.<sup>169</sup>

### Workplace

Domestic violence affects women at work and can be more deadly than IPV confined

## Family Violence Option

Along with Community Legal Services and the Community Justice Project, the WLP has assisted DPW in its efforts to provide confidentiality and flexibility to IPV victims through the implementation of the FVO since 1997. WLP participates as a member of DPW's TANF/Domestic Violence Task Force, through which WLP has been involved in developing state policies and procedures implementing the FVO. WLP continues to work closely with DPW to monitor FVO implementation and training of state workers on the FVO.

to the home. A 2009 study found that firearms are the weapon most often used in workplace IPV, even in cases where a victim had a protection order that barred the abuser from carrying a gun.<sup>170</sup> IPV may also affect a victim's ability to maintain employment, for instance, by causing frequent absenteeism when the victim requires medical treatment or seeks legal or other services.<sup>171</sup> IPV victims who are unable to maintain employment are more likely to remain economically dependent on their abusers, making it more difficult for them to escape the violence. They are also less likely to have employer-provided health insurance benefits that would help them obtain the medical care they need in the short and long-term.

A handful of existing workplace protections in Pennsylvania may help IPV victims remain economically independent from their abusers and maintain employer-provided benefits. State law prohibits employers from depriving crime victims, including IPV victims involved in the criminal process, of their "employment, seniority position or benefits, or threat-

en[ing] or otherwise coerc[ing] [them] with respect thereto, because the employee attends court by reason of being a victim of, or a witness to, a crime or a member of such victim's family."<sup>172</sup> In 2011, Philadelphia amended its Fair Practices Ordinance to prohibit employers from discriminating against an employee due to his or her status as a domestic or sexual violence victim.<sup>173</sup> Philadelphia also adopted an ordinance providing unpaid leave to domestic or sexual violence victims to address the violence, including seeking medical attention, receiving IPV services and counseling, participating in safety planning, relocating,

or seeking legal services for themselves or a member of their family or household.<sup>174</sup>

### **Immigration**

Immigrant IPV victims face numerous obstacles: barriers to legal status, lack of access to public benefits, employment issues, and crime reporting barriers. A complete discussion of these issues is beyond the scope of this chapter.<sup>175</sup> It is clear that immigrant victims of IPV require specialized legal assistance and that insufficient free or low-cost representation is available in Pennsylvania.

## RECOMMENDATIONS FOR REFORM

### Behavioral and Physical Health Care

- Trauma-informed care should be expanded. IPV-related trauma may contribute to long-term, serious behavioral health complications.<sup>176</sup> IPV service providers and behavioral health services must be prepared to respond to the needs of these victims.
- Medical advocacy projects should be expanded across the Commonwealth. Victims in all 67 counties should have access to IPV services in health care settings.<sup>177</sup>
- Health care providers should routinely assess for IPV. In addition to hospitals, obstetrics and gynecology offices, and primary care practices, there may also be opportunities for increased screening at pediatric emergency centers of adults who seek treatment for their children, to determine whether the adults have experienced IPV.<sup>178</sup> IPV victims are more likely to seek medical care for their children than they are for themselves.<sup>179</sup>
- Appropriate medical coding and reimbursement should be developed for routine assessment for IPV and follow-up services related to domestic violence, including behavioral health services.

### Courts

- Judges, court personnel, and mental health professionals should be educated about domestic violence and stalking and the importance of addressing victim and child safety in PFA and custody determinations. All judicial and professional staff involved in judicial procedures relating to protection from abuse and custody should avail themselves of quality educational programs and benchbooks on the dynamics and consequences of IPV and the applicable federal, state, and local laws.<sup>180</sup> Without this knowledge, appropriate decisions about safety and custody of children cannot be made.
- Access to legal assistance for IPV victims should be increased. Legal services that provide pro bono or reduced-cost representation to IPV victims require sufficient funding to meet the need.<sup>181</sup> Additional opportunities for representation must be identified and supported, including through a right to counsel for civil litigants in child custody proceedings,<sup>182</sup> as well as through law school clinical programs, and other pro bono services.
- The Commonwealth must increase and expand court-sponsored assistance for pro se litigants beyond the assistance courts may currently provide at intake. This should include written and oral information in multiple languages, instructions and forms for preparation of pro se court filings, and “self-help centers” that provide information and electronic preparation and filing of forms.
- Courts should provide litigants with a full and fair hearing, adjudicate matters in a timely manner, and treat litigants with respect.

## Law Enforcement

- The Pennsylvania State Police should include domestic violence and stalking education in its annual training. Currently, the Municipal Police Officers' Education and Training Commission (MPOETC), which establishes the minimum training courses for municipal police officers throughout Pennsylvania, does not require in-service IPV or stalking training.<sup>183</sup> Better training on these issues would sensitize officers to the obstacles IPV and stalking victims face, helping them respond appropriately, so as to protect victims and increase the safety of the community.
- Police training and policies and procedures on responding to IPV should be developed in all local and state law enforcement agencies. Police response to IPV must be improved and myths and biases that deter appropriate police response must be eliminated.

## Government

- DPW should monitor implementation and train its staff on the Family Violence Option to maximize its effectiveness for IPV victims.
- The United States and the Commonwealth should enact legislation to prohibit the eviction from or denial of public housing based on a victim's history of domestic violence. IPV victims suffer discrimination when they apply for federally-subsidized public housing, despite some protection under VAWA and the Fair Housing Act. Pennsylvania should pass legislation prohibiting this type of discrimination, following the lead of other states.<sup>184</sup>
- More free, low cost, and pro bono resources should be made available to immigrant domestic violence victims pursuing self petitions for citizenship.

## Services

- The Commonwealth should increase funding for IPV services. IPV services need a dedicated stream of funding sufficient to meet the needs of victims across the state, rather than the existing patchwork of vulnerable funding sources.
- The availability and early use of batterer treatment programs should be expanded.
- Batterer treatment programs should be improved. Research should be pursued to identify effective models to reduce battering, and monitor existing programs for their effectiveness and impact on victims.
- Alternative means of holding batterers accountable other than through counseling should be identified.
- Pennsylvania should institute statewide standard domestic violence data collection. In order to fully understand the impact of IPV on society, the Pennsylvania Department of Health should collect data on the number of incidences and medical visits to either emergency rooms or primary care physicians as a result of IPV.

## Employment

- Pennsylvania should enact legislation to address the needs of IPV victims in the workplace. Pennsylvania should require employers to provide paid leave for victims of IPV and stalking and mandate other employer protections for IPV victims in the workplace. Paid leave permits victims to obtain IPV-related services, including medical and legal assistance, without losing their jobs. Employer safety assistance, such as variable work schedules, office transfers, and escorts to parking lots, is essential to victim safety on the job.

## Community

- Pennsylvania should create state-wide and local coordinated community response approaches to IPV. The integration and coordination of law enforcement, advocates, health care providers, social services, employers, and schools, will help to ensure that the system works faster and better for victims, that victims are protected and receive the services they need, and that batterers are held accountable and cease their abusive behavior.

## Congress

- Congress should adopt Senate Bill 1925, the Violence Against Women Reauthorization Act of 2011. Adoption of VAWA 2011 will continue necessary funding for services that benefit victims of IPV and expand important safety protections to IPV victims in the justice, immigration, and housing systems.<sup>185</sup>

## ENDNOTES

<sup>1</sup> Center for Disease Control (CDC), Intimate Partner Violence: Definitions, <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html> (last visited Sept. 1, 2011); World Health Organization (WHO) World Report on Health and Violence, Ch. 4 at 93 (2002), *available at* [http://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap4.pdf](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap4.pdf). Intimate partner violence is an aspect of the broader category of domestic violence, which includes violence directed to any family or household member or intimate partner.

<sup>2</sup> Some studies suggest that men are as likely to be victimized by female-perpetrated domestic violence as women, but these studies often do not distinguish between different types of domestic violence: intimate partner violence based on coercive control, situational violence that results from progressive escalation of conflict, and violence as a form of resisting an intimate partner's coercive and controlling tactics. In cases of intimate partner violence based on coercive control, which is the definition most commonly associated with the term "domestic violence," the victims are predominantly female and the perpetrators are predominantly male. Michael P. Johnson, *Domestic Violence: It's Not About Gender—Or Is It?* 67 *J. of Marriage and Family* 1126, 1128 (2005).

<sup>3</sup> Dominic J. Parrott & Amos Zeichner, *Effects of Trait Anger and Negative Attitudes Towards Women on Physical Assault in Dating Relationships*, *J. of Family Violence*, 301, 302 (2003) (notes that some "researchers have found that traditional sex-role attitudes are negatively related to relationship violence," and raises the possibility that "only a subgroup of men who are violent in intimate relationships hold conservative sex-role attitudes" as an explanation for conflicting results in the body of research, citing Gortner et al. *Psychological Aspects of Perpetrators of Domestic Violence and their Relationships with the Victims*, 20 *Psychiatr. Clin. North Am.* 337 (1997) & Amy Holtzworth-Munroe et al., *A Brief Review of the Research on Husband Violence. Part I: Maritally Violence versus Nonviolence Men*, 2 *Aggr. Viol. Behav.* 65 (1997)).

<sup>4</sup> Johnson, *supra* note 2, at 1128.

<sup>5</sup> Leslye E. Orloff & Janice v. Kaguyutan, *Offering A Helping Hand: Legal Protections For Battered Immigrant Women: A History Of Legislative Responses*, 10 *Am. U.J. Gender Soc. Pol'y & L.* 95, 97-98 (2001).

<sup>6</sup> M.C. Black, et al., *The National Intimate Partner and Sexual Violence Survey* 38-39, 74 (2011) (hereinafter NISVS Survey), *available at* [http://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Report2010-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf).

<sup>7</sup> *Id.* at 38-39.

<sup>8</sup> *Id.* at 41.

<sup>9</sup> *Id.* at 39.

<sup>10</sup> *Id.* at 29; Stalking Resource Center, *Stalking Facts*, [http://www.ncvc.org/src/main.aspx?dbID=DB\\_statistics195](http://www.ncvc.org/src/main.aspx?dbID=DB_statistics195) (last visited Jan. 30, 2012).

<sup>11</sup> Shannan Catalano, U.S. Dep't of Justice, Bureau of Justice: Selected Findings: Female Victims of Violence 2 (2009), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf>.

<sup>12</sup> *Id.* at 3.

<sup>13</sup> *Id.*

<sup>14</sup> See Pennsylvania Domestic Violence Task Force, Report of the Pennsylvania Domestic Violence Task Force 21 (2010) (citing Jody Raphael, *Battering Through the Lens of Class*, 11 *Am. U.J. Gender Soc. Pol'y & L.* 367, 370 (2003)) [hereinafter DV Task Force Report]; Joan Zorza, *New Study on Domestic Violence in the Workplace*, 3 *Family & Intimate Partner Violence Quarterly* 217, 218 (2011).

<sup>15</sup> Written communication to WLP by Nancy E. Carnes, Supervisory Writer/Editor, FBI Criminal Justice Information Service Div'n (March 11, 2011); Phone conversation with Greg Scarbro, Unit Chief, FBI UCR

Program (April 18, 2011) (stating that nationwide, only 44 percent of law enforcement agencies use NIBRS, and only 15 states collect NIBRS data from 100 percent of their law enforcement agencies).

<sup>16</sup> Karin V. Rhodes & Catherine L. Kothari, *Missed Opportunities: Emergency Department Visits by Police-Identified Victims of Intimate Partner Violence*, 47 *Annals of Emergency Medicine* 190 (2006) (of 964 female victims identified by a prosecutor's office in a single year, 64% had been seen in an ER within the year, but only 30% had been screened for IPV and only about 6% had been identified as IPV victims), available at [http://www.sp2.upenn.edu/ortner/docs/rhodes\\_doc3.pdf](http://www.sp2.upenn.edu/ortner/docs/rhodes_doc3.pdf).

<sup>17</sup> NISVS Survey, *supra* note 6, at 75, Table 7.4.

<sup>18</sup> *Id.* at 79, Table 7.6.

<sup>19</sup> U.S. Department of Justice, *Violence by Intimates: Analysis of Data of Crimes by Current or Former Spouses, Boyfriends, or Girlfriends* 20 (1998), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/vi.pdf>.

<sup>20</sup> National Network to End Domestic Violence (NNEDV), 2010 Domestic Violence Counts: A 24-Hour Census of Domestic Violence Shelters and Services, Pennsylvania Summary, available at <http://www.nnedv.org/resources/census/2010-report.html>.

<sup>21</sup> Pennsylvania Coalition Against Domestic Violence (PCADV), 2009-10 Annual Report, available at [http://www.pcadv.org/Resources/steppingstones\\_annualreport.pdf](http://www.pcadv.org/Resources/steppingstones_annualreport.pdf).

<sup>22</sup> Zygmunt A. Pines, Administrative Office of Pennsylvania Courts, 2010 Caseload Statistics of the Unified Judicial System of Pennsylvania 27 (2011), available at <http://www.pacourts.us/NR/rdonlyres/EA170C86-5376-4501-AED1-9E77CAD8F81E/0/2010Report.pdf>.

<sup>23</sup> Grant Proposal of City of Philadelphia for DOJ/OVW Grant to Encourage Arrest Policies and Enforcement of PFAs, at 2 (submitted 2/24/11).

<sup>24</sup> PCADV, Domestic Violence Fatalities in Pennsylvania — 2010, at 1 (2010), available at <http://www.pcadv.org/Resources/2010FatalityReportWeb.pdf> (as PCADV notes, this report likely undercounts deaths related to domestic violence because it relies on media accounts. There is no database in Pennsylvania that tracks all domestic -related fatalities).

<sup>25</sup> *Id.* at 2.

<sup>26</sup> *Id.* at 3.

<sup>27</sup> *Id.*

<sup>28</sup> NISVS, *supra* note 6 at 53.

<sup>29</sup> Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 *Lancet* 1331 (2002).

<sup>30</sup> Peggy E. Goodman, *The Relationship Between Intimate Partner Violence and Other Forms of Family and Societal Violence*, 24 *Emerg. Med. Clin. N. Am.* 889, 892 (2006).

<sup>31</sup> Mary Ellsberg, et al., *Intimate Partner Violence and Women's Physical and Mental Health in the WHO Multi-Country Study on Women's Health and Domestic Violence: an Observational Study*, 371 *Lancet* 1165, 1167 (2008).

<sup>32</sup> Campbell, *supra* note 29, at 1332.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> Linda Chamberlain & Rebecca Levenson, Family Violence Prevention Fund, *Reproductive Health and Partner Violence Guidelines* 5-6 (2010), available at [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro\\_Guide.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf).

<sup>37</sup> Elizabeth Miller, et al., *Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy*, 81 *Contraception* 316, 318 (2010).

<sup>38</sup> Karen M. Devries, et al., *Intimate Partner Violence during Pregnancy: Analysis of Prevalence Data from 19 Countries*, 18 *Reproductive Health Matters* 158 (2010).

<sup>39</sup> Campbell, *supra* note 29, at 1333.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*; Maria A. Pico-Alfonso, et al., *The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide*, 15 *J. of Women's Health* 599, 603 (2006).

<sup>42</sup> Campbell, *supra* note 29, at 1334.

<sup>43</sup> *Id.*; Ellsberg et al., *supra* note 31, at 1166-68.

<sup>44</sup> Choking is the blocking of an airway by an object, such as food, and is not a crime. Strangulation is externally obstructing seriously or fatally the normal breathing of an individual, and is a crime. Maureen Funk & Julie Schuppel, *Strangulation Injuries*, 102 *Wisconsin Medical J.* 41, 42 (2003); Allison Turkel, "And Then He Choked Me": *Understanding and Investigating Strangulation*, 13 *Domestic Violence Rep.* 81 (2008).

<sup>45</sup> Funk & Schuppel, *supra* note 44, at 42.

<sup>46</sup> *Id.*

<sup>47</sup> Campbell, *supra* note 29, at 1334; Ellsberg et al., *supra* note 31.

<sup>48</sup> NISVS study, *supra* note 6, at 79, Table 7.6, n.2.

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

<sup>50</sup> Goodman, *supra* note 30, at 896.

<sup>51</sup> National Resource Center on Domestic Violence (NRCDV), *Children Exposed to Intimate Partner Violence: An information Packet* 5-6 (2002).

<sup>52</sup> See, e.g., Jeffrey L. Edleson, *The Overlap Between Child Maltreatment and Woman Battering*, 5 *Violence Against Women* 134, 149 (1999).

<sup>53</sup> Goodman, *supra* note 30, at 893.

<sup>54</sup> Sandra A. Graham-Berman & Julia Seng, *Violence Exposure and Traumatic Stress Symptoms as Additional Health Predictors in High-Risk Children*, 146 *J. of Pediatrics* 349, 352 (2005).

<sup>55</sup> *Id.*

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

<sup>57</sup> NRCDV, *supra* note 51, at 4.

<sup>58</sup> *Id.* at 6; Sandra A. Graham-Bermann & Alytia A. Levendosky, *Traumatic Stress Symptoms in Children of Battered Women*, 13 *J. of Interpersonal Violence* 111, 122 (1998).

<sup>59</sup> NRCDV, *supra* note 51, at 6.

<sup>60</sup> *Id.*; Graham-Berman & Seng, *supra* note 58.

<sup>61</sup> NRCDV, *supra* note 51, at 6.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at 5-7.

<sup>64</sup> *Id.* at 7.

<sup>65</sup> The impact of any one negative experience cannot be separated from the impact of others. First, if a person had had one adverse experience as a child, there was an 80% chance that the child had experiences more negative experiences. Second, the study rated participants on the total number of adverse childhood experiences rather than looking at which childhood experiences were associated with which adult statuses. Vincent J. Felitt, *The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead* (2002), available at [http://www.acestudy.org/files/Gold\\_into\\_Lead-\\_Germany1-02\\_c\\_Graphs.pdf](http://www.acestudy.org/files/Gold_into_Lead-_Germany1-02_c_Graphs.pdf).

<sup>66</sup> *Id.*

<sup>67</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(1) (2010).

<sup>68</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(2) (2010).

<sup>69</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(5) (2010).

<sup>70</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(6) (2010).

<sup>71</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(7) (2010).

<sup>72</sup> *Id.*

<sup>73</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(8) (2010).

<sup>74</sup> 23 Pa. Cons. Stat. Ann. §6108(a)(3) (2010).

<sup>75</sup> 23 Pa. Cons. Stat. Ann. § 6108(a)(4) (2010).

<sup>76</sup> 23 Pa. Cons. Stat. §§ 5323(e), 5328(a)(2) (2011).

<sup>77</sup> *See, e.g.,* Sharwline Nicholson v. Scoppetta, 3 N.Y.3d 357 (N.Y. 2004) (concluding, while answering certified questions from the federal appeals court in a case stemming from a challenge to New York’s policy of removing children from the custody of IPV victims, that, “more is required for a showing of neglect under the New York law than the fact that the child was exposed to domestic abuse against the caretaker.”); Child welfare proceedings are beyond scope of our expertise, and so we refrain from delving into Pennsylvania practices and from making recommendations in this report.

<sup>78</sup> Elizabeth Richardson Vigdor & James A. Mercy, *Do Laws Restricting Access to Firearms by Domestic Violence Offenders Prevent Intimate Partner Homicide?*, 30 Eval. Review 313, 337 (2006).

<sup>79</sup> Daniel W. Webster, *Women with Protective Orders Report Failure to Remove Firearms from Their Abusive Partners: Results from an Exploratory Study*, 19 J. of Women’s Health 93, 96 (2010) (IPV victims from “New York City and Los Angeles reported that judges issued orders for firearm surrender in only 26% of the cases involving protective orders against armed abusers.”).

<sup>80</sup> Pines, *supra* note 22, at 27.

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

<sup>82</sup> Women’s Law Project, *Justice in the Domestic Relations Division of Philadelphia Family Court: A Report to the Community* 11 (2003), available at [http://www.womenslawproject.org/resources/WLP\\_FamlyCourt.pdf](http://www.womenslawproject.org/resources/WLP_FamlyCourt.pdf) (“Of litigants in custody, support, and PFA proceedings [in Philadelphia], 85% to 90% lack legal representation and must represent themselves appear pro se,” citing David I. Grunfeld, *10 Questions for Judge Idee C.*

*Fox, Supervising Judge, Domestic Relations Division, Philadelphia Court of Common Pleas Family Court, The Phila. Lawyer* 34 (2002)) [hereinafter Family Court Report].

<sup>83</sup> Amy Farmer & Jill Tiefenthaler, *Explaining the Recent Decline in Domestic Violence*, 21 *Contemporary Economic Policy* 158, 159 (2003).

<sup>84</sup> Family Court Report, *supra* note 82, at 4-5, 31, 59-64.

<sup>85</sup> *Id.* at 31.

<sup>86</sup> Margaret Klaw & Mary Scherf, *Feminist Advocacy: The Evolution of Pennsylvania's Protection From Abuse Act*, 1 U. Pa. J. L. & Soc. Change 33 (1993) (recommending a comprehensive study of gender bias in Pennsylvania courts).

<sup>87</sup> Family Court Report, *supra* note 82, at 68-70 (recounting refusal of judges in Philadelphia Family Court to permit the introduction or consideration of evidence of domestic violence in custody matters).

<sup>88</sup> *See also*, Barry Goldstein, *Extreme Custody Decisions That Risk Lives*, 4 *Fam. & Intimate Partner Violence Quarterly* 165 (2011).

<sup>89</sup> Sonia Gauthier, *The Perceptions of Judicial and Psychosocial Interveners of the Consequences of Dropped Charges in Domestic Violence Cases*, 16 *Violence Against Women* 1375, 1376-77 (2010).

<sup>90</sup> *Id.* at 1377.

<sup>91</sup> Family Court Report, *supra* note 82, at 38-43, 55, 64-66.

<sup>92</sup> *Id.* at 19, 23-24.

<sup>93</sup> *See* Futures Without Violence, *Enhancing Judicial Skills (EJS) in Domestic Violence Cases*, [http://www.futureswithoutviolence.org/section/our\\_work/judges](http://www.futureswithoutviolence.org/section/our_work/judges) (last visited Sept. 7, 2011).

<sup>94</sup> Marsha E. Wolf, et al. *Barriers to Seeking Police Help for Intimate Partner Violence*, 18 *J. of Family Violence* 121, 124-126 (2003).

<sup>95</sup> A.P. Worden & B.E. Carlson, *Attitudes and Beliefs about Domestic Violence: Results of a Public Opinion Survey: Beliefs about Causes*, 20 *J. of Interpersonal Violence* 1219 (2005); Elizabeth C. McMullan et al, *Future Law Enforcement Officers and Social Workers: Perceptions of Domestic Violence*, 25 *J. of Interpersonal Violence* 1367, 1380 (2010) (finding that "social work students [are] more sensitive to domestic violence identification and reporting than law enforcement and other criminal justice students.").

<sup>96</sup> Wolf, *supra* note 94, at 124-126.

<sup>97</sup> *Id.*

<sup>98</sup> *Castle Rock v. Gonzales*, 545 U.S. 748 (2005).

<sup>99</sup> Pennsylvania Commission on Crime and Delinquency, *Pennsylvania's Recovery Act STOP Violence Against Women Formula Grant Program Implementation Plan* (2009), [http://www.portal.state.pa.us/portal/server.pt/community/are\\_you\\_a\\_member\\_of\\_a\\_stop\\_coordinating\\_team\\_/14415](http://www.portal.state.pa.us/portal/server.pt/community/are_you_a_member_of_a_stop_coordinating_team_/14415) (last visited Sept. 6, 2011).

<sup>100</sup> Pennsylvania Commission on Crime and Delinquency, *STOP Implementation Plan FY 2009-2012*, [http://www.portal.state.pa.us/portal/server.pt/community/are\\_you\\_a\\_member\\_of\\_a\\_stop\\_coordinating\\_team\\_/14415](http://www.portal.state.pa.us/portal/server.pt/community/are_you_a_member_of_a_stop_coordinating_team_/14415) (last visited Sept. 6, 2011).

<sup>101</sup> Office of Victims' Services, Commonwealth Of Pennsylvania Commission On Crime And Delinquency, *Annual Report Fiscal Year 2009-2010*, <http://www.portal.state.pa.us/portal/server.pt?open=512&objid=5255&&Pageid=495590&Level=2&Css=L2&Mode=2>.

<sup>102</sup> United States Department of Justice, Civil Rights Division, Investigation of the New Orleans Police Department ix (2011), available at [http://www.justice.gov/crt/about/spl/nopd\\_report.pdf](http://www.justice.gov/crt/about/spl/nopd_report.pdf).

<sup>103</sup> *Id.* at 49

<sup>104</sup> *Id.* at 50.

<sup>105</sup> John Krimm & Marjorie M. Heinzer, *Domestic Violence Screening in the Emergency Department of an Urban Hospital*, 94 J Natl. Med Assoc. 484, 489-9 (2002).

<sup>106</sup> Agency for Healthcare Research and Quality, Program Brief: Mental Health Research Findings 2 (2009), available at <http://www.ahrq.gov/research/mentalhth.pdf>.

<sup>107</sup> Pamela Ratner, *The Incidence of Wife Abuse and Mental Health Status in Abused Wives in Edmonton Alberta*, 84 Can. J. Public Health 246-69 (1993).

<sup>108</sup> Sandra L. Bloom, *Mental Health Aspects of IPV/DV: Survivors, Professionals, and Systems*, originally published in A.P. Giardino et al. (eds.), *Intimate Partner Violence and Spousal Abuse: A resource for Professionals Working with Children and Families* 1-13 (2010), available at [http://www.sanctuaryweb.com/PDFs\\_new/Bloom%20Mental%20Health%20Aspects%20of%20IPV.pdf](http://www.sanctuaryweb.com/PDFs_new/Bloom%20Mental%20Health%20Aspects%20of%20IPV.pdf); Substance Abuse and Mental Health Services Administration (SAMHSA), *Trauma-Informed Care and Trauma Services*, available at <http://samhsa.gov/nctic/trauma.asp>.

<sup>109</sup> SAMHSA, *supra* note 108.

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

<sup>111</sup> *Id.*

<sup>112</sup> Jeannine L. Lisitski, *Philadelphia Hospital Emergency Department Protocol and Response to Intimate Partner Violence* 3 (unpub'd Bryn Mawr course paper 5/22/10) (citing American Medical Association, American College of Emergency Physicians, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology).

<sup>113</sup> Joint Commission on Accreditation of Healthcare Organizations, PC.01.02.09 on Victims of Abuse, [http://www.futureswithoutviolence.org/section/our\\_work/health/\\_health\\_material/\\_jcaho](http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_jcaho) (last visited Sept. 1, 2011).

<sup>114</sup> Lisitski, *supra* note 112, at 4.

<sup>115</sup> Elizabeth M. Datner et al. *Identifying Pregnant Women Experiencing Domestic Violence in an Urban Emergency Department*. J. Interpers. Violence, 124-135 (2007).

<sup>116</sup> Rhodes & Kothari, *supra* note 16, at 197.

<sup>117</sup> Abby L. Spencer & Lisa M. Kern, *Primary Care Program Directors' Perceptions of Women's Health Education: A Gap in the Graduate Medical Education Persists*, J. of Women's Health, 549-556 (2008).

<sup>118</sup> L. Kevin Hamberger & Mary Beth Phelan, *Domestic Violence Screening in Medical and Mental Health Care Settings: Overcoming Barriers to Screening, Identifying, and Helping Partner Violence Victims*, Prevention of Intimate Partner Violence 61 (2006).

<sup>119</sup> William J. Rudman, Family Violence Prevention Fund, Coding and Documentation of Domestic Violence (2000), available at <http://www.endabuse.org/userfiles/file/HealthCare/codingpaper.pdf>.

<sup>120</sup> See *infra* notes 130-131 and accompanying text.

<sup>121</sup> 18 Pa. Cons. Stat. § 5106 (2010).

<sup>122</sup> See Janet Nudelman & Helen Rodriguez Trias, *Building Bridges between Domestic Violence Advocates and Health Care Providers* (1999), <http://www.mincava.umn.edu/documents/bridges/bridges.html> (last visited Sept. 6, 2011).

<sup>123</sup> 35 Pa. Stat. § 7661.3 (2010).

<sup>124</sup> Jeffrey Cobin & Elizabeth Fisher, *Evaluating the Implementation of Hospital-Based Domestic Violence Programs*, 1 Family Violence & Health Practice 2 (2005).

<sup>125</sup> As of 2007, PCADV funded 35 medical advocacy projects across Pennsylvania. PCADV, 2006/07 Annual Report 7, available at [http://www.pcadv.org/Resources/06\\_07\\_Annual%20Report.pdf](http://www.pcadv.org/Resources/06_07_Annual%20Report.pdf).

<sup>126</sup> Cobin & Fisher, *supra* note 124, at 6.

<sup>127</sup> Krimm & Heinzer, *supra* note 105, at 489.

<sup>128</sup> Jeannine L. Lisitski, *supra* note 112.

<sup>129</sup> *Id.*

<sup>130</sup> In addition to provisions aimed at improving access to health care and the health care system's response to IPV, the ACA includes provisions designed to promote the health and well-being of IPV victims. For example, the ACA provides federal funding to the states to identify communities with concentrations of at risk populations, including domestic violence victims, to assess the quality of existing home visiting programs, through which victims may be connected to services they need, and to develop and implement evidence-based maternal, infant, and early childhood visitation programs. 42 U.S.C.S. § 711(2010). The ACA also authorizes and provides funding to the states for ten years for a pregnancy assistance fund to help pregnant and parenting teenagers and women; these funds may also be used to assist pregnant IPV victims. 42 U.S.C. § 18202(2010); 42 U.S.C.S. § 18203(d)(2010).

<sup>131</sup> Press Release, U.S. Dep't of Health & Human Servs., *Affordable Care Act Ensures Women Receive Preventive Services at No Additional Cost* (Aug. 1, 2011), <http://www.hhs.gov/news/press/2011pres/08/20110801b.html> (last visited Sept. 6, 2011).

<sup>132</sup> 40 Pa. Stat. § 1171.3 (2010).

<sup>133</sup> See Family Violence Prevention Fund, *How Health Reform May Affect Victims of Domestic, Sexual, and Dating Violence* (2010), available at <http://endabuse.org/userfiles/file/HealthCare/Health%20Reform%20Memo.pdf>.

<sup>134</sup> 42 U.S.C. 300gg-4 (2010).

<sup>135</sup> 42 U.S.C.S. § 1320d, et seq (2010).

<sup>136</sup> 45 CFR 164.508 (2010).

<sup>137</sup> 45 CFR 164.512(c)(i) (2010).

<sup>138</sup> 45 CFR 164.512(2)(i) (2010).

<sup>139</sup> 45 CFR 164.512(c)(2)(ii) (2010).

<sup>140</sup> See PCADV, *supra* note 21.

<sup>141</sup> See, e.g., Susan F. Grossman, et al., *Shelter and Service Receipt for Victims of Domestic Violence in Illinois*, 25 J. of Interpersonal Violence 2077, 2077-2079 (2010) (providing a discussion of empirical research on shelter use).

<sup>142</sup> Subadra Panchanadeswaran & Laura A. McCloskey, *Predicting the Timing of Women's Departure from Abusive Relationships*, 22 J. of Interpersonal Violence 50 (2007).

<sup>143</sup> Farmer & Tiefenthaler, *supra* note 83, at 164.

<sup>144</sup> See PCADV, *supra* note 125, at 10.

<sup>145</sup> VAWA I. Violence Against Women Act of 1994, Pub. L. No. 103-322, 108 Stat. 1902 (codified in pertinent part at 42 U.S.C.A. § 13981); see Sarah Lorraine Solon, ed, *Tenth Annual Review of Gender and Sexuality Law: Criminal Law Chapter: Domestic Violence*, 10 Geo. J. Gender & L. 369, 377-389 (2009) (providing history and summary of VAWA provisions).

<sup>146</sup> 42 USCS § 10401, et seq (2010).

<sup>147</sup> Office for Victims of Crime, OVC Fact Sheet: Crime Victims Fund, <http://www.ojp.usdoj.gov/ovc/publications/factshts/cvf2010/intro.html#vc> (last visited Sept. 1, 2011).

<sup>148</sup> Women Against Abuse, Annual Report July 1, 2010 - June 30, 2011, at 4-5 (2011), available at <http://waa.ehclients.com/images/uploads/assets/WAA-Annual-Report-Web.pdf>.

<sup>149</sup> See Pennsylvania Coalition Against Rape (PCAR), *Proposed Funding Cuts Would Hinder Aid to Victims*, The PCAR Pinnacle, <http://www.pcar.org/blog/proposed-funding-cuts-would-hinder-aid-victims> (May 12, 2011) (referring to proposed funding cuts for victims of domestic violence and sexual assault) (last visited Sept. 6, 2011).

<sup>150</sup> NNEDV, *supra* note 20.

<sup>151</sup> Carol E. Tracy & Terry Fromson, Domestic Violence Task Force, Domestic Violence Task Force, City of Philadelphia: Year One Report—March 15, 2005, 29 (2005) [2005 Domestic Violence Task Force Report].

<sup>152</sup> E-mail from Tony Lapp, Menenergy, to Amal Bass, Women’s Law Project (Jan. 11, 2012; 11:05 EST) (on file with author).

<sup>153</sup> Edward W. Gondolf & David Russell, The Case Against Anger Control for Batterers, 1986, <http://www.biscmi.org/documents/Anger%20Control%20For%20Batterers.html> (last visited Jan. 13, 2012).

<sup>154</sup> Larry Bennett & Oliver Williams, Controversies and Recent Studies of Batterer Intervention Program Effectiveness 1 (2001) (citing Edward W. Gondolf, *The Effect of Batterer Counseling on Shelter Outcome*, 3 J. of Interpersonal Violence 275 (1988)).

<sup>155</sup> See, e.g., Edward W. Gondolf, *Evaluating Batterer Counseling Programs: a Difficult Task Showing Some Effects and Implications*, 9 Aggression & Violent Behavior 605, 614 (2004).

<sup>156</sup> E-mail from Tony Lapp, Menenergy, to Amal Bass, Women’s Law Project, *supra* note 152.

<sup>157</sup> 2005 Domestic Violence Task Force Report, *supra* note 151, at 29.

<sup>158</sup> U.S. Dep’t of Housing and Urban Development, *Assessing Claims of Housing Discrimination against Victims of Domestic Violence under the Fair Housing Act (FHA) and the Violence Against Women Act (VAWA)* 3 (2011).

<sup>159</sup> *Id.* at 4.

<sup>160</sup> 42 U.S.C. § 3604 (2010).

<sup>161</sup> See, e.g., *Barnette v. Pickering*, No. 09-cv-264-PB, 2009 U.S. Dist. LEXIS 122587, at \*5-6 (D.N.H. Dec. 22, 2009); see National Housing Law Project, Domestic Violence and Housing: A Manual and Toolkit for California Advocates 42 (2009), available at <http://nhlp.org/files/NHLP%20Domestic%20Violence%20%20Housing%20Manual.pdf>.

<sup>162</sup> Philadelphia, Pa., City Code § 9-1108 (2011).

<sup>163</sup> *Id.* § 9-1106 (2010).

<sup>164</sup> See Taryn Lindhorst, et al., *Screening for Domestic Violence in Public Welfare Offices*, 14 *Violence Against Women* 5 (2008).

<sup>165</sup> 55 Pa. Code § 141.61 (2011); *See also*, Amy Hirsch & Aisha Baruni, *General Assistance: Can It Be Made Accessible to Survivors of Domestic Violence* (2003), available at <http://www.clsphila.org/files/DV%20and%20GA%20for%20advocates%2010-03.pdf>.

<sup>166</sup> 42 U.S.C. § 602 (a)(7) (2010).

<sup>167</sup> 55 Pa. Code § 187.27(a)(4) (2011); Women's Law Project, *Waivers of Welfare Program Requirement for Domestic Violence Victims* (2004), available at <http://www.womenslawproject.org/resources/FVO%20Deskguide.9-04.pdf>.

<sup>168</sup> *Id.*

<sup>169</sup> March 2011 data provided by the Department of Public Welfare on file with WLP.

<sup>170</sup> Zorza, *supra* note 14, at 218; Johnny Lee & Denise Trauth, *Domestic Violence Assaults in the Workplace Study* (2009), available at [http://peaceatwork.org/Peace@Work\\_IPV-Workplace-Assaults\\_09.pdf](http://peaceatwork.org/Peace@Work_IPV-Workplace-Assaults_09.pdf).

<sup>171</sup> *See* DV Task Force Report, *supra* note 14, at 21.

<sup>172</sup> 18 Pa. Stat. Ann. § 4957 (2010).

<sup>173</sup> Philadelphia, Pa., City Code § 9-1103 (2011).

<sup>174</sup> *Id.* 9-3202.

<sup>175</sup> Information about the needs of immigrant IPV victims is available at Legal Momentum, <http://www.legalmomentum.org/our-work/vaw/iwp.html>.

<sup>176</sup> Office of Victims' Services, Commonwealth Of Pennsylvania Commission On Crime And Delinquency, *Annual Report Fiscal Year 2009–2010*, <http://Www.Portal.State.Pa.Us/Portal/Server.Pt?Open=512&Objid=5255&&Pageid=495590&Level=2&Css=L2&Mode=2>.

<sup>177</sup> *See id.* at 19.

<sup>178</sup> M. Denise Dowd, *The Emerging Role of the Pediatric Emergency Department in Intimate Partner Violence*, 5 *Clin. Ped. Emerg. Med.* 276, 277 (2004).

<sup>179</sup> *Id.* (citing Martinet al. *Physical Abuse of Women Before, During, and After Pregnancy*, 285 *JAMA* 1581 (2001)).

<sup>180</sup> DV Task Force Report, *supra* note 14, at 16.

<sup>181</sup> *See id.*

<sup>182</sup> Pennsylvania Bar Association, *Legal Services to the Public Committee, Resolution in Support of Recognizing a Right to Counsel for Indigent Individuals in Certain Civil Cases* (2007), available at <http://www.pabar.org/public/committees/lspublic/resolutions/right%20to%20counsel%20resl%20boardapprovdoc.pdf>.

<sup>183</sup> DV Task Force Report, *supra* note 14, at 10.

<sup>184</sup> *See, e.g.*, R.I. Gen. Laws § 34-37-2.4 (2011); Wash. Rev. Code. § 59.18.580 (2010).

<sup>185</sup> S. 1925, 112th Cong. (1st Sess. 2011).

## Section C. The Impact of **POVERTY** on Women's Health

### INTRODUCTION

*Women are disproportionately burdened by poverty and the health risks and conditions associated with it. This is due in large part to the persistence of discriminatory practices and stereotypes in the workplace, home, and society at large. In the workplace, women are paid less than men for the same work and are also sidelined into lower paying jobs. Pregnancy, caretaking, and the impact of domestic violence and sexual assault can remove women partially or completely from gainful employment.<sup>1</sup> Once out of the paid employment economy, women in the United States are often consigned to a welfare system that has been gender-based from the outset.*

*Poverty has led many Pennsylvanians, especially women and children, to suffer from a host of physical and mental health problems. These conditions include obesity, malnutrition, diabetes, coronary heart disease, asthma, HIV, cervical cancer, and high blood pressure. Poverty is also associated with low breastfeeding rates, poor health outcomes from treatable illnesses, and post-traumatic stress disorder (PTSD). The safety net of public and private programs has not alleviated either poverty or its negative impact on health.*

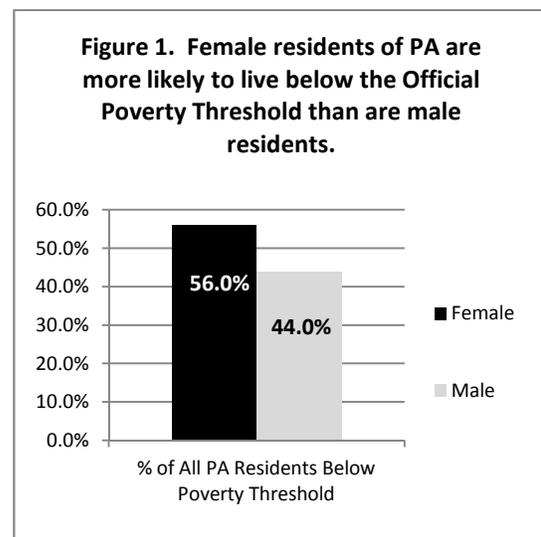


## Poverty in Pennsylvania

The 2010 American Community Survey (ACS), published by the U.S. Census Bureau, provides extensive data on poverty in all 50 states. The ACS defines poverty based on the “Official Poverty Threshold,” a tool developed by the U.S. Census Bureau that determines who is poor by applying a formula originally developed in the 1960s, relying on annual income thresholds that vary by family size and composition.<sup>2</sup> Pursuant to this threshold, a family of three (a single parent and two children) with income under \$17,568 is considered poor.<sup>3</sup> The ACS data show that the burden of poverty falls disproportionately on women, especially single mothers and minority women, and children. Shockingly, more than 82 percent of Pennsylvanians living below the Official Poverty Threshold at the end of 2011 did not receive welfare cash benefits to alleviate their needs.<sup>4</sup>

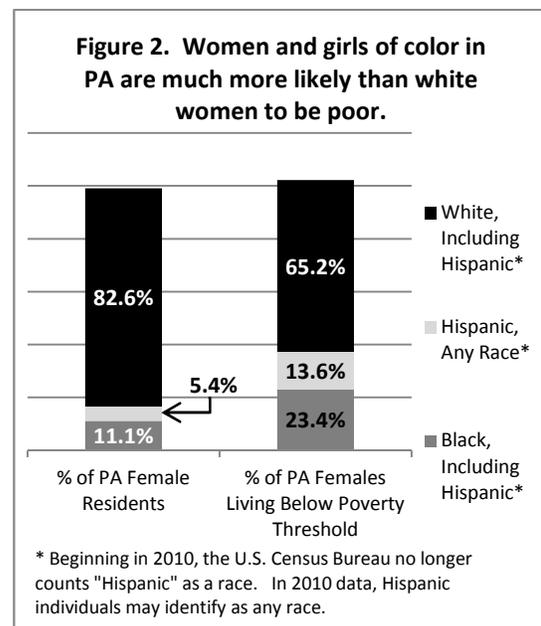
### Women are more likely than men to be poor.

According to the ACS, 1,648,184 Pennsylvanians, 13.4 percent of the state’s population, lived below the Official Poverty Threshold in 2010.<sup>5</sup> Women made up 56 percent of those living in deep poverty even though they only made up 51.4 percent of the state population.<sup>6</sup> See Figure 1. Put another way, 14.6 percent of women live in poverty, compared to 12.1 percent of men in Pennsylvania.<sup>7</sup>



### Women of color are much more likely than white women to be poor.

The picture is much worse for women and girls of color than for white females. Although 11.1 percent of PA females are African American, they account for 23.4 percent of females living in poverty.<sup>8</sup> Similarly, 5.4 percent of PA women and girls are Hispanic, but they account for 13.6 percent of Pennsylvania females living in poverty.<sup>9</sup> See Figure 2.



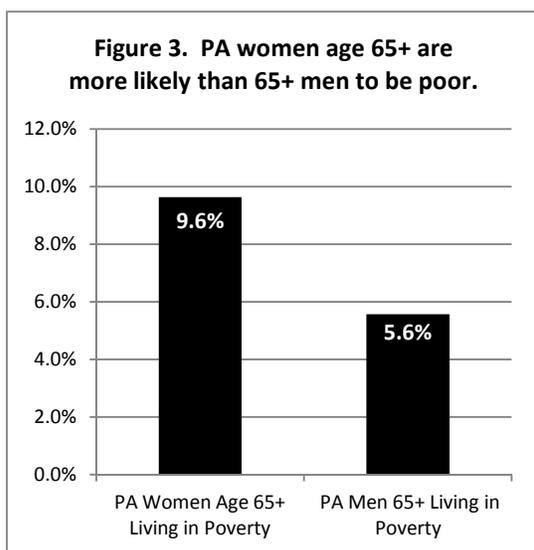
### Female-headed families are much more likely to be poor than any other family type.

According to the ACS, more than 3 million families live in Pennsylvania; Over 9 percent of these families live in poverty.<sup>10</sup> As a subset, female-headed families are three times more likely to live in poverty; nearly

30 percent of all female-headed families in Pennsylvania live below the Official Poverty Threshold.<sup>11</sup> For all races, female-headed families are dramatically more likely to be extremely poor.<sup>12</sup>

### Older women are more likely to be poor than are older men.

Poverty has a profound effect on older adults, and especially on older women and racial and ethnic minorities. Based on the 2010 ACS, 9.6 percent of Pennsylvania women age 65 and older lived in poverty, compared to only 5.6 percent of men in the same age group.<sup>13</sup> See Figure 3. This disparity is true, regardless of race.<sup>14</sup>

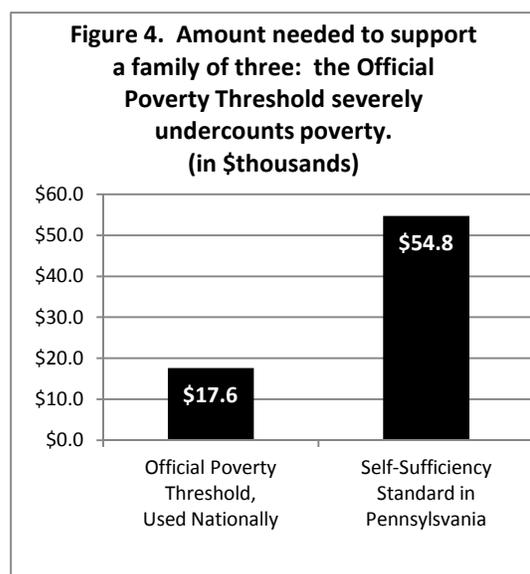


### Looking Beyond the Official Poverty Threshold

Although commonly used, the Official Poverty Threshold is widely believed to be inaccurate. For example, it does not take into account increasing standards of living and expenses that reduce usable income, such as taxes, rising health costs, job-related transportation and child care expenses; it also fails to take certain anti-poverty measures, such as food stamps and the earned income tax credit, into account.<sup>15</sup> The Census Bureau announced in November 2011 that it is testing, for research

purposes, a new, unofficial, measure, which it is calling the “Supplemental Poverty Measure (SPM).”<sup>16</sup> The SPM represents an attempt to understand fluctuations in poverty, depending on a number of variables such as home ownership, geography, governmental support through non-cash programs (e.g., food stamps, housing, and child care), and the costs associated with working.<sup>17</sup>

The Self-Sufficiency Standard (Standard), which was developed by Wider Opportunities for Women, is a non-governmental, more nuanced method of measuring poverty than the Official Poverty Threshold. It takes into account regional differences in costs-of-living, including the costs of major budget items such as housing, child care, food, health, transportation and taxes.<sup>18</sup> As an example, based on the Standard, a single parent in Philadelphia with a preschooler and a school-age child needs to earn \$54,705 yearly, or around \$25.90 per hour, to meet the family’s basic needs.<sup>19</sup> This amount is equivalent to more than three full-time minimum wage jobs,<sup>20</sup> and is more than three times the Official Poverty Threshold of \$17,568 for the same size family. See Figure 4.



The percentage of Pennsylvania families living in poverty based on the Self-Sufficiency Standard is 21 percent, as compared to 9 percent under the Official Poverty Threshold.<sup>21</sup> Further, 58 percent of households below the Standard include

children.<sup>22</sup> Like the census data, the Standard demonstrates a connection between race and income inadequacy. Over 40 percent of African American households and 50 percent of Hispanic households in Pennsylvania are below the Standard.<sup>23</sup>

## Impact on Women's Health

Poverty has a profound impact on women's health. Poor women are three times as likely to consider themselves in only fair or poor health as are women with higher incomes.<sup>24</sup> The health impact of poverty is exacerbated by the lack of health care, food, and housing that accompanies poverty.

### Poverty is directly linked to chronic disease.

Poverty has been linked to many chronic health conditions. There is a high prevalence of diabetes among poor populations, and some evidence shows that poverty can cause pre-diabetes and diabetes by impairing insulin production.<sup>25</sup> In addition to diabetes, a recent study links lifelong socioeconomic position with coronary heart disease, finding that people of higher socioeconomic positions are less likely to develop it.<sup>26</sup> There are also links between poverty, asthma,<sup>27</sup> and HIV.<sup>28</sup>

### Poverty negatively affects mental health.

Poverty is associated with an increased risk of PTSD for women and children. Over one-third of low income women report experiencing depression or anxiety, compared to 23 percent of women with higher incomes.<sup>29</sup> Research shows that people who live in poor neighborhoods are often exposed to violence, which may lead to PTSD and other depressive symptoms.<sup>30</sup> One study posits that these depressive effects are greater in female youths than in male youths.<sup>31</sup>

### Reduced access to health care impairs women's health.

Women living in poverty are often unable to access even basic health care for themselves and their families,<sup>32</sup> and as a result, their health suffers. Unsurprisingly, these women are often unable to afford private health insurance and do not have access to insurance through their employment. They may also be unable to access government subsidized health benefits. Adult women who are not disabled, pregnant, elderly or caregivers for young children are likely ineligible for Medical Assistance (MA, commonly referred to as Medicaid) in Pennsylvania.<sup>33</sup> The increased risk of chronic illness associated with poverty makes their lack of access to medical care especially dangerous. For women living in poverty, their inability to access preventive health services and treatment for chronic conditions can have serious, long-term health consequences. Poverty is linked to failure to obtain preventive health care services such as pap smears<sup>34</sup> and mammograms.<sup>35</sup>

### Reduced access to nutritious food has health consequences.

Poverty can make it impossible to pay for adequate food. Missing meals causes "food insecurity," which triggers a host of health problems. According to a United States Department of Agriculture (USDA) study on food security, 11 percent of Pennsylvania households experienced either low or very low food security from 2006-2008.<sup>36</sup>

The Food Research Action Center has found that Philadelphia's First Congressional District is the second-hungriest district in the country.<sup>37</sup>

Food insecurity is especially dangerous for infants and toddlers, who are in critical stages of neurological, social, and physical development.<sup>38</sup> Even slight interruptions in food security can have long-term developmental effects.<sup>39</sup> A child's nutrition can impact his or her cognitive development, motor skills, and learning potential, and may contribute to psychosocial disorders.<sup>40</sup> Malnutrition can affect a child's ability to fight off infections.<sup>41</sup> Food insecurity can also cause mental health problems such as depression and anxiety in mothers,<sup>42</sup> which in turn affect the health and well-being of their children.<sup>43</sup>

Obesity and related health risks are higher in poor communities than in non-poor communities.<sup>44</sup> Obesity is associated with a host of related health problems, including coronary heart disease, type 2 diabetes, high blood pressure, certain types of cancer, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis.<sup>45</sup> In fact, 30 percent of Pennsylvania women suffer from high blood pressure, and 9 percent suffer from diabetes.<sup>46</sup> Also, studies show that excess weight can cause the early onset of puberty among adolescent girls,<sup>47</sup> which is in turn associated with increased risky behaviors such as drug and alcohol use and unprotected sex<sup>48</sup> and increased prevalence of psychosocial and behavioral disorders.<sup>49</sup> Some evidence suggests that obesity affects women more significantly than men.<sup>50</sup>

Lack of access to nutritious foods affects health status and contributes to obesity.<sup>51</sup> People living in poverty cannot afford to pay for healthful foods, such as fresh fruits and vegetables, which have lower calorie counts and are more nutritious than less

## **Poverty and Access to Healthy Food in Southeastern Pennsylvania (SEPA)**

The 2010 Southeastern Pennsylvania Household Health Survey found that poor nutrition is related to lack of access to healthy food and leads to poor health. The data revealed that:

- Adults in SEPA who eat fewer than three servings of fruits or vegetables each day are more likely than those who eat three servings or more to report health status as fair or poor.
- Approximately one in eight SEPA adults living below the Official Poverty Threshold report that finding fruits and vegetables in their neighborhood is difficult or very difficult.
- More than one in ten SEPA adults reported having to cut the size of or skip a meal in the past year due to lack of money, with women more likely than men to do so. Those cutting or skipping a meal were twice as likely to describe their health as fair or poor than those who had not.<sup>i</sup>

<sup>i</sup> Cmty. Health Data Base, *Data Findings: Nutrition and Access to Quality Food in Southeastern Pennsylvania*, Mar. 7, 2011, <http://www.chdbdata.org/datafindings-details.asp?id=86> (last visited Mar. 22, 2012).

expensive food.<sup>52</sup> There are significantly fewer supermarkets in poor neighborhoods than in affluent neighborhoods.<sup>53</sup> For example, there is currently not a single supermarket in Chester, Pennsylvania, a city of about 30,000 in which 36 percent of residents live below the Official Poverty



Threshold.<sup>54</sup> The first grocery store in Chester in 11 years that will provide affordable nutritious food to its low-income residents is scheduled to open in February 2013.<sup>55</sup>

**Homelessness has health risks.**

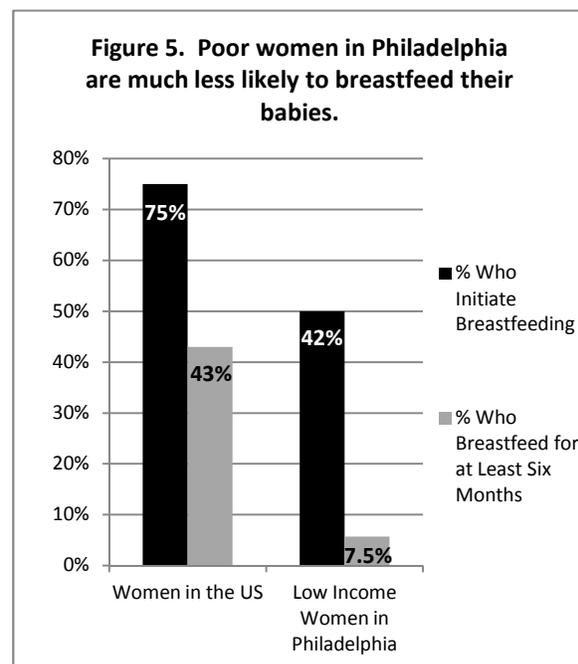
Homelessness, a common consequence of poverty, further negatively impacts women's health. Poor women in Pennsylvania experience homelessness at increasing rates. Between 2008 and 2009, Pennsylvania saw a two percent increase in the number of single, homeless women, and a nine percent increase in the number of homeless women in families.<sup>56</sup> Pregnancy and caring for children places women at increased risk for homelessness. A study of adult childbearing women in Philadelphia found that 11.4 percent of the cohort had experienced homelessness within either the three years before or the four years following birth of a child, with 20 percent of African-American women experiencing homelessness within that seven year period.<sup>57</sup>

Homeless mothers are more likely to have been hospitalized than non-homeless, low-

income mothers,<sup>58</sup> suggesting inadequacy of primary health care.<sup>59</sup> Homeless mothers are at a greater risk for HIV infection than non-homeless, low-income mothers.<sup>60</sup> They are also at a great risk of respiratory problems and other communicable diseases because of overcrowded and under-ventilated living conditions, inadequate hygiene, and poor nutrition.<sup>61</sup> Homeless women who become pregnant are at risk of pregnancy complications because of their lack of prenatal care, inadequate nutrition, and exposure to violence and stress.<sup>62</sup> Homeless women also face an increased risk of physical and sexual assault which causes significant short and long-term health problems.<sup>63</sup>

**Lower breastfeeding rates among poor women are linked to poor health outcomes.**

Lower breastfeeding rates in low-income families<sup>64</sup> have negative health consequences for both mothers and babies. Nationally, 75 percent of women initiate breastfeeding, and 43 percent continue for at least six months.<sup>65</sup> A recent Philadelphia study



found that among low-income mothers, less than half initiated breastfeeding, and only 7.5 percent continued breastfeeding for six months.<sup>66</sup> Breastfeeding rates did not vary significantly by race or ethnicity, but the study revealed that mothers younger than twenty-years-old were less likely to breastfeed than mothers over thirty-years-old.<sup>67</sup>

An earlier study found that possible deterrents to breastfeeding include fear of pain or embarrassment, lack of workplace accommodations, cultural issues, and fear of HIV transmission.<sup>68</sup> The benefits of breastfeeding include helping a newborn's digestive system develop and function,

providing antibodies that strengthen the baby's immune system, decreasing the risk of sudden infant death syndrome (SIDS), and decreasing the mother's risk of certain cancers.<sup>69</sup> The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which provides benefits to pregnant women and new mothers, may have a negative effect on breastfeeding; WIC vouchers account for half of all baby formula purchases.<sup>70</sup> The Pennsylvania WIC program does, however, incentivize breastfeeding by offering enhanced food packages to women who exclusively breastfeed and by offering other support to breastfeeding women.<sup>71</sup>

## Poverty Assistance and Other Financial Support Systems

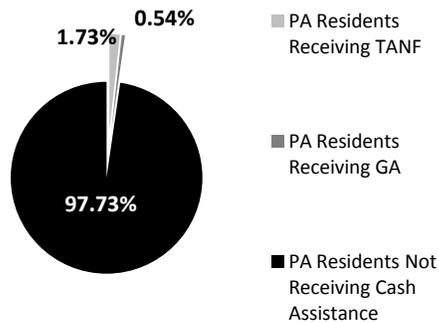
There are a range of governmental and non-governmental programs to help women and children in poverty. These programs grew out of legislation adopted in the 1930s in response to the Great Depression. While the more respectable and politically popular insurance programs established by the Social Security Act were created with male wage earners in mind, needs-based programs were created to help impoverished single mothers who were widows.<sup>72</sup> Discussions about the anti-poverty cash, food, and medical assistance programs have been highly critical of poor women, especially African American women; poor women have become the "undeserving poor," who have been blamed for their impoverishment.<sup>73</sup> Attacks on these programs over the decades have morphed into attacks on welfare mothers, who have been labeled as promiscuous welfare cheats who fail to take care of their children and whose

sexual and maternal behavior must be controlled.<sup>74</sup> The evidence shows otherwise. Rather than being sexually promiscuous, immoral, and inadequate as mothers, "poor mothers on welfare in America are most often engaged in a desperate struggle to procure the basic necessities for themselves and for their children."<sup>75</sup>

While these programs have provided help to many people, they fail to reach all those in need and grants are far below the amount needed to support a family. The inadequacies of these programs have been compounded by the recent impact of the economy on access to employment, the institution of budget cuts and regulatory requirements at the state level, and reduced federal contributions to these programs. Moreover, access to benefits continues to be restricted by rules that presume recipients are welfare cheaters and that stigmatize them.

## Poverty Assistance

**Figure 6. PA provides cash assistance to only 2.27% of its residents.**



### Cash Assistance

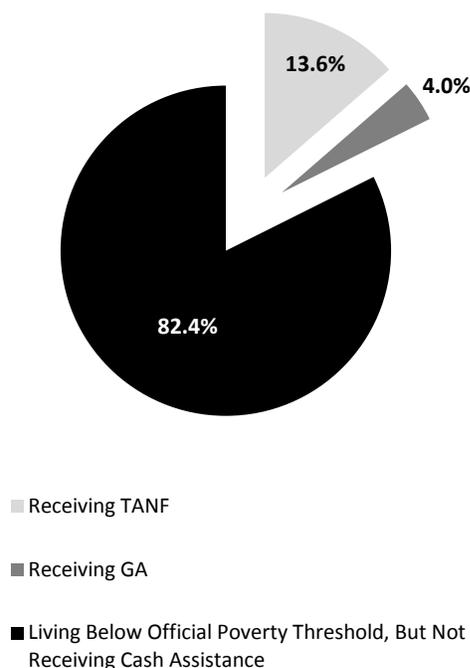
Cash assistance in Pennsylvania is provided through two programs: Temporary Assistance for Needy Families (TANF) and General Assistance (GA).

TANF is the primary cash assistance program in Pennsylvania. It is a federally-funded program that allows states to assist low income families by providing cash assistance, childcare, education, and job training.<sup>76</sup> Most of the adults who receive TANF are female.<sup>77</sup> States have discretion in determining eligibility and in deciding how to administer the TANF funds, subject to overriding federal limitations.<sup>78</sup> In Pennsylvania, TANF is available for pregnant women, as well as dependent children and their parents or other relatives who live with and care for them.<sup>79</sup>

GA is a state-funded program that provides cash assistance for categories of individuals who are not eligible for TANF, including disabled or sick adults without children, victims of domestic violence, individuals in drug and alcohol treatment programs, children living with unrelated adults, and adults caring for sick or disabled individuals or unrelated children.<sup>80</sup> Two GA categories that affect women are time limited: victims of domestic violence and persons who are drug or alcohol dependent are eligible for only nine months of assistance in a lifetime.<sup>81</sup>

Cash assistance does not reach all individuals in poverty. DPW has reported that in December 2011, fewer than 300,000 of the 1.65 million people living in poverty in Pennsylvania were receiving cash assistance.<sup>82</sup> In that month, 288,882 adults and children received cash assistance: 219,973 of them received TANF and 68,909 received GA.<sup>83</sup> The U.S. Census Bureau estimated Pennsylvania's population to be

**Figure 7. Only 17.6% of PA residents living below the Official Poverty Threshold receive cash assistance from the government.**



12,742,886 on July 1, 2011.<sup>84</sup> Of the 12.7 million Pennsylvania residents, 13.4 percent lived in poverty, but only 2.27 percent received cash assistance.<sup>85</sup> See Figure 6.

Of the 1.65 million Pennsylvanians living below the Official Poverty Threshold, 82.4 percent received no cash assistance from the Commonwealth of Pennsylvania.<sup>86</sup> Only 17.6 percent received cash assistance: 13.6 percent of them received TANF and 4 percent received GA.<sup>87</sup> See Figure 7.

TANF caseloads are severely reduced from pre-TANF levels. In November 2011, Pennsylvania's TANF caseload was less than half of what it was in February 1997.<sup>88</sup> Following a severe drop in the first five years after TANF replaced the former Aid to Families with Dependent Children program, caseloads fluctuated up and down within a smaller range between 2001 and the present.<sup>89</sup> It is clear that Pennsylvania is assisting far fewer individuals and families than are in need and for whom it previously provided assistance.

Moreover, Pennsylvania intends to serve even fewer individuals. In February 2012, Pennsylvania Governor Tom Corbett proposed the complete elimination of the GA program along with its automatic eligibility for MA, taking away the lifeline for over 67,000 Pennsylvanians.<sup>90</sup> Pennsylvania is pursuing both budget cuts and cost saving regulatory changes that will limit the amount of assistance it can provide. The Pennsylvania General Assembly adopted a 2011-12 budget that reduced funding to poverty programs in Pennsylvania by hundreds of millions of dollars<sup>91</sup> and legislation that gives the Secretary of the Department of Public Welfare (DPW), who oversees these programs, unfettered authority to reduce programs without going through the required public regulatory review process.<sup>92</sup> The Governor's proposed 2012-13 budget continues this trend by proposing a \$319

million reduction in cash assistance through the elimination of the state's General Assistance program and hundreds of millions of dollars of reductions to other human services programs.<sup>93</sup> This reduction in state funds for cash assistance will occur while the federal funding level also experiences a net reduction because the federal government has maintained TANF funding at the amount established in 1996<sup>94</sup> and it has allowed the depletion of both the TANF Emergency Fund, which was created in 2009 to help families through the economic downturn,<sup>95</sup> and TANF supplemental grants that are essential to states with historically low grants.<sup>96</sup>

At the same time, the Pennsylvania General Assembly and DPW have pursued harsh, punitive, and unwarranted program changes that will further limit the numbers of people receiving assistance. TANF, which is a five year time limited program that requires work activities, already limits its reach at a time when the economy is depressed and work is hard to find in a state with a 7.7 percent unemployment rate.<sup>97</sup> In 2011, Pennsylvania adopted a program to drug test people with felony drug convictions and terminate assistance for those who fail.<sup>98</sup> This program, which may cost more than it saves, stigmatizes assistance recipients as undeserving addicts and punishes individuals instead of treating them. Another proposal currently pending before the General Assembly would require applicants to obtain photographs for Electronic Benefit Transfer cards which may be difficult for the homebound to obtain, and are an unnecessary additional layer of costly verification.<sup>99</sup> DPW has also proposed a regulatory change that would cut off cash assistance to an entire family if an adult subject to work requirements violates a work requirement due to transportation-related reasons that are not their fault, subjecting an entire

## **Poverty, Single Parenting, and the Inadequacy of Social Programs**

In its profile of Betty Carr, a 28-year-old single mother living with two children in Berks County, Pennsylvania, the *Reading Eagle* highlights the way single parenting and domestic violence exacerbate poverty and brings attention to the inadequacy of government social programs and the lack of affordable housing.

To escape domestic violence, Ms. Carr and her children had to move out of their home. Then, as a result of taking time off from work to stay home with a sick child, Ms. Carr lost her job in the food service industry. Without a home and without a job, she found temporary shelter and faced many challenges to finding permanent housing with an annual income of slightly more than \$11,000 (consisting of food stamps and cash assistance), saying, "It's very difficult to live on that." She is looking for a job and plans to enroll in community college to increase her chances of lifting herself out of poverty.<sup>i</sup>

<sup>i</sup> Jason Brudereck, *The Parenthood Trap: Single Moms and Poverty*, *Reading Eagle*, Mar. 25, 2012, <http://readingeagle.com/article.aspx?id=375295> (last visited Mar. 26, 2012).

family to destitution due to bus delays or traffic congestion.<sup>100</sup>

In addition, the cash assistance provided is far from sufficient to support individuals and families. The rates for cash assistance in Pennsylvania have been stagnant since January 1990, more than twenty years ago. In Pennsylvania, the maximum monthly

grant for a family of three ranges from \$365 to \$421 a month, depending on county of residence.<sup>101</sup> Most families live in counties where the monthly maximum for a family of three is \$403.<sup>102</sup> A monthly rate of \$421 in 2011 represents almost a 30 percent decrease in value from 1996 in inflation-adjusted dollars.<sup>103</sup> Although cash assistance grants are meant to cover all of a family's daily expenses except food — including rent, utilities, clothing, transportation, and other costs of living — rates have not kept up with inflation, and therefore the grants do not go as far as they are intended to go. GA provides only \$205/month in most Pennsylvania counties.<sup>104</sup>

Welfare reform has not lived up to its promise to lift people out of poverty. Welfare-to-work programs operated by the DPW have failed to arm recipients with skills to obtain stable jobs that pay adequate wages, even in the boom economy of the 1990s, let alone in the current recession economy. Research shows that while the wages of workers with college degrees may hold steady, wages for those with a high school diploma or less have dropped substantially;<sup>105</sup> individuals who lack a college degree are less likely to be employed.<sup>106</sup> National data show that over half of the TANF population has only a high school diploma, and 41.5 percent have less than a high school diploma.<sup>107</sup>

Nearly half of Pennsylvania heads of household who have less than a high school education were living below the Self-Sufficiency Standard in 2007, compared with 26 percent of those with a high school diploma, 22 percent of households with some college, and only nine percent of households with a college degree or more.<sup>108</sup>

Pennsylvania, like many states, needs workers with middle-level skills, those that require more than a high school diploma.<sup>109</sup>

In 2004, 51 percent of the Pennsylvania labor market was comprised of middle-skill jobs, as compared to 19 percent for low-skill jobs and 30 percent for high-skill jobs.<sup>110</sup> In 2007, 53 percent of the Pennsylvania labor market was comprised of middle-skill jobs, yet only 42 percent of Pennsylvania workers had sufficient training for middle-skill jobs.<sup>111</sup> For TANF to succeed in lifting recipients out of poverty, it must provide substantial and relevant educational opportunities, so that recipients may compete successfully for middle-level jobs.

Despite the importance of education in lifting TANF recipients out of poverty, TANF rules pressure states to limit the kinds and amounts of educational programs available to recipients. Under TANF, to avoid financial penalties, states must meet goals relating to the numbers of individuals engaged in work activities.<sup>112</sup> The rules relating to this “work participation rate” permit a state to count only 30 percent of individuals in vocational education or high school attendance and to count someone in vocational education only for twelve months.<sup>113</sup> This formula severely restricts access to necessary education and training. Less than eight percent of work-eligible adult TANF recipients are engaged in education and training activities nationwide.<sup>114</sup> Furthermore, employment and training programs have experienced deep budgetary cuts in Pennsylvania, reducing individual recipients’ access to training programs that allowed them to maintain their benefits.<sup>115</sup>

DPW’s KEYS program is an example of the kind of programs that are more likely to lift women out of poverty. Since 2005, this program has assisted approximately 1,000 parents at any time by helping them attend and complete community college and prepare for careers in health care and other “high priority occupations.”<sup>116</sup>

## ***Increasing the Child Support Pass-Through***

Improving child support for low-income families is absolutely crucial to improving the status of poor families in Pennsylvania because cash assistance grants have not increased in 22 years. When a family with an absent parent receives welfare benefits, the family is required to assign its right to child support to the state welfare department, which takes part of the money to reimburse welfare benefits and pays a portion to the family. This is called the Child Support Pass-Through.

Advocacy efforts by the Women’s Law Project (WLP) and Community Legal Services (CLS) between 1995 and 1998 twice prevented the elimination of this minimal pass-through. In 2008, WLP, CLS, and the Community Justice Project (CJP) joined forces to convince the legislature to increase the amount of the pass-through from the prior amount of \$50. Starting in October 2008, families on welfare began receiving the first \$100/month of support that is paid on time for a family with one child, and the first \$200/month of timely-paid support that is paid for a family with two or more children.

Studies on leaving TANF demonstrate that most women who leave TANF for employment enter low wage jobs in primarily female industries, with typical wages between \$7 and \$8 an hour.<sup>117</sup> Studies also show that, on average, parents who leave TANF earn wages below the poverty level and lack benefits such as health insurance, sick leave, pensions, and vacation.<sup>118</sup> Further, these jobs are often unstable, and

studies have shown that many workers who leave TANF become unemployed again within a year.<sup>119</sup>

In addition, in light of the inadequacy of DPW's cash grant, special allowances are essential to allow families receiving TANF or SNAP benefits to obtain employment, education, or training. Special allowances cover the costs of transportation, books, school supplies, and other work supports that families face when trying to better themselves and move off welfare. Yet, DPW has proposed eliminating and reducing several types of transportation-related special allowances and reducing the lifetime limit for other work, education and training-related allowances from \$2,000 to \$1,000.<sup>120</sup> Rather than eliminate or drastically reduce the availability of special allowances these supports must be retained and increased to allow those leaving the welfare rolls for work to succeed.<sup>121</sup>

### Food

The federal Supplemental Nutrition Assistance Program (SNAP), previously known as the Food Stamp Program, utilizes a monthly electronic benefit transfer to provide government assistance to low income individuals for the purchase of food. In December 2011, 1,827,134 people were eligible for food stamps in Pennsylvania.<sup>122</sup> Since 2006-07, the number of food stamp recipients in Pennsylvania has increased by nearly 63 percent.<sup>123</sup> In January 2012, DPW announced plans to restrict access to food stamps by implementing an asset-based eligibility test in addition to the income-based eligibility test by May 2012.<sup>124</sup> The DPW Secretary proposed cutting families off food stamps if they had more than \$2,000 in savings and other assets; households with seniors would be eligible only if they have less than \$3,250 in assets. Houses, retirement benefits, and a car would be exempt, but any additional vehicle worth more than \$4,650 would

not.<sup>125</sup> Although DPW, in response to a public outcry, increased the proposed asset limits to \$5,500 for people under age 60 and \$9,000 for households with people 60 and above,<sup>126</sup> the imposition of any asset test will take food away from families and seniors with few resources. In addition to those who will become ineligible for SNAP if the new asset limits are implemented, many individuals who will still qualify for benefits are likely to have difficulty getting benefits due to the paperwork and administrative requirements which will result from the verification of asset limits.

While SNAP provides essential assistance to many people in Pennsylvania, the monthly allowance is inadequate to feed a family for a month, let alone support a nutritious diet. The average monthly benefit in fiscal year 2011 amounted to a mere \$128.40 or \$4.28 a day for an individual.<sup>127</sup> For a household, the average monthly benefit was \$270.45 or \$9.00 per day.<sup>128</sup> Research in Philadelphia shows that even if a family receives the maximum food stamp benefits, they are still unable to afford what the U.S. Dept of Agriculture considers an adequate diet. The family would come up about \$2,000 short in a year, because, while food prices have risen steadily, food stamp benefits have not.<sup>129</sup> A 2010 survey conducted in Southeastern Pennsylvania revealed that 11.2 percent of adults had to skip or cut the size of a meal in the past year because they could not afford an adequate food supply.<sup>130</sup>

Charitable resources attempt to supplement SNAP, including food banks<sup>131</sup> and food pantries.<sup>132</sup> Furthermore, Pennsylvania has been successful in improving access to nutritious food through its Fresh Food Financing Initiative, which provided startup money for supermarkets in underserved areas.<sup>133</sup> Since its creation, the Initiative has funded eighty-eight fresh food retail stores in thirty-four Pennsylvania counties and has

improved access to healthful food for half a million Pennsylvanians.<sup>134</sup> The federal government recently announced a similar initiative.<sup>135</sup> While helpful, such efforts cannot satisfy the food needs of Pennsylvania's population.

### Health Care

Individuals without employer-based health insurance who cannot afford to purchase health insurance may be able to obtain health coverage either through MA, the federally subsidized health insurance provided through DPW, or government-subsidized health clinics.

MA is a program that provides health care coverage for individuals who fall into certain categories and meet financial eligibility requirements. It is funded by a federal-state matching formula and operated through the state. Pennsylvania's MA program primarily covers children, pregnant women, people with disabilities, and the elderly.<sup>136</sup> Low-income adults who are not disabled, pregnant, elderly, or parents of dependent children are eligible for MA in only limited circumstances and for limited time periods, such as for family planning and cervical and breast cancer treatment. As a result of MA's restrictive eligibility requirements, only one out of ten non-elderly women is covered by the program.<sup>137</sup>

In December 2011, Pennsylvania's MA program covered 2,181,399 eligible adults and children.<sup>138</sup> The number of MA recipients in Pennsylvania has increased by nearly 16 percent since fiscal year 2006-2007.<sup>139</sup> Women who are able to enroll in MA may still face barriers to health care. MA in Pennsylvania does not cover abortion care except in cases of rape, incest, or life endangerment of the pregnant woman.<sup>140</sup> MA coverage does, however, include medical services for pregnant women and family planning services, including counseling and

patient education, oral contraceptives, and emergency contraception.<sup>141</sup>

Problematically, MA enrollees may have difficulty finding doctors who accept MA, as doctors increasingly refuse to accept MA because of low reimbursement rates as compared with commercial insurance.<sup>142</sup> Therefore it may be challenging for MA enrollees to find a doctor close to home, and even after they have found a practitioner who accepts MA, they may have to wait much longer for a first appointment than women with commercial insurance would have to wait. As MA has increased its use of managed care for delivery of health care, additional barriers to health care have arisen.<sup>143</sup>

Immigrants living in Pennsylvania face greater challenges in obtaining MA. While a detailed description of the complexities faced by immigrants is beyond the scope of this chapter, access to health care for immigrants is generally limited. Except for emergency medical assistance, which includes labor and delivery, only "qualified" immigrants are fully eligible for MA.<sup>144</sup> Limited language access compounds the difficulties immigrants must overcome to obtain health care.<sup>145</sup>

Until recently, Pennsylvania offered an insurance program for adults who were ineligible for MA but who had insufficient income to buy health insurance. This program, adultBasic, was eliminated at the end of February 2011.<sup>146</sup> Almost two-thirds of adultBasic's 40,764 subscribers were women,<sup>147</sup> and therefore the termination of this program greatly impacts women. DPW agreed to review the MA eligibility of former adultBasic members, but only about four percent of them ended up qualifying for MA.<sup>148</sup> Altogether, only about 40 percent of adultBasic subscribers have obtained alternate insurance through plans tracked by the state, and most of those



plans cost more and provide less coverage than adultBasic.<sup>149</sup>

For children who are ineligible for MA, the federal Children's Health Insurance Program (CHIP) provides either free or subsidized health care coverage, depending on family income. CHIP benefits cover a broad range of services, including immunizations, routine check-ups, diagnostic testing, prescriptions, dental, vision, and hearing services.<sup>150</sup> However, barriers to access exist, most notably the requirement that children whose family incomes are too high to qualify for free coverage must be uninsured for six months before they can enroll in CHIP.<sup>151</sup>

For adults ineligible for MA, government-subsidized health centers provide free or graduated fee health care to uninsured or low income individuals.<sup>152</sup> In Philadelphia, the health centers provide health care, including internal medicine, pediatrics,

laboratory tests, x-rays, immunizations, prescriptions, dental care for children and limited dental care for adults, prenatal care as part of the Maternal and Infant Care (MIC) Program, and family planning services as part of the WIC Program.<sup>153</sup> However, capacity for these services is inadequate and waits for appointments can be lengthy.<sup>154</sup>

Adults age 65 and older are eligible for Medicare, a comprehensive, federally funded health insurance program. However, recent legislative proposals could drastically reduce the availability of health care through Medicare.<sup>155</sup>

The Patient Protection and Affordable Care Act (ACA), which President Obama signed into law in 2010, aims to improve low income individuals' access to health care.<sup>156</sup> Most significantly, the ACA will expand MA coverage for all people under age 65 who earn below 133 percent of the federal Poverty Line.<sup>157</sup> Further, individuals who earn between 133 percent and 400 percent of the federal Poverty Line will receive subsidies to purchase health insurance.<sup>158</sup>

Until 2014, when many of these provisions take effect, many Pennsylvanians will remain uninsured. Pennsylvania Fair Care is an ACA insurance program for uninsured adults with pre-existing conditions; it is funded by the federal government and administered by Pennsylvania. It is intended to provide affordable insurance, but has limitations. The cost may be more than many people can pay; the monthly premium is about \$283.<sup>159</sup> In addition, to be eligible, a person must have been uninsured for six months prior to the date of application.<sup>160</sup>

Pennsylvania can take steps to increase insurance coverage for low-income individuals. Under the ACA, Pennsylvania is permitted to begin now to phase in an expansion of MA coverage for low income adults that is not required until 2014.<sup>161</sup>

### Child Care

Some low-income parents and caretakers may be eligible for child-care subsidies in Pennsylvania through DPW. In order to be eligible, they must earn 200 percent of the Official Poverty Threshold or less, have children under the age of thirteen, and work or attend an educational program for at least twenty hours per week.<sup>162</sup> In 2011,

133,781 Pennsylvania children received federal and state child-care assistance, and more than 10,000 more were on a waiting list.<sup>163</sup> However, federal stimulus money used to fund these programs expired in September 2011, and state cuts are expected as well, which will mean longer waitlists and less assistance for Pennsylvania families.<sup>164</sup>

### Difficulties Accessing Poverty Assistance Benefits

Even if they meet all of the formal eligibility requirements, recipients and applicants face barriers to processing and maintaining their benefits due to inadequate staffing and other inefficiencies in DPW's County Assistance Offices (CAOs). For example, people seeking benefits complain of full voicemail boxes, unanswered and unreturned phone calls, and lost paperwork.<sup>165</sup> They waste time resubmitting lost papers, waiting in the office, and making phone calls to correct mistakes.<sup>166</sup> These problems have resulted in erroneous denials of benefits and delays in getting assistance. The situation has been exacerbated by the economic downturn, which has created an

increase in the need for assistance and a decrease in CAO staffing.<sup>167</sup> While caseloads are rising, the numbers of caseworkers responsible for handling these cases is going down; the number of workers at the welfare office has dropped by 14.2 percent since 2002, and worker caseloads have gone up 89 percent.<sup>168</sup> These barriers may be even greater for people who experience homelessness, as certain program requirements, such as staying in contact, may be difficult for someone with no permanent home.<sup>169</sup> Programs may require applicants to travel to meet with caseworkers, which can be both expensive and time consuming.<sup>170</sup>

### Special Considerations for Victims of Domestic Violence

Pennsylvania has worked hard to implement the Family Violence Option (FVO) to address the concerns of domestic violence victims, who often turn to public assistance programs for help fleeing violence but may have difficulty complying with program requirements that may place them at risk of further violence. Pennsylvania adopted the FVO in January 1997 and has developed excellent policies and procedures for providing TANF applicants and recipients access to community referrals, confidentiality in the CAOs, and waivers of program requirements that may place them in danger. DPW also developed training pro-

grams to train its CAO staff and continues to train new hires. Nonetheless, lack of awareness about available benefits hampers access. Data suggest that more recipients could benefit from Pennsylvania's adoption of the FVO if they were aware of it.<sup>171</sup> Despite research that as many as half of all women receiving public assistance have been victims of domestic violence,<sup>172</sup> as of December 2011, only 1,412 TANF recipients statewide had waivers of work requirements and 3,344 had support waivers.<sup>173</sup> This data suggest that training of caseworkers who are unfamiliar with or incorrectly apply the FVO would generate

increased notification of applicants and recipients about the FVO, thereby ensuring notice to all who are potentially eligible to

benefit. Advocates continue to work cooperatively with DPW staff toward increased implementation and improved training.

## ***Family Violence Option***

WLP, along with advocacy partners CLS and CJP, have assisted DPW in its efforts to provide confidentiality and flexibility to domestic violence victims through the implementation of the FVO since 1997. WLP participates on DPW's TANF/Domestic Violence Task Force, through which WLP has been involved in developing state policies and procedures related to the FVO, including providing domestic violence victims with referrals for services, confidential disclosure of abuse and location information, and waivers of TANF or GA program requirements that may penalize a domestic violence victim or place her or her family at risk of future abuse.

## **Shelter and Housing**

There are a number of programs offering different types of support for poor people who need help, either in finding housing or in affording it. A full description and analysis of these programs is beyond the scope of this report.<sup>174</sup> Victims of domestic violence face challenges with respect to obtaining both short-term shelter to escape domestic violence and long term housing. Shelter resources are limited and protections against discrimination in housing on the basis of domestic violence, while improving, should be expanded.

Domestic violence victims often rely on community-based domestic violence shelters when they must flee abuse quickly. As a result of insufficient funding, clients needing shelter services are turned away. For example, Philadelphia's only overnight shelter for domestic violence victims, Women Against Abuse, has a 100 bed capacity. In fiscal year 2010-11, it had to deny 7,705 requests for shelter.<sup>175</sup> The City of Philadelphia, which has provided funding for the Women Against Abuse shelter, cut its allocation in 2008 and has never

reinstated the funding.<sup>176</sup> The current state budget maintains statewide domestic violence service funding at last year's funding level.<sup>177</sup>

Currently, the Violence Against Women and Justice Department Reauthorization Act of 2005 (VAWA) prohibits discrimination on the basis of one's status as a victim of domestic violence for tenants of and applicants for federally subsidized housing.<sup>178</sup> But VAWA does not apply to private sellers or landlords who do not rely on federal subsidies.

The Federal Fair Housing Act prohibits discrimination in housing on the basis of "race, color, religion, sex, familial status, or national origin."<sup>179</sup> Some courts have construed this protection to include one's status as a victim of domestic violence,<sup>180</sup> but most courts do not include domestic violence victims as a protected class under the Fair Housing Act.<sup>181</sup>

At the local level, the Philadelphia Fair Practices Ordinance prohibits discrimination against domestic or sexual violence

victims by owners of commercial housing or any other real property.<sup>182</sup> The Philadel-

phia Commission on Human Relations enforces this ordinance.<sup>183</sup>

## Retirement Benefits

Older women are at an increased risk of poverty as compared to older men because of lower lifetime earnings and longer life expectancies.<sup>184</sup> In 2010, 9.6 percent of women 65 and older were living in poverty, compared to only 5.6 percent of men in this age group.<sup>185</sup> Women rely on Social Security more than men and receive less in Social Security than men.<sup>186</sup> Many women rely on their husbands' pensions in their old age. However, in some cases women are unable to access a fair share of their spouses' pensions. The U.S. Congress, in an effort to protect each spouse from his or her

spouse's selection of a pension benefit that does not provide income security to both spouses, passed the Retirement Equity Act of 1984; it requires all privately-sponsored pension plans to obtain the consent of an employee's spouse to any form of benefit payment that does not provide at least a 50 percent survivor benefit to such spouse.<sup>187</sup> Many states have passed laws requiring such consent for public pensions,<sup>188</sup> but Pennsylvania has not. Currently, there is no law prohibiting a public employee in Pennsylvania from transferring his pension to someone other than his spouse.

## RECOMMENDATIONS FOR REFORM

### Poverty Programs

- Improve Pennsylvania's Cash Assistance Programs.
  - Pennsylvania must remove barriers to enrollment and increase cash assistance benefits to reflect the true cost of living.
  - The rates, which have been stagnant since 1990, should be adjusted for inflation and changes in costs of living. The current rates are vastly inadequate, even judged by the Official Poverty Threshold, which most advocates agree is below the true poverty level.<sup>189</sup>
  - Congress should revise its “work participation rate” formula so that states can permit TANF recipients to participate in vocational education and training without risk of penalty. Countable educational programs should include post-secondary education, adult basic education, English as a second language, and other skill developing programs.
  - Pennsylvania should expand its KEYS program and provide greater support for women attending higher education.
  - TANF work programs should be assessed by their actual effect on employment rates and earnings.<sup>190</sup> Currently, states are judged by how many enrollees are participating in work programs.<sup>191</sup> The federal government should place more emphasis on the *effectiveness* of work programs, and less on enrollment numbers alone.
  - DPW should facilitate access to the benefits of the FVO for domestic violence victims who may be placed at risk of further violence by welfare requirements through ongoing training of staff with emphasis on caseworker disclosure of the benefits of the FVO to TANF applicants and recipients.
  - Pennsylvania legislators should refrain from cutting existing assistance programs and implementing punitive unnecessary requirements that will increase the number of impoverished women and children.
- Increase Funding for and Access to Food Stamp (SNAP) Benefits.
  - Congress should increase funding for food stamp programs so that food stamp benefits are sufficient to cover an adequate diet in the relevant community. This change would not only allow low-income families to purchase healthful and adequate food, but it would provide a sort of economic stimulus by infusing money into local grocers and food suppliers.<sup>192</sup>

- Pennsylvania should suspend DPW’s proposed plan to implement an asset test for determining SNAP eligibility.
- Maintain and Expand Funding for Child-Care Assistance.
  - The state and federal governments should not cut funding for child-care subsidies for poor parents and caretakers. If this assistance is cut, many parents will be forced to stay home with their children, thus preventing them from earning wages that could lead to their self-sufficiency.<sup>193</sup> Other parents will have no choice but to send their children to unlicensed child-care facilities.<sup>194</sup> Further, considering the long wait lists that exist, the state and federal governments should expand funding for child-care subsidies.
- Improve CAO Customer Service.
  - Increased staff is needed for DPW’s CAOs.<sup>195</sup> In Philadelphia, for example, from 2005 to 2010, staffing at the CAOs decreased by 300 positions, while case-loads increased at an average of 160 cases per caseworker.<sup>196</sup> In light of reports of people unable to reach anyone at DPW, full voicemail boxes, and lost paperwork, increased staff is needed to ensure that clients’ needs are being addressed in a timely and effective manner.
  - Technological improvements will increase DPW’s overall efficiency. For example, DPW could allow people to communicate with caseworkers via email<sup>197</sup> or expand its online benefits application system to allow users to upload documents.<sup>198</sup>
- Improve Access to Nutritious Food.
  - State and federal legislators should adopt legislation that provides financial incentives or subsidies for the purchase of healthful foods. For example, there could be a Healthful Food Tax Credit built into the tax code (as opposed to fault-based approaches, such as “fat taxes” or a tax on soda and sugary drinks).<sup>199</sup>
  - Pennsylvania and the federal government should also continue to support and expand programs that improve access to healthful foods, such as the Fresh Food Financing Initiative.

## Health Care

- Expand Access to Affordable Health Care.
  - The Pennsylvania General Assembly must do more to make health care affordable and available, pending full implementation of ACA.

- Pennsylvania should exercise the option under the ACA to expand MA eligibility as soon as possible to cover some people who are currently uninsured, including some who were on adultBasic before it expired, people who are temporarily disabled, and people who are looking for work.

## Employment

- Congress should adopt legislation that equalizes women's wages with those paid to men. Access to higher paying jobs, particularly in conjunction with affordable quality child-care, contraceptive services and devices, family planning services, and protection from abuse, will help lift women out of poverty.
- Pennsylvania should adopt legislation that would require spousal consent to benefit elections when a retiring state employee chooses how his or her pension benefits should be paid. Many states have adopted the spousal consent requirement for state employee pensions, but Pennsylvania has not.<sup>200</sup>

## Housing and Shelter

- Pennsylvania should increase funding for domestic violence shelter services. A major cause of homelessness among women is domestic violence. Therefore, Pennsylvania needs to do more to ensure that women and children who are victims of domestic violence have services in place to prevent periods of homelessness. Increased funding would increase the number of shelter beds and transitional residences available to women and children who flee from abuse.
- Pennsylvania should adopt legislation forbidding eviction or denial of housing based on someone's status as a victim of domestic violence. Domestic violence not only affects women who become homeless when they flee abuse, but also women who are discriminated against because they have been abused. Pennsylvania should follow the lead of several other states<sup>201</sup> by enacting state legislation that prohibits discrimination in housing because of one's status as a victim of domestic abuse.

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<sup>2</sup> U.S. Census Bureau, *How the Census Bureau Measures Poverty*, <http://www.census.gov/hhes/www/poverty/about/overview/measure.html> (last visited Mar. 19, 2012); Alemayehu Bishaw, U.S. Dept of Commerce, Poverty: 2009 and 2010: American Community Survey Briefs 3 (Oct. 2011), *available at* <http://www.census.gov/prod/2011pubs/acsbr10-01.pdf>.

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<sup>4</sup> See U.S. Census Bureau, Poverty Status in the Past 12 Months: 2010 American Community Survey 1-Year Estimates, Table S1701, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_S1701&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_S1701&prodType=table) (last visited Mar. 21, 2012) [hereinafter Poverty Status in the Past 12 Months (Table S1701)]; Dep't of Public Welfare, Bureau of Program Support, Division of Statistical Analysis, Assistance Eligibility Statistics (Dec. 2011) (on file with author).

<sup>5</sup> U.S. Census Bureau, Poverty Status in the Past 12 Months by Sex by Age: 2010 American Community Survey 1-Year Estimates, Table B17001, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_B17001&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B17001&prodType=table) (last visited Mar. 21, 2012) [hereinafter Poverty Status in the Past 12 Months by Sex by Age]; Poverty Status in the Past 12 Months (Table S1701), *supra* note 4.

<sup>6</sup> Poverty Status in the Past 12 Months (Table S1701), *supra* note 4.

<sup>7</sup> *Id.*

<sup>8</sup> U.S. Census Bureau, Poverty Status in the Past 12 Months by Sex by Age (Black or African American Alone): 2010 American Community Survey 1-Year Estimates, Table B17001B, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_B17001B&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B17001B&prodType=table) (last visited Mar. 21, 2012) [hereinafter Poverty Status in the Past 12 Months by Sex by Age (Black or African American Alone)].

<sup>9</sup> U.S. Census Bureau, Poverty Status in the Past 12 Months by Sex by Age (Hispanic or Latino): 2010 American Community Survey 1-Year Estimates, Table B17001I, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_B17001I&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B17001I&prodType=table) (last visited Mar. 21, 2012) [hereinafter Poverty Status in the Past 12 Months by Sex by Age (Hispanic or Latino)]; U.S. Census Bureau, Poverty Status in the Past 12 Months by Sex by Age (White Alone) : 2010 American Community Survey 1-Year Estimates, Table B17001A, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_B17001A&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_B17001A&prodType=table) (last visited Mar. 21, 2012) [hereinafter Poverty Status in the Past 12 Months by Sex by Age (White Alone)].

<sup>10</sup> U.S. Census Bureau, Poverty Status in the Past 12 Months of Families: 2010 American Community Survey 1-Year Estimates, Table S1702, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_1YR\\_S1702&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_S1702&prodType=table) (last visited Mar. 21, 2012).

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<sup>12</sup> *Id.*

<sup>13</sup> Poverty Status in the Past 12 Months by Sex by Age, *supra* note 5.

<sup>14</sup> Poverty Status in the Past 12 Months by Sex by Age (White Alone), *supra* note 9; Poverty Status in the Past 12 Months by Sex by Age (Black or African American Alone), *supra* note 8; Poverty Status in the Past 12 Months by Sex by Age (Hispanic or Latino), *supra* note 9.

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<sup>21</sup> *Overlooked and Undercounted*, *supra* note 18, at 9.

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<sup>23</sup> *Id.* at 11.

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<sup>111</sup> *Id.*

<sup>112</sup> 42 U.S.C.S. § 607 (2011); 42 U.S.C.S. § 609(a)(3) (2011).

<sup>113</sup> 45 C.F.R. 261.2(i) (2011); 42 C.F.R. 261.33 (2011).

<sup>114</sup> Hearing Advisory, U.S. House of Representatives, Ways & Means Comm. Democrats, Chairman McDermott Announces Hearing on the Role of Education and Training in the TANF Program (Apr. 15, 2011), *available at* <http://dems.waysandmeans.house.gov/press/PRArticle.aspx?NewsID=11134>.

<sup>115</sup> Christopher Moraff, *PA. Cuts Impending Welfare-to-Work*, Phila. Tribune, Aug. 28, 2011, <http://www.phillytrib.com/newsarticles/item/186-pa-cuts-impeding-%E2%80%98welfare-to-work%E2%80%99.html> (last visited Mar. 22, 2012).

<sup>116</sup> Zurflieh, *supra* note 109, at 1-3.

<sup>117</sup> Legal Momentum, Welfare Reform at Age 15: A Vanishing Safety Net for Women and Children 5 (2011), *available at* <http://www.legalmomentum.org/our-work/women-and-poverty/resources--publications/welfare-reform-15.pdf> (citing Elizabeth Lower-Basch & Mark Greenberg, *Single Mothers in the Era of Welfare Reform*, in *The Gloves-off Economy: Workplace Standards at the Bottom of America's Labor Market* 163, 175 (Annette Bernhardt ed., 2008)).

<sup>118</sup> *Id.* (citing Comm. on Ways & Means, U.S. House of Representatives, *Background Material and Data on the Programs within the Jurisdiction of the Committee on Ways and Means 2008*, at 7-85 to 7-86 (2008); Elizabeth Lower-Basch & Mark Greenberg, *Single Mothers in the Era of Welfare Reform*, in *The Gloves-off Economy: Workplace Standards at the Bottom of America's Labor Market* 163, 175 (Annette Bernhardt ed., 2008); Christine Devere, Congressional Research Serv., *Welfare Reform Research: What Do We Know About Those Who Leave Welfare?* (2001)).

<sup>119</sup> Legal Momentum, *supra* note 117, at 5 (citing Christine Devere, Congressional Research Serv., *Welfare Reform Research: What Do We Know About Those Who Leave Welfare?* (2001)).

<sup>120</sup> Dep't of Public Welfare, Expedited Proposed Revisions to the Special Allowance for Supportive Services Requirement and Preamble, <http://www.dpw.state.pa.us/publications/budgetinformation/act22-expeditedregulatorychangestothedpw/index.htm> (last visited Mar. 22, 2012).

<sup>121</sup> Cmty. Justice Project & Cmty. Legal Servs., Special Allowances Are Needed So Parents Can Leave Welfare for Work (Feb. 14, 2011), *available at* <http://pennbpc.org/sites/pennbpc.org/files/Special-Allowances-Audit.pdf>.

<sup>122</sup> Pa. Dep't of Public Welfare, Bureau of Program Support, Division of Statistical Analysis, Table 2: Number of Adults and Children Eligible for Assistance, by County (Dec. 2011) (on file with author).

<sup>123</sup> Pa. Dep't of Public Welfare, *supra* note 90.

<sup>124</sup> Alfred Lubrano, *Pennsylvania to Impose Asset Test for Food Stamps*, Phila. Inquirer, Jan. 10, 2012, [http://articles.philly.com/2012-01-10/news/30612157\\_1\\_food-stamps-supplemental-nutrition-assistance-program-federal-poverty-level](http://articles.philly.com/2012-01-10/news/30612157_1_food-stamps-supplemental-nutrition-assistance-program-federal-poverty-level) (last visited Mar. 22, 2012).

<sup>125</sup> *Id.*

<sup>126</sup> Alfred Lubrano, Corbett Raises Limit on Assets for Food Stamps, but Critics Blast the Idea of a Test, *Phila. Inquirer*, Feb. 2, 2012, [http://articles.philly.com/2012-02-02/news/31016934\\_1\\_asset-food-stamp-program-food-stamps](http://articles.philly.com/2012-02-02/news/31016934_1_asset-food-stamp-program-food-stamps) (last visited Mar. 22, 2012).

<sup>127</sup> U.S. Dep't of Agriculture, U.S. Food & Nutrition Serv., *Supplemental Nutrition Assistance Program: Average Monthly Benefit Per Person (Data as of March 1, 2012)*, [http://www.fns.usda.gov/pd/18SNAPavg\\$PP.htm](http://www.fns.usda.gov/pd/18SNAPavg$PP.htm) (last visited Mar. 22, 2012).

<sup>128</sup> U.S. Dep't of Agriculture, U.S. Food & Nutrition Serv., *Supplemental Nutrition Assistance Program: Number Of Households Participating (Data as of March 1, 2012)*, [http://www.fns.usda.gov/pd/19SNAPavg\\$HH.htm](http://www.fns.usda.gov/pd/19SNAPavg$HH.htm) (last visited Mar. 22, 2012).

<sup>129</sup> Mariana Chilton & John Cook, *Babies' Hunger Reflects Inflation*, *Phila. Inquirer*, Apr. 1, 2008, [http://articles.philly.com/2008-04-01/news/24989677\\_1\\_food-prices-food-insecurity-thrifty-food-plan](http://articles.philly.com/2008-04-01/news/24989677_1_food-prices-food-insecurity-thrifty-food-plan) (last visited Mar. 22, 2012).

<sup>130</sup> Cmty. Health Data Base, *Data Findings: Nutrition and Access to Quality Food in Southeastern Pennsylvania*, Mar. 7, 2011, <http://www.chdbdata.org/datafindings-details.asp?id=86> (last visited Mar. 22, 2012).

<sup>131</sup> *See, e.g.*, Central Pennsylvania Food Bank, <http://www.centralpafoodbank.org/> (last visited Mar. 22, 2012).

<sup>132</sup> *See, e.g.*, Pennsylvania Food Pantries, <http://www.foodpantries.org/st/pennsylvania> (last visited Mar. 22, 2012).

<sup>133</sup> The Food Trust, *Pennsylvania Fresh Food Financing Initiative*, <http://www.thefoodtrust.org/php/programs/fff.php> (last visited Mar. 22, 2012).

<sup>134</sup> *Id.*

<sup>135</sup> U.S. Dep't of Health & Human Servs., *News Release: Obama Administration Details Healthy Food Financing Initiative*, Feb. 19, 2010, <http://www.hhs.gov/news/press/2010pres/02/20100219a.html> (last visited Mar. 22, 2012).

<sup>136</sup> Monica R. Costlow, et al., Pa. Medicaid Policy Ctr., *The Basics of Medical Assistance in Pennsylvania 2* (2009).

<sup>137</sup> Pa. Health Law Project, *Uninsured Pennsylvanians: Meet Your friends, Neighbors, Co-Workers 16* (2009), available at <http://www.phlp.org/wp-content/uploads/2011/03/Uninsured-Pennsylvanians.pdf>.

<sup>138</sup> Dep't of Public Welfare, *supra* note 122.

<sup>139</sup> Pa. Dep't of Public Welfare, *supra* note 90.

<sup>140</sup> Guttmacher Inst., *State Policies in Brief: State Funding of Abortion Under Medicaid* (2011), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_SFAM.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf).

<sup>141</sup> Pa. Dep't of Pub. Welfare, *HealthCare Benefits Packages Manual*, available at <http://services.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ma/338/138-A-public.pdf>.

<sup>142</sup> Peter J. Cunningham, Ctr. for Studying Health Sys. Change, *State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions 1* (2011), available at <http://www.rwjf.org/files/research/72046.pdf>.

<sup>143</sup> For example, some report that MA managed care organizations do not have enough specialists that are part of their network. Phil Galewitz, *Medicaid Managed Care Programs Grow; So Do Issues*, *USA Today*, Nov. 12, 2010, [http://www.usatoday.com/money/industries/health/2010-11-12-medicaid12\\_CV\\_N.htm](http://www.usatoday.com/money/industries/health/2010-11-12-medicaid12_CV_N.htm) (last visited Mar. 22, 2012).

<sup>144</sup> See the Health and Public Benefits sections on the website of the National Immigration Law Center for an explanation of immigrant eligibility for MA, *available at* <http://www.nilc.org>; Leonardo D. Cuello, Pa. Health Law Project, *Health Care for Immigrants: A Manual for Advocates* (2011) (provides information on immigrant eligibility for MA in Pennsylvania), *available at* <http://www.phlp.org/wp-content/uploads/2011/11/Immigrant-Health-Care-Manual-For-Advocates-09-2011.pdf> [hereinafter PHLP Manual].

<sup>145</sup> See the website for the Pennsylvania Immigration and Citizenship Coalition for more information, *available at* <http://www.nilc.org/health.html>; PHLP Manual, *supra* note 144, at 27.

<sup>146</sup> Don Sapatkin, *Pa.'s adultBasic Health Insurance Runs out of Funds, Shuts Down*, Phila. Inquirer, Mar. 1, 2011, [http://articles.philly.com/2011-03-01/news/28640503\\_1\\_adultbasic-bare-bones-insurance-corbett](http://articles.philly.com/2011-03-01/news/28640503_1_adultbasic-bare-bones-insurance-corbett) (last visited Nov. 27, 2011).

<sup>147</sup> Karen Heller, Op-Ed., *Quietly or Loudly, Governors Make Bad Moves*, Phila. Inquirer, Mar. 6, 2011, [http://articles.philly.com/2011-03-06/news/28657077\\_1\\_teachers-union-charles-zogby-spending-cuts](http://articles.philly.com/2011-03-06/news/28657077_1_teachers-union-charles-zogby-spending-cuts) (last visited Nov. 27, 2011).

<sup>148</sup> Don Sapatkin, *Nearly Half of Pa.'s Dropped adultBasic Subscribers Might Qualify for Free Medicaid*, Phila. Inquirer, Apr. 14, 2011, [http://articles.philly.com/2011-04-14/news/29417801\\_1\\_adultbasic-insurance-health-insurance-corbett-administration](http://articles.philly.com/2011-04-14/news/29417801_1_adultbasic-insurance-health-insurance-corbett-administration) (Nov. 27, 2011). William Kibler, *End to adultBasic Causes 'Nightmares' for Some*, Altoona Mirror, March 4, 2012, <http://www.altoonamirror.com/page/content.detail/id/558702/End-to-adultBasic-causes--nightmares--for-some.html?nav=742> (last visited Mar. 22, 2012).

<sup>149</sup> Kibler, *supra* note 148.

<sup>150</sup> Pennsylvania's Children's Health Insurance Program, <http://www.chipcoverspakids.com/> (last visited Mar. 22, 2012); Benefits Handbook, CHIP of Pennsylvania, [http://www.ibx.com/htdocs/custom/chip\\_manual/benefitschart.html](http://www.ibx.com/htdocs/custom/chip_manual/benefitschart.html) (last visited Mar. 22, 2012).

<sup>151</sup> Pennsylvania's Children's Health Insurance Program, *CHIP Frequently Asked Questions*, <http://www.chipcoverspakids.com/faq/eligibility-criteria-and-benefits/> (last visited Mar. 22, 2012).

<sup>152</sup> U.S. Dep't of Health & Human Servs., Health Resources & Servs. Admin., *Find a Health Center*, [http://findahealthcenter.hrsa.gov/Search\\_HCC.aspx](http://findahealthcenter.hrsa.gov/Search_HCC.aspx) (last visited Mar. 22, 2012) ("You pay what you can afford, based on your income.").

<sup>153</sup> Phila. Unemployment Project, *Philadelphia District Health Centers*, [http://www.philaup.org/health/hc\\_phc.html](http://www.philaup.org/health/hc_phc.html) (last visited Sept. 8, 2011).

<sup>154</sup> Philadelphia Unemployment Project, *Health Care*, <http://www.philaup.org/health/health.html#top> (last visited Mar. 22, 2012) ("You may have to wait up to 3 months for a first appointment. Join PUP and help us get more staff and more hours at health centers.").

<sup>155</sup> See, e.g., H.R. Con. Res. 34, 112th Cong. (2011), which would change Medicare to a voucher system for seniors in the future.

<sup>156</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter Affordable Care Act].

<sup>157</sup> 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2011).

<sup>158</sup> 26 U.S.C. § 36B (2011).

<sup>159</sup> See Pennsylvania Insurance Dep't, *PA Fair Care*, <http://www.pafaircare.com/> (last visited Mar. 19, 2012).

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

<sup>161</sup> Affordable Care Act, *supra* note 156, at § 2001, as amended by § 10201(b) (2010) (codified at 42 U.S.C. § 1396a).

<sup>162</sup> Pa. Dep't of Public Welfare, *Child Care Works Subsidized Child Care Program*, <http://www.dpw.state.pa.us/forchildren/childcareearlylearning/childcareworkssubsidizedchildcareprogram/index.htm> (last visited Mar. 22, 2012).

<sup>163</sup> Adrienne Lu, *Child-Care Subsidies in Danger*, *Phila. Inquirer*, May 21, 2011, at A1.

<sup>164</sup> *Id.*

<sup>165</sup> Kate Giammarise, *Welfare Taxed*, *Pittsburgh City Paper*, Dec. 2, 2010, <http://www.pittsburghcitypaper.ws/gyrobase/Content?oid=oid%3A88595> (last visited Mar. 22, 2012).

<sup>166</sup> Tara Marks, *Overwhelming the Overwhelmed: Proposed Budget Cuts to Beleaguered Welfare Offices Are Penny Wise and Pound Foolish*, *Pittsburgh-Post Gazette*, Apr. 12, 2011, <http://clsphila.wordpress.com/2011/05/03/overwhelming-the-overwhelmed-proposed-budget-cuts-to-beleaguered-welfare-offices-are-penny-wise-and-pound-foolish/#more-638> (last visited Mar. 22, 2012).

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> Stanley J. Czerwinski, Director, Physical Infrastructure Issues, U.S. Gen. Accounting Office, Testimony Before the Subcommittee on Housing and Transportation, Committee on Banking, Housing, and Urban Affairs U.S. Senate: Homelessness: Improving Program Coordination and Client Access to Programs 11 (Mar. 6, 2002), available at <http://www.gao.gov/new.items/d02485t.pdf>.

<sup>170</sup> *Id.* at 12.

<sup>171</sup> 55 Pa. Code § 108 (2010).

<sup>172</sup> See Taryn Lindhorst, et al., *Screening for Domestic Violence in Public Welfare Offices: An Analysis of Case Manager and Client Interactions*, 14 *Violence Against Women* 5, 6 (2008).

<sup>173</sup> Pa. Dep't of Public Welfare, Bureau of Program Support, Division of Statistical Analysis, *Domestic Violence — December 2011 DPW Statistical Report* (2011).

<sup>174</sup> For more information about housing programs, consult the National Coalition for the Homeless, an organization that works to bring about the systemic changes necessary to prevent and end homelessness and to protect the rights of people experiencing homelessness, available at <http://www.nationalhomeless.org>.

<sup>175</sup> Women Against Abuse, *Annual Report July 1, 2010 - June 30, 2011*, 1 at 4-5, 7, available at <http://waa.ehclients.com/images/uploads/assets/WAA-Annual-Report-Web.pdf>.

<sup>176</sup> Holly Otterbein, *Trend of Disbelief: The Number of Abused Women Seeking Shelter in Philly is Skyrocketing. The number of Beds for Them Isn't*, *Philadelphia Citypaper*, Aug. 4, 2011, <http://www.citypaper.net/news/2011-08-04-news.html> (last visited Mar. 23, 2012).

<sup>177</sup> Pa. Office of the Budget, *2012-13 Governor's Budget General Fund 2012-13: Proposed Budget Line-Item Appropriations* (2012), available at [http://www.portal.state.pa.us/portal/server.pt/community/current\\_and\\_proposed\\_commonwealth\\_budgets/4566](http://www.portal.state.pa.us/portal/server.pt/community/current_and_proposed_commonwealth_budgets/4566).

<sup>178</sup> 42 U.S.C. § 1437(d), (f) (2011).

<sup>179</sup> 42 U.S.C. § 3604 (2011).

<sup>180</sup> See, e.g., *Bouley v. Young-Sabourin*, 394 F. Supp. 2d 675, 678 (D. Vt. 2005).

<sup>181</sup> See Nat'l Hous. Law Project, *Domestic Violence and Housing: A Manual for California Advocates* 42 (2009), available at <http://www.nhlp.org/files/NHLP%20Domestic%20Violence%20%20Housing%20Manual.pdf>; see, e.g., *Barnette v. Pickering*, No. 09-cv-264-PB, 2009 U.S. Dist. LEXIS 122587, at \*5-6 (D.N.H. Dec. 22, 2009).

<sup>182</sup> Phila., Pa., Code §§ 9-1108 (2011).

<sup>183</sup> For more information, see <http://www.phila.gov/humanrelations/>.

<sup>184</sup> Melissa M. Favreault, Urban Inst., *Women and Social Security 1* (2005), available at [http://www.urban.org/UploadedPDF/900902\\_women\\_ss.pdf](http://www.urban.org/UploadedPDF/900902_women_ss.pdf).

<sup>185</sup> Poverty Status in the Past 12 Months by Sex by Age, *supra* note 5.

<sup>186</sup> Nat'l Women's Law Ctr., Fact Sheet: Social Security: Vital to Pennsylvania Women and Families (2011), available at [http://www.nwlc.org/sites/default/files/pdfs/pennsylvania\\_ss\\_factsheet.pdf](http://www.nwlc.org/sites/default/files/pdfs/pennsylvania_ss_factsheet.pdf). Concerns about the viability of the Social Security Fund have led to various proposals to reduce benefits that will affect future generations.

<sup>187</sup> 29 U.S.C. § 1055(c)(2) (2011).

<sup>188</sup> See, e.g., Kan. Stat. Ann. § 74-4918a (2011); Or. Rev. Stat. § 238A.190 (2009).

<sup>189</sup> Legal Momentum, *Improving the Federal Safety Net for Women and Children: An Agenda for TANF Reform 2* (2009), available at <http://www.legalmomentum.org/assets/pdfs/lm-tanf-reform-agenda.pdf>.

<sup>190</sup> *Id.* at 1.

<sup>191</sup> *Id.*

<sup>192</sup> LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Testimony Before the Subcommittee on Income Security & Family Support, Committee on Ways & Means, U.S. House of Representatives 3* (Oct. 8, 2009), available at <http://www.cbpp.org/files/10-8-09testimony.pdf>.

<sup>193</sup> See Lu, *supra* note 163.

<sup>194</sup> See *id.*

<sup>195</sup> Cmty. Legal Servs. of Phila., Pub. Benefits Unit, *Memorandum to Governor-Elect Corbett's Transition Team, Welfare Committee, Briefing Papers on Important Department of Public Welfare Issues*, at sec. 1, p. 2 (Dec. 8, 2010).

<sup>196</sup> *Id.*

<sup>197</sup> *Id.* at sec. 1, p. 3.

<sup>198</sup> *Id.*

<sup>199</sup> Winstanley, *supra* note 50, at 1157.

<sup>200</sup> See, e.g., Kan. Stat. Ann. § 74-4918a (2011); Or. Rev. Stat. § 238A.190 (2009).

<sup>201</sup> See, e.g., R.I. Gen. Laws § 34-37-2.4 (2011); Wash. Rev. Code. § 59.18.580 (2010).



## Section D. The Impact of Sex Bias in **CAREGIVING** on Women's Health

### INTRODUCTION

*Gendered stereotypes of women as homemakers and mothers underlie the disproportionate share of family caregiving placed on women. Women comprise the majority of family caregivers for older persons, adults with disabilities, and children, including children with special needs.<sup>1</sup> This burden is exacerbated by the failure of society to develop adequate legal, social, and economic supports for caring for aging and disabled adults and for children. Caregivers are more likely than non-caregivers to experience heart disease, depression, lower back and neck pain, and lower resistance against infection.<sup>2</sup> Legal reform, increased work flexibility, and expansion of social services will alleviate the negative impact of caregiving on women.*



## Caregiving

This section discusses different types of caregiving, including long-term caregiving of adults and the elderly, caregiving of children with special needs, and parenting of children without special needs.

### Caregiving to the Elderly, Adults with Long-Term Health Needs, and Children with Special Needs

According to a 2009 survey, a total of 65.7 million persons in the United States provided unpaid care to an adult or child with special needs at some point during the year.<sup>3</sup> The majority of these informal caregivers are women, making up between 59 to 75 percent of caregivers.<sup>4</sup>

Almost a quarter of caregivers care for two individuals simultaneously, and 10 percent care for three or more persons.<sup>5</sup> Not surprisingly, caregivers who live with those they assist face the highest demands on their time, equaled only by the time spent by those caring for special needs children under age 18.<sup>6</sup> Approximately 19 percent of informal caregivers spend more than forty hours a week caring for a chronically ill relative.<sup>7</sup>

At least 65 percent of the aging population nationwide relies exclusively on family and friends to provide care for them on a daily basis, with another 30 percent relying on a combination of family and paid assistance.<sup>8</sup> The choice to provide family-based care is rooted in both economic factors, which relate to the expense of institutional care, and personal factors, including the preference of most aging adults to stay home rather than enter a nursing home. Many caregivers feel that they have no choice in assuming their caregiving responsibility.<sup>9</sup>

The typical caregiver of adults is a woman in her mid to late forties, who contributes at least twenty hours per week of unpaid care for an aging relative with long-term health conditions while simultaneously working

outside the home.<sup>10</sup> Caregivers of persons with age-related diseases are more likely to be women, and daughters are more likely than sons to care for aging or disabled parents.<sup>11</sup> Even when men take on caregiving responsibilities, they commit less time on average to caregiving than do women, and are more likely to assume “low-burden” caregiving tasks.<sup>12</sup>

The typical recipient of care is female, with an average age of 61; 44 percent of recipients of care are over age 75.<sup>13</sup> The leading health needs of recipients are old age, Alzheimer's and dementia, mental illness, cancer, heart disease, and stroke.<sup>14</sup>

In Pennsylvania, 1.39 million family caregivers serve adults requiring long-term care at any given time.<sup>15</sup> With 15 percent of Pennsylvanians currently aged 65 or older, Pennsylvania's aging population is the third largest in the country,<sup>16</sup> and is growing faster than the national average.<sup>17</sup> Three-quarters of adult individuals requiring long-term care depend exclusively on family care in Pennsylvania.<sup>18</sup>

### Parenting

In addition to meeting the demands of caring for adults with long-term health needs and children with special needs, women continue to provide a disproportionate amount of daily parenting-related care. There are 35 million families with children under the age of 18 in the United States.<sup>19</sup> Of these families, 30 percent are single parent households, and mothers are the single parent 79 percent of the time.<sup>20</sup> Even among married couples, women provide up to two-thirds more childcare

than their husbands.<sup>21</sup> Research shows that not only do mothers take on greater child-care responsibilities,<sup>22</sup> but they also lose more paid work hours, and work more hours total, including home related chores,<sup>23</sup> than do fathers.

In 2010, in Pennsylvania, there were 1.3 million families with children under 18 years of age.<sup>24</sup> Almost a quarter of these families were headed by a single mother.<sup>25</sup> Of the single parent households, 75 percent were headed by a single mother.<sup>26</sup> According to a 2009 report, 58 percent of these single mother households lack adequate income due to a combination of factors such as pay inequity, gender discrimination, and child care expenses.<sup>27</sup>

### Dual Caregiving: the Sandwich Generation

Research has also focused on the demands placed on the “sandwich generation” of women — those who are simultaneously parenting and caring for an adult.<sup>28</sup> Over 40 percent of caregivers of aging relatives also have children under the age of 18.<sup>29</sup>

Single mothers face particular obstacles in meeting the conflicting demands of working and caring for both children and aging or disabled relatives. They must alone deal with childcare, elder care, financial planning, and working.<sup>30</sup> If caregiving demands require these women to take leave from work, reduce their hours, or leave their paid jobs entirely, they stand to lose access to health benefits for themselves and their children.<sup>31</sup>

## Impact on Women’s Health

The physical and mental burdens of caregiving cause women’s health to deteriorate; caregivers are more likely to suffer ill health than non-caregivers.<sup>32</sup> According to a recent national poll, full-time workers who also care for an elderly or disabled family member, friend, or relative have a significantly lower sense of well-being than non-caregivers.<sup>33</sup> For women caregivers, this negative impact on their well-being is compounded by the harmful effects of gender discrimination and stereotyping related to the caregiving role.<sup>34</sup>

### Physical Health

Women caregivers are at a heightened risk of physical ill-health. In a recent survey, over half of female caregivers reported having a chronic health condition.<sup>35</sup> Female caregivers are less likely to take preventative health measures including being able to rest, get adequate sleep, exercise, take time off when they are sick, take prescribed medications, or attend doctors’ appointments.<sup>36</sup> The combination of decreased time and

ability to take preventative health measures and the physical stress of caregiving creates a higher incidence of physical health conditions amongst caregivers.<sup>37</sup>

Stress factors that impact a caregiver’s physical health include “the care recipient’s behavior problems, cognitive impairment, and functional disabilities; the duration and amount of care provided; the need for vigilance (such as constantly having to watch a person with Alzheimer’s disease to prevent self-harm or wandering); and caregiver and patient co-residence.”<sup>38</sup> In addition, the physical tasks required of many caregivers place particular strain on women caregivers as they age.<sup>39</sup> Common caregiver tasks may include shopping for groceries, doing housework, assisting the care recipient with dressing, eating, and bathing, and moving an adult in and out of a bed or a chair.<sup>40</sup>

Providing high levels of ongoing care also weakens caregivers’ immune systems, lead-

ing to premature aging and increased likelihood of contracting a chronic disease.<sup>41</sup> Caregiving is correlated with high blood pressure, stroke, diabetes, and herniated disks.<sup>42</sup> Research has also shown a dramatic impact on caregiver's cardiovascular health,<sup>43</sup> and one study found a heightened risk of death linked to the physical stresses of caregiving.<sup>44</sup>

### **Mental Health**

Research has consistently shown that women caregivers suffer greater mental health problems than non-caregivers.<sup>45</sup> Female caregivers report higher levels of depressive symptoms than both male caregivers and all non-caregivers.<sup>46</sup> Research demonstrates that the higher risk of mental health conditions is caused by the caregiving experience itself, including the pressures and expectations that women will fill the caregiving role.<sup>47</sup> Women caregivers' mental health is strained because of the high burden of providing day-to-day assistance, the resulting likelihood of stress and conflict between their roles as employees and caregivers, and the sense that they must fulfill their role without seeking support from others.<sup>48</sup> According to a recent review of the research on caregiver health, "older caregivers, people of low socioeconomic status and those with limited support networks report poorer psychological health than caregivers who are younger and have more economic and interpersonal resources."<sup>49</sup> When they do seek support, many caregivers struggle to find it, with 27.5 percent reporting that they did not know whom to call for help at home for aging friends and relatives.<sup>50</sup>

The severity of the mental health impact of caregiving increases for those caring for persons with intensive health needs, such as Alzheimer's and other forms of dementia, multiple sclerosis, stroke, or other severe

disabilities. The majority of caregivers for Alzheimer's patients are women, and these women not only report their health as deteriorating since taking on caregiving roles, but are also more likely than men to report feeling isolated and suffering from quality of life disturbances such as lack of sleep, lack of privacy, depression, and anxiety.<sup>51</sup> Depression rates are similarly higher among those caring for stroke patients, with as many as 52 percent of caregivers suffering depression at a rate consistently higher than control groups.<sup>52</sup>

### **Caregiver Access to Health Services**

Caregivers face significantly greater obstacles than non-caregivers in accessing medical care.<sup>53</sup> Despite the increased health risks and needs faced by caregivers as a result of the mental and physical burdens of caregiving, caregiving women are half as likely as non-caregiving women to get needed medical care, such as filling a prescription.<sup>54</sup> This deficit in health care may occur when a woman either gives up her job or reduces her hours to part-time in order to meet her caregiving obligations or is terminated from her job due to discrimination based on her role as a caregiver, and loses needed health insurance benefits.<sup>55</sup> Because women who leave their jobs to become caregivers are unlikely to return, the barriers to access to health insurance can be long-term. Even women who do return to full-time employment after taking a leave or reducing their hours are more likely to have "benefit-poor" jobs, which results in reduced life-long health benefits.<sup>56</sup> The lack of access to paid sick leave makes it even more difficult for working women to take time to care for their own health. In a recent survey, 47 percent of women lose pay when they stay home to care for a sick child.<sup>57</sup>

## Applicable Laws

### Protection Against Caregiving Discrimination in Employment

Women caregivers are subject to discrimination in the workplace as a result of their caregiving obligations. One study found that similarly qualified working mothers are less likely than working fathers to be hired and to be promoted; they are also likely to be offered significantly lower salaries than fathers and be held to lower performance standards.<sup>58</sup> Women with children face a “mommy penalty” and receive up to 15 percent less in salary than childless women for the same work.<sup>59</sup>

Federal and Pennsylvania anti-discrimination laws do not explicitly prohibit employment discrimination against people based on their caregiving responsibilities—whether for children, elderly parents, or ill partners.<sup>60</sup> However, as recognized by the Equal Employment Opportunity Commission, which published guidelines in 2007 entitled *Enforcement Guidance: Unlawful Disparate Treatment of Workers with Caregiving Responsibilities*,<sup>61</sup> claims for Family Responsibility Discrimination (FRD) can and are being brought under existing federal and state anti-discrimination and employment laws, including laws prohibiting:

- **Sex Discrimination in Employment:** Federal, state and local laws that prohibit sex discrimination in employment also prohibit family responsibilities discrimination if an employer takes an adverse action against an employee because of the employee’s caretaking responsibilities and that action is based on sex-based stereotypes or treats employees differently based on their sex.<sup>62</sup> Employers may not make employment decisions based on stereotypical assumptions about the effect of having children on an employee’s job performance.<sup>63</sup> These laws include Title VII

of the Civil Rights Act of 1964,<sup>64</sup> which applies to employers with 15 or more employees, including state and local governments, and, in Pennsylvania, the Pennsylvania Human Relations Act,<sup>65</sup> which applies to employers with four or more employees. Several local Pennsylvania governments have adopted anti-discrimination ordinances that prohibit sex discrimination in employment, including Allegheny County,<sup>66</sup> Allentown,<sup>67</sup> Doylestown Borough,<sup>68</sup> Easton,<sup>69</sup> Erie County,<sup>70</sup> Harrisburg,<sup>71</sup> Haverford,<sup>72</sup> Lansdowne,<sup>73</sup> Lower Merion,<sup>74</sup> Philadelphia,<sup>75</sup> Pittsburgh,<sup>76</sup> Reading,<sup>77</sup> Scranton,<sup>78</sup> State College,<sup>79</sup> Swarthmore,<sup>80</sup> West Chester,<sup>81</sup> and York.<sup>82</sup> The Allegheny County, Doylestown Borough, Easton, Erie, Harrisburg, Lansdowne, Philadelphia, Reading, State College, and West Chester anti-discrimination ordinances provide broader protection against familial status discrimination, as these localities explicitly include familial status as a prohibited basis for employment discrimination. Of these, only Philadelphia and State College ordinances prohibit discrimination based on caregiving and only Philadelphia’s ordinance clearly prohibits discrimination based on caregiving of adult family members in addition to children.

- **Disability Discrimination in Employment:** The Americans with Disabilities Act (ADA) prohibits employers with 15 or more employees from discriminating based on a worker’s own disability or based on the disability of a family member or other person with whom the worker is closely associated.<sup>83</sup> The PHRA and many local Pennsylvania ordinances also prohibit disability discrimination by employers. Un-

## ***A Health Condition Must be Serious to Qualify for FMLA***

A Pennsylvania woman, who was terminated following a four day absence to care for her ill four-year old son, filed suit claiming that her termination violated the Family Medical Leave Act. The court dismissed her case, concluding that she was not entitled to protection under the FMLA because her son's condition, an ear infection, was not a "serious health condition" as defined by the FMLA. 5, 871 F. Supp. 238 (E.D. Pa. 1994)

der these laws, an employer may not treat a caregiver differently based on stereotypes about the person's ability to do his or her job while providing care to a disabled person.<sup>84</sup>

- **Family Responsibility Discrimination in Federal Employment:** Federal Executive Order 13152, signed by President Clinton in 2000, prohibits discrimination in the workplace against federal government employees on the basis of their "status as a parent."<sup>85</sup>
- **Family Leave Discrimination:** The Family Medical Leave Act of 1993 (FMLA), discussed in greater detail in the next section, prohibits interference with and retaliation for requesting or taking FMLA-protected family leave, which provides for 12 weeks unpaid leave per year for serious illness, the birth or adoption of a child, or caring for a family member with a serious health condition.<sup>86</sup> No Pennsylvania state or local law currently prohibits discrimination based on the taking of family leave.

## **Support for Caregivers, Care Recipients, and Parents**

When a woman must interrupt employment due to caregiving responsibilities, she must take permitted leave time, reduce her hours, or lose her job. Leave time may or may not be available under employer policies or federal, state or local laws and may or may not be accompanied by medical benefits. Reduction and loss of employment leads to loss of both income and employer-provided benefits. This forces many caregivers to rely on limited leave programs and on often-inadequate federal, state, local, and private assistance programs for services and cash assistance.

**Employment Family Leave:** The FMLA, which provides unpaid leave from work to help families balance the competing demands of work and family, expressly recognizes that, "due to the nature of the roles of men and women in our society, the primary responsibility for family caretaking often falls on women, and such responsibility affects the working lives of women more than it affects the working lives of men."<sup>87</sup> The FMLA provides 12 unpaid weeks of family leave annually for serious illness, the birth or adoption of a child, or family caregiving for those with a serious health condition and eligible employees are provided with continuation of group health insurance and restoration of employment at the end of the leave.<sup>88</sup> FMLA leave is limited, however, in the following ways:

- Only employers with 50 or more employees are required to provide FMLA leave.<sup>89</sup>
- Employees are only eligible for leave after they have worked at least 12 months and a total of 1,250 hours in the 12 months preceding the leave.<sup>90</sup>
- Family sick leave is available only for "serious medical conditions," which

means it does not provide leave for routine caregiving demands such as appointments or parent-teacher conferences, childcare, or children's illnesses other than a "serious health condition."<sup>91</sup>

- FMLA leave is unpaid; as a consequence, up to 78 percent of covered employees cannot afford to take their rightful FMLA leave at all.<sup>92</sup>

Pennsylvania law does not require employers to provide paid or unpaid leave to employees.

### **Family Caregiver Support Programs:**

The National Family Caregiver Support Program, established in 2000, provides grants to states to provide support services to family caregivers and grandparents or other older relative caregivers.<sup>93</sup>

Priority is given to older caregivers with the greatest social and economic needs, and to caregivers providing care to individuals with severe disabilities. The range of support services covered include information about and access to available services, individual counseling, caregiver training, support groups, and respite care. These programs rely on volunteers and the support of non-profit organizations and associations to make these services available, and programs are administered by existing state agencies on aging.

Since 1987, the Pennsylvania Department of Aging has administered the Pennsylvania Family Caregiver Support Program (FCSP), a state-funded program for caregiver support, and the model developed in Pennsylvania became a model for the federally-funded National Family Caregiver Support Program.<sup>94</sup> It has received some federal funding since 2000. The FCSP assesses a family's needs, and provides benefits to those caring for a relative aged sixty and over, as well as to older persons caring for

## **Requesting FMLA Leave Is Protected Under Both Federal And State Law**

In a case in which the employee was denied FMLA leave and terminated thereafter, a Pennsylvania federal district court denied an employer's motion for summary judgment in its favor and allowed the employee's claims of interference with her FMLA rights and retaliation for asserting her FMLA rights to proceed under both the FMLA and the PHRA. Noting that the "correlating purposes of the FMLA and PHRA" to prohibit sex discrimination which can occur in caretaker roles, the court, in a decision of first impression, predicted that the Pennsylvania Supreme Court would find requesting FMLA leave to be a protected activity under the PHRA. *Erdman v. Nationwide Insurance Co.*, No. 1:05-CV-0944, 2010 U.S. Dist. LEXIS 3217 (M.D. Pa. 2010).

children, or persons caring for an individual of any age who is suffering from Alzheimer's or other forms of dementia. Reimbursement for family caregiving includes cash assistance to help with monthly out-of-pocket expenses, including respite care services and home health supplies, as well as a one-time grant for home adaptations for persons living with disabilities. The program also provides counseling and training for family caregivers, as well as assistance in accessing benefits from a range of other local, state and federal programs, including health insurance.<sup>95</sup>

The advantage of Pennsylvania's FCSP in conjunction with other state aging care services is its flexibility in allowing families to guide which services and supports they

need. The disadvantage of the state FCSP is that it requires caregivers to reside with the care-recipient in order to receive services. As a result, local agencies on aging have been unable to use state funding for families in need of support who do not meet the co-residency requirement.

Legislation to expand the Pennsylvania FCSP has been introduced repeatedly since 2007 without success; the most recent legislation, House Bill 224, was introduced in the Pennsylvania House of Representatives on January 24, 2011. The legislation, if adopted, will expand eligibility for family caregiver benefits by including relatives and non-relative caregivers who do not reside with the care-receiving person, and increase reimbursement rates, including a one-time home adjustment grant, for the first time since the program's inception.<sup>96</sup>

**Respite Care:** The Lifespan Respite Care Act, enacted by Congress in 2006, aims to coordinate various funding sources to streamline respite service delivery and



improve the training and support of respite workers and family caregivers.<sup>97</sup> Respite care provides short term, time-limited relief for caregivers in order to improve the quality of life of caregivers and care recipients alike. Federal funding for Lifespan Respite Care Programs under this Act was made available to states starting in 2009.

In 2010, Pennsylvania received its first grant under the Lifespan Respite Care Act,<sup>98</sup> to support the establishment of a statewide lifespan respite system.<sup>99</sup> Because the grant is small, however, Pennsylvania's program is limited to addressing the coordination of respite organizations and improving awareness of existing services.

OPTIONS, a state-funded program targeted at care recipients, is available to those over age 60 at the nursing home level of care without income limitations, and services are covered on a sliding-scale system. The program assesses needs, provides case management, and enables access to a range of home and community-based services, including home health and support, respite care, and transportation. A more recent cost-sharing component was added to this program to decrease waiting lists and improve access to those living at up to 300 percent of the federal poverty level.<sup>100</sup>

**Health Insurance Reform:** The Patient Protection Affordable Care Act (ACA) creates programs that will reduce the care burden and expand access to healthcare to the thousands of women providing family care who are currently uninsured themselves.<sup>101</sup>

- **Changes to Medicaid coverage will increase coverage for long-term care services.** As of October 1, 2010, states can now offer Medicaid reimbursement for home and community-based care, which previously required a Medicaid waiver in order to be paid.<sup>102</sup> In addition, new federal funding is available for

Aging and Disability Resource Centers (ADRC), to provide cohesive entry points to long-term care services, and to support those who need nursing home levels of care but want to stay home.<sup>103</sup>

Another program will provide financial support to protect spouses of those receiving Medicaid home and community-based services from impoverishment.<sup>104</sup>

- **A range of programs will streamline care coordination and support family caregivers.** Starting as a pilot program in January 2012, the Independence At Home program will provide in-home primary care services to Medicare beneficiaries with chronic conditions. This will relieve family caregivers who are otherwise responsible for coordinating care and arranging appointments and transportation.<sup>105</sup> Federally-funded geriatric centers will be mandated to provide free or low-cost training programs for family caregivers, and a new Community Care Transitions Program will provide services to assist patients transitioning home after hospital discharge.<sup>106</sup> While these programs will take time to implement on a national scale, they are anticipated to reduce family caregivers' disproportionate responsibilities in providing and coordinating these services without adequate training or support.
- **Health insurance coverage will expand.** Under health reform, insurance coverage will no longer be conditional on employment; thus, family caregivers and mothers who are forced to switch to part-time employment or leave their jobs will no longer lack access to health care coverage because of their caregiving responsibilities. Most U.S. citizens and permanent residents will be required to carry health insurance, and new subsidies will become available to help low-income persons

who are not eligible for Medicaid or Medicare to obtain insurance, while the eligibility criteria for Medicaid will expand.<sup>107</sup>

- **Medical workforce development will improve physician training in the much-needed fields of primary care and geriatric medicine.** As the population ages, the need for primary care physicians and doctors trained in geriatric medicine will grow. However, doctors trained in these fields earn much less than their counterparts who choose to specialize in other areas.<sup>108</sup> The ACA will provide grants and financial incentives to encourage students and health care professionals to enter the field of geriatric medicine and receive training in chronic care management and long-term care.<sup>109</sup>

**Child Care Assistance:** Pennsylvania offers a number of programs to subsidize and improve the quality of child care. However, existing programs are inadequate to meet the need and adoption of additional programs would mitigate the caretaking burden for parents. Pennsylvania offers the following limited programs:

- **Head Start** programs provide early childhood education to children between the ages of 3 and 5 for low-income families; only 36 percent of eligible four-year olds, however, actually attend Head Start programs.<sup>110</sup> Head Start early childhood development and education programs are offered across Pennsylvania, and 27 Early Head Start programs are also offered for children under three. Pregnant women who have other children enrolled in Head Start are also eligible for Early Head Start programs. Head Start in Pennsylvania reserves 10 percent of spots for disabled children. In some rural areas,

Head Start services may be offered in the home.<sup>111</sup>

- **Child Care Works** provides child care subsidies for families earning up to 200 percent of the federal poverty level.<sup>112</sup> Families are required to contribute co-payments in proportion to their income, and reimbursement for care is tiered to reward higher-quality care.<sup>113</sup> Parents must be in school or employed in order to qualify. The demand for child care assistance is high, with at least 110,000 children receiving subsidized care daily and 10,461 children on the state-wide waiting list for assistance as of September 2010.<sup>114</sup> Pennsylvania's reimbursement rates to child care providers are at or below the 75<sup>th</sup> percentile of current market rates for child care services,<sup>115</sup> and the program also faces challenges of ensuring the quality of the child care and securing sufficient and qualified child care staff to meet the high demand for care.<sup>116</sup>
- **Quality of Care.** There are no federal or state standards for private childcare safety, staffing, or teaching curricula; many childcare providers are not regulated even by state licensing standards.<sup>117</sup> A recent study showed that 35 percent of home-based childcare is considered "inadequate" nationwide.<sup>118</sup> Families who cannot receive subsidies may have to resort to such poor-quality childcare, or else women may be forced to stay home or reduce their working hours due to the lack of affordable childcare. Three percent of home-based childcare in Pennsylvania is accredited.<sup>119</sup>

Pennsylvania operates two additional programs aimed at improving the quality of childcare. The Keystone STARS program is a voluntary program for

quality improvement, with 65 percent of Pennsylvania's licensed child care centers and 29 percent of home-based providers enrolled. The STARS Program is a rating and improvement system in which providers earn a quality rating.<sup>120</sup> This rating system allows parents the opportunity to choose a child care program from a range of high quality choices.<sup>121</sup> The T.E.A.C.H. program offers scholarship funding and support systems to improve the education level and compensation of child care workers.<sup>122</sup>

Pennsylvania does not offer a form of assistance that would significantly help parents:

- **Tax Credits and Deductions.** Pennsylvania is one of only 14 states that levy state income tax but do not offer a dependent care tax credit.<sup>123</sup> Pennsylvania also does not offer any tax credit for care of the elderly or the disabled.<sup>124</sup> While Pennsylvanians can still claim a child and dependent care tax credit on their federal income tax returns, the lack of a state dependent tax credit harms families with high employment-based care expenses for children or other dependents. Because women are still the primary family caregivers of children and other dependents, "Tax code provisions that assist women in paying for care for children and adult dependents take some of the burden off women and lessen barriers to women's participation in the workforce, enabling them to support themselves and their families."<sup>125</sup> These kinds of tax supports are particularly helpful for single mothers, who are more likely to face poverty.<sup>126</sup> In addition, a tax credit can improve the quality of care families can afford by offsetting a greater percentage of higher quality care. The federal tax

credit sets a minimal quality requirement by covering expenses only for those care facilities that meet all applicable state and local laws.<sup>127</sup>

- Additional tax credits and deductions that can be helpful for family caregivers include long-term care insurance, medical expenses, and dedicated caregiver tax provisions. Although Pennsylvania state tax provisions allow individuals to

exclude any income from health savings accounts or medical savings accounts if such income is used exclusively for medical expenses,<sup>128</sup> this benefit is clearly limited to those who hold a health or medical savings account as part of their health benefit plan. Pennsylvania does not offer any other tax credits that cover the expenses of caregiving or health expenses.<sup>129</sup>

## RECOMMENDATIONS FOR REFORM

To improve women's health, legislators must adopt caregiving models and policies that alleviate the care burden on women and must acknowledge that women are “the backbone of our health care system by providing long-term care in the home to those with chronic illness or disabilities” as well as to the elderly, and children.<sup>130</sup> All policy approaches must recognize the diversity of needs of aging caregivers, single parents, women of color, and low-income women. Necessary reforms include:

### Employment Protection

- Federal, state and local government should prohibit family responsibilities discrimination by adopting or amending existing employment discrimination statutes and ordinances to prohibit employment discrimination based on familial status using a broad definition of familial status that encompasses care of a range of family members.
- Federal, state and local governments should enact earned paid leave laws for workers to provide employees with guaranteed paid leave to address essential aspects of family caretaking.
- Federal, state and local governments should encourage employers to adopt flexible workplace options, such as flexible schedules and reassignments to different workplace locations, that increase productivity while facilitating women meeting their competing financial and family caregiving burdens.

### Health Care

- Pennsylvania should support the work of the Lifespan Respite Advisory Council with long-term funding to enable increased training, screening, and placement of respite providers with families in need. Further collaborations should be developed with the Aging and Disability Resource Centers (ADRC).
- Pennsylvania should strengthen and appropriately fund the new ADRC network to improve routes of access to essential home and community-based services. Partner agencies and organizations must ensure that these services are provided to the families with the greatest need.
- Pennsylvania lawmakers should enact H.B. 224 to expand Pennsylvania's program to allow access for families who do not reside with the care recipient, consistent with the federal program. Pennsylvania should also expand access to support groups and training programs for family caregivers. Support groups, mental health services, and training programs have all been demonstrated to improve family caregivers' health and well-being.

**Child Care**

- Pennsylvania should amend its tax code to include a family refundable tax credit that covers the care of the full range of family member dependents, including aging parents, that targets low income workers, and is tailored to incentivize higher quality care.

## ENDNOTES

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<sup>2</sup> Dan Witters, *In U.S., Caregivers Suffer From Poorer Physical Health*, Gallup, Feb. 4, 2011, available at <http://www.gallup.com/poll/145940/caregivers-suffer-poorer-physical-health.aspx>; Harvard Med. Sch. Family Health Guide, *Caring for the Caregiver* (2004), available at <http://www.health.harvard.edu/fhg/updates/update0304a.shtml>.

<sup>3</sup> *Caregiving in the U.S.* *supra* note 1, at 4, 14 (studying caregiving of individuals older than 18 and children with special needs).

<sup>4</sup> *Id.*; Family Caregiver Alliance, Fact Sheet: Women and Caregiving, [http://www.caregiver.org/caregiver/jsp/content\\_node.jsp?nodeid=892](http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=892).

<sup>5</sup> *Caregiving in the U.S.*, *supra* note 1, at 14.

<sup>6</sup> *Id.* at 21-22, 25.

<sup>7</sup> Usha Ranji & Alina Salganicoff, *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey 39* (2011), available at <http://www.kff.org/womenshealth/8164.cfm>.

<sup>8</sup> Family Caregiver Alliance, *supra* note 4.

<sup>9</sup> *Caregiving in the U.S.*, *supra* note 1, at 20.

<sup>10</sup> *Id.* at 5, 9; Ari Houser & Mary Jo Gibson, AARP Pub. Policy Inst., *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update 1*, available at [assets.aarp.org/rgcenter/il/i13\\_caregiving.pdf](http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf).

<sup>11</sup> Catherine E. Mosher & Sharon Danoff-Burg, *Effects of Gender and Employment Status on Support Provided to Caregivers*, 51 *Sex Roles* 589, 590 (2004).

<sup>12</sup> *Caregiving in the U.S.*, *supra* note 1, at 23, 29. The index developed to measure the burden of caregiving in the AARP & National Alliance for Caregiving report is based on the number of hours of care and the number of key daily activities with which they assisted.

<sup>13</sup> *Caregiving in the U.S.*, *supra* note 1, at 14-15.

<sup>14</sup> *Id.* at 4-5.

<sup>15</sup> Houser & Gibson, *supra* note 10, at 4.

<sup>16</sup> The Pa. Elder Econ. Sec. Initiative, Fact Sheet for Advocates (2010), available at <http://www.carie.org/wp-content/uploads/2010/03/PA-One-Pager-for-Advocates-FINAL.pdf>.

<sup>17</sup> Michael Birnbaum, *The Urban Inst., Health Policy for Low-Income People in Pennsylvania* (1999), cited in Lynn Friss Feinberg et al., *Family Caregiver Support: Policies, Perceptions and Practices in 10 States Since Passage of the National Family Caregiver Support Program*, 162 (2002), available at [http://www.caregiver.org/caregiver/jsp/content/pdfs/op\\_200211\\_10\\_state\\_pennsylvania.pdf](http://www.caregiver.org/caregiver/jsp/content/pdfs/op_200211_10_state_pennsylvania.pdf) [hereinafter *Family Caregiver Support: Policies, Perceptions and Practices*].

<sup>18</sup> Greg Link et al., *Family Caregiver Support: State Facts at a Glance 83* (2006), available at <http://www.ncsl.org/Portals/1/Documents/Health/forum/item0166605.pdf>.

<sup>19</sup> Robert D. Winsor & Ellen A. Ensher, *Choices Made in Balancing Work and Family: Following Two Women on a 16 Year Journey*, 9 *J. of Management Inquiry* 218, 228 (2000).

<sup>20</sup> *Id.*

- <sup>21</sup> Janice M. Steil, *Contemporary Marriage: Still an Unequal Partnership*, in *Close Relationships: A Sourcebook* 126 (Hendrick et al. eds., 2000).
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- <sup>23</sup> *Id.* at 113.
- <sup>24</sup> Pa. State Data Ctr., *Census 2010 Demographic Profile, State and Counties* (2011), available at <http://pasdc.hbg.psu.edu/Data/PASStats/tabid/1014/Default.aspx>.
- <sup>25</sup> *Id.* The percentage of families headed by a single mother, was derived by dividing the number of families with a female householder and children by the total number of families in Pennsylvania.
- <sup>26</sup> *Id.* The percentage of households in Pennsylvania headed by a single mother was derived by first subtracting the number of married couples with children from the total number of families with children to provide the total number of single parent households in Pennsylvania. Second, the number of families with a female householder and children as divided by the total number of single parent households.
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- <sup>30</sup> Nat'l Alliance for Caregiving, *supra* note 28, at 17.
- <sup>31</sup> Family Caregiver Alliance, *supra* note 4.
- <sup>32</sup> Family Caregiver Alliance, *supra* note 4, at nn. 28, 29 & 34.
- <sup>33</sup> Dan Witters, *In U.S., Working Caregivers Face Wellbeing Challenges*, Gallup, Dec. 8, 2010, available at <http://www.gallup.com/poll/145115/Working-Caregivers-Face-Wellbeing-Challenges.aspx>.
- <sup>34</sup> Jennifer Yee & Richard Schulz, *Gender Differences in Psychiatric Morbidity Among Family Caregivers: A Review and Analysis*, 40 *Gerontologist* 147, 162 (2000).
- <sup>35</sup> Usha Ranji & Alina Salganicoff, *supra* note 7, at 38.
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- <sup>37</sup> See, e.g., Carolyn Cannuscio et al., *Reverberations of Family Illness: A Longitudinal Assessment of Informal Caregiving and Mental Health Status in the Nurses' Health Study*, 92 *Am. J. of Pub. Health* 1305, 1309-10 (2002).
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- <sup>40</sup> *Caregiving in the U.S.*, *supra* note 1, at 22.
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<sup>43</sup> See Abby C. King et al., *Ambulatory Blood Pressure and Heart Rate Responses to the Stress of Work and Caregiving in Older Women*, 49 J. of Gerontology 239 (1994), cited in Kirstin Auerbacher et al., *Combination of Caregiving Stress and Hormone Replacement Therapy is Associated with Prolonged Platelet Activation to Acute Stress Among Postmenopausal Women*, 69 Psychosomatic Med. 916 (2007).

<sup>44</sup> Richard Schulz & Scott R. Beach, *Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study*, 282 JAMA 2215, 2218-19 (1999).

<sup>45</sup> Charlene Harrington & Cassandra Crawford, *Health Policy: Crisis and Reform in the U.S. Health Care Delivery System* 150 (2004); Yee & Schulz, *supra* note 34, at 155.

<sup>46</sup> Yee & Shultz, *supra* note 34, at 148.

<sup>47</sup> *Id.* at 155.

<sup>48</sup> *Id.* at 158-60.

<sup>49</sup> Schulz & Sherwood, *supra* note 38, at 106.

<sup>50</sup> Lynn Friss Feinberg et al., *State Profile: Pennsylvania, Selected State Background Characteristics 1* (2004), available at [http://www.caregiver.org/caregiver/jsp/content/pdfs/state\\_profile\\_pa.pdf](http://www.caregiver.org/caregiver/jsp/content/pdfs/state_profile_pa.pdf).

<sup>51</sup> Mary Mittelman, *Community Caregiving*, 4 *Alzheimers Care Q.* 273, 277 (2003).

<sup>52</sup> Anne Forster, *Caregiver Burden in Stroke*, 9 *Stroke Rev.* 127 (2005).

<sup>53</sup> Family Caregiver Alliance, *supra* note 4, at n.42.

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

<sup>55</sup> Joan C. Williams & Heather Boushey, Ctr. for Am. Progress, *The Three Faces of Work-Life Conflict: The Poor, the Professionals and the Missing Middle* 30, 51, 57-58, 63 (2010), available at <http://www.americanprogress.org/issues/2010/01/pdf/threefaces.pdf>.

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

<sup>57</sup> Usha Ranji et al., *supra* note 7, at 4.

<sup>58</sup> Shelley J. Correll et al., *Getting a Job: Is There a Motherhood Penalty?*, 112 *Am. J. of Soc.* 1316-17, 1321-22 (2007).

<sup>59</sup> Neil H. Buchanan, *Why Do Women Lawyers Earn Less than Men? Parenthood and Gender in a Survey of Law School Graduates* (2008). available at <http://ssrn.com/abstract=1280464>.

<sup>60</sup> Joan C. Williams & Stephanie Bornstein, *Caregivers in the Courtroom: The Growing Trend of Family Responsibilities Discrimination*, 41 *U.S.F. L. Rev.* 171, 171 (2006), cited in Steven I. Locke, *Family Responsibilities Discrimination and the New York City Model: A Map for Future Legislation*, 51 *S. Tex. L. Rev.* 19, 20 n.4 (2009). This definition of FRD includes the “maternal wall” of discrimination against pregnant and child-rearing women, and against men who care for children or other family members.

<sup>61</sup> Equal Employment Opportunity Comm’n (EEOC), *Enforcement Guidance: Unlawful Disparate Treatment of Workers with Caregiving Responsibilities*, Notice No. 915-002 (2007) [hereinafter EEOC, *Enforcement Guidance*]; see e.g., *Back v. Hastings on Hudson Union Free Sch. Dist.*, 365 F.3d 107 (2d Cir. 2004); see also *Lust v. Sealy, Inc.*, 383 F.3d 580, 583 (7th Cir. 2004).

<sup>62</sup> EEOC, *Enforcement Guidance*, *supra* note 61.

<sup>63</sup> *Id.* at § 2(B).

<sup>64</sup> 42 U.S.C.S. § 2000e(k).

<sup>65</sup> 43 Pa. Stat. §§ 951-63.

<sup>66</sup> Allegheny County, Pa., Code § 215-32 (2009), *available at* <http://ecode360.com/?custId=AL1955>.

<sup>67</sup> Allentown, Pa., Code §§ 181.01-181.03 (2011), *available at* <http://www.allentownpa.gov/Portals/0/files/Legislative/Ordinances/2010/7ABC.pdf>.

<sup>68</sup> Doylestown, Pa., Code ch. 1, § 359 (2010), *available at* [http://www.e-codes.generalcode.com/codes/1641\\_A/1641-001.pdf#xml=http://www.e-codes.generalcode.com/searchresults.asp?cmd=pdfhits&index=1641\\_A&filename=1641-001.pdf&fn=E:\siteinfo\ecodes\codebooks\1641\\_A\1641-001.pdf](http://www.e-codes.generalcode.com/codes/1641_A/1641-001.pdf#xml=http://www.e-codes.generalcode.com/searchresults.asp?cmd=pdfhits&index=1641_A&filename=1641-001.pdf&fn=E:\siteinfo\ecodes\codebooks\1641_A\1641-001.pdf).

<sup>69</sup> Easton, Pa., Code §§ 79-1, 79-3 (2006), *available at* <http://www.ecode360.com/?custId=EA2741>.

<sup>70</sup> Erie, Pa., Code art. VIII, *available at* <http://eriecountygov.org/dept/HRC/ordinance.pdf>.

<sup>71</sup> Harrisburg, Pa., Code §§ 4-101 to -115 (2001).

<sup>72</sup> Haverford, Pa., Code § 183-1 (2011), *available at* [http://www.haverfordtownship.com/egov/docs/1297453793\\_689270.pdf](http://www.haverfordtownship.com/egov/docs/1297453793_689270.pdf).

<sup>73</sup> Lansdowne, Pa., Code § 38-1 (2006), *available at* <http://lansdowneborough.com/hrc-ordinance/>.

<sup>74</sup> Lower Merion, Pa., Code § 93-2 (2010), *available at* <http://www.ecode360.com/ecode3-back/getSimple.jsp?custId=LO0641&guid=14769671>.

<sup>75</sup> Phila., Pa., Code §§ 9-1100 to 9-1125 (2011) (effective June 21, 2011), *available at* [http://www.phila.gov/humanrelations/pdfs/Fair\\_Practices\\_Ordin2.pdf](http://www.phila.gov/humanrelations/pdfs/Fair_Practices_Ordin2.pdf).

<sup>76</sup> Pittsburgh, Pa., Code §§ 651 to 659 (2011), *available at* <http://library.municode.com/index.aspx?clientId=13525&stateId=38&stateName=Pennsylvania>.

<sup>77</sup> Reading, Pa., Code §§ 1-521 to 1-526 (2009), *available at* <http://www.accessdoctors.state.pa.us/law/L8-CityOfReading.html>.

<sup>78</sup> Scranton, Pa., Code § 296-3 (2003) *available at* <http://ecode360.com/?custId=SC1588>.

<sup>79</sup> State College, Pa., Code ch. V, §§ 901-911 (1981), *available at* <http://statecollegepa.us/DocumentView.aspx?DID=1123>.

<sup>80</sup> Swarthmore, Pa., Code § 207.01 (2010), *available at* [http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/swarthmore/codifiedordinancesoftheboroughofswarthmo?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:swarthmore\\_pa](http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/swarthmore/codifiedordinancesoftheboroughofswarthmo?f=templates$fn=default.htm$3.0$vid=amlegal:swarthmore_pa).

<sup>81</sup> West Chester, Pa., Code §§ 37A-1 to 37A7- (2006), *available at* <http://www.ecode360.com/?custId=WE0442>.

<sup>82</sup> York, Pa., Code arts. 185.01 to 185-99 (2011), *available at* <http://yorkcity.org/user-files/file/City%20Council/Codified%20Ordinances/CO-Part%201%20-%20Administrative.pdf>.

<sup>83</sup> The “association” provision of the ADA prohibits discrimination against employees or job applications based on their “relationship or association” with an individual with a disability. 42 U.S.C. § 12112(b)(4) (2011). Section 501 of the Rehabilitation Act provides the same protection to federal workers. 29 U.S.C. § 791(g) (2011) (incorporating ADA standards).

<sup>84</sup> EEOC, Enforcement Guidance, *supra* note 61, at § 2(E).

<sup>85</sup> Exec. Order No. 13,152, 65 Fed. Reg. 26,115 (2000); *see also* Stephanie Bornstein & Robert J. Rathmell, Ctr. for Work Life Law, Caregivers as a Protected Class?: The Growth of State and Local Laws Prohibiting Family Responsibilities Discrimination 4 (2009).

<sup>86</sup> Family and Medical Leave Act, 29 U.S.C. § 2601 (2006).

<sup>87</sup> Family and Medical Leave Act, 29 U.S.C. § 2601(a)(5) (2011).

<sup>88</sup> 29 U.S.C. §§ 2612, 2614.

<sup>89</sup> The precise scope of the FMLA covers employers with fifty or more employees for each working day during each of twenty or more workweeks of the current or preceding year. *Id.* § 2611(4)(A).

<sup>90</sup> *Id.* § 2611(2)(A)(i)-(ii). An employee is also ineligible if their employer employs less than 50 employees within 75 miles of the employee's particular worksite. *Id.* § 2611(2)(B)(ii).

<sup>91</sup> Under the FMLA, a serious health condition is defined as an "illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider." *Id.* § 2611(11); see *Seidle v. Provident Mut. Life Ins. Co.*, 871 F. Supp. 238, 242, 246-47 (E.D. Pa. 1994) (concluding that termination of employment to care for child with an ear infection does not violate FMLA because not serious health condition).

<sup>92</sup> See Sarah Fass, Nat'l Ctr. for Children in Poverty, *Paid Leave in the States: A Critical Support for Low-Wage Workers and Their Families* 6 (2009), available at <http://www.paidfamilyleave.org/pdf/PaidLeaveinStates.pdf>.

<sup>93</sup> The Family Caregiver Support Program was established in 2000, under Section 371 of the Older Americans Act of 1965, Pub. L. No. 89-73, 79 Stat. 218 (1965) (codified as amended at 42 U.S.C. §§ 3030s-3030s-2 (2011)).

<sup>94</sup> Family Caregiver Support: Policies, Perceptions and Practices, *supra* note 17, at 161.

<sup>95</sup> Pa. Dep't of Aging, Pennsylvania's Family Caregiver Support Program (2007), available at <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616680&mode=2>.

<sup>96</sup> H.B. 224, 2011 Gen. Assem., Reg. Sess. (Pa. 2011); see also State Rep. Phyllis Mundy, *News Release: Mundy Reintroduces Bill to Modernize Pa.'s Elderly Caregiver Program*, (Jan. 24, 2011), <http://www.pahouse.com/PR/120012411.asp> (last visited Dec. 5, 2011).

<sup>97</sup> 42 U.S.C. §§ 300ii-300ii-4 (2006).

<sup>98</sup> Lifespan Respite Care Act, Pub. L. No. 109-442, 109th Cong., (2005).

<sup>99</sup> Jamie Buchenauer, Lifespan Respite Care Program: Project Summary (on file with the Women's Law Project).

<sup>100</sup> Pa. Dep't of Aging, *Benefits and Rights for Older Pennsylvanians* 60-63 (2010).

<sup>101</sup> Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>102</sup> ACA, §10202 (2010) (codified at 42 U.S.C. § 1396d).

<sup>103</sup> *Id.* at § 2405 (2010) (codified at 42 U.S.C. § 3012).

<sup>104</sup> *Id.* at § 2404 (2010) (codified at 42 U.S.C. §1396r-5(h)(1)(A)).

<sup>105</sup> *Id.* at § 3024 (2010) (codified at 42 U.S.C. § 1395cc-5).

<sup>106</sup> *Id.* at § 3026 (2010) (codified at 42 U.S.C. § 1395b-1).

<sup>107</sup> *Id.* at § 1501 (codified at 42 U.S.C.S. § 18091); *Id.* at § 1402 (2010) (codified at 42 U.S.C. § 18071); *Id.* at § 2001 (2010) (codified at 42 U.S.C.S. § 1396a).

<sup>108</sup> Family Caregiver Alliance, *Health Care Reform and Family Caregivers* (2010), available at <http://caregiver.org/caregiver/jsp/content/pdfs/HCR%20provisions%20for%20caregivers-2010.pdf>.

<sup>109</sup> ACA, §§5101, 5102 (2010) (codified at 42 U.S.C. §§ 294q, 294r).

<sup>110</sup> See Linda Giannarelli & James Barsimantov, *Urban Inst., Child Care Expenses of America's Families 18* (2000), available at [http://www.urban.org/UploadedPDF/310028\\_occa40.pdf](http://www.urban.org/UploadedPDF/310028_occa40.pdf). Government programs to assist low-income families do not come close to satisfying the available need; many have extensively long waiting lists. See Linda Giannarelli, Sarah Adelman & Stefanie Schmidt, *Urban Inst., Getting Help with Child Care Expenses 20* (2003), available at [http://www.urban.org/UploadedPDF/310615\\_OP62.pdf](http://www.urban.org/UploadedPDF/310615_OP62.pdf). By one estimate, only roughly 21% of low-income families receive any financial assistance for child care. *Id.* at 27.

<sup>111</sup> Pennsylvania Dep't of Public Welfare, *Head Start*, Dec. 13, 2011, <http://www.dpw.state.pa.us/forchildren/childcareearlylearning/headstart/index.htm> (last visited Mar. 22, 2012).

<sup>112</sup> Pa. Dep't of Pub. Welfare, *Child Care Works Subsidized Child Care Program*, <http://www.dpw.state.pa.us/forchildren/childcareearlylearning/childcareworkssubsidizedchildcareprogram/index.htm> (last visited Sept. 2, 2011).

<sup>113</sup> Nat'l Women's Law Ctr., *State Child Care Assistance Policies 2010: Pennsylvania*, <http://www.nwlc.org/resource/state-child-care-assistance-policies-2010-pennsylvania> (last visited Sept. 2, 2011).

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> Pa. Partnerships for Children, *Childcare in Pennsylvania: 2006 Fact Sheet*, available at [http://www.papartnerships.org/pdfs/factsheet\\_childcare06.pdf](http://www.papartnerships.org/pdfs/factsheet_childcare06.pdf).

<sup>117</sup> Maxine Eichner, *Globalization and the Underinvestment in Families: Families, Human Dignity, and State Support for Caretaking: Why the United States' Failure to Ameliorate the Work-Family Conflict is a Dereliction of the Government's Basic Responsibilities*, 88 N.C. L. Rev. 1593, 1605 (2010).

<sup>118</sup> *Id.* at 1611.

<sup>119</sup> Nat'l Ass'n of Child Care Resource & Referral Agencies, *Fact Sheet: 2009 Child Care in the State of Pennsylvania* (2009), available at <http://www.naccrra.org/randd/data/docs/PA.pdf>.

<sup>120</sup> Philip Sirinides, *Demonstrating Quality: Pennsylvania Keystone STARS 2010 Program Report 3* (2010), available at <http://www.ocdelresearch.org/Reports/Keystone%20STARS/Keystone%20STARS%202010%20Evaluation%20Report.pdf>.

<sup>121</sup> *Id.*

<sup>122</sup> Pa. Partnerships for Children, *Childcare in Pennsylvania: 2006 Fact Sheet*, available at [http://www.papartnerships.org/pdfs/factsheet\\_childcare06.pdf](http://www.papartnerships.org/pdfs/factsheet_childcare06.pdf).

<sup>123</sup> Nat'l Women's Law Ctr., *Making the Grade for Care: Ranking State Child and Dependent Care Tax Provisions* (2011), available at <http://www.nwlc.org/sites/default/files/pdfs/nwlc-makinggradeforcare2011.pdf>.

<sup>124</sup> Pa. Dep't of Revenue, *Pennsylvania Personal Income Tax Guide*, ch. 6, tbl.3 (2009), available at [http://www.portal.state.pa.us/portal/server.pt/community/pa\\_personal\\_income\\_tax\\_guide/14826](http://www.portal.state.pa.us/portal/server.pt/community/pa_personal_income_tax_guide/14826).

<sup>125</sup> Nat'l Women's Law Ctr., *Making Care Less Taxing: Improving State Child and Dependent Care Tax Provisions 8* (2011), available at [http://www.nwlc.org/sites/default/files/pdfs/nwlc-mclt2011-without\\_report\\_card\\_inside\\_and\\_bookmarked.pdf](http://www.nwlc.org/sites/default/files/pdfs/nwlc-mclt2011-without_report_card_inside_and_bookmarked.pdf).

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

<sup>127</sup> *Id.* at 32.

<sup>128</sup> Pa. Dep't of Revenue, *Pennsylvania Tax Compendium: December 2010*, at 16 (2010).

<sup>129</sup> Pa. Dep't of Revenue, Pennsylvania Personal Income Tax Guide, ch. 6, tbl.3 (2009), *available at* [http://www.portal.state.pa.us/portal/server.pt/community/pa\\_personal\\_income\\_tax\\_guide/14826](http://www.portal.state.pa.us/portal/server.pt/community/pa_personal_income_tax_guide/14826).

<sup>130</sup> Nat'l Alliance for Caregiving, The Evercare Survey of the Economic Downturn and Its Impact on Family Caregiving 1 (2009), *available at* [http://www.caregiving.org/data/EVC\\_Caregivers\\_Economy\\_Report%20FINAL\\_4-28-09.pdf](http://www.caregiving.org/data/EVC_Caregivers_Economy_Report%20FINAL_4-28-09.pdf).

# The Impact of Sex Bias in the **WORKPLACE** on Women's Health

## INTRODUCTION

*Women comprise a large segment of the workforce in the United States and in Pennsylvania. Anti-discrimination laws opened the doors for women to enter the workforce in greater numbers, including jobs traditionally reserved for men.<sup>1</sup> Women work for the same reason men do: they have to work in order to support their families.<sup>2</sup> The societal perception that discrimination in the workplace has disappeared because of the advances in the law is, unfortunately, erroneous. Despite its illegality and the growing numbers of women joining the workforce, discrimination continues, manifesting itself in a variety of ways. Women continue to be paid less than men for comparable or equal work, remain concentrated in stereotypically female low-paying occupations, are subjected to sexual harassment, face discrimination on the basis of pregnancy and caregiving, and are denied advancement to managerial and higher paying positions.<sup>3</sup> The intersection of gender, race, and ethnicity compounds the discrimination experienced by women in the workplace. While work can be good for women,<sup>4</sup> employment discrimination leads to physical and psychological problems and reduced access to health care.*



## Sex Discrimination in the Workplace

Women's participation in the workforce has grown exponentially since the 1950s, when only 34 percent of adult women worked outside the home and 28 percent of these working women were employed part-time.<sup>5</sup> The workforce was divided into male and female job categories, with the more prestigious jobs listed in the newspaper as exclusively for men.<sup>6</sup> It was common for identical jobs to be run separately under male and female listings, with separate pay scales.<sup>7</sup>

Cultural and legislative changes, fueled by the civil rights and women's rights movements, have made the workplace more hospitable to women.<sup>8</sup> Women's participation in the workforce has steadily increased, and by the year 2000, 60 percent of American women were in the workforce, and women made up 46.6 percent of the total workforce.<sup>9</sup> The percentage of women working is largely the same regardless of race; 53 percent of African-American women, 54 percent of Asian women, and 50 percent of Hispanic women participated in the workforce in 2009.<sup>10</sup> However, the growth of women in the labor force has stabilized, with 54.4 percent of women in the workforce in 2009.<sup>11</sup>

Women with children are also working in increasing numbers. From March 1975 to March 2000, the labor force participation rate of mothers with children under 18 years of age rose from 47.4 percent to a peak of 72.9 percent.<sup>12</sup> In March 2009, three-quarters of unmarried mothers and nearly 70 percent of married mothers were in the workforce.<sup>13</sup> With the increase of mothers in the workforce, the number of families resembling the traditional male breadwinner/female homemaker model has fallen from 44.7 percent in 1975 to 20 percent in 2008.<sup>14</sup>

While greater numbers of women have entered the workforce, a large percentage of women are concentrated in part-time positions. In 2009, over a quarter of all female wage and salary workers worked part-time, while only 13 percent of male wage and salary workers worked part-time.<sup>15</sup> Women's concentration in part-time work reduces women's earnings and access to health benefits.<sup>16</sup>

In addition to refusals to hire or promote women, gender discrimination in the workplace persists in many forms:

### Sex Segregation

Sexual stereotypes perpetuate the workplace segregation of women. Women remain concentrated in so-called "female jobs," such as secretarial and administrative support, retail sales, home health care, and child care, which are generally low-paying. On the other hand, women remain underrepresented in traditionally male jobs, such as construction, fire fighting, and police work.<sup>17</sup>

### Wage Discrimination

Nationwide, women who work full-time earn 80 percent of what men who work full-time earn.<sup>18</sup> In almost all occupations, including traditionally female occupations, the median earnings of women are less than the median earnings of men.<sup>19</sup> The ten most common occupations for women employ 28.8 percent of all female full-time workers, and women earn less than men in each of these occupations.<sup>20</sup> Of these occupations, the greatest disparity is seen among accountants and auditors, where women earn only 74.9 percent of the amount their male counterparts earn, and the smallest disparity is seen among customer service representatives, where

women earn 95.4 percent of what their male counterparts make.<sup>21</sup>

Racial and ethnic disparities in pay persist as well, as African American women earn less than white women and Latinas earn less than either.<sup>22</sup> Latina women earn 59.8 percent and African American women earn 69.6 percent of the median weekly earnings of white men.<sup>23</sup>

In Pennsylvania, women who work full-time earn only 79.3 percent of what men earn.<sup>24</sup> In 2005-2007, the median pay of women in the top ten female-concentrated jobs was only 84 percent of men's median pay in the top ten male-concentrated jobs.<sup>25</sup> Even more striking is the gender gap for higher paying jobs where there is a mix of men and women.<sup>26</sup> Thirty percent of physicians/surgeons, financial advisors, and lawyers are women, but men in these professions are paid up to double what their female counterparts are paid.<sup>27</sup>

### **Sexual Harassment**

Women are regularly subjected to unwelcome sexual advances and harassment based on their gender. Surveys suggest that 40 to 90 percent of women in the United States workforce have been the victims of some form of sexual harassment on the job.<sup>28</sup> In a recent study, 44 percent of women between ages 30 and 39 reported experiencing sexual harassment in the workplace.<sup>29</sup> Women in certain occupations, such as hotel housekeeping, are particularly vulnerable.

### **Pregnancy Discrimination**

In violation of existing law, pregnant women are fired based on perceived limitations in their ability to do their job and denied reasonable accommodations to allow them to continue to do their job.<sup>30</sup> As discussed later, the limited legal protection for family leave forces women out of the workforce.

## **Hotel Housekeepers are Particularly Vulnerable**

Hotel housekeepers are regularly subjected to sexual harassment by male guests. In the follow up to the alleged sexual assault of a housekeeper by the head of the International Monetary Fund in May 2011, housekeepers, security personnel, and union officials have confirmed that housekeepers are particularly vulnerable to sexual assault and rape, and that, while many hotel employers are sensitive and responsive to staff complaints, others try to keep it quiet, perceiving it as bad for business.<sup>i</sup>

<sup>i</sup> Steven Greenhouse, *Sexual Affronts a Known Hotel Hazard* NY Times Bus. Day at B1-2 (May 21, 2011).

### **Caretaking Discrimination**

Women bear primary responsibility for family caretaking, including child care and elder care.<sup>31</sup> Nationally, up to 75 percent of all family caregivers are women,<sup>32</sup> and mothers perform 1/4 to 2/3 more child care than their partners.<sup>33</sup> Cultural assumptions that caretaking women will or should leave the workplace and cannot do it all render these caretaking women vulnerable to discrimination; they are “mommy-tracked,” or “hit the maternal wall” and receive fewer promotions, less prestigious work, or less pay.<sup>34</sup> A recent study found that similarly qualified working mothers are offered on average \$11,000 less in salary for the same job, are only about 56 percent as likely to be recommended for hire, are significantly less likely to be promoted, and are held to higher performance standards.<sup>35</sup> Some working mothers find that the discrimination begins when they become pregnant with a second child or multiple

## **Pregnancy Discrimination in Southeastern PA**

Tina, an African American, worked as an aide at a health care facility, a job that required her to occasionally lift patients. While pregnant, Tina developed back pain and her obstetrician gave her a “doctor’s note,” restricting her from heavy lifting. Her supervisor refused to accommodate the work restriction, telling Tina to take leave under the Family and Medical Leave Act (FMLA). Tina refused to take FMLA leave, because it would end before her baby was expected and thereby leave her unemployed when her baby was born. Her supervisor stopped scheduling Tina for shifts, effectively terminating her employment. Meanwhile, her supervisor assigned a white employee who was pregnant to lighter shifts, showing how race and gender intersect in employment discrimination cases.<sup>i</sup>

<sup>i</sup>The factual situation described is taken from a real case, but the identifying information has been removed to protect confidentiality.

children, when the employer assumes that an employee with more than one child will be insufficiently committed to her job.<sup>36</sup>

### **Breastfeeding Discrimination**

Some employers also refuse to accommodate nursing mothers who express milk in the workplace, forcing them to stop breastfeeding for fear of losing their jobs.

### **Domestic Violence Discrimination**

Domestic violence can have negative repercussions in the workplace. Abusers may stalk victims at work, and victims may miss work for legal proceedings and appointments, medical care, or counseling. These victims sometimes face reprimands, denial of promotion, or termination from employment.<sup>37</sup>

### **Unprotected Domestic Workers**

Most anti-discrimination laws exclude protection against discrimination for the 1.8 million domestic workers caring for the children, parents, and property of others in American homes.<sup>38</sup> Domestic workers, the vast majority of whom are women and foreign born or women of color, are particularly vulnerable to abuse and sexual harassment.<sup>39</sup>

## **Impact on Women’s and Children’s Health**

While work is generally beneficial to women, sex discrimination in the workplace negatively affects the health of women and children in a variety of ways, often with life-long implications. The stress that is caused by discrimination against women has been shown to cause psychological problems, such as depression and post-traumatic stress disorder (PTSD), and physical ail-

ments, such as immune dysfunction, diabetes, and cardiovascular illness.<sup>40</sup> Discrimination also adversely affects the health of the mother and her child when it results in lack of workplace breastfeeding accommodations, insufficient family leave time, and reduced access to health insurance and health care.

### **Stress Caused by Discrimination in the Workplace Leads to Health Problems for Women.**

Studies from the 1980s suggest that the sex segregation and stereotypes that prevent career advancement also place women at particular risk for coronary heart disease (CHD). Among women, a correlation was found between CHD and the dual roles of working outside the home and managing family responsibilities.<sup>41</sup> According to this research, the increased risk of CHD among female clerical workers is associated with decreased job mobility. Other research links this finding to occupational stress caused by “lack of autonomy and control over the work environment, under-utilization of skills, and lack of recognition of accomplishments.”<sup>42</sup>



Recent research supports earlier findings and clarifies the role of workplace discrimination in causing stress and harm to women’s health. In a 2008 survey of U.S. workers, 26 percent of working women reported being under unreasonable amounts of stress at work, driven in large part by lack of equal opportunity, fair pay, and work/life balance.<sup>43</sup> This stress, caused by discrimination in the workplace, has now been connected scientifically to the incidence of depression, PTSD, immune dysfunction, diabetes, and cardiovascular illness among women.<sup>44</sup> Research has shown that the trauma of discrimination negatively affects psychological health more than most other traumatic events, and can be as psychologi-

cally harmful as being physically or sexually assaulted as an adult.<sup>45</sup> Stress caused by discrimination brings about biological changes that increase not only adverse psychological conditions, but also vulnerability to physical disorders such as Type 2 diabetes, heart disease, various immune disorders, and neurodegenerative processes such as Alzheimer’s and Parkinson’s disease.<sup>46</sup> The impact may vary, based on the severity, duration, and controllability of the discrimination.<sup>47</sup> Women who face repeated discrimination are at greater risk for harmful health consequences, and women who are members of multiple stigmatized groups, such as women of color, may be at greater risk.<sup>48</sup>

Sexual harassment in particular may be extremely traumatizing and result in PTSD. Studies report that 90 - 95 percent of sexually harassed women suffer from debilitating stress reactions such as anxiety, depression, headaches, sleep disorders, weight loss or gain, nausea, and lowered self-esteem.<sup>49</sup>

The impact of stress caused by pregnancy discrimination also has health implications. Prenatal stress may be linked to infant illness.<sup>50</sup> The American College of Obstetricians and Gynecologists has stated that psychosocial stress, defined as “the imbalance that a pregnant woman feels when she cannot cope with demands,”<sup>51</sup> may predict a woman’s reduced “attentiveness to personal health matters, her use of prenatal services, and the health status of her offspring.”<sup>52</sup>

### **Failing To Accommodate Mothers Who Express Breast Milk In The Workplace Impacts The Health Of Mothers And Children.**

Working women are less likely to breastfeed than women who do not work.<sup>53</sup> Due to lack of time and locations to express milk at work, working mothers may find it difficult to meet the American Academy of Pediat-

rics' recommendation that mothers breast-feed their infants exclusively for the first six months, preferably for the first year of life and "beyond for as long as mutually desired by mother and child."<sup>54</sup> Many babies in Pennsylvania are never breastfed; only 63.8 percent of babies born in Pennsylvania in 2007 were ever breastfed with only 36.2 percent still breastfeeding at six months.<sup>55</sup> As a result of low-breastfeeding rates, women and their babies lose the wide range of health benefits associated with breastfeeding, including, for premature babies, decreased incidence or severity of infectious diseases and better cognitive outcomes.<sup>56</sup> Other known benefits of breast milk for babies include reducing the risks of sudden infant death syndrome, Type 1 diabetes, certain childhood cancers, high cholesterol, and asthma, and helping children maintain a healthy weight.<sup>57</sup> Furthermore, antibodies pass from the mother to the child through breast milk, protecting the child from infectious diseases until the child's immune system is able to develop the antibodies on its own.<sup>58</sup> Mothers also benefit in that breastfeeding is associated with healthy weight loss after giving birth, decreased risk of ovarian cancer, and decreased risk of breast cancer, among other potential health benefits.<sup>59</sup>

### **Lack of Sick Leave Impacts the Health of Mothers, Children, and the Community.**

The inaccessibility of paid leave or adequate unpaid leave has consequences for women's and children's health. A recent study found that people with paid sick days reported better health, less delayed health care, and fewer visits to the emergency room.<sup>60</sup> In

addition, contagious workers may spread their illnesses to co-workers because they have inadequate leave time. The spread of disease in this way could create a public health disaster with little benefit for employers. For example, workers in the restaurant industry have reported high rates of illness and little access to sick leave.<sup>61</sup> The Restaurant Opportunities Centers United reported that more than 63 percent of workers in the restaurant industry have handled food while sick, placing their co-workers and the public at risk.<sup>62</sup>

The impact of inadequate leave time is felt in the home as well. Specifically, research suggests that children recover more quickly from illnesses when their parents care for them, and many pediatricians encourage parents to take an involved role in their children's medical care.<sup>63</sup> Without access to paid or unpaid leave, working mothers are less likely to seek medical care for themselves or take their children for well visits or sick visits for mild illnesses than they are to seek medical services for more serious illnesses.<sup>64</sup>

### **Sex Discrimination May Reduce Women's Access to Health Insurance**

Historically, health insurance in the United States has been a benefit employers provide to their employees. Sex discrimination that results in a woman losing her job also results in the loss of her benefits, including health insurance for herself and her family.<sup>65</sup> Furthermore, women are more likely to lack employer provided health care in the first place because they are more likely to work part-time.<sup>66</sup>

## Applicable Laws

Federal, state, and local laws address many aspects of sex discrimination in the workplace, but the current legal framework does not go far enough. While some employees who suffer sex discrimination in the workplace have legal options available to them, other employees may find that their employer's discriminatory actions are not currently considered illegal. Many laws only apply to employers of a certain size. In addition, independent contractors and some people with managerial responsibilities are not "employees" or are otherwise excluded from anti-discrimination and employment laws and are therefore not protected.

This section addresses different types of employment laws: anti-discrimination laws, family leave laws, legal protection and accommodation for breastfeeding, and health insurance access laws. Anti-discrimination laws prohibit employers from discriminating against employees on the basis of sex or other categories. Family leave laws provide employees with access to paid or unpaid time off from work. Below, the Family and Medical Leave Act (FMLA) is discussed as both an anti-discrimination law and a family leave law. The discussions of breastfeeding accommodation and health insurance access focus on the ACA.

### Anti-Discrimination Laws

A number of federal, state and local laws prohibit sex discrimination in employment in Pennsylvania. They offer significant, but inadequate protections:

**Title VII of the Civil Rights Act of 1964 and the Pregnancy Discrimination Act (PDA)**<sup>67</sup> prohibit sex discrim-

## Title VII Protection Has Limitations

Lawyer Alyson Kirleis was paid less than male partners in her Pittsburgh, PA law firm, maintained on a separate and lower partner track for female lawyers, and subjected to a hostile work environment. When she sued her law firm for discrimination, the federal court dismissed her case because, as a partner, even one with limited managerial power, she did not fit the definition of "employee" under federal and state anti-discrimination laws. Ms. Kirleis was unsuccessful in her claim, highlighting the limited reach of Title VII's protection. The Women's Law Project, the National Partnership for Women and Families, and the National Women's Law Center filed an *amicus* ("friend of the court") brief in the U.S. Court of Appeals for the Third Circuit in support of Ms. Kirleis.<sup>i</sup>

<sup>i</sup> Brief of The National Partnership for Women & Families, the National Women's Law Center, and the Women's Law Project as *Amici Curiae* in Support of Plaintiff-Appellant Alyson J. Kirleis's Appeal from the District Court's Order Granting Summary Judgment to Defendant-Appellee, *Kirleis v. Dickie, McCamey, & Chilcote*, P.C., No. 06-cv-1495, 2010 U.S. App. LEXIS 14530, (3d Cir. 2010), available at [http://www.womenslawproject.org/Briefs/Kirleis\\_amicus\\_brief.pdf](http://www.womenslawproject.org/Briefs/Kirleis_amicus_brief.pdf).

ination in the workplace and apply only to employers with 15 or more employees. Title VII and the PDA are enforced by the Equal Employment Opportunity Commission (EEOC).<sup>68</sup> Prohibited sex discrimination includes:

## **Title VII Prohibits Sex-Based Stereotyping**

Pennsylvania factory worker Brian Prowel's co-workers subjected him to repeated comments, graffiti, and name-calling, mocking his effeminate mannerisms and appearance. Following his termination from employment, Mr. Prowel filed a sex discrimination lawsuit against his former employer for harassment and retaliation against him, alleging that the discrimination stemmed from sex-based stereotyping. After the federal District Court for the Western District of Pennsylvania dismissed Mr. Prowel's lawsuit, concluding that Title VII does not prohibit discrimination based on sexual orientation, Mr. Prowel appealed to the Third Circuit Court of Appeals. The Circuit Court reinstated Mr. Prowel's lawsuit, finding that a plaintiff may bring a claim of gender stereotyping sex discrimination under Title VII even if there is also evidence of sexual orientation discrimination. The Women's Law Project and Legal Momentum submitted an *amicus* ("friend of the court") brief in support of Mr. Prowel.<sup>i</sup>

<sup>i</sup> Brief *Amici Curiae* Of Twenty-One Organizations Committed To Equality For Working Women In Support Of Appellant, *Prowel v. Wise Business Forms, Inc.*, No. 07-3997, 579 F.3d 285 (3d Cir. 2009), available at [http://www.womenslawproject.org/Briefs/Prowel\\_amicus\\_21Organizations.pdf](http://www.womenslawproject.org/Briefs/Prowel_amicus_21Organizations.pdf).

- **Pregnancy Discrimination**, which involves treating a woman (an applicant or employee) unfavorably because of pregnancy, childbirth, or a medical condition related to pregnancy or childbirth. Title VII applies to hiring, firing, pay, job assignments, promotions, layoff, training, fringe benefits, such as

leave and health insurance, and any other term or condition of employment. Title VII, as amended by the PDA, prohibits employers from treating pregnant employees differently from non-pregnant employees who are similar with regard to their "ability or inability to work."<sup>69</sup> For example, employers must accommodate pregnant women who need temporary help performing the functions of their jobs if they accommodate other employees who have similar limitations at work.<sup>70</sup> Unfortunately, some courts permit employers to refuse to accommodate pregnant employees, even when non-pregnant employees are accommodated, because pregnancy is not a work-related condition.<sup>71</sup>

- **Sexual harassment**, which is prohibited under Title VII when unwelcome sexual advances, requests for sexual favors, or other verbal or physical harassment of a sexual nature is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted). Both the victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex. The harasser can be the victim's supervisor, a supervisor in another area, a co-worker, or someone who is not an employee of the employer, such as a client or customer.<sup>72</sup>
- **Sex-Based Stereotyping**, which is unlawful under Title VII when the discrimination is based on stereotypes about the traditional roles and characteristics of women and men. While adherence to traditional sex-based stereotypes is often at the root of discrimination against lesbian, gay, bisexual, and transgendered employees, neither Title VII nor any other federal law specifical-

ly prohibits discrimination based on sexual orientation. Thus, Title VII protects a gay employee who experiences a hostile work environment because his co-workers and supervisors perceive him as “effeminate,” but does not protect an employee who is harassed because he is gay.

- **Family responsibility discrimination**, which Title VII prohibits only when the discrimination is based on sex-based stereotypes about caregivers.<sup>73</sup>

**Federal Executive Order 13152**, signed by President Clinton in 2000, prohibits discrimination in the workplace against federal government employees on the basis of their “status as a parent.”<sup>74</sup>

**The Americans with Disabilities Act (ADA)** prohibits employers with 15 or more employees from discriminating on the basis of the disability of a family member or other person with whom the worker is closely associated.<sup>75</sup> Under the ADA, therefore, an employer may not treat a caregiver differently based on stereotypes about the person’s ability to do his or her job while providing care to a disabled person.<sup>76</sup>

**The Family and Medical Leave Act of 1993 (FMLA)** prohibits employers from interfering with and retaliating against employees for requesting or taking FMLA protected family leave.<sup>77</sup> The details of the FMLA leave provisions are discussed later.

**The Equal Pay Act** requires that male and female employees receive the same pay for the same work.<sup>78</sup>

**The Pennsylvania Human Relations Act (PHRA)** prohibits discrimination against many protected classes, including sex/pregnancy and disability, in the workplace.<sup>79</sup> This law applies to employers with

four or more employees and is enforced by the Pennsylvania Human Relations Commission (PHRC).<sup>80</sup> Like Title VII, the PHRA prohibits familial status/caregiver discrimination only if the discrimination is related to sex-based stereotypes based on traditional roles and characteristics of women and men.

### **Local Anti-discrimination Laws:**

Several Pennsylvania cities and other local governments have also adopted anti-discrimination ordinances that prohibit many types of discrimination in employment, including discrimination based on sex and/or disability. These laws vary in terms of the minimum number of employees required to bring an employer under their coverage. Localities that have adopted such laws include:

- Allegheny County (applicable to employers with four or more employees),<sup>81</sup>
- Allentown (applicable to employers with four or more employees),<sup>82</sup>
- Doylestown Borough (applicable to employers with one or more employees),<sup>83</sup>
- Easton (applicable to employers with one or more employees),<sup>84</sup>
- Erie County (applicable to employers with four or more employees),<sup>85</sup>
- Harrisburg (applicable to employers with four or more employees),<sup>86</sup>
- Haverford (applicable to employers with four or more employees),<sup>87</sup>
- Lansdowne (applicable to employers with one or more employees),<sup>88</sup>
- Lower Merion (applicable to employers with four or more employees),<sup>89</sup>

## **Philadelphia's Fair Practices Ordinance**

In 2011, Philadelphia adopted groundbreaking amendments to its Fair Practices Ordinance. It is now unlawful in Philadelphia for an employer to discriminate on the basis of domestic or sexual violence victim status, genetic information, or familial status. Philadelphia also added protection for domestic workers with respect to the terms, conditions or privileges of employment but not in hiring and firing.<sup>i</sup>

<sup>i</sup> Phila., Pa., Code § 9-1102 (2011) (effective June 21, 2011).

- Philadelphia (applicable to employers with one or more employees),<sup>90</sup>
- Pittsburgh (applicable to employers with five or more employees),<sup>91</sup>
- Reading (applicable to employers with five or more employees),<sup>92</sup>
- Scranton (applicable to employers with four or more employees),<sup>93</sup>
- State College (applicable to employers with four or more employees),<sup>94</sup>
- Swarthmore (applicable to employers with one or more employees),<sup>95</sup>
- West Chester (applicable to employers with one or more employees),<sup>96</sup> and
- York (applicable to employers with four or more employees).<sup>97</sup>

The Allegheny County, Doylestown Borough, Easton, Erie County, Harrisburg, Lansdowne, Philadelphia, Reading, State College, and West Chester anti-discrimina-

tion ordinances provide broader protection against familial status discrimination, as these localities have explicitly amended their ordinances to include familial status as a prohibited basis for employment discrimination. Of these, only Philadelphia and State College ordinances specifically prohibit discrimination based on caregiving, and only Philadelphia's ordinance clearly prohibits discrimination based on caregiving of adult family members in addition to children.

### **Family Leave Laws**

The only guaranteed family leave enjoyed by Pennsylvanians is the unpaid leave required by the federal FMLA, which does not provide leave to all employees. Under the FMLA, workers whose employers employ 50 or more employees within 75 miles of a worksite and who have worked for at least one year and for at least 1,250 hours over the past year must receive up to 12 weeks of unpaid leave during any 12 month period to address medical needs, such as the birth and care of a newborn or newly adopted child, or caring for oneself or an immediate family member with a serious health condition.<sup>98</sup>

FMLA does not permit unpaid leave for medical conditions that do not fall within its definition of a "serious health condition," leaving employees without access to leave for minor medical conditions that may still require rest and treatment such as antibiotics. For example, the flu counts for FMLA purposes as a "serious health condition" only on a case-by-case basis, meaning workers may have no choice but to go to work when they or a family member has the flu.<sup>99</sup> Only slightly over half of all private sector employees work for employers that meet the size criterion of the FMLA.<sup>100</sup>

Lower-income workers are more likely to work for smaller employers without FMLA obligations.<sup>101</sup> This law leaves many employees without unpaid leave, including in

particular women, who are more likely than men to work part-time<sup>102</sup> and therefore are not likely to be eligible for FMLA leave.

Even with FMLA protection, many low-wage, part-time employees cannot afford to take unpaid leave. Low-income parents are the least likely to take unpaid leave and also the most likely to have children at risk of serious health problems.<sup>103</sup> Furthermore, parents whose children have chronic health problems are less likely to have paid leave than parents with healthy children.<sup>104</sup>

Those with leave, whether paid or unpaid, may choose not to take it because they fear retaliation from their employers if they take time off to recover from a medical condition or care for a family member. Approximately one in six employees has been or has a family member who has been penalized by an employer for taking time off to deal with an illness.<sup>105</sup> The fear of retaliation and lack of access to paid and unpaid leave results in working mothers leaving their sick children, ailing partners, or elderly parents in the care of others, avoiding needed medical care for themselves or their family members, and spreading illness by going to work or by sending their children to school while sick.

Pennsylvania law does not require employers to provide any *paid* sick leave for employees, which may have a disproportionate impact on working women who often bear the brunt of the caregiving responsibilities at home.<sup>106</sup> While legislation has been repeatedly introduced in Pennsylvania to expand the reach of the FMLA and provide paid leave for both familial illness and domestic and sexual violence, the Pennsylvania General Assembly has not adopted any such legislation.

By virtue of an ordinance adopted by Philadelphia City Council, domestic violence or sexual violence survivors and their family or household members who work in Philadel-

## **Many Employment Discrimination Complaints Are Filed**

Many complaints of employment discrimination are filed each year with the agencies charged with enforcing anti-discrimination laws, showing how widespread sex discrimination remains in workplaces across Pennsylvania and the country. The EEOC received 28,028 charges of sex discrimination across the country in 2009.<sup>i</sup> In 2008-09, the PHRC received 948 complaints of sex discrimination in the workplace in Pennsylvania. The Philadelphia Commission on Human Relations docketed 84 sex discrimination cases, 18 sexual harassment cases, 17 sexual orientation cases, and one gender identity case in the employment setting in 2008.<sup>ii</sup> The federal judicial caseload statistics show that 14,334 civil rights employment cases were filed in federal court between March 2009 and March 2010, including sex discrimination suits.<sup>iii</sup>

<sup>i</sup> U.S. Equal Employment Opportunity Comm'n, Charge Statistics FY 1997 Through FY 2010, <http://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm> (last visited June 8, 2011).

<sup>ii</sup> Phila. Comm'n on Human Relations, 2008 Annual Report 7 (2008), *available at* [http://www.phila.gov/humanrelations/pdfs/Annual\\_Report\\_2008\\_F.pdf](http://www.phila.gov/humanrelations/pdfs/Annual_Report_2008_F.pdf).

<sup>iii</sup> U.S. Courts, U.S. District Courts – Civil Cases Commenced, by Basis of Jurisdiction and Nature of Suit, During the 12-Month Periods Ending March 31, 2009 and 2010, at 2 (2010), *available at* <http://www.uscourts.gov/Viewer.aspx?doc=/uscourts/Statistics/FederalJudicialCaseloadStatistics/2010/tables/C02Mar10.pdf>.

phia have the right to unpaid leave from work to address medical, legal, and counseling needs resulting from domestic or sexual violence.<sup>107</sup>

### **Breastfeeding Accommodation Protection**

If a mother decides to breastfeed after a child is born, Pennsylvania provides no protection for women who want to express breast milk in the workplace, and thereby maintain her milk supply, beyond the federal protections under the Patient Protection and Affordable Care Act (ACA)/Fair Labor Standards Act (FLSA). Effective March 23, 2010, the Affordable Care Act amends the FLSA to require employers to provide: (1) “reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child’s birth each time such employee has need to express the milk;”<sup>108</sup> and (2) “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.”<sup>109</sup> The law allows employers with fewer than 50 employees to apply for an exemption if accommodating an employee who expresses breast milk would impose an “undue hardship.”<sup>110</sup> Furthermore, the law does not protect employees who are exempt from the FLSA’s overtime requirements, including certain employees who work in an executive, administrative, or professional capaci-

ty, outside sales employees, and computer professionals.<sup>111</sup> This law also does not protect employees who: (1) work at small businesses with fewer than two employees that have annual sales or business of less than \$500,000; *and* (2) are not regularly involved in interstate commerce in their individual capacity.<sup>112</sup>

### **Access to Health Insurance**

There are no current laws that require universal health care or employer-sponsored health insurance. By 2014, the full implementation of the ACA may lessen the impact of workplace sex discrimination on a woman’s access to health insurance. First, the health reforms aim to make health insurance more affordable for employers to provide to employees, hopefully resulting in an expansion of health care coverage to employees who have not been traditionally covered through their workplaces.<sup>113</sup> Second, the law aims to make health insurance more affordable for individuals who do not receive health insurance through employment by establishing new marketplaces for buying insurance and offering subsidies for low-income individuals.<sup>114</sup>

## RECOMMENDATIONS FOR REFORM

To deter sex discrimination in the workplace and better promote the health and well-being of women and children, it is vital that the lawmakers at all levels of government prohibit all forms of employment discrimination against women and better enforce the federal, state, and local laws already in place. Necessary reforms include:

### Federal, State, and Local Law

- Congress, the Pennsylvania General Assembly, and local lawmakers should require employers to provide temporary accommodations to those unable to perform job functions due to temporary conditions, including pregnancy-related conditions. Anti-discrimination laws do not go far enough to protect pregnant employees and should be amended to require employers to accommodate employees with temporary conditions affecting their ability to perform job duties, regardless of the cause of the condition. Federal, state, and local law should require employers to provide short-term assistance to individuals with temporary conditions in a manner consistent with the Americans with Disabilities Act's requirement that employers accommodate individuals with disabilities of longer duration, thereby allowing pregnant women to remain employed throughout their pregnancies, while imposing only a minimal burden on employers.

### Federal Law

- Congress should adopt legislation that better protects employees from sex discrimination in pay. The Paycheck Fairness Act would strengthen the protections guaranteed by the Equal Pay Act, by closing a loophole in defenses employers may assert for pay differences between men and women, prohibiting retaliation, strengthening penalties for equal pay violations, and authorizing additional training for EEOC staff.<sup>115</sup>
- Congress should adopt legislation to eliminate discrimination against lesbian, gay, bisexual, and transgendered employees. The Employment Non-Discrimination Act (ENDA) would prohibit discrimination against employees on the basis of sexual orientation or gender identity in employers with 15 or more employees, thereby sending a strong message to employers that discrimination against employees on the basis of sexual orientation is prohibited and giving employees clear federal protection under the law.<sup>116</sup>

### Pennsylvania Law

- The General Assembly should adopt paid leave legislation. Pennsylvania should pass legislation to provide paid sick leave for families and leave for domestic and sexual violence victims to address the violence in their lives. This legislation should provide paid sick leave for routine illnesses, such as the common cold, thereby protecting co-workers and the public against the spread of illness.
- The General Assembly should amend the PHRA to prohibit discrimination in employment on the basis of family responsibilities. This legislation should define such caretaking to include care for the employee's spouse, children (including through adoption or other legal custodial relationship), household members, parents, and all other persons

related to the employee and the employee's spouse and children by marriage, blood, or consanguinity.

- The General Assembly should require employers to accommodate employees who express breast milk in the workplace. Pennsylvania must go beyond the protections of the FLSA, as amended by the ACA: (1) to cover those exempt from FLSA's overtime requirements; (2) to protect women whose children are over one-year-old; and (3) to provide compensated break time.

## ENDNOTES

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- <sup>3</sup> Lindgren et al., *supra* note 1, at 77-78, 134, 182.
- <sup>4</sup> Bonita C. Long, *Women and Work-Place Stress*, ERIC Digests, Aug. 5, 1997, *available at* <http://ericdigests.org/1997-3/stress.html>.
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- <sup>6</sup> Borgna Brunner, *The Wage Gap: A History of Pay Inequity and the Equal Pay Act*, <http://www.infoplease.com/spot/equalpayact1.html> (last visited June 3, 2011).
- <sup>7</sup> *Id.*
- <sup>8</sup> Toossi, *supra* note 5, at 18.
- <sup>9</sup> *Id.* at 18, 24.
- <sup>10</sup> U.S. Dep't of Labor, *Women in the Labor Force: A Databook 10-11* (2010), *available at* <http://www.bls.gov/cps/wlf-databook-2010.pdf>.
- <sup>11</sup> *Id.* at 1.
- <sup>12</sup> U.S. Dep't of Labor, *supra* note 10, at iii; *See also*, Sharon R. Cohany & Emy Sok, *Trends in Labor Force Participation of Married Mothers of Infants*, *Monthly Lab. Rev.* 9-10 (2007).
- <sup>13</sup> U.S. Dep't of Labor, *supra* note 10, at iii.
- <sup>14</sup> Heather Boushey, *The New Breadwinners*, <http://www.shriverreport.com/awn/economy.php> (last visited June 6, 2011).
- <sup>15</sup> U.S. Dep't of Labor, *Highlights of Women's Earnings in 2009*, at 2, *available at* <http://www.bls.gov/cps/cpswom2009.pdf>; U.S. Cong. Joint Econ. Comm., *Women and the Economy: 25 Years of Progress but Challenges Remain* 4 (2010), *available at* [http://jec.senate.gov/public/?a=Files.Serve&File\\_id=8be22cb0-8ed0-4a1a-841b-aa91dc55fa81](http://jec.senate.gov/public/?a=Files.Serve&File_id=8be22cb0-8ed0-4a1a-841b-aa91dc55fa81).
- <sup>16</sup> Stuart J. Ishimaru, Acting Chairman, U.S. Equal Employment Opportunity Comm'n, *Statement at the U.S. Senate Committee on Health, Education, Labor and Pensions Hearing: A Fair Share for All: Pay Equity in the New American Workplace* 2 (Mar. 11, 2010), *available at* <http://www.eeoc.gov/eeoc/events/upload/Ishimaru-Testimony-HELP-Equal-Pay-Hearing-FINAL.pdf>.
- <sup>17</sup> Ctr. for Workforce Info. & Analysis, *Occupation of the Experienced Civilian Labor Force By Sex and Minority* 2-3, 5, 11 (2000), *available at* [http://www.paworkstats.state.pa.us/eo/pa2\\_eeo04.pdf](http://www.paworkstats.state.pa.us/eo/pa2_eeo04.pdf); *see also* Women's Bureau, U.S. Dep't of Labor, *20 Leading Occupations of Employed Women: 2010 Annual Averages*, <http://www.dol.gov/wb/factsheets/20lead2010.htm> (last visited June 7, 2011).
- <sup>18</sup> U.S. Dep't of Labor, *supra* note 10, at 2.
- <sup>19</sup> Ariane Hegewisch et al., *Inst. for Women's Policy Research, Fact Sheet: The Gender Wage Gap by Occupation* 1 (2011).
- <sup>20</sup> *Id.*
- <sup>21</sup> *Id.*

<sup>22</sup> U.S. Dep't of Labor, Highlights of Women's Earnings in 2009, at 1 (2010), *available at* <http://www.bls.gov/cps/cpswom2009.pdf>.

<sup>23</sup> Hegewisch et al., *supra* note 19, at 6.

<sup>24</sup> U.S. Dep't of Labor, *supra* note 22, at 36.

<sup>25</sup> Mark Price et al., Keystone Research Ctr., The State of Women in the Pennsylvania Workforce 12 (2008), *available at* [http://keystoneresearch.org/sites/keystoneresearch.org/files/KRC\\_womenswages.pdf](http://keystoneresearch.org/sites/keystoneresearch.org/files/KRC_womenswages.pdf).

<sup>26</sup> *See id.*

<sup>27</sup> *Id.* at 11-13.

<sup>28</sup> David Benjamin Oppenheimer, *Exacerbating the Exasperating: Title VII Liability of Employers for Sexual Harassment Committed By Their Supervisors*, 81 Cornell L. Rev. 66, 91 (1995) (citing several surveys relating to the incidence of sexual harassment on the job); Jennifer L. Vinciguerra, *The Present State of Sexual Harassment Law: Perpetuating Post Traumatic Stress Disorder in Sexually Harassed Women*, 42 Clev. St. L. Rev. 301, 304 n.26, 307 (1994) (citing studies and surveys documenting the pervasiveness of sexual harassment in the workplace).

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<sup>31</sup> Laura T. Kessler, *The Attachment Gap: Employment Discrimination, Women's Cultural Caregiving, and the Limits of Economic and Liberal Legal Theory*, 34 U. Mich. J.L. Reform 371, 378-80 (2001); Peggie R. Smith, *Elder Care, Gender, and Work: The Work-Family Issue of the 21<sup>st</sup> Century*, 25 Berkeley J. Emp. & Lab. L. 351, 355-60 (2004).

<sup>32</sup> Family Caregiver Alliance, Women and Caregiving: Facts and Figures, [http://www.caregiver.org/caregiver/jsp/content\\_node.jsp?nodeid=892&expandnodeid=384](http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=892&expandnodeid=384) (last visited June 6, 2011).

<sup>33</sup> Janice M. Steil, *Contemporary Marriage: Still An Unequal Partnership*, in *Close Relationships: A Sourcebook* 125, 126 (Hendrick et al. eds., 2000).

<sup>34</sup> Joan C. Williams & Nancy Segal, *Beyond the Maternal Wall: Relief for Family Caregivers Who Are Discriminated Against on the Job*, 26 Harv. Women's L.J. 77, 98-101 (2003).

<sup>35</sup> Shelley J. Correll et al., *Getting a Job: Is There a Motherhood Penalty?*, 112 Am. J. Soc. 1297, 1316 (2007).

<sup>36</sup> Cynthia Thomas Calvert, Ctr. for WorkLife Law, Family Responsibilities Discrimination: Litigation Update 2010, at 3 (2010), *available at* [www.worklifelaw.org/pubs/FRDupdate.pdf](http://www.worklifelaw.org/pubs/FRDupdate.pdf).

<sup>37</sup> Pa. Domestic Violence Task Force, Report of the Pennsylvania Domestic Violence Task Force 21-22 (2010) (citing Jody Raphael, *Battering Through the Lens of Class*, 11 Am. U.J. Gender Soc. Pol'y & L. 367, 370 (2003) (arguing that domestic violence victims may remain economically dependent on their abusers when they are unable to maintain employment, hindering their ability to escape the violence)).

<sup>38</sup> Laura Dresser, *Cleaning and Caring in the Home: Shared Problems? Shared Possibilities?*, in *The Gloves Off Economy: Workplace Standards at the Bottom of America's Labor Market* 4, 7 (Annette Bernhardt et al. eds., 2008); *see also* 42 U.S.C. § 2000e(b) (2010) (limiting protection to employees of employers with fifteen or more employees); 43 Pa. Cons. Stat. § 954b (2011) (limiting protection to employees of employers with four or more employees). *But see* Phila., Pa., Code § 9-1102 (2011) (effective June 21, 2011), *available at* [http://www.phila.gov/humanrelations/pdfs/Fair\\_Practices\\_Ordin2.pdf](http://www.phila.gov/humanrelations/pdfs/Fair_Practices_Ordin2.pdf) (protecting employees of employers with one or more employees and specifically including protection for caregivers of adult family members).

<sup>39</sup> See, e.g., Domestic Workers United & DataCenter, *Home Is Where the Work Is: Inside New York's Domestic Work Industry* 2, 37 (2006), available at <http://www.domesticworkersunited.org/homeiswheretheworkis.pdf>.

<sup>40</sup> Kimberly Matheson et al., *Cortisol and Cardiac Reactivity in the Context of Sex Discrimination: The Moderating Effects of Mood and Perceived Control*, 1 *Open Psychol. J.* 1, 1 (2008).

<sup>41</sup> Suzanne G. Haynes & Manning Feinleib, *Women, Work and Coronary Heart Disease: Prospective Findings from the Framingham Heart Study*, 70 *Am. J. Pub. Health* 133, 139 (1980).

<sup>42</sup> *Id.* at 140.

<sup>43</sup> Kenexa Res. Inst., *Mothers, Sisters and Daughters Alike: Women Suffer Work Stress in Different Ways Than Men* 2 (2010), available at <http://www.kenexa.com/getattachment/cfba99e2-eb80-4b5d-bb43-9a019df0e3fc/Mothers-Sisters-and-Daughters-Alike--Women-Suffer.aspx>.

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<sup>45</sup> Kimberly Matheson & Hymie Anisman, *Biological and Psychosocial Responses to Discrimination*, in *The Social Cure: Identity, Health and Well-being* 133, 134 (Jolanda Jetten et al. eds., forthcoming 2012).

<sup>46</sup> *Id.* at 136.

<sup>47</sup> *Id.* at 147-49.

<sup>48</sup> See *id.*

<sup>49</sup> Vinciguerra, *supra* note 28, at 301-06, 315-27.

<sup>50</sup> Roberta Ruiz & Judith Fullerton, *The Measurement of Stress in Pregnancy*, 1 *Nursing & Health Sci.* 19, 19 (1999).

<sup>51</sup> *Id.* at 20.

<sup>52</sup> Am. Coll. of Obstetricians & Gynecologists, Dist. II/NY, *Preconception Care: A Guide for Optimizing Pregnancy Outcomes* 5 (2009), available at <http://www.health.state.ny.us/publications/2026.pdf>.

<sup>53</sup> Alison Jacknowitz, *The Role of Workplace Characteristics in Breastfeeding Practices*, *Women & Health*, Issue 2 2008, at 87, 88.

<sup>54</sup> Am. Acad. of Pediatrics, *Breastfeeding and the Use of Human Milk*, 115 *Pediatrics* 496, 499 (2005).

<sup>55</sup> Ctrs. for Disease Control and Prevention, *Breastfeeding Report Card, United States: Outcome Indicators*, <http://www.cdc.gov/breastfeeding/data/reportcard2.htm> (last visited June 7, 2011) (stating that only five states – Arkansas (61.3%), Kentucky (58.7%), Louisiana (56.6%), Mississippi (52.5%), and West Virginia (53.0%) – have lower overall breastfeeding rates than Pennsylvania).

<sup>56</sup> *Id.* at 496-97.

<sup>57</sup> *Id.*

<sup>58</sup> Pawan Rawal et al., *Role of Colostrum in Gastrointestinal Infections*, *Indian J. Pediatrics* 917, 917 (2008).

<sup>59</sup> Am. Acad. of Pediatrics, *supra* note 54, at 497.

<sup>60</sup> Kevin Miller et al., Inst. for Women's Policy Research, *Paid Sick Days in Connecticut Would Improve Health Outcomes, Help Control Health Care Costs* 1 (2011), available at <http://www.iwpr.org/publications/recent-publications>.

<sup>61</sup> Rest. Opportunities Ctrs. United, *Serving While Sick: High Risks & Low Benefits for the Nation's Restaurant Workforce, and Their Impact on the Consumer* 19, 27 (2010).

<sup>62</sup> *Id.* at 11.

<sup>63</sup> See Britt Marie Ygge & Judith E. Arnetz, *A Study of Parental Involvement in Pediatric Hospital Care: Implications for Clinical Practice*, 19 J. Pediatric Nursing 217, 217 (2004).

<sup>64</sup> Am. Acad. of Pediatrics, *Family Pediatrics: Report of the Task Force on the Family*, 111 Pediatrics 1541, 1553 (2003).

<sup>65</sup> For a discussion of barriers women face when obtaining individual health insurance, see the Insurance Section.

<sup>66</sup> Joan C. Williams & Holly Cohen Cooper, *The Public Policy of Motherhood*, 60 J. Soc. Issues 849, 854-55 (2004).

<sup>67</sup> 42 U.S.C. § 2000e(k) (2011).

<sup>68</sup> For detailed information on Title VII and the procedures for filing complaints with the EEOC, see [www.eeoc.gov](http://www.eeoc.gov).

<sup>69</sup> 42 U.S.C. § 2000e(k) (2011).

<sup>70</sup> See Brief of *Amici Curiae* of American Civil Liberties Union, American Civil Liberties Union of Maryland, A Better Balance, Equal Rights Advocates, Legal Aid Society — Employment Law Center, Legal Momentum, National Partnership for Women & Families, National Women's Law Center, Public Justice Center, Southwest Women's Law Center, Women's Law Center of Maryland, Inc., and Women's Law Project in support of Plaintiff-Appellant and in Support of Reversal, *Peggy Young v. United Parcel Service, Inc.*, No. 11-2078 (4th Cir. 2012), available at [http://www.aclu.org/files/assets/2012.3.5\\_aclu\\_et\\_al\\_amicus\\_brief.pdf](http://www.aclu.org/files/assets/2012.3.5_aclu_et_al_amicus_brief.pdf).

<sup>71</sup> See, e.g., *Noecker v. Reading Hospital and Medical Center*, 2010 U.S. Dist. LEXIS 7945, \*5, \*17 (granting employer's motion for summary judgment where employer refused to accommodate a pregnant woman because the temporary duty policy applied only to work-related injury/illness and the modified duty policy applied only to permanent work restrictions).

<sup>72</sup> U.S. Equal Employment Opportunity Comm'n, *Sexual Harassment*, [http://www.eeoc.gov/laws/types/sexual\\_harassment.cfm](http://www.eeoc.gov/laws/types/sexual_harassment.cfm) (last visited June 8, 2011).

<sup>73</sup> U.S. Equal Employment Opportunity Comm'n, *Enforcement Guidance: Unlawful Disparate Treatment of Workers with Caregiving Responsibilities*, Notice No. 915.002 § II(A)(3) (2007), available at <http://www.eeoc.gov/policy/docs/caregiving.html> (indicating that while Title VII provides protection for employees who experience discrimination related to sex-based stereotypes about caregiving, "Title VII does not prohibit discrimination based solely on parental or other caregiver status, so an employer does not generally violate Title VII's disparate treatment proscription if, for example, it treats working mothers and working fathers in a similar unfavorable (or favorable) manner as compared to childless workers").

<sup>74</sup> Exec. Order No. 13,152, 65 Fed. Reg. 26,115, 26,115 (May 2, 2000); see also Stephanie Bornstein & Robert J. Rathmell, Ctr. for WorkLife Law, *Caregivers as a Protected Class?: The Growth of State and Local Laws Prohibiting Family Responsibilities Discrimination 4* (2009), available at <http://www.worklifelaw.org/pubs/LocalFRDLawsReport.pdf>.

<sup>75</sup> The "association" provision of the ADA prohibits discrimination against employees or job applicants based on their "relationship or association" with an individual with a disability. 42 U.S.C. § 12112(b)(4) (2009). Section 501 of the Rehabilitation Act provides protection to federal workers with disabilities. 29 U.S.C. § 791(g) (2010) (incorporating ADA standards).

<sup>76</sup> U.S. Equal Employment Opportunity Comm'n, *supra* note 73.

<sup>77</sup> 29 U.S.C. §§ 2612, 2615 (2009).

<sup>78</sup> 29 U.S.C. § 206(d) (2009); see [www.eeoc.gov](http://www.eeoc.gov) for more information on how the Equal Pay Act is enforced.

- <sup>79</sup> Pennsylvania Human Relations Act, 43 Pa. Cons. Stat. §§ 951-963 (2011).
- <sup>80</sup> See Welcome to PHRC: Pennsylvania's Civil Rights Agency, [http://www.phrc.state.pa.us/portal/server.pt/community/phrc\\_home/18970](http://www.phrc.state.pa.us/portal/server.pt/community/phrc_home/18970) (last visited June 8, 2011).
- <sup>81</sup> Allegheny County, Pa., Code §§ 215-30 to 215-38 (2009), available at <http://ecode360.com/?custId=AL1955>.
- <sup>82</sup> Allentown, Pa., Code §§ 181.02-181-99 (2011), available at <http://www.allentownpa.gov/Portals/0/files/Legislative/Ordinances/2010/7ABC.pdf>.
- <sup>83</sup> Doylestown Borough, Pa., Code ch. 1, §§ 357-363 (2010), available at [http://www.e-codes.generalcode.com/codes/1641\\_A/1641-001.pdf#xml=http://www.e-codes.generalcode.com/searchresults.asp?cmd=pdfhits&index=1641\\_A&filename=1641-001.pdf&fn=E:\siteinfo\ecodes\codebooks\1641\\_A\1641-001.pdf](http://www.e-codes.generalcode.com/codes/1641_A/1641-001.pdf#xml=http://www.e-codes.generalcode.com/searchresults.asp?cmd=pdfhits&index=1641_A&filename=1641-001.pdf&fn=E:\siteinfo\ecodes\codebooks\1641_A\1641-001.pdf).
- <sup>84</sup> Easton, Pa., Code §§ 79-1 to -79-7 (2006), available at <http://www.ecode360.com/?custId=EA2741>.
- <sup>85</sup> Erie County, Pa., Code arts. I-XV (2007), available at <http://eriecountygov.org/dept/HRC/ordinance.pdf>.
- <sup>86</sup> Harrisburg, Pa., Code chs. 4-101.6, 4-105.1 (2001).
- <sup>87</sup> Haverford, Pa., Code §§ 183-1to 183-7 (2011), available at [http://www.haverfordtownship.com/egov/docs/1297453793\\_689270.pdf](http://www.haverfordtownship.com/egov/docs/1297453793_689270.pdf).
- <sup>88</sup> Lansdowne, Pa., Code §§ 38-1 to 38-5 (2006), available at <http://lansdowneborough.com/hrc-ordinance>.
- <sup>89</sup> Lower Merion, Pa., Code §§ 93-1 to 93-7 (2010), available at <http://www.ecode360.com/ecode3-back/getSimple.jsp?custId=LO0641&guid=14769664>.
- <sup>90</sup> Phila., Pa., Code §§ 9-1100 to 9-1125 (2011) (effective June 21, 2011), available at [http://www.phila.gov/humanrelations/pdfs/Fair\\_Practices\\_Ordin2.pdf](http://www.phila.gov/humanrelations/pdfs/Fair_Practices_Ordin2.pdf).
- <sup>91</sup> Pittsburgh, Pa., Code §§ 651 to 659 (2011), available at <http://library.municode.com/index.aspx?clientId=13525&stateId=38&stateName=Pennsylvania>.
- <sup>92</sup> Reading, Pa., Code §§ 1-521 to 1.534 (2009), available at <http://www.readingpa.gov/documents/Chapter%201%20Administration%20and%20Government.pdf>.
- <sup>93</sup> Scranton, Pa., Code §§ 296-1 to 296-10 (2003), available at <http://ecode360.com/?custId=SC1588>.
- <sup>94</sup> State College, Pa., Code ch. V, §§ 901-911 (1981), available at <http://statecollegepa.us/DocumentView.aspx?DID=1123>.
- <sup>95</sup> Swarthmore, Pa., Code §§ 207.01, 207.05 (2010), available at [http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/swarthmore/codifiedordinancesoftheboroughofswarthmo?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:swarthmore\\_pa](http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/swarthmore/codifiedordinancesoftheboroughofswarthmo?f=templates$fn=default.htm$3.0$vid=amlegal:swarthmore_pa).
- <sup>96</sup> West Chester, Pa., Code §§ 37A-1 to 37A7- (2006), available at <http://www.ecode360.com/?custId=WE0442>.
- <sup>97</sup> York, Pa., Code arts. 185.01 to 185-99 (2011), available at <http://yorkcity.org/user-files/file/City%20Council/Codified%20Ordinances/CO-Part%201%20-%20Administrative.pdf>.
- <sup>98</sup> Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 (2009). See <http://www.dol.gov/dol/topic/benefits-leave/fmla.htm> for more information on how FMLA rights are enforced.
- <sup>99</sup> U.S. Dep't of Labor, FMLA-87 (Dec. 12, 1996), available at <http://www.dol.gov/whd/opinion/FMLA/prior2002/FMLA-87.pdf> (explaining that "the cold or flu may be a serious health condition . . . if the individual is incapacitated for more than three consecutive calendar days and receives continuing treatment by a health care provider.").

<sup>100</sup> Katherin Ross Phillips, The Urban Inst., *Getting Time Off: Access to Leave Among Working Parents 1* (2004), available at [http://www.urban.org/UploadedPDF/310977\\_B-57.pdf](http://www.urban.org/UploadedPDF/310977_B-57.pdf).

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

<sup>102</sup> U.S. Dep't of Labor, *supra* note 22, at 2.

<sup>103</sup> S. Jody Heymann et al., *Working Parents: What Factors Are Involved in Their Ability to Take Time Off From Work When Their Children Are Sick?*, 153 *Archives Pediatric & Adolescent Med.* 870, 873 (1999).

<sup>104</sup> Lisa Clemans-Cope et al., *Access to and Use of Paid Sick Leave Among Low-Income Families with Children*, 122 *Pediatrics* e480, e483 (2008).

<sup>105</sup> Nat'l P'ship for Women & Families, *Paid Sick Days Help Protect Economic Security for Working Families During the Recession 2*, available at [http://www.nationalpartnership.org/site/DocServer/Fact\\_Sheet\\_Paid\\_Sick\\_Days\\_Protect\\_During\\_Recession\\_Final.pdf?docID=5381&autologin=true&AddInterest=1341](http://www.nationalpartnership.org/site/DocServer/Fact_Sheet_Paid_Sick_Days_Protect_During_Recession_Final.pdf?docID=5381&autologin=true&AddInterest=1341) (last visited June 15, 2011).

<sup>106</sup> Kessler, *supra* note 31, at 379-80.

<sup>107</sup> Phila., Pa., Code § 9-3203 (2008), available at [http://www.phila.gov/humanrelations/pdfs/CertifiedCopy\\_090660-1.pdf](http://www.phila.gov/humanrelations/pdfs/CertifiedCopy_090660-1.pdf).

<sup>108</sup> 29 U.S.C. § 207(r)(1)(A) (2010).

<sup>109</sup> 29 U.S.C. § 207(r)(1)(B) (2010).

<sup>110</sup> 29 U.S.C. § 207(r)(3) (2010).

<sup>111</sup> 29 C.F.R. § 541.0(a) (2004).

<sup>112</sup> Reasonable Break Time for Nursing Mothers, 75 Fed. Reg. 80,073, 80,074 (Dec. 21, 2010). For more information about this provision and how it is enforced, see <http://www.dol.gov/whd/nursingmothers/>.

<sup>113</sup> Christine Eibner et al., Rand Health, *Establishing State Health Insurance Exchanges 1* (2010), available at [http://www.rand.org/pubs/technical\\_reports/2010/RAND\\_TR825.pdf](http://www.rand.org/pubs/technical_reports/2010/RAND_TR825.pdf).

<sup>114</sup> *Id.*

<sup>115</sup> Paycheck Fairness Act, S. 182, 2009 Leg. Reg. Sess. (2009); Paycheck Fairness Act, H.R. 12, 2009 Leg. Reg. Sess. (2009).

<sup>116</sup> Employment Non-Discrimination Act, H.R.1397, 2011 Leg. Reg. Sess. (2011).

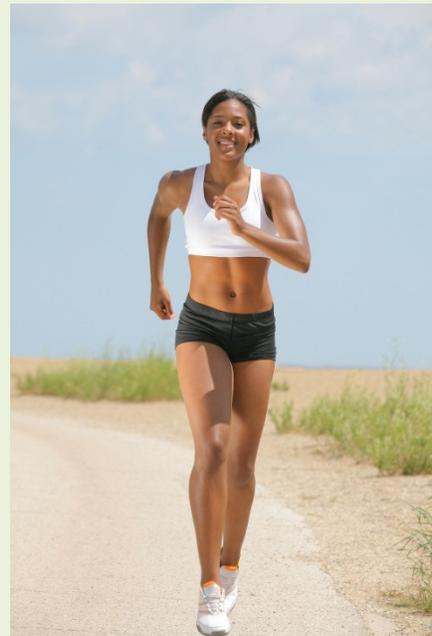
## Section A. The Impact of Sex Bias in

# ATHLETIC OPPORTUNITY & TREATMENT

### on Women's Health

#### INTRODUCTION

*Physical activity is key to the health of girls and women. Girls today are participating in organized sports in increasing numbers, thanks in large part to Title IX of the Education Amendments of 1972, a federal law prohibiting sex discrimination in educational programs receiving federal financial assistance.<sup>1</sup> Research demonstrates, however, that girls are not exercising enough and remain less physically active than boys. This lack of physical exercise places young women at risk for obesity, major health problems, and risky behavior. Sex bias and school non-compliance with Title IX deprive young women of equal opportunities to participate in sports and to acquire the health benefits of physical activity. Advocacy to bring schools into full compliance with Title IX is necessary to improve the health of young women.*



## Are Young Women Getting Enough Opportunities for Physical Activity?

Childhood and adolescence are critical times to lay the foundation for lifelong physical activity. Playing sports while young makes it more likely that girls — and later women — will remain active as they age.<sup>2</sup> Unfortunately, too many young people, especially girls, are not active enough.

- Only one-third of girls participates in sports; one-third barely meets minimal physical activity standards, and one-third remains completely sedentary.<sup>3</sup>
- A greater number of boys are active in organized sports than girls, and girls are less likely to be involved in sports clubs and recreational sports.<sup>4</sup>
- Females are more likely to be physically inactive than males and African American girls are more likely to be physically inactive than Caucasian girls.<sup>5</sup>
- Pennsylvania girls between the ages of 6 and 17 engage in less physical activity than boys.<sup>6</sup>

There is no dispute that physical exercise contributes to a healthier life:

- Physical activity early in life can help prevent major diseases, including cancer, cardiovascular disease, diabetes, osteoporosis, obesity-related diseases, and Alzheimer's disease.<sup>7</sup> Strenuous long-term physical activity decreases a woman's risk of breast cancer.<sup>8</sup>
- Girls who participate in sports are less likely to take up smoking<sup>9</sup> or use illicit drugs.<sup>10</sup> Female athletes are also less

likely to experience unintended pregnancy.<sup>11</sup>

- Playing sports helps promote better overall mental health among teenage girls; regular exercise builds self-confidence, promotes healthy body image, reduces stress, and lowers rates of depression among teenagers.<sup>12</sup>

Yet, girls face barriers to engaging in physical activity, including lack of time, lack of access and opportunity, interpersonal barriers, and psychological barriers.<sup>13</sup> More than any other factor, gender norms influence participation in physical activity by young women; social attitudes about femininity and intentional and unintentional expectations about how girls should behave discourage and prevent girls from participating in sports.<sup>14</sup>

The consequences of this lack of exercise negatively affect the health of Pennsylvania's young women. Almost 30 percent of Pennsylvania's children ages 10 to 17 are overweight or obese with 22 percent of Pennsylvania girls falling into this category.<sup>15</sup> While teen smoking rates are declining, 18 percent of Pennsylvania high school students smoked in 2006, with no discernible difference between male and female students.<sup>16</sup> Among Pennsylvania's teens/young adults aged 13 to 21, more females report ever having an alcoholic drink.<sup>17</sup> In 2005, 21 percent of Pennsylvania female teens/young adults reported feeling sad or hopeless for two consecutive weeks, as compared to six percent of males; 10 percent of female teens/young adults reported considering suicide in a 12 month period, as compared to two percent of males.<sup>18</sup>

## Applicable Legal Requirements

**Title IX of the Education Amendments of 1972** is the primary law affecting equal opportunity in athletics. A federal law, Title IX requires federally funded educational programs to provide girls with equal participation opportunities and equal treatment and benefits. Equal participation is measured under the three-part test. An institution can prove compliance with the equal participation requirement based on any one of the following:

**Prong 1:** Providing male and female athletic participation opportunities that are substantially proportionate to the male and female student enrollment, OR

**Prong 2:** Demonstrating a history of continuously and consistently adding athletic opportunities for female students, OR

**Prong 3:** Demonstrating full and effective accommodation of the athletic interests and abilities of members of the underrepresented sex.

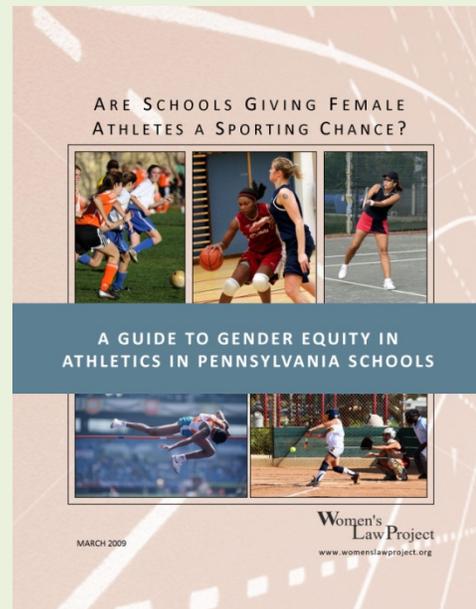
Equal treatment and benefits requires overall equivalence in: (1) equipment and supplies, (2) scheduling of games and practice time, (3) travel and related expenses, (4) coaching, (5) locker rooms, practice and competitive facilities, (6) publicity, (7) medical and training facilities and services, (8) housing and dining facilities and services, (9) academic tutoring, (10) support services, and (11) recruiting resources.

Pennsylvania law also requires equal treatment in the athletic arena.

- **The Pennsylvania Equal Rights Amendment** provides for “equality of rights under the law” in Pennsylvania. It may be used to correct athletic inequities in schools, state athletic associations, and local government-sponsored youth athletic programs.<sup>19</sup>

## WLP’s Guide to Gender Equity

WLP has published a guide for equity in athletics in Pennsylvania. This guide, *Are Schools Giving Female Athletes A Sporting Chance? A Guide To Gender Equity In Athletics In Pennsylvania*, available at [www.womenslawproject.org/resources/TitleIX\\_SportingChance](http://www.womenslawproject.org/resources/TitleIX_SportingChance), is designed to help students, athletes, administrators, athletic directors, coaches, and parents understand the rights students have under Title IX and Pennsylvania laws that apply to athletic equity. It also provides tools for evaluating gender equity in school athletics programs and suggests strategies for addressing inequities.



- **The Pennsylvania Human Relations Act** prohibits discrimination on the basis of sex in public accommodations, which includes schools and community athletic organizations.<sup>20</sup>
- **The Pennsylvania Fair Educational Opportunities Act** prohibits sex discrimination in post-secondary educational institutions and a variety of vocational and trade schools.
- **The Pennsylvania Code** requires Pennsylvania schools to provide health,

safety and physical education.<sup>21</sup> The Code does not address the quantity or quality of physical education provided.<sup>22</sup> The Code also requires equal access for both sexes in interscholastic and intramural athletic programs to school facilities, coaching and instruction, scheduling of practice time and games, number of activities at each level of competition, equipment, supplies, and services, and funding appropriate to the sport.<sup>23</sup>

## Extent of Non-Compliance

While the number of young women participating in intercollegiate and interscholastic sports has increased dramatically since the adoption of Title IX, equality has not been achieved.

### ***Slippery Rock University***

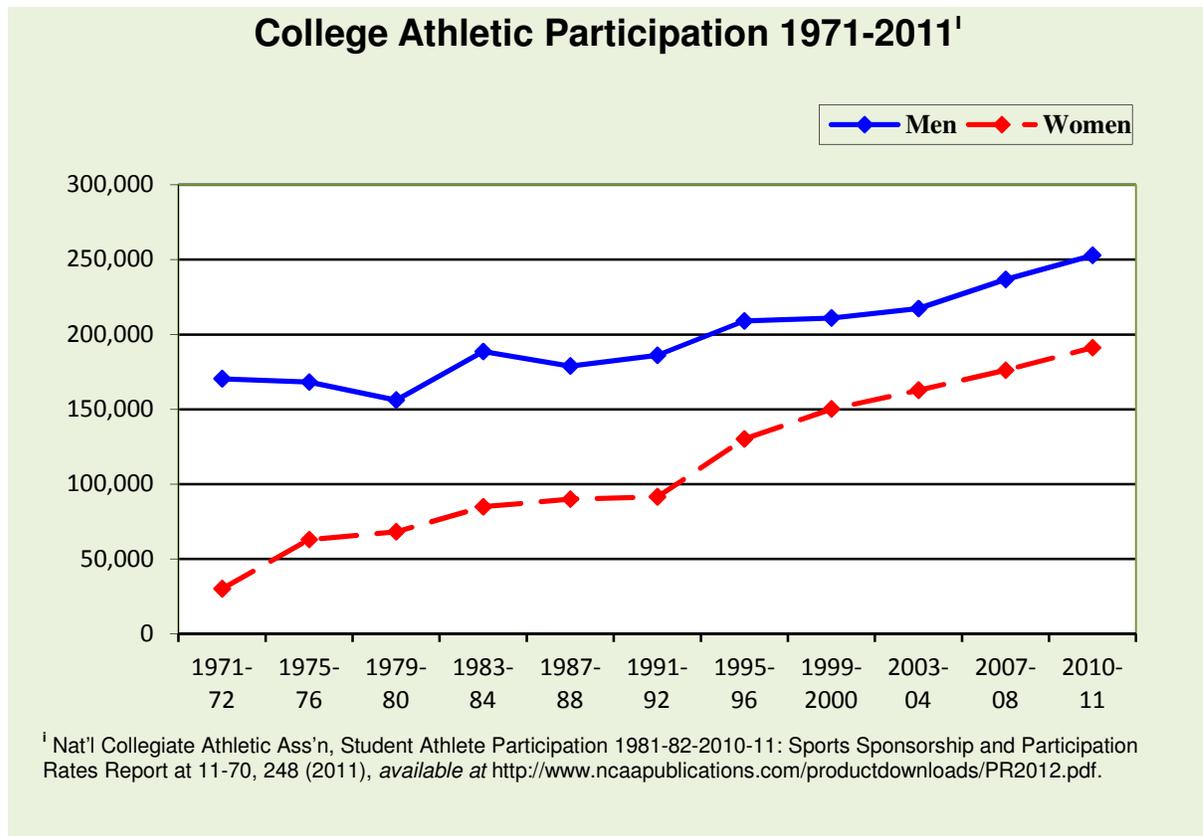
Faced with plans to eliminate three women's sports teams, 12 female students at Slippery Rock University fought back and won the permanent reinstatement of one team, the temporary reinstatement of two others, and an array of significant improvements in the treatment of female athletes. Represented by the Women's Law Project, they filed a lawsuit that quickly stopped the proposed team cuts.<sup>i</sup> A negotiated settlement led to improvements in the number of athletic slots for and treatment of female athletes.

<sup>i</sup>*Choike v. Slippery Rock Univ.* C.A. No. 06-0622, 2006 U.S. Dist. LEXIS 49886 (W.D. PA., July 21, 2006).

### **College**

Measuring equity at the college and university level is facilitated by the fact that the **Equity in Athletics Disclosure Act (EADA)**<sup>24</sup> requires co-educational colleges that receive federal student financial assistance and have an intercollegiate athletic program, to submit an annual athletic equity report to the U.S. Department of Education and make it public. The National Collegiate Athletic Association (NCAA) also publishes reports regarding the athletic equity data it collects from its members.<sup>25</sup> The EADA data includes each institution's full time enrollment and athletic participation by sex, as well as staffing and revenues and expenses by men's and women's teams. The public availability of this data allows anyone to calculate whether a school is providing athletic participation opportunities to female students that are substantially proportionate to female enrollment under Prong 1 of Title IX's participation test. These reports are also helpful in analyzing equal treatment.

While the EADA and NCAA data are helpful in evaluating whether a particular institution is providing equal opportunity and treatment as required by Title IX, this



data must be reviewed cautiously; some institutions manipulate the data to reflect more equitable athletic opportunities than exist, as recently reported by the New York Times.<sup>26</sup> Examples of such manipulation include counting women on teams who are not on those teams and counting male practice players on women's teams as female participants.<sup>27</sup> Even if the data overcount female athletic opportunities, the data may still show that equity has not yet been achieved.

**Nationally**, Title IX has unquestionably improved female participation in college sports. In 1972, fewer than 30,000 females played intercollegiate sports, accounting for just 15 percent of college athletes.<sup>28</sup> By the 2010-11 academic year, the number of women playing on intercollegiate sports teams increased to over 190,000, making up 43 percent of college athletes.<sup>29</sup> However, while college enrollment is 57 percent female,<sup>30</sup> female athletic participation is

only 43 percent, representing a significant and persistent gap between the number of female college students and athletes. Men have higher participation rates than women both in terms of the total number of athletes and relative to their respective enrollments.<sup>31</sup> This participation gap is perpetuated by gender disparities in athletic expenditures for women's sports, which have stagnated and by some measures even decreased since the 2001-02 school year.<sup>32</sup>

**Pennsylvania** colleges and universities mirror national trends. The Women's Law Project (WLP) studied EADA data for 112 Pennsylvania colleges and universities for the three academic years from 2001 through 2004 and released a report of its findings in 2005.<sup>33</sup> While WLP found that some schools were meeting their obligations under Title IX, it also found that most Pennsylvania colleges and universities were failing to provide equal athletic opportunities for their female students. Even though

## University of Pennsylvania

In 1994, women on the University of Pennsylvania (Penn) softball team had to pay their own way to a spring training program and sold pretzels and tee shirts to reduce the cost, while the men's baseball team's trip to California for spring training was paid mostly by donated funds. Female athletes and their coaches identified many other areas of inequitable treatment but were unable to obtain any remedies from Penn. Five female athletes and nine coaches of women's sports consulted with WLP. With WLP's assistance, they filed an OCR complaint against Penn that alleged a wide range of Title IX violations, including a shortage of athletic opportunities for females, inequitable provision of equipment and supplies, and discrimination in the amount, level, and compensation of coaching.<sup>1</sup> The dispute was successfully resolved by a brokered negotiation that substantially increased funding for women's sports and greatly improved coaching and athletic facilities for female athletes.

<sup>1</sup>*Women's Law Project v. University of Pennsylvania*, OCR No. 03942076 (May 26, 1994).

women made up 53.4 percent of Pennsylvania's college population, females had only 43 percent of the athletic opportunities offered by the 112 colleges and universities studied.<sup>34</sup> In other words, the data showed that Pennsylvania colleges needed to create 8,000 more athletic opportunities for women in order to achieve equity.<sup>35</sup> WLP also found that Pennsylvania colleges spent less money on women's sports, allocated fewer resources on recruiting female athletes, and offered less scholarship money on the

whole to female athletes.<sup>36</sup> Review of the budget expenditures showed:

- 11 million dollars more was spent on male athletic teams than female teams in operating expenses, which include lodging, uniforms and transportation.
- 6 million dollars more was spent on sports scholarships for male athletes than for female athletes.
- Twice as much money was spent on recruiting male athletes as on female athletes.
- 60 cents were spent on female athletes for every dollar spent on male athletes.<sup>37</sup>

### High School

**Nationally**, no federal law requires each secondary school to disclose annually and publicly the same type of data by gender that colleges are required to report. While a handful of states have adopted athletic equity reporting requirements for their secondary schools, Pennsylvania has not done so. Only limited secondary school athletic data by gender are currently available. Statewide athletic participation data is collected and reported by the National Federation of State High School Associations (NFHS); they are not broken down by school or school district. The U.S. Department of Education Civil Rights Data Collection (CRDC) collects information on a periodic basis from varying sets of public schools relating to their obligations to provide equal educational opportunity. These data include information about athletic participation and enrollment by sex but are not collected and publicly reported for all schools on an annual basis.<sup>38</sup>

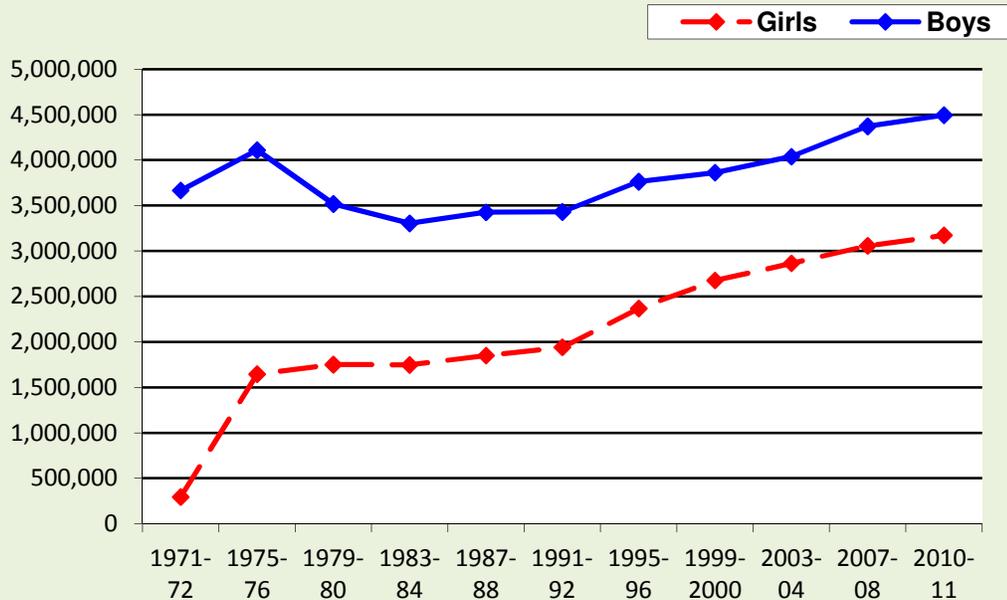
NFHS data confirm that Title IX resulted in gains for young women in high school athletics across the United States. At the

time Title IX was passed, only 294,000 girls participated in interscholastic high school sports nationwide, representing just seven percent of all high school athletes.<sup>39</sup> In the 2010-11 school year, over 3 million girls were playing high school sports, making up 41 percent of athletes in U.S. high schools.<sup>40</sup> Although this is a significant improvement, it masks a persistent disparity between girls and boys. The number of girls participating in high school sports has **not even** reached the level of male sports participation in 1971, and the number of males playing sports has reached all-time highs in recent years, rising to almost 4.5 million in 2009-10.<sup>41</sup> As a result of this trend, the disparity between the number of sports participation opportunities available to male and female high school students has not only persisted, but has **widened** in recent years. In 2002, boys had 1.15 million more opportunities to participate in high schools sports than girls. Five years later,

the disparity in athletic participation in favor of boys grew to 1.3 million.<sup>42</sup> The athletic gender disparity is greatest in urban schools, where only 45 percent of the girls are involved in athletics compared to 73 percent of the boys in grades 3-12.<sup>43</sup>

Drawing on the CRDC data collected by the U.S. Department of Education for selected years, the Women’s Sports Foundation analyzed the Title IX gap between enrollment and athletic participation in public schools for school years 1993-94, 1999-2000, and 2005-06.<sup>44</sup> The analysis found that the gender gap declined from 14 percent in 1993-94 to 11 percent in 1999-2000, but increased to 12 percent in 2005-06.<sup>45</sup> The analysis further found that boys consistently received a larger share of athletic opportunities than girls for each school.<sup>46</sup> In terms of available athletic opportunities, girls fared worst in urban areas.<sup>47</sup>

**High School Athletic Participation 1971-2011<sup>i</sup>**



<sup>i</sup> Nat'l Fed'n of State High Sch. Ass'n, 2010-11 High School Athletics Participation Survey 52 (2011), available at <http://www.nfhs.org/content.aspx?id=3282>.

## ***Fair is Fair: Insisting on Compliance in Pennsylvania High Schools***

Parent and student advocacy assisted by WLP led to the addition of girls' teams in the Downingtown Area School District in Bucks County and Penns Valley Area School District in Centre County. WLP also filed an OCR complaint against the Northern York School District alleging failure to provide equal opportunities and treatment; the complaint resulted in a settlement agreement with WLP in which the school district agreed to upgrade the girls' softball field, implement a process to achieve equitable opportunities for its female students to participate in sports, and adopt policies and procedures to promote equity.

**Pennsylvania high schools** similarly fail to provide equal opportunity to their female students. In the 2010-11 school year, Pennsylvania schools provided 170,630 athletic opportunities to boys while providing girls with only 146,057 athletic opportunities.<sup>48</sup> Although high school enrollment is estimated at about 50-50 boys-girls, Pennsylvania offers girls over 24,500 fewer athletic opportunities than it offers boys. At the individual school level, the inequities are more striking. While many Pennsylvania schools are equitable, many others provide their female students with fewer opportunities and benefits and lower quality facilities and support. The Women's Sports Foundation found on average that only 37 percent of Pennsylvania's female students enrolled in grades 9-12 in public schools were participating in athletics in 2005-06.<sup>49</sup>

The Pittsburgh Tribune-Review examined gender equity in 129 public high schools in southwestern Pennsylvania during the 1999-2000 school year, and found that:

- Two out of three athletes were male.
- For every dollar spent on male athletes, only 69 cents were spent on female athletes.
- On average, schools spent \$493 on each male athlete and \$350 on each female athlete.
- Only 14 of 129 schools offered girls athletic opportunities in numbers substantially proportionate to their numbers in the student population, as required by part one of the three-part Title IX participation test.<sup>50</sup>

In 2010, the Pittsburgh Public School District released the results of a gender equity audit of its nine high schools that it undertook at the request of WLP. The audit revealed a stark pattern of gender inequality in athletic programming for female students.<sup>51</sup> The auditor found that **not a single high school is offering girls a fair share of athletic opportunities.**<sup>52</sup> In order to give girls the same access to athletic opportunities that boys have, the school district must create 784 new athletic opportunities for girls.<sup>53</sup> The auditor also noted numerous "moderate disparities" in the treatment of female athletes in areas including facilities and locker rooms, scheduling of practices and competitions, number of competitions, coaching, equipment and supplies, training, and publicity.<sup>54</sup>

WLP has received calls from and has assisted parents and students seeking improvement in their schools. Frequently, complaints assert failure to provide equal athletic opportunities; provision of vastly inferior facilities to the girls' teams relative to the

boys' teams, with baseball stadiums and football stadiums on the top of the list; and inferior scheduling of competitions subject to priority scheduling for boys' teams. Often a school's acceptance of booster or other third party funds supports the disparity and the school has failed to understand and/or address its responsibility to provide equitable opportunity and treatment regardless of the source of the funds.

Title IX is enforced through complaints filed with the U.S. Department of Education's Office for Civil Rights (OCR). In addition to pursuing relief by filing a complaint with OCR, individuals who have suffered discrimination on the basis of sex by an educational institution that receives federal funding may file a lawsuit against

the school under Title IX. While going to court can be a lengthy and costly process, filing a complaint with the OCR can result in a multi-year investigation. Unfortunately, OCR is overburdened and understaffed. Its Washington, D.C. headquarters and twelve regional offices have approximately six hundred full-time employees, who handle a range of cases including, but not limited to, Title IX investigations.<sup>55</sup> In order to handle its caseload, the office regularly asks schools to investigate themselves and develop their own solutions. This tactic too often results in sluggish progress.<sup>56</sup> One report suggests that the OCR perceives Title IX cases as being particularly politically sensitive, resulting in heightened scrutiny within the office, exacerbating delays.<sup>57</sup>

## RECOMMENDATIONS FOR REFORM

### Schools

- Schools must take steps to comply with Title IX. Schools must assess their compliance with legal equity requirements and voluntarily take it upon themselves to give more opportunities to women and girls so that the onus is not on students to step forward.

### OCR

- OCR should aggressively increase and improve Title IX enforcement. It must increase compliance audits and more effectively and efficiently process complaints. Students are in school for a short time and should be given relief during their academic careers. In addition, the complaining party should be given a greater role in the administrative process, both in submitting and reviewing information relevant to the complaint and in determining the appropriate remedies to be included in resolving the complaint. Increased staffing and resources for OCR will be required.

### Congress & the Pennsylvania General Assembly

- Congress and the Pennsylvania General Assembly should adopt laws requiring annual disclosure of secondary school Title IX information. Legislation must be adopted requiring secondary schools to publicly report athletic participation and treatment data on an annual basis so that schools, parents, and students can readily access the information they need to know if their school is treating their children fairly and to correct inequities. Bills have been introduced at both the federal and state level. The Pennsylvania Equity in Interscholastic Athletics Disclosure bill, introduced in the Pennsylvania Senate and House at the urging of the Women's Law Project, was approved by the Pennsylvania Senate and passed out of the House Education Committee in 2010. The 2009-10 legislative session ended before it was finally approved. The Pennsylvania legislation has been reintroduced in both chambers of the Pennsylvania General Assembly,<sup>58</sup> and the federal legislation has been reintroduced as well.<sup>59</sup>

### Pennsylvania Department of Education

- Pennsylvania should improve physical education in schools. The Pennsylvania Education Department must audit the provision of physical education instruction delivered in its elementary and secondary schools, and restructure physical education requirements and monitor implementation to improve the quantity and quality of physical activity of young women.

**ENDNOTES**

<sup>1</sup> 20 U.S.C. § 1681(a) (2010).

<sup>2</sup> See Tucker Center for Research on Girls & Women in Sport, *Developing Physically Active Girls: An Evidence-based Multidisciplinary Approach* 27 (University of Minnesota 2007), available at [www.tuckercenter.org/projects/tcrr](http://www.tuckercenter.org/projects/tcrr) [hereinafter Tucker Center].

<sup>3</sup> *Id.* at 3; see also Women's Sports Found., *Increasing Sport Equity & Physical Education Participation: A Women's Sports Foundation Public Policy Guide 9-12* (2007) (summarizing school and community national physical education and physical activity standards for children); U.S. Dep't of Health and Human Services, *2008 Physical Activity Guidelines for Americans 15* (recommending children and adolescents (aged 6–17) do one hour or more of physical activity every day, with one hour or more a day either moderate or vigorous intensity aerobic physical activity, vigorous intensity activity on at least three days per week, and muscle-strengthening and bone-strengthening activity at least three days per week), available at [http://www.health.gov/paguidelines/pdf/fs\\_prof.pdf](http://www.health.gov/paguidelines/pdf/fs_prof.pdf).

<sup>4</sup> Tucker Center, *supra* note 2, at 3; U.S. Dep't of Health and Human Servs., *Physical Activity and Health: A Report of the Surgeon General 199-200* (1996) [hereinafter 1996 Surgeon General's Report], available at <http://www.cdc.gov/nccdphp/sgr/pdf/sgrfull.pdf>.

<sup>5</sup> 1996 Surgeon General's Report, *supra* note 4, at 190-91.

<sup>6</sup> Child and Adolescent Health Measurement Initiative (CAHMI), *2007 National Survey of Children's Health*, available at <http://www.nschdata.org/DataQuery/DataQueryResults.aspx> [hereinafter 2007 National Survey of Children's Health] (data retrieved by restricting results from question K7Q1 to Pennsylvania, sub-group "sex of child").

<sup>7</sup> Don Sabo et al., Women's Sports Found., *Her Life Depends On It: Sport, Physical Activity and the Health and Well-Being of American Girls 8-12* (2004), available at <http://www.womenscolleges.org/files/pdfs/Womens-Sports.pdf>.

<sup>8</sup> Leslie Bernstein et al., *Physical Exercise and Reduced Risk of Breast Cancer in Young Women*, 86 *J. Nat'l Cancer Inst.* 1403 (1994); Cher M. Dallal et al., *Long-Term Recreational Physical Activity and Risk of Invasive and In Situ Breast Cancer: The California Teachers Study*, 167 *Archives Internal Med.* 408 (2007).

<sup>9</sup> Sabo et al., *supra* note 7, at 13-14.

<sup>10</sup> *Id.* at 8-12.

<sup>11</sup> *Id.* at 17-18.

<sup>12</sup> Sabo et al., *supra* note 7, at 22-23.

<sup>13</sup> Tucker Center, *supra* note 2, at 5.

<sup>14</sup> *Id.* at 30-34.

<sup>15</sup> 2007 National Survey of Children's Health, *supra* note 6; Child and Adolescent Health Measurement Initiative (CAHMI), *Pennsylvania State Fact Sheet*, <http://nschdata.org/Viewdocument.aspx?item=560> (last visited Dec. 18, 2011).

<sup>16</sup> Pa. Dep't of Health, *2008-09 Pennsylvania Youth Tobacco Survey 3* (2009), available at <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=598865&mode=2>.

<sup>17</sup> Gallup Org., *Pennsylvania Adolescent Health Study 14-16* (2006), available at <http://www.dsf.health.state.pa.us/health/lib/health/familyhealth/PAAdolescentHealthStudy2006.pdf>.

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

<sup>19</sup> Pa. Const. Art. I, § 28.

<sup>20</sup> 43 Pa. Stat. Ann. §§ 951-63 (2010).

<sup>21</sup> 22 Pa. Code §§ 4.27(a), 4.21(e)(6), 4.21(f)(8), 4.22(c)(7), 4.23(c)(8) (2011).

<sup>22</sup> *Id.*

<sup>23</sup> 22 Pa. Code § 4.27(d).

<sup>24</sup> 20 U.S.C. § 1092(g) (2010).

<sup>25</sup> See, e.g., Nat'l Collegiate Athletic Ass'n, Student Athlete Participation 1981-82 — 2010-11: Sports Sponsorship and Participation Rates Report 11-70, 248 (2011) [hereinafter NCAA Participation Rates], available at <http://www.ncaapublications.com/productdownloads/PR2012.pdf>.

<sup>26</sup> Katie Thomas, *College Teams, Relying on Deception, Undermine Gender Equity*, N.Y. Times, Apr. 26, 2011, [http://www.nytimes.com/2011/04/26/sports/26titleix.html?\\_r=1&pagewanted=all](http://www.nytimes.com/2011/04/26/sports/26titleix.html?_r=1&pagewanted=all) (last visited Nov. 21, 2011).

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> NCAA Participation Rates, *supra* note 25, at 68-69.

<sup>30</sup> See Am. Council on Educ., Undergraduate and Graduate Enrollment, by Attendance Status, Age, and Gender: Fall 2007, at 1, available at [http://www.acenet.edu/AM/Template.cfm?Section=Search&section=fact\\_sheets&template=/CM/ContentDisplay.cfm&ContentFileID=7294](http://www.acenet.edu/AM/Template.cfm?Section=Search&section=fact_sheets&template=/CM/ContentDisplay.cfm&ContentFileID=7294).

<sup>31</sup> U.S. Gov't Accountability Office, Intercollegiate Athletics: Recent Trends in Teams and Participants in National Collegiate Athletic Association Sports2 (2007), available at <http://www.gao.gov/new.items/d07535.pdf>.

<sup>32</sup> John Cheslock, Women's Sports Found., Who's Playing College Sports?: Trends in Participation 15 (2007), available at <http://www.womenscolleges.org/files/pdfs/Women-Sports-in-College.pdf> (listing the statistics regarding the gender-based participation gap); Nat'l Collegiate Athletic Ass'n, 2005-06 NCAA Gender-Equity Report 22, available at <http://www.ncaa.org/wps/wcm/connect/0462e7804e0d4e469171f11ad6fc8b25/GenderEquityRept-Final.pdf?MOD=AJPERES&CACHEID=0462e7804e0d4e469171f11ad6fc8b25> (showing that the share of all athletic funds spent on Division I female athletes fell from 37 percent in 2003-04 to 34 percent in 2005-06).

<sup>33</sup> Women's Law Project, Gender Equity in Intercollegiate Athletics: Where Does Pennsylvania Stand? (2005), available at <http://www.womenslawproject.org/resources/GenderEquityNov05.pdf> Up to date Information on individual colleges may be found on EADA.gov. However, no more recent overall analysis of the data on Pennsylvania colleges exists.

<sup>34</sup> *Id.* at 8.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> See <http://www2.ed.gov/about/offices/list/ocr/docs/crdc-2009-10-factsheet.html> for more information about the Civil Rights Data Collection (CRDC).

<sup>39</sup> Nat'l Fed'n of State High Sch. Ass'n, 2010-11 High School Athletics Participation Survey 52 (2011), available at <http://www.nfhs.org/content.aspx?id=3282>.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.* at 52 (stating that in 2001-02, there were 3,960,517 male athletes and 2,806,998 female participants, and in 2009-10 there were 4,455,740 male participants and 3,172,637 female athletes in high school sports).

<sup>43</sup> Don Sabo & Phil Veliz, Women's Sports Found., *Go Out and Play: Youth Sports in America* 26 (2008), available at <http://www.womenssportsfoundation.org/home/research/articles-and-reports/mental-and-physical-health/go-out-and-play>.

<sup>44</sup> Don Sabo & Phil Veliz, Women's Sports Found., *Progress Without Equity: The Provision of High School Athletic Opportunity in the United States, by Gender 1993-94 through 2005-06* (2011), available at <http://www.womenssportsfoundation.org/home/research/articles-and-reports/school-and-colleges/the-provision-of-hs-athletic-opportunity-in-the-us-by-gender-1993-94-through-2005-06>.

<sup>45</sup> *Id.* at 8.

<sup>46</sup> *Id.* at 8-9, 10, 11.

<sup>47</sup> *Id.* at 9.

<sup>48</sup> Nat'l Fed'n of State High Sch. Ass'n, *Interactive Participation Survey Statistics for PA 2010-11*, <http://www.nfhs.org/Participation/SportSearch.aspx> (last visited Mar. 20, 2012).

<sup>49</sup> Sabo & Veliz, *supra* note 44, at 28, 37 (Table 14, Percentage of Athletic Opportunities (Girls)).

<sup>50</sup> Carl Prine, *Second String: Gender Inequality in High School Sports*, Pittsburgh Tribune-Review, Oct. 15, 2001, <http://www.pittsburghlive.com/x/pittsburghtrib/news/specialreports/titleix/> (last visited Nov. 21, 2011).

<sup>51</sup> Peggy Pennepacker, High School Title IX Consulting Services, Pittsburgh Public School District, PA.: *Title IX Athletic Program Compliance Review* (2010), available at <http://www.pps.k12.pa.us/14311059122535553/lib/14311059122535553/Education%20Committee/2010/April/Final-Report-SDPittsburgh.pdf>. Publicly released by the Pittsburgh School District on April 7, 2010, the audit was performed by Peggy Pennepacker, an independent auditor. The audit was conducted at the request of the Women's Law Project, following complaints from parents and student athletes that girls were being treated unfairly.

<sup>52</sup> *Id.* at 10-12, 102-06.

<sup>53</sup> *Id.*

<sup>54</sup> *Id. passim.*

<sup>55</sup> Katie Thomas, *Long Fights for Sports Equity, Even With a Law*, N.Y. Times, Jul. 28, 2011, <http://www.nytimes.com/2011/07/29/sports/review-shows-title-ix-is-not-significantly-enforced.html?pagewanted=all> (last visited Nov. 21, 2011).

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

<sup>57</sup> *Id.*

<sup>58</sup> H.B. 209, Gen. Assem., Reg. Sess. (Pa. 2011); S.B. 209, Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>59</sup> H.R.458, 2011 Leg. Reg. Sess. (2011); S.1269, 2011 Leg. Reg. Sess. (2011).



## Section B. The Impact of **SEXUAL VICTIMIZATION in EDUCATION** on Women's and Girls' Health

### INTRODUCTION

*Young women are subjected to sexual victimization in school from elementary school through college. "Sexual victimization" as used in this chapter encompasses both sexual assault and sexual harassment and includes behavior ranging from sexual comments and inappropriate touching to rape. Young women are at greatest risk of being raped between the ages of sixteen and twenty-four and at higher risk if they are in college.<sup>1</sup> Such victimization not only deprives young women of an education, but also causes physical, emotional, and mental health problems that may follow them through life. In some cases, the victim is so distraught that she becomes suicidal.<sup>2</sup> Increased prevention efforts and enforcement of laws that prohibit such conduct in our schools are necessary to protect the health, well-being, and lives of students.*



## Prevalence of Sexual Victimization

As discussed below, surveys demonstrate that the prevalence of sexual victimization of students is alarming. It is difficult to know the full extent of its prevalence due to underreporting. Fear of retaliation, self-blame, lack of confidence that something will be done, and lack of understanding that what was done to them is a reportable problem are some of the many reasons victims do not report sexual harassment or assault.<sup>3</sup> As a consequence, our educational and law enforcement institutions are not responding to the vast majority of victimizations.

### Elementary and Secondary Schools

Surveys conducted by the American Association of University Women (AAUW) have provided insight into the prevalence of sexual victimization in middle and high schools. In its 2001 survey, the AAUW reported that eight out of ten students in grades eight through eleven personally experienced sexual victimization in school at some time in their school career.<sup>4</sup> In response to the AAUW's 2011 survey, almost 50 percent of the students in grades 7-12 reported experiencing some form of sexual victimization in the 2010-11 school year.<sup>5</sup> Overall, girls are more likely than boys to be sexually victimized and to experience it more frequently.<sup>6</sup> While similar percentages of boys and girls report victimization in 7<sup>th</sup> grade, as students grow older, the gender disparity widens, with 62 percent of 12<sup>th</sup> grade girls reporting sexual victimization as compared to 39 percent of 12<sup>th</sup> grade boys.<sup>7</sup>

The victimization students experience ranges from sexual comments and gestures to being forced to do something sexual.<sup>8</sup> The most common form is non-physical, such as being targeted with sexual comments, jokes, or gestures.<sup>9</sup> In 2001, the

second most common experience was being touched, grabbed or pinched in a sexual way.<sup>10</sup> In 2011, being called gay or lesbian in a negative way was the second most commonly reported form of victimization, followed by being shown sexual pictures and being touched in an unwelcome sexual way.<sup>11</sup> In 2011, cyber-harassment was also reported by more than one-third of girls and almost one-quarter of boys.<sup>12</sup>

Secondary school students rarely report sexual victimization. Less than nine percent of students who responded to the 2011 AAUW survey had reported victimization to a teacher, guidance counselor, or other adult at the school; only about a quarter said they talked about it with a family member, including siblings.<sup>13</sup> This low reporting rate is in stark contrast to the nearly 50 percent of the students who responded to the survey that they had been victimized in that school year.<sup>14</sup>

Students are primarily sexually victimized by other students, but teachers and other school employees also sexually victimize students.<sup>15</sup> Almost ten percent of students in grades K-12 experience educator-inflicted sexual misconduct sometime in their school career.<sup>16</sup>

The victimization starts early in life; more than one-third of students first experience sexual harassment in elementary school.<sup>17</sup> A significant portion of sexual assault victims were victimized before they entered college.<sup>18</sup> Data shows that women who were victims of sexual assault before college are more likely to be victimized during college.<sup>19</sup>

At the local school district level, the Pennsylvania Department of Education collects school safety data, which include data about sexual offenses and sexual harassment.

Pennsylvania's 500 local school districts, 29 intermediate units, 83 career and technical centers, and 135 charter schools reported 642 sexual offenses and 483 instances of sexual harassment during the 2008-09 school year.<sup>20</sup> However, the Department has been criticized for "neither verifying the violence statistics it received from schools [nor] issuing its annual report in a timely manner."<sup>21</sup> In addition, schools have been charged with depressing statistics by pressuring staff not to report violent incidents to central offices. The *Philadelphia Inquirer*, in a year-long investigation of school violence in the Philadelphia School District, uncovered "tardy notification, failure to report, and statistical discrepancies pointing to the active suppression of information that would reveal how violent Philadelphia schools really are."<sup>22</sup> Alarming, this 2010 investigation also found that 90 percent of the District's 177 elementary schools dealt with at least one sex crime in the past five years.<sup>23</sup>

Experts have concluded that schools frequently misidentify and mislabel sexual victimization in schools.<sup>24</sup> By inappropriately casting it as bullying, mutual horseplay, or rough housing, schools fail to respond adequately or at all to sexual victimization, and students are suffering as a consequence.<sup>25</sup>

### College Campuses

Research demonstrates that women attending college are particularly vulnerable to sexual assault to an extent greater than non-college peers.<sup>26</sup> Young women in the first two years of college are at the highest risk of sexual assault.<sup>27</sup> Recent studies estimate that 20-25 percent of young women will

experience a completed or attempted rape during their college career.<sup>28</sup> Applying these percentages to Pennsylvania's college population, at least 54,000 - 99,000 female college students experience attempted or completed sexual assault while in college.<sup>29</sup> A 2007 campus sexual assault study of over 6,800 undergraduate students found that 13.7 percent of undergraduate women had been victims of at least one completed sexual assault in college, and 19 percent — or one in five — reported being a victim of attempted or completed sexual assault in college.<sup>30</sup> Of those, 4.7 percent were subjected to physically forced sexual assault, 7.8 percent were sexually assaulted while incapacitated due to voluntary alcohol or drug consumption, and 0.6 percent were sexually assaulted after having been drugged without their knowledge.<sup>31</sup> Most campus sexual assaults were committed by a perpetrator who was known to the victim.<sup>32</sup>

College students are subjected to the full range of sexual assault and harassment. In a 2005 campus study, almost two-thirds of the college students surveyed reported experiencing some form of sexual harassment; nearly one-third of the students described being touched, grabbed, or forced to do something sexual.<sup>33</sup> Both male and female students were likely to be sexually harassed: women were typically subjected to sexual comments and gestures, and men were more likely to be targeted with homophobic comments.<sup>34</sup> Translating this study's results into Pennsylvania terms, at least 262,500 of Pennsylvania's 397,722 female college students may be subjected to sexual harassment while attending Pennsylvania's colleges and universities.<sup>35</sup>

## ***Victims Typically Know Their Attackers***

Female college students usually know the person who sexually assaulted them. Most often, the attacker is a:

- Boyfriend
- Ex-boyfriend
- Classmate
- Friend
- Acquaintance
- Co-worker

Various estimates suggest that only 5-11.5 percent of campus sexual assaults are reported to law enforcement, meaning that 88.5-95 percent go unreported.<sup>36</sup> Because they frequently know their perpetrators, college students are less likely to report sexual victimization.<sup>37</sup> The rates of reporting are higher for forcible rape than for drug-facilitated and incapacitated rape.<sup>38</sup> Less than ten percent of those who experienced sexual harassment reported it to a college official.<sup>39</sup>

In Pennsylvania, two types of data exist on reports of campus sexual victimization. Pursuant to federal law requiring colleges and universities to report certain crime statistics,<sup>40</sup> the number of reports made to an array of campus entities and authorities can be found online on the Campus Safety and Security Data Analysis Cutting Tool website.<sup>41</sup> According to Pennsylvania colleges and universities, 357 forcible sex offenses were reported to campus security authorities in Pennsylvania in the 2008-09 academic year.<sup>42</sup> Compounding the problem of low reporting by victims, there are serious concerns that colleges and universi-

ties do not publicly report all known instances of sexual victimization.<sup>43</sup>

Information about the number of campus sexual assaults reported to police can also be found on the Pennsylvania State Police website. In 2009, police statewide reported receiving 173 complaints of campus sexual assaults; 165 of them were founded, or determined to be actual offenses. Of these reports, 57 were for forcible rape, almost all of which were founded.<sup>44</sup>

College women are most often victimized by a boyfriend, ex-boyfriend, classmate, friend, acquaintance, or coworker.<sup>45</sup> In students' responses to surveys, college professors are not often identified as attackers; they are identified as the perpetrator in a low number of cases involving unwanted sexual contact.<sup>46</sup>

Studies confirm the existence of a rape-supportive campus culture that fuels sexual violence.<sup>47</sup> A 2001 study reported that male students who committed sexual assaults were encouraged by peers to do so, particularly if they drank two or more times a week.<sup>48</sup> Some men may have stereotypical views of women's sexual behavior and may believe that women prefer to be coerced into engaging in sexual activity.<sup>49</sup> Thus, "If a woman says no, a man is to proceed as if she said yes."<sup>50</sup> That young men continue to act on this false assumption is exemplified by the highly publicized behavior of Yale fraternity men who in the past seven years have, among other things, repeatedly congregated on campus chanting "No means yes! Yes means anal" and "We Love Yale Sluts," and published a "Preseason Scouting Report" rating incoming freshmen women as to how many beers it would take to get them to have sex with them.<sup>51</sup>

Perpetrators are frequently repeat offenders.<sup>52</sup> In a 2002 campus study, researchers David Lisak and Paul M. Miller found that

“the majority of sexual assaults are committed by serial, violent predators.” Specifically, they found that 120 rapists were responsible for 1,225 separate acts of interpersonal violence, including 483 acts of rape. Sixty-three percent of the perpetrators were responsible for 439 of the 483 rapes, and repeat rapists averaged 5.8 rapes each; these offenders were additionally responsible for 1,000 other crimes of violence that included non-penetrating acts of sexual assault, domestic battery, and child physical and sexual abuse.<sup>53</sup> It is notable that not one of these perpetrators was prosecuted for these crimes.<sup>54</sup> Lisak believes that prevention efforts geared to persuading these serial rapists not to rape are unlikely to be effective; rather, he urges the creation of community-based intervention methods in which men and women “who are part of the social milieu in which rapes are spawned can be mobilized to identify perpetrators and intervene in high-risk situations.”<sup>55</sup>

Of particular note is the frequency with which college athletes perpetrate sexual assault.<sup>56</sup> A 1995 study of campus police and internal judicial affairs records at twenty NCAA Division I institutions found that, while male student-athletes comprised only 3.3 percent of the total male population, they accounted for 19 percent of reported sexual assault perpetrators.<sup>57</sup> Significant

effort goes into suppressing publicity around such incidents and reaching confidential settlements with athletes who have pro bono representation.<sup>58</sup> This raises serious questions about whether victims of athlete assaults are subjected to an uneven playing field, whether athletic department officials are improperly involved in responding to allegations of sexual assault by athletes, and whether universities are failing to respond appropriately to sexual assaults by athletes.<sup>59</sup>

Female athletes are also particularly vulnerable to sexual harassment, including by their coaches. The coach-student relationship, the physical nature of sports, and the focus on the athlete’s body create increased opportunity and likelihood of harassment.<sup>60</sup> In Washington State, from 1993 to 2003, 159 coaches were fired or reprimanded for sexual misconduct ranging from rape to sexual harassment; these cases primarily involved male coaches victimizing girls.<sup>61</sup>

Fraternities also play a considerable role in campus sexual victimization of women. In the 2007 campus study discussed previously, over one-quarter of incapacitated sexual assault victims reported that the assailant was a fraternity member at the time of incident.<sup>62</sup> News reports of sexual assaults at fraternities abound.<sup>63</sup>

## Impact on Women’s Health

Sexual victimization results in a broad range of physical and psychological harms, from emotional upset to long-term physical and emotional trauma and, in some cases, death.

Rape is one of the most violating experiences imaginable. While many cases do not present with obvious physical injuries,<sup>64</sup> injuries may include: non-genital injury (25 to 45 percent of rape victims), genital injury

(19 percent to 22 percent), and sexually transmitted infections (STIs) (almost 40 percent), as well as bruises, black-eyes, cuts, scratches, and swelling.<sup>65</sup> Between 1 and 5 percent of victims become pregnant, resulting in an estimated 32,000 rape-related pregnancies in the United States annually.<sup>66</sup> Sexual violence victims may be subject to chronic reproductive health conditions such

as painful, prolonged, and heavy menstrual periods, and sexual dysfunction.<sup>67</sup>

In the aftermath of a rape, victims experience a wide range of psychological harm: shock, humiliation, anxiety, depression, substance abuse, suicidal thoughts, loss of self-esteem, social isolation, anger, distrust of others, fear of STIs, such as HIV/AIDS, and guilt.<sup>68</sup> Many subsequently suffer from chronic conditions, including long-term depression and post-traumatic stress disorder (PTSD).<sup>69</sup> Sexual violence survivors are more likely to engage in behaviors that place their health at risk, including unsafe sex practices and substance use.<sup>70</sup> Rape victims are more likely to attempt suicide than non-crime victims and victims of other crimes.<sup>71</sup>

Sexual harassment affects the health of young women in similar ways. In addition to negative effects on their education,<sup>72</sup> victims of sexual harassment may experience depression, anxiety, sleeplessness, headaches, weight loss or gain, loss of confidence and self esteem, and PTSD.<sup>73</sup>

Students who have been sexually harassed have reported being very upset after the harassment, with girls more likely to report a negative impact.<sup>74</sup> Students have also reported feeling sick to their stomachs, having a hard time sleeping, feeling fearful, and experiencing thoughts of suicide.<sup>75</sup> In some cases, sexual harassment results in the victim taking her own life.<sup>76</sup>

Considering the health consequences of sexual victimization, access to health care is essential. Yet, a 2002 study of campus response to sexual assault found that only 58 percent of colleges and universities notify victims in their published information of the availability of on- and off-campus counseling, medical treatment, or other student services.<sup>77</sup> With respect to on-campus resources, 70 percent of schools provided notice of student counseling services, and 48 percent provided notice of student health services; with respect to off-campus services, 26 percent provided notice of mental health services, and 56 percent provided notice of medical services.<sup>78</sup>

## Applicable Laws

### Criminal Justice

Sexual assault is a crime. Students who are sexually victimized may report it to law enforcement by contacting the local police and/or prosecutor and seek redress through the criminal justice system. Pennsylvania's crime code criminalizes forcible rape, sexual assault (sexual intercourse or deviate sexual intercourse without consent), involuntary deviate sexual intercourse, statutory sexual assault, aggravated indecent assault, indecent exposure, and attempts to commit such crimes.<sup>79</sup> These crimes are punishable by incarceration.

### Title IX

Sexual harassment that deprives or limits access to educational opportunities, services, or benefits is unlawful sex discrimination under Title IX,<sup>80</sup> a federal law that prohibits sex discrimination by federally funded educational programs. Title IX applies to public and to private schools, most of which receive federal funding. Guidance from the Office for Civil Rights of the Department of Education (OCR) makes clear that sexual harassment is a broad term that includes sexual assault.<sup>81</sup> Educational programs subject to Title IX are obligated to address sexual harassment and must take steps to prevent students

from being denied access to education as a result of a hostile learning environment created by sexual harassment. To do so, educational institutions must recognize and respond to incidents of sexual harassment consistent with Title IX's requirements.<sup>82</sup>

Title IX protects both students and employees and applies to discrimination by both school staff and students.<sup>83</sup> Sex discrimination includes:

- sexual harassment: “unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature,”<sup>84</sup> and
- sexual violence: “sexual acts perpetrated against a person’s will or where a person is incapable of giving consent due to the victim’s use of drugs or alcohol”<sup>85</sup> or due to disability. Sexual acts, include “rape, sexual assault, sexual battery, and sexual coercion.”<sup>86</sup>

Title IX also applies to gender-based harassment based on sex-stereotyping.<sup>87</sup>

OCR, which is responsible for enforcing Title IX, has issued regulations that impose specific obligations on schools and guidance to assist educational institutions in eliminating and preventing sexual harassment.<sup>88</sup> As OCR clearly reinforced in its April 2011 guidance, “If a school knows or reasonably should know about student-on-student harassment that creates a hostile environment, Title IX requires the school to take immediate action to eliminate the harassment, prevent its recurrence, and address its effects.”<sup>89</sup> Regardless of how it learns of possible sexual harassment, once it knows of the harassment, the school must promptly investigate and address it.

OCR’s procedural requirements are intended to both prevent and respond to sexual harassment. Title IX requires a school to:

- Distribute broadly a notice of nondiscrimination;
- Designate an employee to coordinate and carry out its responsibilities under Title IX, often referred to as a Title IX coordinator; and
- Adopt and publish widely a grievance process providing prompt and equitable resolution of complaints of sexual harassment.<sup>90</sup>

Schools also must ensure that employees are properly trained in procedures so they know to report harassment to appropriate school officials and how to respond.<sup>91</sup>

When evaluating whether a school’s procedures are compliant, OCR considers:

whether the procedures provide for: notice to students and employees of the procedure, including where complaints may be filed; application of the procedure to complaints alleging harassment carried out by employees, other students, or third parties; adequate, reliable, and impartial investigation of complaints, including the opportunity to present witnesses and other evidence; designated and prompt timeframes for the resolution of the complaint process; notice to the parties of the outcome of the complaint; and an assurance that the college will take steps to prevent recurrence of any harassment and to correct its discriminatory effects on the complainant and others, if appropriate.<sup>92</sup>

In appropriate circumstances, the school should promptly take interim measures before an investigation is completed to eliminate a hostile environment and prevent retaliation. These measures may include: changing housing or class schedules, issuing no-contact orders, providing escorts,

providing counseling, providing medical or tutoring services, or contacting law enforcement, all undertaken while taking care to minimize the burden on the complainant.<sup>93</sup>

Following criticism that OCR provided insufficient guidance to schools, leaving victims at the mercy of often unduly complex, interminable, and inequitable proceedings,<sup>94</sup> OCR published additional guidance on April 4, 2011.<sup>95</sup> OCR has now clarified that:

- The standard of proof in school administrative proceedings is the preponderance of the evidence standard (which means “more likely than not”), rather than the higher standard of clear and convincing evidence.<sup>96</sup>
- Although some complaints may be resolvable through voluntary informal procedures, “it is improper for a student who complains of harassment to be required to work out the problem directly with the alleged perpetrator,”<sup>97</sup> and “in the cases involving allegations of sexual assault, mediation is not appropriate even on a voluntary basis.”<sup>98</sup>
- The fact that a law enforcement investigation may be ongoing does not relieve the school of its obligation to investigate the conduct independently and promptly, and schools may not delay the commencement or conclusion of internal hearings because criminal investigations are ongoing.<sup>99</sup>
- Schools must fully inform students of the right to file a criminal complaint and must not in any way discourage victims from pursuing criminal remedies.<sup>100</sup>
- When a complainant requests an internal school hearing, the school must

provide both parties “similar and timely access to any information that will be used at the hearing,” including opportunities for pre-hearing meetings and presentation of character witnesses, and review of complainant and perpetrator statements.<sup>101</sup>

- Both parties must be notified of the outcome of complaints and any appeal; the victim must be informed of the sanction to be imposed so that she understands if a hostile environment has been eliminated.<sup>102</sup>

In a 2010 publication, OCR also clarified that schools must consider whether student conduct that is labeled bullying is actually unlawful sexual harassment under Title IX, and schools must meet their obligation to respond to it accordingly.<sup>103</sup>

**Administrative Enforcement:** OCR enforces Title IX through policy guidance, periodic compliance reviews, and investigation of individual complaints. Under the current administration, OCR has issued policy guidance that significantly clarifies the responsibilities of educational programs with regard to sexual violence. While improved guidance is promising, improvements in undertaking compliance reviews and handling of individual complaints are needed. Enforcement through OCR’s administrative procedures is frequently challenging and ineffective. Understaffed and underbudgeted,<sup>104</sup> with only 600 full-time staff members working at 13 offices nationwide,<sup>105</sup> OCR’s ability to fulfill its mission through compliance reviews and complaint resolution is limited.

A study by the Center for Public Integrity found that OCR rarely performs sexual victimization compliance reviews on its own initiative.<sup>106</sup> Enforcement is thus left to responding to individual complaints

about individual schools, leaving many schools in non-compliance.<sup>107</sup>

An individual may file a complaint with OCR against a school within 180 calendar days of the last act that the complainant believes was discriminatory.<sup>108</sup> Once OCR accepts a complaint as properly before it, it investigates the complaint and attempts to resolve violations. The investigation may be a comprehensive and detailed examination of the school's policies, procedures, and response to a particular complainant, including interviews of relevant staff and parties. However, the quality of investigations undertaken by OCR's multiple enforcement offices and resulting outcomes are variable.<sup>109</sup> Investigations also may drag on for years, sometimes well after the departure of affected students.<sup>110</sup>

Moreover, as the only statutory penalty OCR is authorized to use is withdrawal of federal funding and OCR has never exercised that authority, resolving complaints through voluntary agreements has become the norm.<sup>111</sup> Even when a violation is found, OCR does not impose sanction.<sup>112</sup> In addition, as OCR's case processing system does not involve complainants in negotiating the resolution of their complaint, complainants are left with no say as to the nature of the corrective action required of the school.<sup>113</sup>

The shortcomings in OCR's enforcement procedures are extremely unfortunate. As set forth below, judicial enforcement is governed by stricter standards and OCR's more comprehensive and detailed guidance is a more promising avenue for students subjected to sexual victimization.<sup>114</sup>

**Judicial Enforcement:** In addition to or instead of filing a complaint with OCR, individuals who have suffered discrimination on the basis of sex by an educational institution that receives federal funding may file a lawsuit against the school under Title

IX. A court may determine a school liable for damages under Title IX only if it is established that a school employee or student sexually harasses a student, an official with authority to address the harassment has actual knowledge of it, and the official is deliberately indifferent in responding to it.<sup>115</sup> This standard is significantly narrower than the "knew or should have known" standard applied by OCR. For a school to have "actual knowledge," an official with authority to take corrective action to end the discrimination must know of the harasser's conduct; for this purpose, knowledge based on prior complaints by other students or prior knowledge about the risk a student poses also counts.<sup>116</sup>

A school may be liable for not preventing or responding to sexual harassment under other laws and legal theories. The U.S. Constitution provides a means of holding state schools and colleges accountable for failing to prevent sexual victimization under certain circumstances. A state violates the Due Process clause of the Fourteenth Amendment to the U.S. Constitution when it affirmatively places a person in a position of danger by acting with deliberate indifference to a known danger.<sup>117</sup> In addition, Pennsylvania common law may also afford relief when a school or college fails to protect a student from harm if the school has a "special relationship" with the student that imposes a duty to protect the student.<sup>118</sup>

### Disclosure Requirements

The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act<sup>119</sup> (Clery Act) requires colleges to disclose information about campus crime and safety policies. On an annual basis, colleges and universities must publish campus crime statistics and security policies, including those for sexual assault, both forcible and non-forcible.<sup>120</sup> The crime statistics must cover the most recent calen-

dar year and the two preceding years and must include crimes on campus, in residential housing, on public property adjacent to campus, and in certain non campus properties owned or controlled by the college or a college-recognized student institution.<sup>121</sup> Colleges must issue timely alerts of ongoing threats to students and employees and maintain crime logs.<sup>122</sup> They must develop and publicize policies regarding campus sexual assault programs aimed at preventing sex offenses and procedures to be followed once a sex offense has occurred; this includes informing students about their option to report to police authorities, campus and community resources, and possible academic or housing assistance.<sup>123</sup>

Some colleges fail to comply with the Clery Act because they do not publish policies or have procedures for adjudicating sexual offenses.<sup>124</sup> Campuses also underreport

crimes. A recent investigation by the Center for Public Integrity of campus reporting under the Clery Act identified a number of limitations and loopholes in the Act that may contribute to underreporting, including exemptions for certain campus personnel, and confusion over definitions of sexual offenses.<sup>125</sup> After surveying crisis-services programs and clinics on or near college campuses, the Center found that the numbers of sexual assaults reported by the service programs were much higher than the numbers reported under the Clery Act.<sup>126</sup> This finding is consistent with a 2002 study that found that only 36.5 percent of surveyed schools reported crime statistics in a manner that was fully compliant with the Clery Act.<sup>127</sup> Pennsylvania law also imposes an affirmative reporting duty on colleges and universities to report crime statistics, and the state Attorney General is charged with enforcing this law.<sup>128</sup>

## Complexities of Addressing Sexual Victimization in Educational Programs

Addressing sexual victimization among student populations is complicated. First, it requires a victim to understand that what happened was a violation of her rights and possibly a crime. Next, it requires a victim to come forward and report the events to police and/or school authorities. This is a difficult step for any victim, but particularly difficult for young individuals. Young women may not understand that something could be done about what happened to them or how to report it because many do not define what happened to them as rape or a crime.<sup>129</sup>

Victims may not fully or immediately understand that they were sexually victimized due to the trauma of the event, embarrassment, not understanding legal definitions, reluctance to define someone they know as

a rapist, or fear of being blamed for their own victimization.<sup>130</sup>

Students may not report their victimization due to fear that the perpetrator will retaliate against them or that their family and friends will react negatively to their allegations and the course of action they have chosen, and law enforcement will not treat them properly.<sup>131</sup> This is particularly true when there are no weapons, alcohol is present, and/or there are no serious physical injuries (other than the rape itself), characteristics often found in acquaintance rape.<sup>132</sup>

Fear of retaliation is well-founded. Some men have in fact filed lawsuits against individuals who have reported them as perpetrators of sexual assault to campus authorities, claiming defamation.<sup>133</sup> Fear of the law enforcement system is also

justifiable. Police frequently treat sexual assault victims differently from other victims; influenced by misconceptions about “real rape,” police disbelieve victims, often treating them with suspicion, and prosecutors refuse to prosecute the “he said,” “she said” rape perpetrated by someone the victim knows.<sup>134</sup>

Students may not always understand that they can seek relief through local law enforcement and/or through campus police and judicial procedures. There may be little available information about the campus and police procedures, how the two systems impact each other, and what the potential outcomes will be.<sup>135</sup>

Students who choose to pursue campus remedies, often thinking they will be less arduous than the criminal justice system, may face unexpected barriers. Administrators may respond to students with disbelief or other inappropriate behavior, and campus judiciary processes are often difficult to navigate.<sup>136</sup> Further, if the assault took place while the victim was drinking alcohol or using drugs, she potentially faces charges for violating campus policies on drug and alcohol use.<sup>137</sup>

While some individuals find the campus system adequate, others find it complex and unsatisfactory. Victims may find themselves required to comply with court-like procedures and subjected to cross examina-

tion by the perpetrator, but not allowed to be represented by counsel or accompanied by an advocate.<sup>138</sup> Some schools inappropriately apply a higher burden of proof to the proceedings.<sup>139</sup> The procedures may favor the accused, by, for example, providing the accused with information submitted by the victim, but not providing the victim with statements submitted by the accused.<sup>140</sup> Victims who pursue campus judicial proceedings often feel silenced and revictimized and may ultimately withdraw from school or transfer when offenders are not held accountable or are treated with leniency.<sup>141</sup> Sanctions for offenders often include reprimands, counseling, suspensions, no-contact orders, and other minor sanctions.<sup>142</sup>

If the perpetrator remains in the closed world of the campus, where students attend class together, eat and sleep in close proximity, study in the same libraries, and attend the same events, a victim of sexual assault may constantly live in fear of running into her assailant and his allies.

As described previously, OCR issued guidance in April 2011 to clarify school responsibilities with regard to many of the difficulties victims face when pursuing campus judicial proceedings. Compliance with OCR’s directive will improve campus grievance systems but may not eliminate their complexity or the trauma experienced by victims proceeding through them.

## RECOMMENDATIONS FOR REFORM

Victims of sexual harassment and victimization in school deserve to be provided with avenues for recourse that they can comfortably use, without fear of being disbelieved or further traumatized, and which will truly provide a prompt, fair, and appropriate process and outcome that will allow them to complete their education and recover their health. To accomplish this goal, we recommend the following actions:

### K-12 Schools

- Consistent with Title IX requirements, adopt and widely disseminate a non-discrimination policy that outlines the school's responsibilities with respect to responding to sexual violence and identifies procedures to be followed and the identity of staff to contact if sexual victimization is experienced or observed.
- Provide early education on sexual harassment and sexual victimization by integrating gender violence into the curriculum so that students understand what it is, that it is not acceptable or normative behavior, and how to report it.<sup>143</sup>
- Implement a bystander education program with students. Bystander programs, which are grounded in social psychology research, focus on changing community norms and engaging students by imagining every person as a potential witness (rather than victim or perpetrator) of sexual violence.<sup>144</sup>
- Provide mandatory education, by recognized experts in the area of sexual violence, to the entire school staff, including bus drivers, lunchroom and playground supervisors, custodians and all teaching and athletic personnel on how to identify sexual harassment and how to respond to it.
- Comply with all OCR Title IX guidances on responding to sexual harassment.

### Colleges and Universities

- Create community-based models in which all members of the campus community are informed that campus rapists are frequently repeat offenders and are trained to identify and intervene to prevent rape.
- Adopt a sexual harassment policy that is readily available and clearly describes all forms of sexual misconduct, including what is and is not consent, prevalence of non-stranger sexual assault (acquaintance rape), drug facilitated sexual assault, the effects of sexual assault, how to report an assault, and available resources on campus and in the community.
- Adopt a policy that defines responsibilities of responders and identifies a single coordinating office on call 24/7 to which all reports are immediately sent to ensure that each arm of the university's response team acts promptly and appropriately. The coordinating office should also serve as a liaison with the outside criminal justice system, as appropriate.

- Adopt a written grievance procedure in easily understood language and widely disseminate it so that students know it exists, how it works, and how to file a complaint.
- Train campus police, security personnel, and other individuals charged with responding to sexual victimization to effectively respond to sexual assault complaints. Responders should be trained to listen, take students seriously, and respond swiftly and fairly.
- Make crisis intervention services available to students twenty-four hours a day, every day of the school year, and make free emergency contraception, antibiotics and post-exposure HIV prophylaxis available in school health centers.<sup>145</sup>
- Make long-term counseling services available for students, including access to unlimited free counseling for survivors.<sup>146</sup>
- Provide annual educational programs regarding sexual assault.<sup>147</sup> These programs should focus on relevant legal definitions, different types of sexual assault, the fact that an intoxicated person cannot consent, risk factors, the relationship between sexual assault and drugs and alcohol, and available help and resources. These programs should emphasize that victims are not to blame. It is also important to educate both men and women about recent research showing that most rapists are repeat offenders, thereby encouraging reporting by victims and male participation in prevention.
- Promote reporting of sexual assaults by better handling of reports, having peer educators and advocates, and assuring that victims will not be punished if they report an assault that occurred while they were drinking or using drugs.
- Improve judicial proceedings consistent with the 2011 OCR Dear Colleague guidance to:
  - Promptly and effectively respond to sexual victimization.
  - Offer the victim information about the full range of options, including proceeding through the local law enforcement system.
  - Provide the victim with the same level of information and assistance provided to the perpetrator.
  - Provide interim relief to protect the victim before and during the proceedings.
- Train campus judicial investigators and board members about the complexities of sexual assault so that they can properly investigate and adjudicate these difficult cases.
- Met out appropriate discipline, including suspension and expulsion, in order to eliminate the hostile environment, enable the victim to recapture her life, and prevent repeat offenders from terrorizing their campuses.
- Develop targeted responses to address the higher risks of sexual assault perpetrated by athletes, athletic personnel, and fraternities, including by:
  - Adopting disciplinary policies that immediately suspend from the athletic team any athlete accused of or charged with a sexual assault.

- Removing the coach, who may have a conflict of interest, from the disciplinary decisions involving his or her athlete;<sup>148</sup>
- Disciplining athletes the same way and to the same extent it addresses sexual victimization by non-athletes.<sup>149</sup>

## **NCAA**

- Adopt a gender-violence policy that sets forth guidelines, corrective actions, and sanctions for individuals and schools that violate the guidelines.<sup>150</sup>

## **Pennsylvania**

- Adopt legislation that protects individuals who testify in school internal judicial proceedings from being sued by persons against whom the judicial proceedings were brought. Current Pennsylvania law fails to provide this protection, thus deterring victims from, or punishing victims for, testifying in school grievance proceedings. Victims have been sued for bringing charges against and testifying against perpetrators.<sup>151</sup> Pennsylvania should adopt legislation protecting victims who testify in school proceedings with an absolute privilege.

## **U.S. Department of Education**

- Vigorously enforce Title IX's protection for sexual assault victims:
  - Address complaints promptly and fairly;
  - Undertake proactive compliance reviews to identify areas of non-compliance and improvement;
  - Require full compliance with Title IX regulations, including the appointment of Title IX coordinators, policies, and grievance procedures;
  - Revise complaint procedures to give the complaining party a greater role in the administrative process and complaint resolution;
  - Increase staffing and resources to the Office of Civil Rights to expand its capacity to address complaints more effectually and promptly.

## **Congress**

- Adopt the Campus Sexual Violence Elimination (SaVE) Act, which strengthens the response of colleges and universities to sexual violence and increases student safety by expanding college and university obligations under the Clery Act with respect to content of policies and procedures, notification of rights, statistical reporting, victim confidentiality and educational programming and by reinforcing many aspects of the 2011 OCR Dear Colleague Letter with respect to disciplinary proceedings.<sup>152</sup>

**ENDNOTES**

<sup>1</sup> Rana Sampson, U.S. Dep't of Justice, Acquaintance Rape of College Students 2 (2003), *available at* <http://www.cops.usdoj.gov/pdf/e03021472.pdf> (citing Stephen E. Humphrey & Arnold S. Kahn, *Fraternalities, Athletic Teams and Rape: Importance of Identification With a Risky Group*, 15 J. Interpersonal Violence 1313 (2000)); *see also*, Bonnie S. Fisher et al., U.S. Dep't of Justice, Bureau of Justice Statistics, The Sexual Victimization of College Women (2000), *available at* <http://www.ncjrs.gov/pdffiles1/nij/182369.pdf>.

<sup>2</sup> Kevin Cullen, *It's a Year Later, and Not Much Has Changed*, Boston Globe, Jan. 16, 2011, [http://www.boston.com/lifestyle/family/articles/2011/01/16/its\\_a\\_year\\_later\\_and\\_not\\_much\\_has\\_changed/](http://www.boston.com/lifestyle/family/articles/2011/01/16/its_a_year_later_and_not_much_has_changed/) (last visited Oct. 5, 2011) (decrying lack of change one year after a fifteen-year-old girl hung herself after being subjected to bullying and harassment by nine teens, two of whom were charged with statutory rape and face charges of stalking, criminal harassment and violating civil rights); Kristen Jones, Ctr. for Pub. Integrity, Barriers Curb Reporting on Campus Sexual Assault: Lack of Response Discourages Victims of Rape, Other Crimes (2009), [http://www.publicintegrity.org/investigations/campus\\_assault/articles/entry/1822/](http://www.publicintegrity.org/investigations/campus_assault/articles/entry/1822/) (last visited Nov. 14, 2011) (recounting sexual assault, campus and law enforcement response, and suicide of Dominican College freshman Megan Wright).

<sup>3</sup> Sampson, *supra* note 1, at 4; Catherine Hill & Elena Silva, Am. Ass'n of Univ. Women, Drawing the Line: Sexual Harassment on Campus 4 (2005).

<sup>4</sup> Harris Interactive, Am. Ass'n of Univ. Women Educ. Found., Hostile Hallways: Bullying, Teasing, and Sexual Harassment in School 3 (2001), *available at* <http://www.aaup.org/learn/research/upload/hostilehallways.pdf>.

<sup>5</sup> Catherine Hill & Holly Kearn, Am. Ass'n of Univ. Women, Crossing the Line: Sexual Harassment at School 11 (2011), *available at* [https://svc.aaup.org/ResearchRptReq/index\\_CrossingtheLine\\_download.cfm](https://svc.aaup.org/ResearchRptReq/index_CrossingtheLine_download.cfm).

<sup>6</sup> Harris Interactive, *supra* note 4, at 3.

<sup>7</sup> Hill & Kearn, *supra* note 5, at 11, 13.

<sup>8</sup> Harris Interactive, *supra* note 4, at 2-3, 9-10; Hill & Kearn, *supra* note 5, at 11-13.

<sup>9</sup> Harris Interactive, *supra* note 4, at 3, 20; Hill & Kearn, *supra* note 5, at 11-12.

<sup>10</sup> Harris Interactive, *supra* note 4, at 20.

<sup>11</sup> Hill & Kearn *supra* note 5, at 11-12.

<sup>12</sup> *Id.* at 13.

<sup>13</sup> *Id.* at 2-3, 27.

<sup>14</sup> *Id.*

<sup>15</sup> Harris Interactive *supra* note 4, at 14, 25-26.

<sup>16</sup> Carol Shakeshaft, U.S. Dep't of Educ., Educator Sexual Misconduct: A Synthesis of Existing Literature 20 (2004), *available at* <http://www2.ed.gov/rschstat/research/pubs/misconductreview/report.pdf> (summarizing seven U.S. studies on the prevalence of sexual misconduct by school staff).

<sup>17</sup> Harris Interactive *supra* note 4 at 20, 25.

<sup>18</sup> Nat'l Inst. of Justice, *Two-Part Interview with Christopher Krebs on Campus Sexual Assault*, <http://nij.ncjrs.gov/multimedia/transcripts/krebs.htm> (last visited Mar. 9, 2012).

<sup>19</sup> *Id.*

<sup>20</sup> Pa. Dep't of Educ., School Safety Report: 2007-2008 and 2008-2009 School Years 4-5 (2009), available at <https://www.safeschools.state.pa.us/Main.aspx?App=6a935f44-7cbf-45e1-850b-e29b2f1ff17f&Menu=dbd39a1f-3319-4a75-8f69-d1166dba5d70&res> (To access document, select "School Safety Historic," "2008" and "Executive Summary").

<sup>21</sup> News Release, Pa. Dep't of the Auditor Gen., Auditor General Jack Wagner Says Dept. of Education's Administration of Safe School Activities is Lacking, Dec. 3, 2008, <http://www.auditorgen.state.pa.us/Department/Press/WagnerSaysDeptEdAdminSafeSchoolActivitiesLacking.html> (last visited Mar. 9, 2012).

<sup>22</sup> Susan Snyder et al., *Assault on Learning: Part 2: Underreporting Hides Violence*, Phila. Inquirer, Mar. 28, 2011, [http://www.philly.com/philly/news/special\\_packages/inquirer/school-violence/118737999.html](http://www.philly.com/philly/news/special_packages/inquirer/school-violence/118737999.html) (last visited Oct. 5, 2011) (describing the Philadelphia School District's failure to take seriously an incident in which, following months of taunting, classmates of a twelve-year-old girl at Cleveland Elementary School grabbed her in the cafeteria, wedged their hands under her shirt and tried to fondle her breasts, leaving the victim contemplating killing herself).

<sup>23</sup> Susan Snyder, et al, *Assault on Learning: Part 3: Young and Violent, Even Kindergartners*, Phila. Inquirer, Mar. 29, 2011, [http://www.philly.com/philly/news/special\\_packages/inquirer/school-violence/118813449.html](http://www.philly.com/philly/news/special_packages/inquirer/school-violence/118813449.html) (last visited Mar. 9, 2012).

<sup>24</sup> Nan Stein, *Sexual Harassment Overview Paper*, in National Summit on Gender-Based Violence Among Young People Reading Materials 1, 1 (2011), available at <http://www2.ed.gov/about/offices/list/osdfs/gbvreading.pdf>.

<sup>25</sup> Nan Stein, *Bullying or Sexual Harassment? The Missing Discourse of Rights in an Era of Zero Tolerance*, 45 Ariz. L. Rev 787 (2003).

<sup>26</sup> Fisher, et al., *supra* note 1, at 1.

<sup>27</sup> Christopher P. Krebs et al., Nat'l Inst. of Justice, The Campus Sexual Assault (CSA) Study 2-7 (2007) (citing Fisher, et al., *supra* note 1), available at <http://www.ncjrs.gov/pdffiles1/nij/grants/221153.pdf> [hereinafter CSA Study].

<sup>28</sup> *Id.* at 2-7.

<sup>29</sup> See Pa. Dep't of Educ., College University Fall Enrollment 2008, available at [http://www.portal.state.pa.us/portal/server.pt/community/higher\\_education/8684](http://www.portal.state.pa.us/portal/server.pt/community/higher_education/8684). In Fall 2008, Pennsylvania had over 703,000 college students (full and part time undergraduate and graduate), 56.6 percent of whom, or 397,722, were female.

<sup>30</sup> CSA Study *supra* note 27, at 5-1 – 5-3. Over half of the sample had been in school less than two years, making it difficult to assess overall risk of sexual assault during overall college career. Over a quarter (26.3 percent) of college seniors, however, reported experiencing attempted or completed sexual assault since entering college (6.9 percent forced; 16 percent incapacitated assault).

<sup>31</sup> *Id.* at 5-2.

<sup>32</sup> *Id.* at 2-3.

<sup>33</sup> Hill & Silva, *supra* note 3, at 2.

<sup>34</sup> *Id.* at 3.

<sup>35</sup> Pa. Dep't of Educ., *supra* note 29.

<sup>36</sup> CSA Study *supra* note 27, at 2-9; Dean G. Kilpatrick et al., Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study 44 (2007), available at <http://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf> [hereinafter Drug-Facilitated, Incapacitated, and Forcible Rape].

<sup>37</sup> See CSA Study, *supra* note 27, at 2-9.

<sup>38</sup> See Drug Facilitated, Incapacitated, and Forcible Rape, *supra* note 36, at 44.

<sup>39</sup> Hill & Silva, *supra* note 3, at 2.

<sup>40</sup> 20 U.S.C. § 1092(f)(1) (2012).

<sup>41</sup> See The Campus Safety and Security Data Analysis Cutting Tool, U.S. Dep't of Educ., <http://ope.ed.gov/security/> (last visited Mar. 9, 2012).

<sup>42</sup> These statistics were obtained by searching <http://ope.ed.gov/security/> for aggregated data for all Pennsylvania campuses. This search produced a report for 242 institutions that included 180 forcible sex offenses on campus, 137 in on-campus student housing facilities, 23 off campus, and 17 on public property.

<sup>43</sup> Kristen Lombardi & Kristin Jones, Ctr. For Pub. Integrity, *Campus Sexual Assault Statistics Don't Add Up: Troubling Discrepancies in Clery Act Numbers*, Dec. 3, 2009, [http://www.publicintegrity.org/investigations/campus\\_assault/articles/entry/1841/](http://www.publicintegrity.org/investigations/campus_assault/articles/entry/1841/) (last visited Mar. 9, 2012) (describing inconsistencies between documented instances of assault and reported statistics).

<sup>44</sup> Pennsylvania Uniform Crime Reporting System, Offenses Reported in Pennsylvania 2009, Table 1, <http://ucr.psp.state.pa.us/UCR/Reporting/Annual/AnnualFrames.asp?year=2009> (last visited July 14, 2011).

<sup>45</sup> Fisher, et al., *supra* note 1, at 17.

<sup>46</sup> *Id.*

<sup>47</sup> Nancy Chi Cantalupo, *Burying Our Heads in the Sand: Lack of Knowledge, Knowledge Avoidance and the Persistent Problem of Campus Peer Sexual Violence*, 43 Loy. U. Chi. L.J. 205, 212 (2011).

<sup>48</sup> Martin D. Schwartz et al, *Male Peer Support and a Feminist Routine Activities Theory: Understanding Sexual Assault on the College Campus*, 18 Just. Q. 641, 645-46 (2001).

<sup>49</sup> Sampson, *supra* note 1, at 11-12.

<sup>50</sup> Sampson, *supra* 1, at 12.

<sup>51</sup> Presca Ahn, *Ahn: Why We Filed the Title IX Complaint*, Yale Daily News, April 1, 2011, <http://www.yale.dailynews.com/news/2011/apr/01/why-we-filed-title-ix-complain/> (last visited Feb. 22, 2012).

<sup>52</sup> David Lisak, *Understanding the Predatory Nature of Sexual Violence*, 14 Sexual Assault Rep. 49, 56 (2011); see generally David Lisak & Paul M. Miller, *Repeat Rape and Multiple Offending Among Undetected Rapists*, 17 Violence and Victims 73 (2002).

<sup>53</sup> Lisak, *supra* note 52, at 56; Lisak & Miller, *supra* note 52, at 78.

<sup>54</sup> Lisak, *supra* note 52.

<sup>55</sup> Lisak, *supra* note 52, at 9.

<sup>56</sup> Barbara A. Lee, *Liability for Sexual Assault by College Athlete Under Title IX*, NACUA Notes, Nov. 7, 2008, available at [http://www.studentaffairs.uconn.edu/docs/risk\\_mgt/nacua11.pdf](http://www.studentaffairs.uconn.edu/docs/risk_mgt/nacua11.pdf).

<sup>57</sup> Jeff Benedict, *An Alarming Number of College Athletes Charged with Serious Crime*, Sports Illustrated, Sept. 8, 2010, [http://sportsillustrated.cnn.com/2010/writers/jeff\\_benedict/09/08/athletes.crime/index.html](http://sportsillustrated.cnn.com/2010/writers/jeff_benedict/09/08/athletes.crime/index.html) (last visited Oct. 5, 2011).

<sup>58</sup> Lee Rood, *College Athletes and Criminal Charges: Some Work to Keep Allegations Quiet*, Des Moines Register, Aug. 31, 2008, <http://www.desmoinesregister.com/article/20080831/NEWS10/808310335/College-athletes-and-criminal-charges-Some-work-to-keep-allegations-quietn> (last visited Oct. 5, 2011).

<sup>59</sup> See *Simpson v. Univ. of Colo. Boulder*, 500 F.3d 1170, 1178 (10th Cir. 2007) (reversing summary judgment in favor of the university in a case brought by two students who alleged they were raped by football players

and recruits, finding that the football coach had general knowledge of the serious risk of sexual harassment and assault during college-football recruiting efforts, had known that such assaults had indeed occurred during recruiting visits, and had failed to provide supervision, therefore the school could reasonably be said to have been deliberately indifferent to the sexual violence by athletes); *J.K. v. Ariz. Bd. of Regents*, 2008 U.S. Dist. LEXIS 83855 (D. Ariz. 2008) (denying defendants' motion for summary judgment because plaintiff may be able to establish that defendants were liable under both the U.S. Constitution, for affirmatively placing the plaintiff at risk by failing to respond appropriately to a prior complaint of sexual harassment, and Title IX, for failing to respond appropriately to football player's prior misconduct and rape of plaintiff); Lester Munson, *Landmark Settlement in ASU Rape Case*, ESPN, Jan. 30, 2009, <http://sports.espn.go.com/espn/otl/news/story?id=3871666> (last visited Oct. 5, 2011) (noting an unprecedented public settlement in which the university agreed to pay \$850,000 and appoint a women's safety officer, in contrast to the typical response of seeking confidentiality and protecting the student athlete); Am. Civil Liberties Union, *Simpson v. University of Colorado*, Aug. 24, 2006, <http://www.aclu.org/racial-justice-womens-rights/simpson-v-university-colorado> (last visited Oct. 5, 2011) (reporting the settlement of a case for \$2.85 million, the hiring of a new counselor for the Office of Victim's Assistance, and the appointment of an independent, outside Title IX advisor).

<sup>60</sup> Nancy Hogshead-Makar & Sheldon Elliot Steinbach, *Intercollegiate Athletics' Unique Environments for Sexual Harassment Claims: Balancing the Realities of Athletics with Preventing Potential Claims*, 13 Marq. Sports L. Rev. 173, 175 (2003).

<sup>61</sup> Christine Willmsen & Maureen O'Hagan, *Coaches Who Prey: The Abuse of Girls and the System That Allows It*, Seattle Times, Dec. 14, 2003, <http://community.seattletimes.nwsourc.com/archive/?date=20031215&slug=coachesday1> (last visited Nov. 14, 2011).

<sup>62</sup> CSA Study, *supra* note 27, at 5-15, 5-18, 6-3.

<sup>63</sup> See, e.g., Joanna Lin & Jia-Rui Chong, *USC Fraternity Suspended After Alleged Sex Assault*, Los Angeles Times, Apr. 17, 2009, <http://articles.latimes.com/2009/apr/17/local/me-usc-sexual-assault17> (last visited Oct. 5, 2011); Mike Lindblom, *UW Police Warn of Sexual Assault of Fraternity Party Guest*, The Seattle Times, Feb. 9, 2009, [http://seattletimes.nwsourc.com/html/localnews/2008724693\\_webuwrape09m.html](http://seattletimes.nwsourc.com/html/localnews/2008724693_webuwrape09m.html) (last visited Oct. 5, 2011); Jared McDonald, *Woman Reports Rape at Frat House*, The Daily Pennsylvanian, Nov. 22, 2009, <http://www.dailypennsylvanian.com/article/woman-reports-rape-frat-house> (last visited Oct. 5, 2011).

<sup>64</sup> CSA Study, *supra* note 27, at 5-20.

<sup>65</sup> CSA Study, *supra* note 27, at 1-1.

<sup>66</sup> *Id.* (citing Melisa Holmes et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 Am. J. Obstetrics & Gynecology 320 (1996)).

<sup>67</sup> Sandra L. Martin & Rebecca J. Macy, *Sexual Violence Against Women: Impact on High-Risk Health Behaviors and Reproductive Health* 3 (2009), available at [http://snow.vawnet.org/Assoc\\_Files\\_VAWnet/AR\\_SV\\_ReproConsequences.pdf](http://snow.vawnet.org/Assoc_Files_VAWnet/AR_SV_ReproConsequences.pdf) (citing Jacqueline M. Golding et al., *Prevalence of Sexual Assault History Among Women with Common Gynecologic Symptoms*, 23 Am J. Obstetrics and Gynecology 1013-19 (1998)).

<sup>68</sup> Sampson, *supra* note 1, at 8.

<sup>69</sup> See Shirley Kohsin Wang, et al., Research Summary: Rape: How Women, the Community and the Health Sector Respond 2 (2007).

<sup>70</sup> Martin & Macy, *supra* note 67, at 1-2.

<sup>71</sup> Dean G. Kilpatrick et al., Nat'l Victim Ctr., *Rape In America: A Report to the Nation* 5-6 (1992).

<sup>72</sup> Students have reported feeling less likely to participate in class or going to school, having a hard time paying attention and studying, changing the way they went to or from school, quitting an activity or sport, or even

changing schools. Harris Interactive, *supra* note 4, at 3, 32-33; Hill & Kearnl, *supra* note 5, at 22-23; Hill & Silva, *supra* note 3, at 28, 31-32.

<sup>73</sup> Nan Stein, *Classrooms & Courtrooms: Facing Sexual Harassment in K-12 Schools* 28 (Teachers College Press, 1999); *See* Vance v. Spencer County Public School District, 231 F.3d 253, 259 (2000) (“Given the frequency and severity of both the verbal and physical attacks, it is no wonder that [the student/victim] was diagnosed with depression.”); *See also*, Bonnie Moradi & Yu-Ping Huang, *Objectification Theory and Psychology of Women: A Decade of Advances and Future Directions*, 32 *Psychology of Women Quarterly* 377, 385 (2008); Dawn M. Szymanski, *Sexual Objectification of Women: Advances to Theory and Research*, *The Counseling Psychologist* 11 (2011).

<sup>74</sup> Harris Interactive, *supra* note 4, at 4, 32; Hill & Kearnl, *supra* note 5, at 20; Hill & Silva, *supra* note 3, at 28.

<sup>75</sup> Harris Interactive, *supra* note 4 at 32-33; Hill & Kearnl, *supra* note 5, at 22-23.

<sup>76</sup> *See* Nan Stein, *supra* note 24, at 8 (discussing the suicide of teenager Phoebe Prince, who had endured severe gender-based harassment).

<sup>77</sup> Heather Karjane et al., *Campus Sexual Assault: How America’s Institutions of Higher Education Respond 100-02* (2002), available at <http://www.ncjrs.gov/pdffiles1/nij/grants/196676.pdf>.

<sup>78</sup> *Id.* at 100-01.

<sup>79</sup> 18 Pa. Cons. Stat. §§ 3121-3127 (2011).

<sup>80</sup> 20 U.S.C. § 1681(a)(2010); Davis v. Monroe County Bd. of Educ., 526 U.S. 629, 650 (1999).

<sup>81</sup> Margaret Spellings & Stephanie Monroe, Office for Civil Rights, *Sexual Harassment: It’s Not Academic 4* (2008), available at <http://www2.ed.gov/about/offices/list/ocr/docs/ocrshpam.pdf>.

<sup>82</sup> Office for Civil Rights, *Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, or Third Parties 2* (2001), available at <http://www2.ed.gov/about/offices/list/ocr/docs/shguide.html> (notice of availability published at 66 Fed. Reg. 5512 (Jan. 19, 2001)) [hereinafter *Revised Sexual Harassment Guidance*].

<sup>83</sup> *See* Davis, 526 U.S. 629 (1999); Gebser v. Lago Vista Indep. Sch. Dist., 524 U.S. 274 (1998).

<sup>84</sup> Letter from Russlynn Ali, Assistant Sec’y for Civil Rights, U.S. Dep’t of Educ., *Dear Colleague Letter: Title IX 3* (Apr. 4, 2011), available at <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf> [hereinafter *2011 OCR Dear Colleague Letter*].

<sup>85</sup> *Id.* at 1.

<sup>86</sup> *Id.* at 1-2.

<sup>87</sup> *Id.* at 3, n.9.

<sup>88</sup> *Revised Sexual Harassment Guidance*, *supra* note 82.

<sup>89</sup> 2011 OCR Dear Colleague Letter, *supra* note 84, at 4.

<sup>90</sup> 34 C.F.R. §§ 106.8 & 106.9; *see also* 2011 OCR Dear Colleague Letter, *supra* note 84, at 4, 6-9.

<sup>91</sup> 2011 OCR Dear Colleague Letter, *supra* note 84, at 4.

<sup>92</sup> Office for Civil Rights, *Resolution Letter for OCR Docket No. 15-09-6001 from Catherine D. Criswell* (Sept. 24, 2010), available at <http://www2.ed.gov/about/offices/list/ocr/docs/investigations/15096001-a.pdf>; *see also* 2011 OCR Dear Colleague Letter, *supra* note 84, at 9.

<sup>93</sup> 2011 OCR Dear Colleague Letter, *supra* note 84, at 15-17.

<sup>94</sup> Grayson Sang Walker, Note, *The Evolution and Limits of Title IX Doctrine on Peer Sexual Assault*, 45 Harv. C.R.-C.L. L. Rev. 95, 103-04 (2010); Kristen Jones, *Lax Enforcement of Title IX in Campus Sexual Assault Cases*, Ctr. for Pub. Integrity, Feb. 25, 2010, [http://www.publicintegrity.org/investigations/campus\\_assault/articles/entry/1946/](http://www.publicintegrity.org/investigations/campus_assault/articles/entry/1946/) (last visited July 28, 2011).

<sup>95</sup> 2011 OCR Dear Colleague Letter, *supra* note 84.

<sup>96</sup> *Id.* at 11.

<sup>97</sup> *Id.* at 8.

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

<sup>99</sup> *Id.* at 4.

<sup>100</sup> *Id.* at 9-10.

<sup>101</sup> *Id.* at 11-12.

<sup>102</sup> *Id.* at 13-14.

<sup>103</sup> Letter from Russlynn Ali, Assistant Sec'y for Civil Rights, U.S. Dep't of Educ., Dear Colleague Letter: Harassment and Bullying (Oct. 26, 2010), available at <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.html>.

<sup>104</sup> Dep't of Educ., Office for Civil Rights, Fiscal Year 2010 Budget Request (2010), available at <http://www2.ed.gov/about/overview/budget/budget10/justifications/cc-ocr.pdf>.

<sup>105</sup> Katie Thomas, *Long Fights for Sports Equity, Even With a Law*, N. Y. Times, Jul. 28, 2011, at A1.

<sup>106</sup> Jones, *supra* note 94; Cantalupo, *supra* note 47, at 257.

<sup>107</sup> Cantalupo, *supra* note 47, at 241.

<sup>108</sup> Office for Civil Rights, OCR Complaint Processing Procedures, <http://www2.ed.gov/about/offices/list/ocr/complaints-how.html> (last visited Feb. 27, 2012) [hereinafter OCR Complaint Processing Procedures].

<sup>109</sup> Cantalupo, *supra* note 47, at 239.

<sup>110</sup> Jones, *supra* note 94; Thomas, *supra* note 105.

<sup>111</sup> Cantalupo, *supra* note 47, at 241; Walker, *supra* note 94, at 102.

<sup>112</sup> Jones, *supra* note 94.

<sup>113</sup> OCR Complaint Processing Procedures, *supra* note 108.

<sup>114</sup> Cantalupo, *supra* note 47, at 235.

<sup>115</sup> *Davis*, 526 U.S. 629 (discussing sexual harassment of students perpetrated by students); *Gebser*, 524 U.S. 274 (discussing sexual harassment of students perpetrated by teachers).

<sup>116</sup> *Gebser*, 524 U.S. 274 at 290; Ariz. Bd. of Regents, 2008 U.S. Dist. LEXIS 83855, at \*46-47 (D. Ariz. Sept. 29, 2008); *Simpson*, 500 F.3d 1170 at 1178.

<sup>117</sup> *Ariz. Bd. of Regents*, 2008 U.S. Dist. Lexis 83855, at \*16-27 (denying defendants' motions for summary judgment).

<sup>118</sup> Brett A. Sokolow et al., *College and University Liability for Violence Campus Attacks*, 34 J.C. & U.L. 319, 322 (2008).

<sup>119</sup> 20 U.S.C. § 1092(f) (2011).

<sup>120</sup> 20 U.S.C. § 1092(f)(1)(F) (2011).

<sup>121</sup> 20 U.S.C. § 1092(f)(1), (12) (2011).

<sup>122</sup> 20 U.S.C. § 1092(f)(3), (4) (2011).

<sup>123</sup> 20 U.S.C. § 1092 (f)(8) (2011).

<sup>124</sup> Jones, *supra* note 2.

<sup>125</sup> Lombardi & Jones, *supra* note 43.

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

<sup>127</sup> Karjane, *supra* note 77, at xiii, 48-51.

<sup>128</sup> 18 Pa. Stat. §§ 20.301-20.305 (2011).

<sup>129</sup> Sampson, *supra* note 1, at 4-5; CSA Study, *supra* note 27, at 2-9-2-10, 5-25, 5-26; Karjane, *supra* note 77, at vii.

<sup>130</sup> Fisher, et al., *supra* note 1, at 15; Patricia L. Fanflik, Am. Prosecutors Research Inst., Nat'l Dist. Attorneys Ass'n, *Victim Responses to Sexual Assault: Counterintuitive or Simply Adaptive?* 10 (2007) (citing V.E. White Kress, et al, *Responding to Sexual Assault Victims: Considerations for College Counselors*, 6 J. College Counseling 124, 125 (2003).

<sup>131</sup> Sampson, *supra* note 1, at 4-5; CSA Study, *supra* note 27, at 2-9, 5-24, 5-26.

<sup>132</sup> Fisher, et al., *supra* note 1, at 15, 22; Sampson, *supra* note 1, at 7.

<sup>133</sup> *See, e.g.,* Hartman v. Keri, 883 N.E.2d 774 (Ind. 2008) (two graduate students were sued for defamation based on formal complaints of sexual harassment they filed with their university).

<sup>134</sup> *See* The Impact of Sexual Violence on Women's Health chapter of this report.

<sup>135</sup> Karjane, *supra* note 77, at 107, 110.

<sup>136</sup> Jones, *supra* note 2.

<sup>137</sup> CSA Study, *supra* note 27, at 2-9.

<sup>138</sup> Kathryn Reardon, *Acquaintance Rape at Private Colleges and Universities: Providing for Victims' Educational and Civil Rights*, 38 Suffolk U. L. Rev. 395, 411-12 (2005).

<sup>139</sup> 2011 OCR Dear Colleague Letter, *supra* note 84, at 11; *see also*, David Burt & Drew Henderson, *Univ. to Revise Sexual Misconduct Policies*, Yale Daily News, Apr. 13, 2011, <http://www.yaledailynews.com/news/2011/apr/13/univ-to-revise-sexual-misconduct-policies/> (last visited Oct. 5, 2011).

<sup>140</sup> Holly Hogan, *Changing Social Norms? Title IX and Legal Activism*, 31 Harv. J. L. & Gender 367, 383 (2008); Nat'l Inst. of Justice, *Sexual Assault on Campus: What Colleges and Universities are Doing About It* (2005), available at <https://www.ncjrs.gov/pdffiles1/nij/205521.pdf>.

<sup>141</sup> Kirsten Lombardi, Ctr. for Pub. Integrity, *A Lack of Consequences for Sexual Assault: Students Found "Responsible" Face Modest Penalties, While Victims are Traumatized*, Feb. 24, 2010,

[http://www.publicintegrity.org/investigations/campus\\_assault/articles/entry/1945/](http://www.publicintegrity.org/investigations/campus_assault/articles/entry/1945/) (last visited July 29, 2011).

<sup>142</sup> *Id.* (reporting that 75 to 90 percent of disciplinary actions for sexual assault that schools reported to OCR were minor sanctions).

<sup>143</sup> Stein, *supra* note 24, at 17.

<sup>144</sup> Mary M. Moynihan & Victoria L. Banyard, *Educating Bystanders Helps Prevent Sexual Assault and Reduce Backlash*, 3 *Family & Intimate Partner Violence Q.* 293, 295 (2011).

<sup>145</sup> *Defining What We Mean: Accountability*, Change Happens: The SAFER Blog, Nov. 15, 2010, 12:20 PM, <http://www.safercampus.org/blog/2010/11/defining-what-we-mean-accountability/> (last visited Oct. 5, 2011).

<sup>146</sup> *Id.*

<sup>147</sup> CSA Study, *supra* note 27, at 6-5.

<sup>148</sup> Lee, *supra* note 56.

<sup>149</sup> *Id.*

<sup>150</sup> See David Haugh, *NCAA Needs to Address Violence Against Women*, *Chi. Trib.*, Nov. 18, 2010, <http://www.chicagotribune.com/sports/college/ct-spt-1118-haugh-ncaa--20101117,0,6337305.column> (last visited Oct. 5, 2011); Michael Marot, *NCAA President Discusses Ways to Curb Violence*, *Assoc. Press*, Nov. 19, 2010, <http://diverseeducation.com/article/14413/> (last visited Oct. 5, 2011).

<sup>151</sup> See, e.g., *Hartman*, 883 N.E.2d 774; *Reichardt v. Flynn*, 823 A.2d 566 (Md. 2003).

<sup>152</sup> S. 834, 2011 Leg. Reg. Sess (2011); H.R. 2016, 2011 Leg. Reg. Sess. (2011).

# health care system **4**

## Section A. The Impact of Sex Bias in **REPRODUCTIVE HEALTH CARE** on Women's Health

### INTRODUCTION

*Reproductive health care provides enormous benefits for women's health.<sup>1</sup> Contraception enables childbearing to be limited and timed, averting unwanted pregnancies and improving the health of women and babies. Some contraceptive methods also prevent transmission of HIV and sexually transmitted infections (STIs). Abortion, which is safe, legal, and one of the most common surgical procedures in the United States, saves lives and is an essential component of women's health care. Maternity care, including prenatal, delivery, and postpartum care, prevents loss of maternal and child life and markedly improves health outcomes for both women and children.*

*Reproductive health care has been under attack for decades, despite the clear health benefits it confers upon women, and despite the constitutional protection that women seeking reproductive health services enjoy.<sup>2</sup> Politically motivated restrictions, cutbacks or outright bans in governmental subsidies, and concerted campaigns of harassment and violence against health care providers have chipped away at reproductive health services and rights. Over the years, these tactics have limited access to abortion for the poor<sup>3</sup> and the young,<sup>4</sup> as courts have weakened the applicable constitutional standards.<sup>5</sup> While the core right remains intact, the legal, political, and economic barriers impeding access to reproductive health care place women's health at risk.*



## Contraception

Contraceptive use in the United States is high: 99 percent of women ages 15-44 who have ever had intercourse have used at least one contraceptive method in their lifetime.<sup>6</sup> According to a survey by the Centers for Disease Control and Prevention (CDC) in 2006–08, of the 62 million women ages 15 to 44 in the United States, about 62 percent were currently using a method of contraception at the time of the interview, including male methods such as vasectomy, condom, and withdrawal.<sup>7</sup>

In 2008 in Pennsylvania, 1,471,900 women of reproductive age were in need of contraceptive services and supplies.<sup>8</sup> These women were sexually active and able to become pregnant, but were not pregnant and did not wish to become pregnant.<sup>9</sup> Of these, 684,770 women were deemed to need publicly supported contraceptive services and supplies, in that they either had an income below 250 percent of the federal poverty level or were younger than 20.<sup>10</sup>

Publicly funded contraceptive services were provided to 325,800 Pennsylvania women in 2008, satisfying 47.6 percent of the need for subsidized care. Almost 42 percent of the need was filled by clinics funded through Title X of the Public Health Service Act,<sup>11</sup> a federal funding program supporting family planning services.<sup>12</sup> These services averted unintended pregnancies and abortions.

Despite high contraceptive use, barriers to contraceptive care persist, increasing the likelihood of unintended pregnancies. Nearly half (49 percent) of all pregnancies in the U.S. are unintended.<sup>13</sup> In 2006, 121,000 Pennsylvania residents had unintended pregnancies — pregnancies that were mistimed or unwanted — at the rate of 49 per 1,000 women aged 15–44.<sup>14</sup> Of these, 70 percent were mistimed and 30 percent unwanted.<sup>15</sup> Rates of unintended

pregnancy are much higher among women living in poverty and low-income women than among higher income women. In 2001, the unintended pregnancy rate was 29 per 1,000 among women whose income was at least twice the poverty level, but it was nearly four times as high, 112 per 1,000, among women whose income was below the poverty line.<sup>16</sup>

## Abortion Care

Abortion is a very common medical procedure. At current rates, one in three women will have had an abortion by the time she is 45 years old.<sup>17</sup> Of the 1.21 million women who had abortions in 2008, 61 percent were already mothers, and most were at least 20 years old.<sup>18</sup> Three-quarters of women who have abortions cite concern for or responsibility to other individuals — including their other children — as a factor in their decision.<sup>19</sup> In 2008, 41,000 women obtained abortions in Pennsylvania, some of whom were from other states, a rate of 17 per 1,000 women aged 15–44, compared with 19.4 per 1,000 nationally.<sup>20</sup> The vast majority of abortions (88 percent) are performed during the first 12 weeks of pregnancy, and 98.5 percent occur during the first 20 weeks.<sup>21</sup>

In 2008, 1,793 facilities provided abortions in the United States.<sup>22</sup> The majority of these facilities are concentrated in metropolitan areas. Thus, 87 percent of counties in the United States, where 35 percent of women live, have no abortion provider.<sup>23</sup> In 2005, in the northeastern United States, 11 percent of women seeking an abortion had to travel more than 50 miles, and three percent had to travel more than 100 miles.<sup>24</sup> In 2008, Pennsylvania had 50 abortion providers, an 11 percent decline from 2005 and a 23 percent decrease from 2000.<sup>25</sup> Over four-fifths of Pennsylvania counties have no abortion provider, and these coun-

ties house 46 percent of the Commonwealth's women.<sup>26</sup>

The overwhelming majority of abortion care is provided in a clinic setting, as opposed to in a hospital or doctor's office.<sup>27</sup> The unavailability of Medicaid and private insurance coverage for abortion care renders hospital-based abortion services too costly for many women in comparison to clinic-based care.<sup>28</sup> Furthermore, the combined impact of burdensome licensing, inspection, and reporting statutes, criminal penalties targeting abortion providers, Catholic hospital mergers, and concerted harassment of providers has all but eliminated abortion care in hospitals (which provide only four percent of all procedures) and physicians' offices (which provide only one percent of all procedures).<sup>29</sup>

### Maternity Care

In 2008 in Pennsylvania, 224,200 women became pregnant; 67 percent of these pregnancies resulted in live births.<sup>30</sup> Based

on data from 2007 to 2009, only 70.6 percent of women in Pennsylvania who gave birth received prenatal care in the first trimester, below the U.S. Healthy People 2020 target of 77.9 percent, which is substantially lower than the U.S. Healthy People 2010 target of 90 percent.<sup>31</sup> Allegheny County achieved the highest rate in the Commonwealth of early initiation of prenatal care, at 85.6 percent, while Philadelphia had the lowest percentage, only 53.5 percent.<sup>32</sup> Between 2007 and 2009, only 66.4 percent of women in Pennsylvania who had live births had early and adequate<sup>33</sup> prenatal care.<sup>34</sup>

The number of women who receive postpartum care, while high among U.S. women who deliver (89 percent), is significantly lower in certain U.S. population subgroups: those who do not receive prenatal care (66 percent) and those with less education (71 percent among women with eight years of education or less).<sup>35</sup>

## Impact on Women's Health

Access to reproductive health care improves women's health in many ways. Contraception prevents unintended pregnancies, allows women with pre-existing conditions to better maintain their health, and reduces the risk of STIs. Abortion services protect the health of women with certain pre-existing health conditions and pregnancy complications, and accessibility to safe and legal abortion services is essential to preventing dangerous illegal abortions. Maternity care protects the health of women during pregnancy and results in healthier babies.

### Contraception

Women have the potential to become pregnant for over thirty years of their lives,

and most spend a significant amount of that time trying to avoid pregnancy. Contraception is highly effective at preventing unintended and unwanted pregnancies.<sup>36</sup>

For some women, avoiding pregnancy is part of staying healthy,<sup>37</sup> as pregnancy may worsen pre-existing health conditions such as diabetes, hypertension, reflux esophagitis, lower extremity or lumbar arthritis, and coronary artery disease.<sup>38</sup> Contraception is essential to family planning, which has significant benefits for the health of women and their children. Women who plan their pregnancies are able to make behavioral changes that lead to better birth outcomes, including seeking prenatal care during their first trimester and maintaining care throughout their pregnancies. A wom-

an whose pregnancy is unplanned is less likely to breastfeed<sup>39</sup> and is less likely to seek prenatal care in the first trimester or at all.<sup>40</sup> She is also more likely to expose the fetus to harmful substances, such as tobacco or alcohol.<sup>41</sup> Mothers who are able to delay the conception of their next child for some time after giving birth lower their risk of adverse perinatal outcomes, including low-birth weight and preterm birth.<sup>42</sup>

Contraceptives have significant additional health benefits beyond the timing and prevention of pregnancy.<sup>43</sup> For example, hormonal contraceptives are helpful in addressing certain menstrual disorders. They can also prevent menstrual migraine headaches, treat pelvic pain and bleeding due to uterine fibroids, lower rates of pelvic inflammatory disease, and reduce the development of certain cancers, ovarian cysts, benign breast cysts, and fibroadenomas.<sup>44</sup> In addition, the use of male or female condoms reduces the risk of STIs.<sup>45</sup>

Although contraception is highly effective at preventing pregnancy, no contraceptive method is perfect. More than half of women who have had an abortion used a contraceptive method during the month they became pregnant.<sup>46</sup>

### Abortion Care

Abortion is an essential component of women's health care. It is a safe procedure — safer, in fact, than childbirth: the risk of death associated with abortion is about one-tenth of the risk associated with childbirth.<sup>47</sup> There are two forms of abortion: surgical and medical. The risk of complications from a surgical abortion is minimal. Less than 0.5 percent of women obtaining surgical abortions experience a complication.<sup>48</sup> Medical abortions, accomplished by taking Mifepristone, approved by the U.S. Food and Drug Administration in 2000, has been well-established in medical literature as a safe alternative to surgical abortion.<sup>49</sup>

Mifepristone is safer than acetaminophen (Tylenol), aspirin, and Viagra.<sup>50</sup>

Continuing a pregnancy endangers some women's health or even their lives. A variety of medical conditions can worsen with pregnancy, including high blood pressure, diabetes and diseases of the heart, kidneys, and blood vessels.<sup>51</sup> In addition, treatment of some medical conditions such as severe depression<sup>52</sup> or cancer<sup>53</sup> can be more difficult or pose greater risks when the patient is pregnant. For these women, abortion is a life-saving medical procedure.

Abortion may also be necessary when pregnancy results from failed contraception.<sup>54</sup> In addition, rape survivors who become pregnant from rape may need abortion care.<sup>55</sup> It is a human rights violation to force a rape victim to carry a pregnancy caused by rape.<sup>56</sup>

Abortion is a medically necessary procedure for women who need to terminate an unwanted pregnancy. Abortion care permits women to direct their own lives, determine their reproductive futures, and participate equally in the economic and social life of the nation.<sup>57</sup> Making abortion care inaccessible directly interferes with a woman's autonomy to determine her life's course, and thus to enjoy equal status as a citizen.<sup>58</sup>

When legal abortion is unavailable, some women turn to illegal procedures, which can be lethal. In the United States, prior to *Roe v. Wade*, illegal abortions were common, with estimates as high as 1.2 million per year in the 1950s and 1960s.<sup>59</sup> In 1965, illegal abortions accounted for 17 percent of all deaths attributed to pregnancy and childbirth.<sup>60</sup> Barriers to safe abortion care appear to have been responsible for recent deaths and injuries. In January 2011, West Philadelphia physician Kermit Gosnell and his staff were charged with crimes including

murder and infanticide related to his illegal abortion practice which targeted low-income and immigrant women.<sup>61</sup> Grand jury and state Senate testimony indicated that women sought care from Gosnell because they could not afford to go to safe, reputable doctors.<sup>62</sup>

### Maternity Care

Comprehensive maternity care is important for effectively protecting the health of the pregnant woman and her newborn. Early initiation of prenatal care allows the medical provider to diagnose any problems with the pregnancy as soon as possible.<sup>63</sup> Furthermore, prenatal care can monitor and treat harmful pregnancy-related conditions, such as gestational diabetes, high blood pressure and placental problems,<sup>64</sup> and connect women with high-risk pregnancies to life-saving obstetrical and neonatal care.<sup>65</sup>

Adequate prenatal care is also critically important for reducing the maternal death rate.<sup>66</sup> In Pennsylvania, there were 92 maternal deaths between 2005 and 2009, constituting 12.7 deaths per 100,000 live births.<sup>67</sup> This is a significant jump from the years 2001-2005, when the maternal mortality rate was 10 per 100,000 live births; African-American women die as a result of pregnancy and childbirth at a much higher rate than white women.<sup>68</sup>

Early initiation of prenatal care also reduces the risk of fetal abnormalities and infections. For example, it gives the medical provider an opportunity to educate women about behavioral risks, such as smoking and poor nutrition. As a result, prenatal care may prevent spina bifida and passage of HIV and other infections to the child. Some studies have shown that access to prenatal care reduces the likelihood of having a baby with low birth weight<sup>69</sup> and reduces the likelihood of delivering preterm.<sup>70</sup> Prematurity, defined as birth before 37 weeks gestation, accounts for one-third



of all infant deaths within the first year of life.<sup>71</sup> In 2009, 10.1 percent of live births in Pennsylvania were preterm.<sup>72</sup>

Postpartum care is recommended by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) because it provides an opportunity for the medical provider to evaluate the mother's well-being, provide any necessary referrals or treatment for underlying medical conditions, and provide information on family planning and infant care.<sup>73</sup> Although "postpartum" is traditionally defined as the first six weeks after delivery, many of the health concerns addressed following delivery may last for a year or longer. These issues include postpartum depression, breastfeeding, bladder/bowel dysfunction, and concerns about sexuality and contraception.<sup>74</sup> As short intervals between pregnancies may lead to low birth weight and preterm birth, contraceptive counseling is particularly important in this post-birth period when pregnancy may occur.<sup>75</sup>

## Barriers to Reproductive Health Care

Women face many barriers that prevent them from obtaining reproductive health care. Some of these barriers are the intended result of governmental policy, which could be remedied with appropriate government support and intervention.

### Barriers to Contraceptive Care: Cost

For women seeking to avoid pregnancy, contraceptives are a recurring expense. With the exception of condoms and emergency contraception (EC), most of the widely used methods require an exam and prescription from a health care provider.<sup>76</sup> Birth control pills cost between \$15-\$50 plus exam costs; Ortho Evra (the patch) and NuvaRing (the vaginal ring) each cost about \$15-\$80 a month plus exam costs.<sup>77</sup> Long-acting methods can cost hundreds of dollars in up-front costs:<sup>78</sup> Depo-Provera, a shot, costs \$50-\$75 per injection, plus any exam costs, and lasts three months; the diaphragm costs \$15-\$75, plus exam costs of \$50-\$200, requires spermicide, and lasts up to two years; Implanon, an implant, costs \$400-\$800 up front for implant, exam, and insertion, and lasts up to three years; an intrauterine device (IUD) costs \$500-\$1,000 up front for IUD, exam, insertion, and follow up visits, and lasts five to twelve years.<sup>79</sup>

While the majority of private health insurance policies cover contraception, some do not, or cover only selected methods or methods prescribed for a non-contraceptive purpose (*e.g.*, birth control pills for period regulation). High co-payments and deductibles can make even covered contraception prohibitively expensive.<sup>80</sup> Women without

adequate contraceptive coverage end up either paying high out-of-pocket costs for preventive care or going without contraception. Surveys have found that women would use different, often more effective, or longer-lasting methods if they did not have to worry about cost.<sup>81</sup>

Fortunately, the contraceptive cost barrier will be substantially ameliorated beginning in 2012, thanks to the Patient Protection and Affordable Care Act of 2010 (ACA) and guidelines from the Obama Administration's Department of Health and Human Services (HHS). On August 1, 2011, Secretary Kathleen Sebelius announced that HHS had accepted the recommendations of the Institute of Medicine (IOM) that key preventive health services for women, including contraception, should be covered by insurance without co-pays or deductibles. The HHS guidelines also adopted the IOM's recommendations for full coverage of other essential reproductive health services such as breastfeeding support; screening and counseling for HIV, domestic violence and gestational diabetes; and strengthened cervical cancer detection.<sup>82</sup>

### Barriers to Contraceptive Care: Threats to Public Funding

Public funding is a major source of support for family planning services for low income women.<sup>83</sup> Federal funding is provided by Title X of the Public Health Service Act, Title V (Maternal and Child Health block grant), Title XIX (Medicaid), and Title XX (Social Services Block Grant); and state-funded programs support women's medical services, excluding abortion, provided by

## ***How Much Does Contraception Cost?***<sup>i</sup>

<b>DEVICE OR PRESCRIPTION</b>		<b>ASSOCIATED PHYSICIAN TREATMENT</b>	
Birth Control Pills	\$15 - \$50 a month	Doctor's visit for exam and history in order to obtain prescription	\$35 - \$250
The Patch (Ortho- Evra)	\$15 - \$80 a month	Medical exam	\$35 - \$250
Vaginal Ring (NuvaRing)	\$15 - \$80 a month	Medical exam	\$35 - \$250
Contraceptive Injection (Depo- Provera)	\$35 - \$75 per injection, given every 3 months	Medical exam	\$35 - \$250 for 1st visit; \$20 - \$40 for each subsequent visit
Diaphragm	Diaphragm costs \$15 - \$75 and lasts 2 years; Spermicide gel, jelly, or cream costs \$8 - \$17 a kit	Medical exam	\$50 - \$200
Implant (Implanon)		Medical exam, implant, and in- sertion	\$400 - \$800 every 3 years
		Removal	\$100 - \$300
Intrauterine De- vice (IUD)		Medical exam, IUD, insertion, and follow-up visits	\$500 - \$1,000 eve- ry 5 – 12 years, depending on de- vice used

<sup>i</sup>Planned Parenthood, Birth Control, <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm> (last visited Mar. 22, 2012)

family planning clinics. Medicaid covers all contraceptive methods approved by the Food and Drug Administration (FDA). It accounts for the largest federal expenditure for contraceptive services. Many states, Pennsylvania included, expanded their family planning funding through a waiver program which allowed them to elevate the income eligibility guideline to cover more individuals.<sup>84</sup> Proposals to restrict eligibility, curtail services, require copays and deductibles, and cap funding threaten this critical funding stream.

For the one-quarter of all poor women who obtain contraceptive services at a health center funded by Title X of the Public Health Service Act, their access not only to contraceptive services but also to primary health care is under attack.<sup>85</sup> Title X is the only federal program devoted entirely to family planning, and Title X-supported family planning centers play an especially important role in serving the uninsured, who often cannot afford to pay out-of-pocket for care provided by private practitioners. In 2006, 234 family planning centers in Pennsylvania received support from Title X.<sup>86</sup> In 2008, Title X-supported centers:

- provided contraceptive care to 287,200 women in Pennsylvania,<sup>87</sup> and
- served 42 percent of women in need of publicly supported contraceptive services and supplies, compared with 27 percent served by such centers nationally.<sup>88</sup>

Nationally, women receive Title X-supported services at state health departments, Planned Parenthood affiliates, community health centers, hospitals, and other health centers.<sup>89</sup> In addition to contraceptives, Title X-supported centers provide STI counseling, testing and treatment, and critical preventive health care

services, including Pap tests and breast exams.<sup>90</sup>

Efforts in Congress and in several state legislatures to bar Planned Parenthood from receiving public funding and to defund Title X entirely threaten women's access to contraception. While Title X has survived so far, its funding was reduced from \$317 to \$300 million in 2011.<sup>91</sup> At the state level, the small family planning appropriation in the Department of Public Welfare budget is under continual attack during the annual legislative budget debates.

### **Barriers to Contraceptive Care: Educational Failure**

A majority of teens will have sex at or before age 19.<sup>92</sup> Teens rely heavily on school as a source of information about contraception and other sexual health issues.<sup>93</sup> It is therefore of great concern that federal funding continues to support abstinence-only programs, which significantly expanded after 1996.<sup>94</sup> In 2009, the Pennsylvania Department of Health and community-based organizations received \$4,613,771 in federal funds for abstinence-only programs.<sup>95</sup> Abstinence-only education programs — fueled by religious doctrine and moral objections to sexual activity — teach that abstaining from extramarital sexual activity is the only way to avoid STIs or unintended pregnancies. They provide no information about contraception, abortion, or the transmission of infectious diseases.<sup>96</sup> Numerous studies have produced no evidence to show that abstinence-only programs stop or materially delay teen sex or reduce the number of sex partners.<sup>97</sup> Nevertheless, although President Obama cut abstinence-only funding in his 2010 budget, the ACA reinstated funding for abstinence-only programs in addition to providing increased funding for comprehensive sexuality education.<sup>98</sup>

While many states require sexual education classes to provide information on contraception, Pennsylvania does not.<sup>99</sup> However, schools in Pennsylvania must teach about STIs, specifically HIV.<sup>100</sup> The Commonwealth has published the *Academic Standards for Health, Safety, and Physical Education*, which includes education on abstinence and STI prevention, but schools are not required to follow a specific curriculum.<sup>101</sup> Many Pennsylvania schools stress abstinence, sometimes to the exclusion of information about contraception and abortion.<sup>102</sup>

### Barriers to Contraceptive Care: Provider Refusal

Some medical and pharmaceutical providers' moral and religious objections to contraception hamper women's access to contraceptives, particularly EC, which must be taken shortly after intercourse to prevent pregnancy. EC prevents the ovary from releasing an egg and does not disturb a fertilized egg implanted in the uterus.<sup>103</sup> Because it does not end a pregnancy but only prevents one, EC is not a form of abortion. Rather, EC prevents abortions because it prevents unwanted pregnancies. Nonetheless, access to EC in pharmacies and hospitals nationally and in Pennsylvania remains uneven.

Some progress has been made in expanding pharmacy access to EC without a prescription. In 2006, Plan B, one form of EC that prevents pregnancy when taken within 72 hours of sexual intercourse, was approved by the FDA as an over-the-counter drug for women aged 18 and older.<sup>104</sup> Three years later, in July 2009, the FDA approved Plan B for use without a prescription for females age 17 and older and as a prescription-only option for females younger than age 17. After reviewing relevant scientific data, on November 30, 2011, FDA commissioner Margaret Hamburg concluded that Plan B "is safe and effective and should be ap-

## **Anspach v. City of Philadelphia**

WLP represented *amici curiae* in support of a health center operated by the City of Philadelphia that was sued by the parents of a teenage girl who consented to EC without their knowledge. The district court granted the city's motion to dismiss the parents' familial privacy, parental liberty, and religious freedom claims. The ruling was subsequently affirmed on appeal by the U.S. Court of Appeals for the Third Circuit, which concluded that the requirement that the state contact parents of a minor or encourage minors to contact their parents would "undermine the minor's right to privacy and exceed the scope of the familial liberty interest protected under the Constitution."<sup>i</sup> This case illustrates that government health care providers do not run afoul of parents' constitutional rights when they provide consenting minors with confidential contraceptive care, including EC.

<sup>i</sup> *Anspach v. City of Philadelphia*, 503 F.3d 256, 262 (3d Cir. 2007).

proved for nonprescription use for all females of child-bearing potential."<sup>105</sup> In an unprecedented and unilateral move, however, HHS Secretary Sebelius overruled the FDA's recommendation on December 7, 2011,<sup>106</sup> leaving Plan B prescription-only for women under age 17.<sup>107</sup>

Pennsylvania has also taken steps to promote access to EC through pharmacies. A 2006 study of 186 pharmacies in the northeast region of Pennsylvania found EC largely inaccessible, with only 32 percent of the surveyed pharmacies stocking it.<sup>108</sup> As awareness of EC grew, so did the drug's

availability. In 2007, the Pennsylvania Board of Pharmacy issued an administrative guidance letter stating that pharmacists have a “professional obligation to dispense EC.”<sup>109</sup> A pharmacist is permitted to decline to fill or refill a prescription for EC for religious, moral, or ethical reasons only if he or she takes steps to avoid the possibility of abandoning or neglecting a patient.<sup>110</sup> The guidance requires pharmacies to “devise reasonable accommodations that will respect the pharmacist’s choice while assuring delivery of services to patients in need.”<sup>111</sup> Following publication of this guidance letter, in 2009, the Women’s Law Project (WLP) surveyed 400 pharmacies in eight western Pennsylvania counties and found that while the majority stocked EC, 27 percent did not have EC immediately available. Even more troubling, of the pharmacies that did not have EC in stock, 43 percent refused to order or carry it even when directly requested to do so.<sup>112</sup>

In addition, in response to a public outcry following a Catholic hospital’s refusal to provide a rape survivor with EC to help her avoid getting pregnant by her assailant, the Pennsylvania Department of Health (DOH) promulgated an administrative guidance in 2008 requiring hospitals with emergency services to offer EC to sexual assault survivors.<sup>113</sup> Any hospital that refuses must notify the DOH that it does not dispense the medication, and those hospitals must provide patients with information about EC and immediately transfer rape survivors to the closest facility that provides EC. Pursuant to the same policy, the DOH publishes an annual list of hospitals that refuse to provide EC to rape survivors.

### **Barriers to Abortion Care**

Legal restrictions, provider shortages, and organized campaigns of violence and harassment have marginalized abortion and have rendered it inaccessible in most parts of Pennsylvania. When women do not

have ready access to abortion services, they delay their procedures to later stages of pregnancy; sometimes, they turn to dangerous self-administered methods or illegal practitioners. Tens of thousands of women’s lives were lost at the hands of unsafe, illegal providers prior to abortion’s legalization in 1973.<sup>114</sup> It is essential for women’s safety that government nurture and support good providers of abortion care.

### **Barriers to Abortion Care: Direct Legal Restrictions**

Restrictive federal and state legislation and the erosion of federal constitutional protections for the abortion right have limited access to abortion care. Congress has enacted several measures directly limiting access to abortion. The most notable is the Hyde Amendment,<sup>115</sup> an annual appropriations rider prohibiting federal Medicaid funding for abortions except in cases of danger to the woman’s life or when the pregnancy resulted from rape or incest. In 2003, Congress enacted the Federal Partial-Birth Abortion Ban Act, criminalizing certain safe abortion procedures.<sup>116</sup>

Since 1973, some states have passed laws protecting women’s access to abortion,<sup>117</sup> but Pennsylvania has gone in the opposite direction by repeatedly enacting restrictive legislation that impedes safe abortion access. Much of this legislation has provoked constitutional challenges over the course of nearly forty years.

Abortion is the only medical procedure regulated through its own chapter of the Pennsylvania Crimes Code. Among the restrictions imposed by the Pennsylvania Abortion Control Act are the following:

- State Medicaid funding does not cover abortion care except in narrowly defined circumstances, *e.g.*, to avert the pregnant woman’s death, or where the pregnancy resulted from rape or in-

cest.<sup>118</sup> In order for Medicaid to cover the procedure, when possible the victim must personally report the sexual assault, together with the name of the offender, if known, to the appropriate law enforcement or child protective services authorities.<sup>119</sup> Medicaid does not cover abortions that are required because the fetus is fatally impaired or because the pregnant woman is grievously ill and needs the procedure to protect her health when her life is not in danger.

- Abortions (with exceptions for procedures required to save the woman's life or in cases of pregnancies caused by rape or incest) may not be provided in public hospitals.<sup>120</sup>
- Except in medical emergencies, a woman must delay her procedure for at least 24 hours after a provider has given her an informed consent lecture designed to discourage abortion. The lecture includes risks and alternatives to abortion, the fact that Medicaid pays for child-birth expenses, and that the "father of the unborn child" may be liable for child support if the patient continues the pregnancy to term.<sup>121</sup>
- At least 24 hours prior to the procedure, women must be offered printed material published by the Commonwealth describing fetal development.<sup>122</sup>
- Young women under age 18 who are not legally emancipated must get one parent to consent to their abortion after the parent receives the informed consent lecture from a doctor.<sup>123</sup> If she cannot get her parent's consent or fears asking for it, she may obtain a court order called a judicial bypass, which permits her to dispense with parental consent.<sup>124</sup>

## ***WLP's Legal Challenges to Pennsylvania Abortion Barriers***

WLP represented the plaintiffs in the following cases:

*Elizabeth Blackwell Health Center v. Knoll* (1995), a successful challenge to Pennsylvania's rape and incest reporting requirements, and second-physician certification requirements, for low-income women seeking Medicaid abortions.<sup>i</sup>

*Planned Parenthood v. Casey* (1992), the landmark U.S. Supreme Court case reaffirming abortion rights and striking down Pennsylvania's husband notification statute.<sup>ii</sup>

*Roe v. Operation Rescue* (1989), a civil action winning injunctive relief against anti-abortion blockades of reproductive health clinics.<sup>iii</sup>

*ACOG v. Thornburgh* (1986), a challenge to Pennsylvania's Abortion Control Act of 1982, in which the U.S. Supreme Court reaffirmed the constitutional principles of *Roe v. Wade*.<sup>iv</sup>

<sup>i</sup> *Elizabeth Blackwell Health Ctr. for Women*, 61 F.3d 170 (3d Cir. 1995).

<sup>ii</sup> *Casey*, 505 U.S. 833 at 877.

<sup>iii</sup> *Roe v. Operation Rescue*, 730 F. Supp. 656, 1989 U.S. Dist. LEXIS 15608 (E.D. Pa. 1989).

<sup>iv</sup> *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

## ***WLP Filed Amicus Curiae (Friend of the Court) Briefs in Opposition to State and Federal Abortion Restrictions***

*Gonzales v. Carhart* (2007), a nationwide *amicus* campaign in which the WLP mobilized diverse organizations in support of women's right to choose the safest and most medically appropriate abortion procedure. The WLP brief was in opposition to a federal ban on intact dilation and extraction procedures. In a 5-4 ruling, the Court upheld the first-ever federal ban on abortion procedures but did not overrule prior holdings that abortion restrictions must never endanger women's health.<sup>i</sup>

*Ayotte v. Planned Parenthood of Northern New England* (2006), an *amicus* brief prepared by WLP on behalf of nine groups in support of Planned Parenthood's position that the lower courts had properly found New Hampshire's parental notification law unconstitutional, because it did not include an exception allowing doctors to perform an emergency abortion for a minor who had not notified her parents without obtaining permission from a judge.<sup>ii</sup> The Supreme Court remanded the case for a determination of whether the statute should be invalidated entirely or whether a more limited remedy was appropriate. When New Hampshire repealed the law in 2007, rehearing at the district court level was moot.<sup>iii</sup>

*Alaska v. Planned Parenthood of Alaska* (2004), an *amicus* brief filed by the WLP in support of Planned Parenthood of Alaska's challenge to Alaska's judicial bypass law. The brief described the enormous burden the judicial bypass procedure would impose upon young women in Alaska who seek an abortion.<sup>iv</sup> Plaintiffs prevailed at trial, and the Alaska Supreme Court affirmed the trial court's ruling in 2007.<sup>v</sup>

*Stenberg v. Carhart* (2002), an *amicus* brief submitted by the WLP on behalf of 75 organizations committed to women's equality.<sup>vi</sup> In a victory for women, the Supreme Court ultimately decided that the Nebraska law banning a specific abortion procedure was unconstitutional.

<sup>i</sup> *Carhart*, 550 U.S. 124 (2007).

<sup>ii</sup> *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006).

<sup>iii</sup> Ctr. for Repro. Rts., Cases and Resources: Parental Involvement Laws, <http://reproductiverights.org/en/case/ayotte-v-planned-parenthood-for-northern-new-england-nh> (last visited Mar. 6, 2012).

<sup>iv</sup> Brief of the National Association of Social Workers Alaska Chapter, Alaska Women's Lobby, Alaska Pro-Choice Coalition, National Center for Youth Law, Juvenile Law Center, and Jane's Due Process as Amici Curiae in support of Plaintiffs-Appellees, *Alaska v. Planned Parenthood of Alaska*, No. 6184, 171 P.3d 577 (Alaska 2007), available at [http://www.womenslawproject.org/Briefs/FINAL\\_brief\\_Alaska.pdf](http://www.womenslawproject.org/Briefs/FINAL_brief_Alaska.pdf).

<sup>v</sup> Ctr. for Repro. Rts., Cases and Resources: Parental Involvement Laws, <http://reproductiverights.org/en/case/planned-parenthood-of-alaska-v-state-ak> (last visited Mar. 6, 2012).

<sup>vi</sup> Brief of Amici Curiae of Seventy-Five Organizations Committed to Women's Equality in Support of Respondent, *Stenberg v. Carhart*, No. 99-830, 530 U.S. 914 (2000), available at [http://www.womenslawproject.org/Briefs/PBfinal\\_equality\\_brief.pdf](http://www.womenslawproject.org/Briefs/PBfinal_equality_brief.pdf).

- Abortion providers are singled out for intrusive and burdensome reporting requirements<sup>125</sup> and extensive facilities regulations,<sup>126</sup> some of which have marginal or no medical benefit for patients and serve only to make abortion care more expensive and complicated to provide.

These restrictions, singly and together, prevent many women from obtaining abortions and substantially delay the procedures of many more. Undue delay in obtaining abortion care threatens women's health: the later in pregnancy the procedure occurs, the more costly it is, the less available it becomes, as few providers offer second-trimester procedures, and, importantly, the greater the difficulty and medical risk of the procedure.<sup>127</sup> Ensuring prompt access to high quality abortion care is essential to safeguard women's health.

### **Barriers to Abortion Care: Cost**

The cost of unsubsidized abortion care is perhaps the single greatest barrier to abortion access in Pennsylvania. In 2011, a clinic-based first-trimester abortion typically costs \$400-\$450.<sup>128</sup> As a point of comparison, in most counties in Pennsylvania, the entire monthly cash assistance allowance for a mother with two children is \$403.<sup>129</sup> Abortion procedures performed in a physician's office or a hospital setting, which may be the appropriate care setting for medically fragile women, generally cost more than clinic-based care.<sup>130</sup>

Many women lack insurance that covers abortion. In 2008, 33 percent of women who obtained abortion care did not have health insurance; 30 percent had private insurance, and 31 percent had Medicaid.<sup>131</sup> Of those with private health insurance, 63 percent paid out of pocket for abortion services, for reasons including lack of abortion coverage in plan, lack of knowledge of plan coverage, high deducti-

bles that prevented use of private insurance for this purpose, or reluctance to use coverage for fear information would be accessible to employer, health care provider, or family member.<sup>132</sup>

Low-income women generally cannot rely on Medicaid to cover the cost of abortion care.<sup>133</sup> Without coverage, they face extraordinary difficulties in raising the money for the procedure, usually causing lengthy delays. Private abortion loan funds are able to defray these expenses only for a minority of the women who seek their assistance. Studies conducted by the Guttmacher Institute estimate that a shocking 18-35 percent of women who would have had an abortion had it been paid for by Medicaid, instead were forced to continue their pregnancy.<sup>134</sup>

Recent developments affecting private insurance coverage of abortion also bode ill for Pennsylvania's women. While the ACA facilitates women's access to many types of health care, it prohibits federal funding of abortion care except in cases of rape, incest, and life endangerment.<sup>135</sup> In addition, it permits states to ban the sale, in the health insurance exchanges to be created by 2014, of insurance covering abortion care. President Obama has issued an executive order reiterating that the ACA extends into the health insurance exchanges the same restrictions on federal funding for abortion care contained in the Hyde Amendment,<sup>136</sup> for the first time expanding abortion restrictions into the private insurance marketplace. While the ACA permits health plans to include coverage for abortion if the insured purchases the abortion coverage entirely with private funds and pays separately for it, many states, including Pennsylvania, are moving to ban abortion coverage in the exchanges altogether.<sup>137</sup>

The Pennsylvania Senate has passed SB 3 of 2011, banning any sale of abortion coverage

in the state exchange except in the case of life endangerment, rape, or incest; at this writing, this legislation awaits a final vote in the state House.<sup>138</sup> Even if Pennsylvania does not directly ban abortion coverage, as this coverage becomes further marginalized and requires unwieldy segregation of premium payments, private insurers may stop offering abortion coverage as an option because of the added obstacles.<sup>139</sup>

The impact of the cost of abortion on the accessibility of care has been documented. Approximately 58 percent of abortion patients report a delay in receiving the procedure, and of these women, 60 percent attribute this delay to the time it took to make arrangements and raise money.<sup>140</sup> More than two-thirds of women having abortions beyond the first trimester say they were delayed because of problems in affording, finding, or getting abortion services.<sup>141</sup> An increase of just \$25 in the cost of an abortion can be expected to prevent one or two out of every 100 low-income women seeking an abortion from being able to obtain one.<sup>142</sup>

### **Barriers to Abortion Care: Misinformation**

Foes of abortion rights perpetuate myths about abortion to dissuade women from obtaining reproductive health care. For example, anti-choice misinformation campaigns have incorrectly tied abortion to pregnancy complications, poor birth outcomes, and infertility, as well as breast cancer and mental health problems.<sup>143</sup> Research demonstrates that these claims are without basis.

Contrary to these myths, the most comprehensive and up-to-date medical research, incorporating studies from 21 countries, found that an abortion “does not increase the risk of suffering major pregnancy complications during future pregnancies or deliveries. There is no added risk of infant

mortality or of having a low birth weight infant, nor is there increased risk of infertility, ectopic pregnancy, or miscarriage following an abortion.”<sup>144</sup> Illegal abortion procedures, however, can be unsafe and increase the risk of obstetric complications and future infertility for the woman.<sup>145</sup> Dozens of studies have examined the link between abortion and breast cancer, and not one peer-reviewed study has concluded that any such link exists. The American Cancer Society, the U.S. National Cancer Institute, and ACOG agree that the existing scientific research does not support a link between abortion and an increased risk of later developing breast cancer.<sup>146</sup>

The claim that legal abortion causes a range of mental health problems known as “post-abortion syndrome” is also unfounded.<sup>147</sup> In 2008, following a two-year review of the “best scientific evidence published,” the American Psychological Association’s Task Force on Mental Health and Abortion found that a woman who chooses abortion is at no greater risk for mental health problems than if she chooses to carry an unintended pregnancy to term. The Task Force noted that all women making decisions about their reproductive health face complex and diverse circumstances, which may lead to variability in their psychological responses.<sup>148</sup>

Some crisis pregnancy centers (CPCs) also provide misinformation about pregnancy and abortion to women under the guise of counseling and health care. The worst of these centers, often staffed by non-medical volunteers, aim to convince women not to terminate their unintended pregnancies and may, through delay tactics, foreclose abortion as an option for women.<sup>149</sup> Some of these centers provide medically inaccurate information and refuse to provide referrals for abortion.<sup>150</sup>

### Barriers to Abortion Care: Violence and Harassment

Patients, doctors, and staff of reproductive health care providers are the targets of concerted campaigns of harassment, intimidation, and violence from opponents of abortion rights. The violence orchestrated against Pennsylvania providers has taken the form of firebombing, arson, clinic blockades, bomb threats, death threats, stalking, clinic invasions, and vandalism. Elsewhere, it has taken the form of murder:

- On May 31, 2009, Dr. George Tiller of the Women's Health Care Services clinic was shot to death at his church by an anti-abortion extremist in Wichita, Kansas. Dr. Tiller was one of the last remaining doctors in the country who performed abortions later in pregnancy. In 1985, his clinic was bombed, and in 1993 he was shot outside of his clinic. Due to fear for his safety, he routinely wore a bullet-proof vest to work and drove in an armored car. His killer, Scott Roeder, was convicted of first-degree murder and sentenced to life in prison.<sup>151</sup>
- In April 2007, a man placed a homemade bomb in the parking lot of the Women's Health Center located in Austin, Texas. A bomb squad was called and disposed of the device, which contained two pounds of nails. No one was injured.<sup>152</sup>
- In October 1998, Dr. Barnett Slepian was fatally shot in his home in Amherst, New York. James Kopp was convicted of second-degree murder and sentenced to 25 years to life in prison. Kopp was also convicted and sentenced to life on federal charges of violating the Freedom of Access to Clinic Entrances Act (FACE).<sup>153</sup>

### *U.S. v. John Dunkle*

In 2007, the U.S. Department of Justice brought a civil Freedom of Access to Clinic Entrances Act case against a Pennsylvania anti-abortion protester named John Dunkle, for posting on the Internet the names, addresses, and photos of Pennsylvania doctors who provide abortion care, accompanied by detailed instructions on how to kill them.<sup>i</sup> The U.S. Attorney for the Eastern District of Pennsylvania won an injunction permanently removing this material from the Internet.<sup>ii</sup> John Dunkle continues to picket Pennsylvania abortion providers at their workplaces and their homes.

<sup>i</sup> *Gonzales v. Dunkle*, 2:07-cv-03577 (E.D. Pa. Nov. 8, 2007) (entering permanent injunction against Dunkle), described in Citizen Media Law Project, *Gonzales v. Dunkle*, Nov. 15, 2007, available at <http://www.citmedialaw.org/threats/gonzales-v-dunkle> (last visited Nov. 2, 2011).

<sup>ii</sup> *Id.*

- In January 1998, a bomb exploded outside of a Birmingham, Alabama abortion clinic. A police officer, Robert Sanderson, was killed; several others were wounded. Eric Robert Rudolph pled guilty and is serving a life sentence.<sup>154</sup>
- In July 1994, Dr. John Bayard Britton and his volunteer escort, Mr. James H. Barrett, were shot and killed outside of a Pensacola, Florida abortion clinic. Barrett's wife June was wounded in the attack. Former minister and anti-abortion activist Paul J. Hill was convicted of murder and sentenced to death.<sup>155</sup>
- In December 1994, John Salvi walked into two Boston-area abortion clinics and began to shoot. He killed two receptionists and wounded five

## ***U.S. Court of Appeals Upholds Modified Pittsburgh Buffer Zone Law***

Following the adoption of the Pittsburgh buffer zone ordinance, an anti-abortion protester filed a lawsuit challenging its legality under both the U.S. and Pennsylvania Constitutions and state law. After the trial court denied the protestor's request for a preliminary injunction to prevent the City from enforcing the ordinance against her, and dismissed certain claims, she appealed to the U.S. Court of Appeals for the Third Circuit. In an October 30, 2009 ruling in *Brown v. City of Pittsburgh*, the Third Circuit upheld the constitutionality of both of the buffer zones in the ordinance — a 15-foot fixed no-protest zone around clinic entrances and a floating 8-foot personal bubble zone of protection around each person approaching the clinic.<sup>1</sup> However, while noting that “the question is close,” the appeals court concluded that the specific factual record before it did not support the combination of the two zones and that the City could therefore keep one but not both kinds of protective zones. The record before the appeals court, developed at a preliminary stage of litigation, did not include any testimony of any clinic escorts, staff or patients. The appeals court remanded the case to the trial judge to permit the City to determine which of the two types of buffer zones it wished to keep, and the City has decided to keep the 15-foot fixed no-protest zone. WLP provided research assistance and support for the adoption of this buffer zone ordinance by Pittsburgh City Council.

<sup>1</sup> *Brown v. City of Pittsburgh*, 586 F. 3d 263 (3d Cir. 2009).

others. He was sentenced to life in prison without parole.<sup>156</sup>

- In March 1993, Dr. David Gunn was killed outside of a Pensacola, Florida clinic by anti-abortion protester Michael Griffin. Griffin was sentenced to life in prison.<sup>157</sup>

The threat of violence, together with lesser forms of harassment such as telephone blockades, vendor and construction boycotts, and frivolous lawsuits by protesters, means that abortion providers are living under a constant state of siege.

Legal remedies against clinic violence exist. While these laws punish violators and improve safety, they do not eliminate all threats of violence or invasive tactics used by protesters. Basic state and federal laws criminalizing assault, harassment, trespass, and arson may apply, as do ordinances prohibiting loitering and picketing. In 1994, following an escalation of clinic violence across the country, Congress adopted the FACE Act,<sup>158</sup> which provides both criminal and civil remedies for the obstruction of entrances and exits of reproductive health care facilities as well as threats and acts of violence against providers and their patients. Since 2009, the Civil Rights Division of the U.S. Department of Justice has opened 20 FACE investigations and has filed six civil FACE complaints, which have already resulted in three consent decrees.<sup>159</sup> By comparison, the Division filed only one civil FACE case in 2007 and none in the preceding eight years.<sup>160</sup>

Courts and legislatures have adopted buffer zones to prevent physical confrontations between patients and protesters. Statutory buffer zones are limited restrictions on expressive activity aimed at unwilling listeners; they exist in many contexts, including reproductive health facilities. There are two basic types of buffer zones: fixed buffer zones that regulate activity within a defined

distance from the entrance to a health care facility, and floating bubble zones (also called personal safety zones) that protect a person from being approached by someone who is protesting, counseling, leafleting, or educating without consent. Courts have upheld such buffer zones in the face of First Amendment challenges as reasonable time, place, and manner restrictions that leave open ample alternative avenues for expression.<sup>161</sup>

The City of Pittsburgh is the only jurisdiction in Pennsylvania with a clinic buffer zone ordinance, which has been enforced since 2005. The Pittsburgh Medical Safety Zone Ordinance helps prevent violence outside health care facilities by prohibiting persons from knowingly congregating, picketing, patrolling, or demonstrating within 15 feet of the entrance to a health care facility.<sup>162</sup>

### **Barriers to Abortion Care: Provider Shortage**

Nationally, while 97 percent of surveyed OB/GYNs have encountered patients seeking abortions, only 14 percent of OB/GYNs provide them.<sup>163</sup> In Pennsylvania, the abortion provider shortage has been particularly dramatic.<sup>164</sup> Furthermore, Catholic hospitals, which have approximately one-fifth of all hospital admissions in the United States and between 10 and 20 percent of the admissions in Pennsylvania,<sup>165</sup> restrict access to contraception,<sup>166</sup> abortion,<sup>167</sup> and even procedures necessary when a woman has an ectopic pregnancy or miscarries.<sup>168</sup> These restrictions are due to Catholic hospitals' adherence to religious doctrine contained in the "Ethical and Religious Directives for Catholic Health Care Services" (Directives). Directive 47 permits "operations, treatments, and medications that have as their direct purpose the cure of [a harmful] condition of a pregnant woman ... when they cannot be safely postponed until the unborn child is viable,

## **Catholic Hospital Penalized for Allowing Medically Necessary Abortion**

A high-profile example of religious interference in maternity care came out of Phoenix, Arizona. In 2009, a nun who was an administrator at St. Joseph's Hospital approved a medically-necessary termination of an 11-week pregnancy to save the life of the pregnant woman after she had developed pulmonary hypertension, a potentially fatal condition that limits heart and lung function. The Catholic Diocese of Phoenix excommunicated the nun and eventually retaliated against the hospital by removing its Catholic affiliation.<sup>i</sup> This example highlights how high the stakes are when Catholic-affiliated hospitals attempt to implement Directive 47 while treating pregnant women.

<sup>i</sup> Mitchell Landsberg, *After An Abortion is Performed to Save a Life, the Facility Loses its Catholic Affiliation*, L.A. Times A10 (Dec. 22, 2010).

even if they will result in the death of the unborn child.”<sup>169</sup> In practice, however, these hospitals may delay treatment or attempt to transfer a potentially unstable patient to a non-Catholic hospital, further endangering the pregnant woman's life.<sup>170</sup>

Pennsylvania's provider shortage is likely to worsen considerably after the enactment of recent TRAP legislation (targeted regulation of abortion providers). Act 122 of 2011, which was passed by the Pennsylvania General Assembly and signed by Governor Tom Corbett on December 22, 2011, requires freestanding clinics to meet the requirements of ambulatory surgical

## **Religion and Doctors' Treatment Recommendations**

The effect of working in religiously-affiliated hospitals on doctors' treatment recommendations was examined in a 2010 study by the National Women's Law Center. The study focused on decisions relating to potentially dangerous pregnancy complications and found "four serious lapses in care resulting from religious restrictions:

- Doctors performed medically unnecessary tests, resulting in delays in care and additional medical complications for patients. These tests were done solely to address hospital administrators' concerns that the treatment complied with religious doctrine.
- Doctors transferred patients with pregnancy complications because their hospitals' religious affiliation prohibited them from promptly providing the medically-indicated standard of care.
- Hospital administrators interfered with doctors' ability to promptly provide patients with the standard of care.
- Hospital administrators interfered with doctors' ability to provide patients with relevant information about their treatment options."<sup>i</sup>

<sup>i</sup> National Women's Law Center, *Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and Health 2* (2011), available at <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf>.

centers, facilities where riskier, more invasive surgeries of up to four hours' duration take place. In contrast, most abortion procedures are performed in 7 to 15 minutes and carry less risk of death than a penicillin injection.<sup>171</sup> Depending upon how they are implemented, these requirements could force safe abortion providers to make costly upgrades with no safety benefit for women. Any increase in cost is likely to force women seeking abortions to resort to out-of-state providers — or tragically, to turn to self-help or illegal practitioners.

### **Barriers to Maternity Care**

Many women who want to continue a pregnancy find it challenging to access prenatal and postpartum care. Under federal law, hospitals must treat women in labor but are under no general legal obligation to provide prenatal or postpartum care.<sup>172</sup> Many Pennsylvania women, particularly poor women, have few options when choosing obstetrical providers, causing them to start prenatal care after the first trimester of pregnancy, receive inadequate care, or get no care at all.<sup>173</sup> At least four trends may contribute to inadequate maternity care in Pennsylvania: (1) obstetrical providers may be leaving the state or limiting services to only gynecological care; (2) maternity wards are closing; (3) fewer obstetrical providers are accepting Medicaid; and (4) restrictions based on faith-based objections at religiously-affiliated hospitals limit the care pregnant women receive.

The extent to which obstetrical providers have shifted their practice area to exclude delivery and high-risk care, have left the state, or have chosen not to enter the state is unclear.<sup>174</sup> Several studies, including one conducted by the United States General Accounting Office (GAO), have found more modest shifts in the supply of obstetrical providers than surveys conducted by

medical professional societies.<sup>175</sup> The GAO reported that, at a rural hospital in Pennsylvania, “four of the nine OB/GYNs who provide obstetrical care serving two counties stopped providing newborn delivery services,” that “the four remaining OB/GYNs were each in their sixties,” and that “[s]ome pregnant women now travel an additional 35 to 50 miles to deliver.”<sup>176</sup> One researcher found the supply of obstetricians decreased by eight percent between 1993 and 2002.<sup>177</sup> To some degree, these shifts in obstetrical care providers may be connected to natural demographic shifts in population. The population of reproductive-age women in Pennsylvania dropped in the early 2000s, reducing the need for obstetrical care in the state.<sup>178</sup>

The closing of maternity units and hospitals is better documented than the shifts in the supply of obstetrical care providers. Between 1997 and 2011, 39 maternity wards in Pennsylvania closed.<sup>179</sup> Many remaining obstetrical providers do not accept Medicaid.<sup>180</sup> As a case in point, in the 2000s, women on Medicaid in Norristown have seen a dramatic decline in access to prenatal care after the federally qualified health center stopped offering prenatal care, one of two hospital clinics closed its maternity unit, and the other hospital clinic made plans to move from downtown Norristown to a suburban location.<sup>181</sup> In 2008-09, 13 percent of Pennsylvania’s women, ages 18-64, were on Medicaid.<sup>182</sup> For these women, it may be challenging to find obstetrical care close to home; even after they have found a practitioner who accepts Medicaid, they may have to wait much longer for a first appointment than women with commercial insurance would have to wait.<sup>183</sup>

Furthermore, maternity care is inaccessible to women who are ineligible for Medicaid and unable to afford private insurance, as well as to underinsured women who do not have maternity coverage. In 2008-09, 12

percent of women ages 18-64 were uninsured in Pennsylvania.<sup>184</sup> Some uninsured women will qualify for Medicaid after they become pregnant. Those who do not qualify for Medicaid may have to pay out-of-pocket for the cost of prenatal care and delivery. Among those who do not qualify for Medicaid in Pennsylvania are undocumented immigrants.<sup>185</sup>

Fortunately, the ACA will likely increase access to maternity care. The purpose of this federal law is to expand access to health care by requiring everyone to obtain health insurance by making health insurance more affordable and by increasing the supply of medical providers.<sup>186</sup> Some of the provisions that are most relevant to reproductive health care include:<sup>187</sup>

**Section 1001:** As of 2010, all new health insurance plans must offer, free of charge to the patient, all screenings and services that the U.S. Preventative Services Task Force recommends, including folic acid supplementation for pregnant women, prenatal and postpartum breastfeeding counseling, and screening for several conditions.<sup>188</sup> In addition, health insurance plans that begin on or after September 23, 2010 will be prohibited from requiring referrals or authorizations for women seeking gynecological or obstetrical care.<sup>189</sup>

**Section 1201:** As of 2014, health insurance plans may not deny coverage to adults with pre-existing conditions.<sup>190</sup> This provision will make health insurance accessible to uninsured pregnant women who are ineligible for Medicaid and were previously ineligible to purchase health insurance or, if they were able to purchase insurance, for whom the current pregnancy was not covered in their health plans.

**Section 1302:** Maternal and newborn care will be included as “essential health benefits,” part of the medical services that new

insurance policies must cover after January 2014.<sup>191</sup>

**Section 1402:** As of 2014, uninsured women with incomes between 100 percent and 400 percent of the federal poverty level will be eligible to receive subsidies for buying health insurance through state insurance exchanges, making insurance affordable to those with low to moderate incomes.<sup>192</sup>

**Section 2001:** As of 2014, states will be required to provide insurance coverage for at least basic essential health services to all uninsured individuals with incomes up to 133 percent of the federal poverty level.<sup>193</sup> This provision is an improvement over the current situation, where a substantial number of pregnant women are uninsured prior to pregnancy.<sup>194</sup>

**Section 2301:** As of 2010, Medicaid will cover maternity services provided by free-standing birth centers, which are licensed facilities separate from a hospital or the woman's home where a woman plans to give birth.<sup>195</sup>

**Section 2951:** Establishes a Maternal, Infant, and Early Childhood Visiting Program to provide grants for services in communities at risk, beginning in fiscal year 2010.<sup>196</sup>

**Section 2952:** Provides support and education for families experiencing postpartum depression and research on postpartum depression, beginning in fiscal year 2010.<sup>197</sup>

**Section 3114:** For services furnished on or after January 2011, certified nurse-midwives must receive reimbursement equal to the rate physicians receive under Medicare, which will likely raise reimbursement rates for nurse-midwives overall.<sup>198</sup>

**Section 4107:** As of 2010, Medicaid must cover comprehensive tobacco cessation services for pregnant women, including diagnostic, therapeutic, and counseling services.<sup>199</sup>

**Section 10212:** Establishes a Pregnancy Assistance Fund to assist pregnant teens, teen parents, and women enrolled in higher education with support, as of 2010.<sup>200</sup>

Some of these reforms will not take effect until 2014. At this writing, a bill is pending in the Pennsylvania Senate that would

expand access to maternity care in the interim by requiring insurers to cover prenatal, pregnancy, and postpartum care.<sup>201</sup>

## RECOMMENDATIONS FOR REFORM

In countless ways, our laws and policies fail to support, and in many cases directly impede, women’s access to reproductive health care. The following list of proposals for policy reform — by no means comprehensive — illustrates ways in which our public policy could be improved to nurture and support women’s reproductive health.

### Contraception

- Family planning services should be cost-free for patients who cannot afford to pay for them and more accessible to women of all socio-economic classes.<sup>202</sup> Family planning funding programs such as Title X should be reauthorized and fully funded.
- Family planning services should be available to all, including undocumented immigrants.
- Pennsylvania schools should replace abstinence-only education with comprehensive, evidence-based sexuality education. Funding of abstinence-only programs should be discontinued.
- Emergency contraception should be available at all hospitals that treat sexual assault survivors.
- Emergency contraception should be readily available at all state-licensed pharmacies and available without prescription for all females of child-bearing potential.
- Pennsylvania should audit the Alternatives to Abortion program as well as the CPCs with whom the program subcontracts; withdraw state funding from CPCs that disseminate misinformation on contraception, pregnancy, or abortion; and correct the misinformation available on websites subsidized in whole or in part with state Alternatives to Abortion dollars.

### Abortion Access

- Abortion care must be affordable for all women who need it:
  - The Medicaid program should fund all medically necessary abortion care for low-income women. Congress should repeal Hyde-type limits on Medicaid; Pennsylvania should repeal funding restrictions in the Abortion Control Act.
  - The Pennsylvania General Assembly should defeat SB 3 and permit women to use their own money to buy abortion coverage in the insurance exchanges.
- Abortion care must be accessible for all women who need it:
  - All legislative efforts to hinder women’s access to abortion should stop. The Pennsylvania General Assembly should repeal Act 122 of 2011, which contains inappropriate requirements for and will close safe abortion providers.
  - The Pennsylvania General Assembly should repeal the restrictions imposed by the Abortion Control Act that do not protect women’s health and that impede access to

- care, including the 24-hour mandatory delay, biased counseling provisions, and parental consent requirement.
- The Pennsylvania General Assembly should follow Pittsburgh's example and pass statewide clinic buffer zone legislation.
  - Pennsylvania's Attorney General should enforce FACE.
  - Pennsylvania's Medicaid reimbursement rate for abortions in cases of rape, incest, and life endangerment should be increased to reflect the reimbursement rate available through commercial insurance.

### **Maternity Care**

- Pennsylvania's Department of Health should revise its regulations to require at least 60 days notice when a maternity unit is to be closed so that the community has adequate notice.<sup>203</sup>
- Pennsylvania's General Assembly should adopt SB 1063 of 2011 to ensure insurance coverage of prenatal, delivery, and post-partum care pending full implementation of the ACA.
- Policy makers should make it a priority to provide more generous supports for pregnant women, including increasing welfare cash assistance grant levels, passing paid family leave legislation, and defeating legislation to punish pregnant women for unhealthy behavior.

## ENDNOTES

<sup>1</sup> “Reproductive health care” includes a broader range of services than those addressed in this chapter. The chapter focuses on contraception, abortion, and maternity care, as these services are at the center of the public policy debate over women’s equality and autonomy.

<sup>2</sup> *See, e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 877 (1992) (reaffirming right to abortion); *Roe v. Wade*, 410 U.S. 113 (1973) (holding that fundamental right to privacy includes right to terminate a pregnancy); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding state ban on distribution of contraceptives to unmarried individuals unconstitutional); *Griswold v. Connecticut*, 318 U.S. 479 (1965) (holding state ban on use of contraceptives by married persons unconstitutional).

<sup>3</sup> *See, e.g.*, *Williams v. Zbaraz*, 448 U.S. 358 (1980) (upholding state funding restrictions on abortion similar to those in the Hyde Amendment); *Harris v. McRae*, 448 U.S. 297 (1980) (upholding constitutionality of Hyde Amendment, restricting Medicaid funding for medically necessary abortions); *Maher v. Roe*, 432 U.S. 464 (1977) (holding that U.S. Constitution does not require government funding programs such as Medicaid to subsidize abortion care).

<sup>4</sup> *See, e.g.*, *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502 (1990) (upholding one-parent notification for minors’ abortions with judicial bypass); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (striking down two-parent notification for minors’ abortions); *Bellotti v. Baird*, 443 U.S. 622 (1979) (upholding mandatory parental consent requirement for minors who seek abortions provided that state offers expeditious and confidential alternative such as judicial bypass).

<sup>5</sup> *See, e.g., Casey*, 505 U.S. 833 at 877 (preserving core of abortion right while changing constitutional standard from strict scrutiny to undue burden test: restrictions on abortion are unconstitutional if their purpose or effect is to impose substantial obstacle in path of woman seeking pre-viability abortion).

<sup>6</sup> William D. Mosher & Jo Jones, National Ctr. for Health Statistics, *Use of Contraception in the United States: 1982–2008*, 23 *Vital Health Stat* 15 (2010), available at [http://www.cdc.gov/NCHS/data/series/sr\\_23/sr23\\_029.pdf](http://www.cdc.gov/NCHS/data/series/sr_23/sr23_029.pdf).

<sup>7</sup> *Id.* at 7, 21. The main reasons given by the remaining 38 percent who were *not* using a method in the month they were interviewed included: currently pregnant or postpartum; trying to become pregnant; not having intercourse; sterility; worry about side effects; and partner not wanting use of birth control.

<sup>8</sup> Jennifer J. Frost, et al., Guttmacher Inst., *Contraceptive Needs and Services, National and State Data, 2008 Update 9* (2010), available at <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.

<sup>9</sup> *Id.* at 6-7.

<sup>10</sup> *Id.* at 6, 9.

<sup>11</sup> *Id.* at 16.

<sup>12</sup> Public Health Services Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (1970).

<sup>13</sup> Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38.2 *Persp. on Sexual & Reprod. Health* 90 (2006), available at <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>.

<sup>14</sup> Lawrence B. Finer & Kathryn Kost, *Unintended Pregnancy Rates at the State Level*, 43 *Persp. on Sexual & Reprod. Health* 78, 81 (2011).

<sup>15</sup> *Id.*

<sup>16</sup> Lawrence B. Finer and Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 43 *Persp. on Sexual & Reprod. Health* 78, 93-94 (2006), available at <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>.

<sup>17</sup> Guttmacher Inst., State Center: State Facts About Abortion: Pennsylvania (Jan. 2011), *available at* <http://www.guttmacher.org/pubs/sfaa/pdf/pennsylvania.pdf> [hereinafter Guttmacher, State Facts].

<sup>18</sup> Guttmacher Inst., Facts on Induced Abortion in the United States (Aug. 2011), *available at* [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.pdf](http://www.guttmacher.org/pubs/fb_induced_abortion.pdf) [hereinafter Guttmacher Inst., Induced Abortion].

<sup>19</sup> *Id.*

<sup>20</sup> Guttmacher Inst., State Facts, *supra* note 17, at 1.

<sup>21</sup> Guttmacher Inst., Induced Abortion, *supra* note 18.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> Rachel K. Jones, et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 *Persp. on Sexual & Reprod. Health* 6, 14 (2008); Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 *Persp. in Sexual & Reprod. Health* 41, 45 (2011).

<sup>25</sup> *Id.*

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

<sup>27</sup> Jones & Kooistra, *supra* note 24, at 46.

<sup>28</sup> *See id.* (in 2009, the median cost of an out-of-pocket abortion at 10 weeks gestation was \$470; abortion care becomes more expensive after the first trimester); *see also* Abortion Health Insurance, [Pregnancyinsurance.net](http://www.pregnancyinsurance.net/Abortion-Health-Insurance.html), <http://www.pregnancyinsurance.net/Abortion-Health-Insurance.html> (last viewed on Nov. 3, 2011) (insurance co-pays can range from \$15-\$150 depending on type of surgery).

<sup>29</sup> *See* Jones & Kooistra, *supra* note 24, at 46-48.

<sup>30</sup> Guttmacher Inst., State Facts, *supra* note 17.

<sup>31</sup> Pennsylvania Dep't of Health, *Objective MICH-10-1: Percent of Births to Mothers Beginning Prenatal Care in First Trimester-2020 Target: 77.9*, Family Health Statistics for Pennsylvania and Counties 61 (2011); *see* Pennsylvania Dep't of Health, *Focus Area 16, Objective 16-06a*, Family Health Statistics for Pennsylvania and Counties 27 (2010).

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

<sup>33</sup> The Healthy People 2020 Goal, set by the U.S. Department of Health and Human Services, is for women to receive “adequate” prenatal care starting in the first trimester. U.S. Dep't Health and Human Servs., Healthy People 2020 Maternal, Infant, and Child Health (MICH), Objective 10.1, *available at* <http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf> [hereinafter Healthy People 2020]. While the Healthy People 2020 guidelines do not define the term “adequate,” there are two different indices that states may use to define whether or not prenatal care is *adequate*: the Kessner Index and the Kotelchuck Index. Both indices rate adequacy of care on frequency and timing of prenatal visits, but the Kotelchuck index also measures the adequacy of the received services. Milton Kotelchuck, *An Evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index*, 84 *Am. J. Pub. Health* 1414, 1415 (table 1) (1994), *available at* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615177/pdf/amjph00460-0056.pdf>.

<sup>34</sup> Pennsylvania Dep't of Health, *supra* note 31, at 62.

<sup>35</sup> S.Y. Chu, et al, *Postpartum Care Visits—11 States and New York City, 2004*, 56 *Morbidity & Mortality Weekly Rep.* 1312 (2007), *available at* <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a2.htm>.

- <sup>36</sup> Amy O. Tsui, et al., *Family Planning and the Burden of Unintended Pregnancies*, 32 *Epidemiologic Rev.* 152 (2010).
- <sup>37</sup> Rowena Bonoan & Julianna S. Gonen, Washington Bus. Group on Health, *Promoting Healthy Pregnancies: Counseling and Contraception as the First Step 2* (2000), available at <http://www.businessgrouphealth.org/pdfs/healthypregnancy.pdf>.
- <sup>38</sup> See Stephanie B. Teal & David M. Ginosar, *Contraception for Women with Chronic Medical Conditions*, 34 *Obstet. Gynecol. Clin. N. Am.* 113 (2007).
- <sup>39</sup> Healthy People 2020, *supra* note 33.
- <sup>40</sup> U.S. Dep't of Health and Human Servs., *Healthy People 2010* at 9-5 (2d ed. 2000), available at <http://www.healthypeople.gov/2010/Document/pdf/Volume1/09Family.pdf> (citing K. Kost, et al., *Predicting Maternal Behaviors during Pregnancy: Does Intention Status Matter?* 30 *Fam. Planning Persp.* 79-88 (1988)).
- <sup>41</sup> *Id.* (citing *The Best Intentions: Unintended Pregnancy & The Well-Being of Children & Families* (S.S. Brown & L. Eisenberg, eds., National Academy Press 1995)).
- <sup>42</sup> Healthy People 2020, *supra* note 33 (citing U.S. Dep't of Health and Human Servs., Ctr. for Disease Control and Prevention, *Preconception and Interconception Health Status of Women Who Recently Gave Birth to a Live-Born Infant- Pregnancy Risk Assessment Monitoring System (PRAMS)*, 56 *Morbidity & Mortality Weekly Rep.* 1 (2007)) [hereinafter *Preconception and Interconception Health Status*]; V. Berghella et al., *Preconception Care*, 65 *Obstetrical Gynecological Survey* 119-31 (2010), available at <http://www.cdc.gov/mmwr/pdf/ss/ss5610.pdf>.
- <sup>43</sup> The focus of this report is the health benefits associated with contraception; however, it is worth noting that some contraceptive methods, like most medications, carry a small risk of side effects. See Johannes Bitzer & James A. Simon, *Current Issues and Available Options in Combined Hormonal Contraception*, 84 *Contraception* 348-356 (“Combined hormonal contraception is generally safe and effective. Development of newer contraceptives has progressed with the goal of reducing unwanted side effects while maintaining efficacy. . . . No hormonal contraceptive, however, is without risks. Choosing the most appropriate hormonal contraceptive should be individualized according to a woman's risk profile, age, concomitant medications and preference.”).
- <sup>44</sup> Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies without Cost-Sharing*, 14 *Guttmacher Policy Rev.* 7 (2011), available at <http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.html>; Ctrs. for Disease Control and Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, 48 *Morbidity & Mortality Weekly Rep.* 1073 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm>.
- <sup>45</sup> Sonfield, *supra* note 44, at 9; Ctrs. for Disease Control and Prevention, *Condoms and STDs: Fact Sheet for Public Health Personnel*, <http://www.cdc.gov/condomeffectiveness/latex.htm> (last visited Oct. 31, 2011).
- <sup>46</sup> Rachel K. Jones, et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34.6 *Persp. on Sexual & Reprod. Health* 294 (2002), available at <http://www.guttmacher.org/pubs/journals/3429402.pdf>.
- <sup>47</sup> Guttmacher Inst., *State Facts*, *supra* note 17.
- <sup>48</sup> *Id.*
- <sup>49</sup> Heather Boonstra, *Voicing Concern for Women, Abortion Foes Seek Limits on Availability of Mifepristone*, 4.2 *Guttmacher Rep. on Pub. Policy* 3 (2001), available at <http://www.guttmacher.org/pubs/tgr/04/2/gr040203.pdf>.
- <sup>50</sup> Ass'n of Reproductive Health Professionals, *Clinical Fact Sheets: Mifepristone Safety Overview* (2008), available at <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/mifepristone-safety-overview>.
- <sup>51</sup> F.G. Cunningham et al., *Chapter 7. Preconceptional Counseling*, *Williams Obstetrics* (McGraw-Hill Medical 2010).

<sup>52</sup> Cunningham et al., *Chapter 55. Neurological and Psychiatric Disorders*, *supra* note 51.

<sup>53</sup> Cunningham et al., *Chapter 57. Neoplastic Diseases*, *supra* note 51.

<sup>54</sup> Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30.1 *Fam. Planning Persp.* 24 (1998), available at <http://www.guttmacher.org/pubs/journals/3002498.pdf>.

<sup>55</sup> Each year an estimated 25,000 U.S. women become pregnant as a result of sexual assault. See F. Stewart & J. Trussell, *Prevention of Pregnancy Resulting from Rape*, 19 *Am. J. Preventive Medicine* 228 (2000); see also M.M. Holmes et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 *Am. J. Obstetrics & Gynecology* 320 (1996) (estimating 32,000 pregnancies caused by sexual assault each year).

<sup>56</sup> Christina Zampas & Jaime M. Gher, *Abortion as a Human Right: International and Regional Standards*, 8 *Human Rights L. Rev.* 249 (2008).

<sup>57</sup> See *Casey*, 505 U.S. 833 at 855-56; see also Reva Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 *Emory L.J.* 815 (2007).

<sup>58</sup> See *Gonzales v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting).

<sup>59</sup> Guttmacher Inst., *Lessons from Before Roe: Will Past be Prologue?*, 6 *Guttmacher Rep. on Pub.* 8 (2003), available at <http://www.guttmacher.org/pubs/tgr/06/1/gr060108.html>.

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

<sup>61</sup> Office of the D.A. City of Phila., *West Phila. Abortion Doctor Charged with Murder* (Jan. 19, 2011), <http://phillyda.wordpress.com/2011/01/19/west-philadelphia-abortion-doctor-charged-with-murder/> (last visited Oct. 27, 2011).

<sup>62</sup> See R. Seth Williams, D.A., Report of the Grand Jury, Misc. No. 0009901-2008, at 3, available at [http://www.phila.gov/districtattorney/grandjury\\_womensmedical.html](http://www.phila.gov/districtattorney/grandjury_womensmedical.html); Taunya English, *Women Sought Inexpensive Care at West Philly Clinic* (Mar. 1, 2010), WHYY, available at <http://whyy.org/cms/news/health-science/2010/03/01/women-sought-inexpensive-care-at-west-philly-clinic/32017> (last visited Oct. 27, 2011).

<sup>63</sup> See, e.g., Kristine Patterson, et al. *Frequent Detection of Acute HIV Infection in Pregnant Women*, 21 *AIDS* 2303 (2007); K.J. Perozzi, et al., *HSV: What You Need to Know to Care for Your Pregnant Patient*, 32 *Am. J. of Maternal/Child Nurs.* 345, 348-49 (2007).

<sup>64</sup> E. Williams & Gabriella Pridjian, *Obstetrics*, in Robert E. Rakel & David P. Rakel, *Textbook of Fam. Med.* 373-74, 379 (Elsevier Inc., 2011).

<sup>65</sup> *Id.* at 373-74, 380-81; M.C. McCormick & J.E. Siegel, *Recent Evidence on the Effectiveness of Prenatal Care*, 1 *Ambulatory Pediatrics* 321 (2001).

<sup>66</sup> Williams & Pridjian, *supra* note 64, at 363 (“Adequate prenatal care has been shown to increase the chances that a woman has a healthy pregnancy and baby.”); Maternal death is defined as, “The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.” Pennsylvania Dep’t of Health, *supra* note at 31, 67.

<sup>67</sup> Pennsylvania Dep’t of Health, *supra* note 31, at 23.

<sup>68</sup> *Id.*

<sup>69</sup> Richard L. Fogel, U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care, Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives* 3 (Sep. 30, 1987).

<sup>70</sup> Jay D. Iams & Roberto Romero, *Preterm Birth*, in Steven G. Gabbe, et al., *Obstetrics: Normal and Problem Pregnancies* 668, 673 (Churchill Livingstone, 2007).

<sup>71</sup> Neil Osterweil, *Prematurity is Root Cause of a Third of U.S. Infant Deaths*, MedPage Today (Oct. 2, 2006), citing W.M. Callaghan, et al. *The Contribution of Preterm Birth to Infant Mortality Rates in the United States*, 4 *Pediatrics* 1566, available at <http://www.medpagetoday.com/OBGYN/Pregnancy/4217>.

<sup>72</sup> Pennsylvania Dep't of Health, *supra* note 31, at 29.

<sup>73</sup> Chu et al., *supra* note 35 (citing American Academy of Pediatrics, American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care* (American College of Obstetricians and Gynecologists 2007)).

<sup>74</sup> Elizabeth Shaw & Janusz Kaczorowski, *Postpartum Care –What's New?*, 19 *Current Opinion in Obstetrics & Gynecology* 561 (2007).

<sup>75</sup> *Preconception and Interconception Health Status*, *supra* note 42, at 13-14.

<sup>76</sup> Other less popular and less effective methods, including the sponge, spermicides, and fertility awareness-based methods, also known as natural family planning, are also available over-the-counter. Over-the-counter methods can also be expensive and are typically not covered by insurance. See Williams & Pridjian, *supra* note 64, at 470-73.

<sup>77</sup> Planned Parenthood, *Birth Control*, <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm> (last visited Oct. 21, 2011).

<sup>78</sup> Sonfield, *supra* note 44, at 9.

<sup>79</sup> Planned Parenthood, *supra* note 77.

<sup>80</sup> Sonfield, *supra* note 44, at 10 (citing 2010 study that found that women with private insurance that covers prescription drugs paid 53 percent of the cost of their oral contraceptives, amounting to 29 percent of their annual out-of-pocket expenditures).

<sup>81</sup> *Id.* at 9.

<sup>82</sup> See U.S. Dep't of Health and Human Servs., *Women's Preventive Services: Required Health Plan Coverage Guidelines*, [www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/) (last visited Nov. 1, 2011) (HHS guidelines for expanding women's preventive services).

<sup>83</sup> In 2008, 67 percent of Pennsylvania women served by health centers funded by Title X of the Public Health Service Act had incomes at or below the federal poverty level, compared with 70 percent nationally. C.I. Fowler et al., *Family Planning Annual Report: 2009 National Summary B-5* (2010), available at <http://www.hhs.gov/opa/pdfs/fpar-2009-national-summary.pdf>.

<sup>84</sup> See PA Family Planning Waiver 1115, CMS Medicaid Waivers and Demonstrations List, HHS, available at <https://www.cms.gov/medicaidstwaivprogdemopgi/mwdl/itemdetail.asp?itemid=CMS1199308> (last visited Nov. 1, 2011) (extends eligibility for family planning services to uninsured women, ages 18 to 44, with countable income at or below 185 percent of the Federal poverty level who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, or Medicare).

<sup>85</sup> Susan A. Cohen, *The Numbers Tell the Story: The Reach and Impact of Title X*, 14 *Guttmacher Policy Rev.* 20 (2011), available at <http://www.guttmacher.org/pubs/gpr/14/2/gpr140220.html>.

<sup>86</sup> Guttmacher Inst., *Contraceptive Needs and Services, 2006* (2009), available at <http://www.guttmacher.org/pubs/win/allstates2006.pdf>. The providers included: Health department clinics (9), Community health centers (48), Planned Parenthood clinics (44), Hospital outpatient clinics (59), Other independent clinics (74).

<sup>87</sup> Frost et al., *supra* note 8, at 16.

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

<sup>89</sup> *Id.* at 7.

<sup>90</sup> Cohen, *supra* note 85.

<sup>91</sup> Jennifer Steinhauer & Robert Pear, *Democrats Allow Trims to Favored Programs*, N.Y. Times (Apr. 11, 2011), [http://www.nytimes.com/2011/04/12/us/politics/12congress.html?\\_r=1&scp=1&sq=reduced%20from%20%24317%20to%20%24300%20million&st=cse](http://www.nytimes.com/2011/04/12/us/politics/12congress.html?_r=1&scp=1&sq=reduced%20from%20%24317%20to%20%24300%20million&st=cse) (last visited Nov. 1, 2011); *see also* Final Program Cuts Highlights FY 2011, *available at* [http://republicans.appropriations.house.gov/\\_files/41211ProgramCutsListFinalFY2011CR.pdf](http://republicans.appropriations.house.gov/_files/41211ProgramCutsListFinalFY2011CR.pdf).

<sup>92</sup> *See* Guttmacher Inst., *Facts on American Teens' Sexual and Reproductive Health* (2011), *available at* <http://www.guttmacher.org/pubs/FB-ATSRH.html#1> (last visited Nov. 3, 2011) (finding that “[b]y their 19th birthday, seven in 10 teens of both sexes have had intercourse.”).

<sup>93</sup> Rachel Jones et al., *Teens Reflect on Their Sources of Contraceptive Information*, 26 *J. of Adolescent Research* 423 (2011).

<sup>94</sup> John Santelli, et al., *Abstinence and Abstinence-only Education: A Review of U.S. Policies and Programs*, 38 *J. Adolescent Health* 72, 75 (2006), *available at* <http://www.rhrealitycheck.org/emailphotos/pdf/Santelli-Abstinence-only-Education-Review-Paper.pdf> (describing the Adolescent Family Life Act, the Title V Welfare Reform Act, and Community-Based Abstinence Education, which provide grants to organizations (including schools) that have as their “exclusive purpose” the promotion of abstinence outside of marriage and do not in any way discuss contraceptives, sexual orientation, and gender identity).

<sup>95</sup> Sexuality Information and Education Council of the United States (SIECUS), *Pennsylvania State Profile Fiscal Year 2009* (2009), <http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1242#top> (last visited Nov. 1, 2011).

<sup>96</sup> *See* Samuel J. Philhower, *A Moral and Political Roadblock to Viable Sex Education: How Abstinence Education Has Established Itself at the Center of Public Policy*, *Women's Rights Law Rep.* 147, 148-49 (2009); Heather D. Boonstra, *Advocates Call for a New Approach After the Era of 'Abstinence-Only' Sex Education*, 12 *Guttmacher Policy Rev.* 6 (2009), *available at* <http://www.guttmacher.org/pubs/gpr/12/1/gpr120106.html>.

<sup>97</sup> *See* Philhower, *supra* note 96, at 149.

<sup>98</sup> Affordable Care Act, § 2954 (2010) (codified at 42 U.S.C. § 710).

<sup>99</sup> Guttmacher Inst., *State Policies in Brief: Sex and STI/HIV Education* (Mar. 2012).

<sup>100</sup> 22 Pa. Code §4.29 (2011).

<sup>101</sup> *Id.*; Pennsylvania Dep't of Educ., *Academic Standards for Health, Safety, and Physical Education* 2, 3, 11 (2002); *see* SIECUS, *supra* note 95.

<sup>102</sup> Guttmacher Inst., *supra* note 99 (Pennsylvania schools are not required to teach sex education but are required to teach HIV prevention and must stress abstinence.); *see also*, SIECUS, *supra* note 95.

<sup>103</sup> Food and Drug Administration (FDA), *FDA's Decision Regarding Plan B: Questions and Answers* (2009), <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm109795.htm> (“If a fertilized egg is implanted prior to taking Plan B, Plan B will not work.”) (last visited Oct. 27, 2011).

<sup>104</sup> FDA, *FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older: Prescription Remains Required for Those 17 and Under*, (Aug. 24, 2006), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108717.htm> (last visited Dec. 15, 2011).

<sup>105</sup> FDA, *Statement from FDA Commissioner Margaret Hamburg, M.D. on Plan B One-Step*, (Dec. 7, 2011), <http://www.fda.gov/NewsEvents/Newsroom/ucm282805.htm> (last visited Dec. 16, 2011).

<sup>106</sup> *Id.*; see also National Women’s Law Center, *National Women’s Law Center Deeply Concerned by HHS Decision on Plan B*, (Dec. 7, 2011), <http://www.nwlc.org/press-release/national-womens-law-center-deeply-concerned-hhs-decision-plan-b> (last visited Dec. 12, 2011).

<sup>107</sup> U.S. Dep’t Health and Human Servs., *A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius*, (Dec. 7, 2011), <http://www.hhs.gov/news/press/2011pres/12/20111207a.html> (last visited Dec. 15, 2011); U.S. Dep’t Health and Human Servs., Memorandum: Supplemental New Drug Application (NDA 21-998/S002) (Dec. 7, 2011), available at <http://www.hhs.gov/news/press/2011pres/12/20111207a.pdf>. There are two other prescription EC pills: a two-pill generic version named Next Choice that also is sold behind the counter for women aged 17 and older and a prescription-only pill named ella, which can prevent pregnancy if taken up to 120 hours or five days after a contraceptive failure or unprotected sexual intercourse. FDA, *FDA Approves Ella Tablets For Prescription EC* (Aug. 13, 2010), <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm> (last visited Oct. 27, 2011); Planned Parenthood, *Morning After Pill (Emergency Contraception)* (2011), <http://www.plannedparenthood.org/health-topics/emergency-contraception-morning-after-pill-4363.asp> (last visited Dec. 15, 2011).

<sup>108</sup> See Cynthia H. Chuang & Laura D. Shank, *Availability of Emergency Contraception at Rural and Urban Pharmacies in Pennsylvania*, 73 *Contraception* 382 (2006).

<sup>109</sup> Pennsylvania State Bd. of Pharmacy, 37 Pa. B. 5807 (2007), available at <http://www.pabulletin.com/secure/data/vol37/37-43/1988.html> (last visited on Nov. 3, 2011).

<sup>110</sup> 49 Pa. Code § 27.103(a) (2011).

<sup>111</sup> Pennsylvania State Bd. of Pharmacy, *supra* note 109.

<sup>112</sup> Women’s Law Project, Summer 2009 Plan B Access Project Narrative (2009) (on file with authors).

<sup>113</sup> 28 Pa. Code § 117.57 (2011).

<sup>114</sup> Leslie J. Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973*, at 77-78, 102, 211-14 (U. Cal. Press 1998); NARAL Pro-Choice America Found., *The Safety of Legal Abortion and the Hazards of Illegal Abortion* (2011), available at <http://www.naral.org/media/factsheets/abortion-distorting-science-safety-legal-abortion.pdf> (“[M]ore than five thousand women may have died as a direct result [of criminal abortion in the United States in 1962],” citing Zad Leavy & Jerome M. Kummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 *S. Cal. L. Rev.* 123, 124 (1962)).

<sup>115</sup> S.1488, 112th Cong. (2011-2012), would codify and make permanent the Hyde Amendment, which currently exists as an amendment to annual appropriations bills. The Hyde Amendment forbids federal funding of abortion care except in cases of pregnancy resulting from rape or incest, and where the life of the pregnant woman is in danger.

<sup>116</sup> 18 U.S.C. § 1531(2011); *Carhart*, 550 U.S. 124 (2007) (upholding the Federal Partial-Birth Abortion Ban Act in the context of a facial challenge but stopping short of overruling prior holdings that abortion restrictions must never endanger women’s health).

<sup>117</sup> According to the Guttmacher Institute, there are seven states that have laws protecting a women’s access to abortion in the absence of *Roe*. These states include California, Connecticut, Hawaii, Maine, Maryland, Nevada, and Washington. Guttmacher Inst., *State Policies in Brief: Abortion Policy in the Absence of Roe* (2011), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_APAR.pdf](http://www.guttmacher.org/statecenter/spibs/spib_APAR.pdf).

<sup>118</sup> 18 Pa. Cons. Stat. Ann. § 3215(c) and (j) (2011).

<sup>119</sup> If the patient is physically or psychologically unable to report the crime to the police or child protective services, this reporting requirement is waived provided that the woman’s treating physician certifies that she is a survivor of rape or incest and is physically or psychologically unable to report the crime. *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F. 3d 170, 181-83 (3d Cir. 1995), *cert. denied*, 516 U.S. 1093 (1996); see

also, Pa. Dep't Public Welfare, *Payment Policy for Abortion Services*, Medical Assistance Bulletin, (1995), available at <http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4167>.

<sup>120</sup> 18 Pa. Cons. Stat. Ann. § 3215(a) (2011).

<sup>121</sup> *Id.* at § 3205.

<sup>122</sup> *Id.* at § 3205; *see also Id.* at § 3208 (describing printed materials).

<sup>123</sup> *Id.* at § 3206(a).

<sup>124</sup> *Id.* at § 3206(c).

<sup>125</sup> *Id.* at §§ 3207, 3214.

<sup>126</sup> 28 Pa. Code § 27.31 et seq (2011).

<sup>127</sup> Guttmacher Inst., *Second Trimester Abortion: Logistics and Lack of Symptoms Are Factors*, 38 *Persp. on Sexual & Reprod. Health* 115 (2006).

<sup>128</sup> Phone interviews with Pennsylvania clinic-based providers, conducted by author in 2011; *see also, e.g.*, Allentown Women's Center, fee schedule, <http://www.allentownwomenscenter.com/fees.html> (last visited Nov. 2, 2011) (cost up to 10 weeks' gestation ranges from \$345 to \$795, with additional fees for anesthesia and sedation).

<sup>129</sup> *See* 55 Pa. Code Ch.183, tbl. 3, *Family Size Allowances*, <http://www.pacode.com/secure/data/055/chapter183/chap183toc.html> (last visited Nov. 2, 2011).

<sup>130</sup> Planned Parenthood, *What Happens During an Abortion — In-Clinic Abortion Cost*, <http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp> (last visited Oct. 27, 2011); *see also* Jones & Kooistra, *supra* note 24, at 46.

<sup>131</sup> Rachel K. Jones, et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients, 2008*, at 10-11 (2010), available at <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>.

<sup>132</sup> *Id.* at 12.

<sup>133</sup> *See* 18 Pa. C.S. § 3215(c), (j) (2011).

<sup>134</sup> Heather Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 *Guttmacher Policy Rev.* 12 (2007), available at <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html>.

<sup>135</sup> *See* Susan A. Cohen, *Insurance Coverage of Abortion: The Battle to Date and the Battle to Come*, 13 *Guttmacher Policy Rev.* 2 (2010), available at <http://www.guttmacher.org/pubs/gpr/13/4/gpr130402.html>.

<sup>136</sup> Exec. Order No. 13535, *Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act*, 75 *Fed. Reg.* 15599 (Mar. 29, 2010), available at <http://edocket.access.gpo.gov/2010/pdf/2010-7154.pdf>.

<sup>137</sup> Cohen, *supra* note 135.

<sup>138</sup> At this writing, Senate Bill 3 has passed the state Senate and the House Insurance Committee and awaits a vote by the full House. This bill would prevent insurance plans participating in the state insurance exchange from covering abortion services except when the pregnancy was caused by rape or incest or the life of the woman is in danger. There would be no exception made for coverage of abortion in catastrophic health situations such as paralysis, organ failure, and infertility; nor for coverage entirely paid by the insured's separate premium payment.

<sup>139</sup> Cohen, *supra* note 135.

<sup>140</sup> Guttmacher Inst., *Induced Abortion*, *supra* note 18, at 2.

<sup>141</sup> Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortion in the United States*, 74 *Contraception* 334 (2006), available at [http://www.guttmacher.org/pubs/2006/10/17/Contraception74-4-334\\_Finer.pdf](http://www.guttmacher.org/pubs/2006/10/17/Contraception74-4-334_Finer.pdf).

<sup>142</sup> *Greenville Women's Clinic v. Bryant*, 66 F. Supp. 2d 691, 714 (D.S.C. 1999), *rev'd on other grounds*, 222 F.3d 157 (4th Cir. 2000).

<sup>143</sup> U.S. House of Representatives Committee on Gov't Reform — Minority Staff, Special Investigations Division, *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers*, at 7, 9, 11 (July 2006), available at <http://democrats.oversight.house.gov/images/stories/documents/20060717101140-30092.pdf>.

<sup>144</sup> NARAL Pro-Choice America Found., *supra* note 114.

<sup>145</sup> Susheela Singh et al., *Guttmacher Inst., Abortion Worldwide: A Decade of Uneven Progress* 33 (2009), available at <http://www.guttmacher.org/pubs/AWWfullreport.pdf>.

<sup>146</sup> American Cancer Society, *Is Abortion Linked to Breast Cancer?* (Sept. 20, 2011), <http://www.cancer.org/Cancer/BreastCancer/MoreInformation/is-abortion-linked-to-breast-cancer> (last visited Nov. 2, 2011).

<sup>147</sup> *See, e.g.,* Julia R. Steinberg & Lawrence B. Finer, *Coleman, Coyle, Shuping, and Rue Make False Statements and Draw Erroneous Conclusions in Analyses of Abortion and Mental Health Using the National Comorbidity Survey*, 46 *J. of Psychiatric Research* 407 (2012), available at <http://www.guttmacher.org/pubs/journals/j.jpsychires.2012.01.019.pdf>.

<sup>148</sup> American Psychological Ass'n, *Report of the APA Task Force on Mental Health and Abortion* 93 (2008), available at <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf>; *see also* Jocelyn T. Warren et al., *Do Severe Depression and Loss of Self-Esteem Follow Abortion? Evidence from a National Study of Adolescents*, 42 *Persp. on Sexual & Reprod. Health* 230 (2010) (comparing mental health of adolescent girls who had not undergone an abortion with girls who had undergone an abortion five years earlier and finding that abortion was not associated with low self-esteem and depression in adolescents).

<sup>149</sup> National Abortion Federation, *Crisis Pregnancy Centers* (2006), [http://www.prochoice.org/about\\_abortion/facts/cpc.html](http://www.prochoice.org/about_abortion/facts/cpc.html) (last visited Mar. 6, 2012).

<sup>150</sup> Victoria Lin & Cynthia Dailard, *Crisis Pregnancy Centers Seek To Increase Political Clout, Secure Government Subsidy*, *Guttmacher Rep. on Public Policy* 4 (2002), available at <http://www.guttmacher.org/pubs/tgr/05/2/gr050204.html>.

<sup>151</sup> Associated Press, *Recent Cases of Abortion-Related Violence*, *N.Y. Times* (June 1, 2009), [http://www.nytimes.com/interactive/2009/06/01/us/20090601\\_ABORTION\\_TIMELINE.html](http://www.nytimes.com/interactive/2009/06/01/us/20090601_ABORTION_TIMELINE.html) (last visited Nov. 2, 2011).

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

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

<sup>156</sup> *Id.*

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

<sup>158</sup> 18 U.S.C.A § 248(a) (2011).

<sup>159</sup> Carrie Johnson, *Justice Department Tougher on Abortion Protesters*, National Public Radio (Sept. 1, 2011), available at <http://www.npr.org/2011/09/01/140094051/obama-takes-tougher-stance-on-abortion-protesters?ft=1&f=3> (last visited Sept. 11, 2011).

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

<sup>161</sup> See, e.g., *Hill v. Colorado*, 530 U.S. 703 (2000) (upholding floating bubble zone); *McCullen v. Coakley*, 573 F. Supp. 2d 382 (D. Mass. 2008), *aff'd*, 571 F.3d 167 (1st Cir. 2009) (upholding fixed buffer zone).

<sup>162</sup> Pittsburgh, Pa., Code tit. 6, §§ 623.01–623.07.

<sup>163</sup> Debra B. Stulberg, et al., *Abortion Provision Among Practicing Obstetricians/Gynecologists*, 118 *Obstetrics & Gynecology* 609 (2011).

<sup>164</sup> See *supra* notes 24-26 and accompanying text.

<sup>165</sup> Catholic Health Association of the United States, *Catholic Health Care in the United States* 1 (2011).

<sup>166</sup> Committee on Doctrine of the National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 24 (2009) [hereinafter *The Directives*] (“The Church cannot approve contraceptive interventions that either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible.” (*internal quotations omitted*)).

<sup>167</sup> *Id.* at 26 (“Abortion... is never permitted.”).

<sup>168</sup> Lori R. Freedman, et al. *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 *Am. J. Pub. Health* 1774 (2008); see Ibis Reproductive Health, *Assessing Hospital Policies & Practices Regarding Ectopic Pregnancy & Miscarriage Management* 11 (2011), available at <http://www.nwlc.org/resource/assessing-hospital-policies-practices-regarding-ectopic-pregnancies-miscarriage-management>.

<sup>169</sup> *The Directives*, *supra* note 166, at 26.

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

<sup>171</sup> Willard Cates, et al., *The Public Health Impact of Legal Abortion: 30 Years Later*, 35 *Persp. in Sexual & Reprod. Health*(2003), available at <http://www.guttmacher.org/pubs/journals/3502503.html>.

<sup>172</sup> The Federal Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012), is a federal statute that requires hospitals to treat anyone with an emergent condition, including labor, regardless of the person's ability to pay for services or her immigration status. This law does not obligate hospitals to provide prenatal care.

<sup>173</sup> Pennsylvania Dep't of Health, *supra* note 31, at 61-62.

<sup>174</sup> See Gene Bishop, Maternity Care Coalition, *Childbirth at a Crossroads in Southeastern Pennsylvania* 19 (2006) [hereinafter *Maternity Care Coalition, Crossroads*]; M MacDowell, et al., *A National View of Rural Health Workforce Issues in the USA*, *International J. of Rural & Remote Health* (2010).

<sup>175</sup> See U.S. General Accounting Office (GAO), *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* 7 (2003); Michelle Mello, et al. *Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care*, 242 *Annals of Surgery* 621, 626 (2005); Maternity Care Coalition, *Medical Malpractice and the Maternity Crisis: Is There a Connection?* 5 (2009).

<sup>176</sup> GAO, *supra* note 175, at 15.

<sup>177</sup> Michelle Mello, et al., *Changes in Physician Supply and Scope of Practice during a Malpractice Crisis: Evidence from Pennsylvania*, *Health Affairs* 425, 432 (2007) (analyzing data from Pennsylvania's Medical Care Availability and Recovery of Error Fund database).

<sup>178</sup> *Id.* at 433; GAO, *supra* note 175, at 18.

<sup>179</sup> Naomi Abraham, *Hospital Maternity Wards are Closing Across the U.S.*, Women e-News (Jan. 21, 2011), <http://www.momobile.org/HospitalMaternityWardsareClosingAcrossTheUS.html> (last visited Nov. 2, 2011).

<sup>180</sup> Pennsylvania Medicaid Policy Ctr., *Medical Assistance Coverage of Pregnant Women and Newborn Children in Pennsylvania* (2008). Medicaid covers medical services for pregnant women, including preventive, hospital, and intensive care and outpatient drugs, usually through a managed care program. The coverage lasts throughout pregnancy and the postpartum period, which is defined as 60 days after delivery and any extra days completing the final month of coverage.

<sup>181</sup> *See* Maternity Care Coalition, *The Status of Maternity Units Access: The Childbirth Crisis — Closing Maternity Units* (2011), <http://www.momobile.org/ObstetricsAccess1.html> (last visited Nov. 2, 2011).

<sup>182</sup> Kaiser Family Found., *Women's Health Policy Facts: Health Insurance Coverage of Women Ages 18-64, by State, 2008-2009* (2010), <http://www.kff.org/womenshealth/1613.cfm> (last visited Nov. 2, 2011).

<sup>183</sup> *See* Maternity Care Coalition, *supra* note 181.

<sup>184</sup> Kaiser Family Found., *supra* note 182.

<sup>185</sup> *See* Pennsylvania Medicaid Policy Ctr., *supra* note 180, at 2.

<sup>186</sup> *See* Affordable Care Act, §§ 5201, 5202, 5203, 5204, 5205, 5207 (2010) (codified at 42 U.S.C. §§ 254q(a), 292s, 297b(a), 294n et seq. & 20 U.S.C. 1078–11) (provisions that may alleviate the scarcity of medical professionals, including any shortage of clinicians practicing obstetrics and gynecology).

<sup>187</sup> For the full text of the Affordable Care Act, *see* <http://www.healthcare.gov/law/about/index.html>; *see generally*, Carol Sakala, *U.S. Health Care Reform Legislation Offers Major New Gains to Childbearing Women and Newborns*, 37 *Birth* 337 (2010); S.R. Collins, et al., *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010*, 93 *Commonwealth Fund Pub.* 1429 (2010).

<sup>188</sup> *Id.* at §27131001 (2010) (codified at 42 U.S.C. § 300gg–13); *See* Sakala, *supra* note 187.

<sup>189</sup> Affordable Care Act, § 2719a(2010) (codified at 42 U.S.C. 300gg–19a).

<sup>190</sup> *Id.* at § 27041201 (2010) (codified at 42 U.S.C. § 300gg–3).

<sup>191</sup> *Id.* at § 1302 (2010) (codified at 42 U.S.C. § 18022).

<sup>192</sup> Affordable Care Act, § 1402 (2010) (codified at 42 U.S.C. § 18071).

<sup>193</sup> Affordable Care Act, § 2001 (2010) (codified at 42 USCS § 1396a).

<sup>194</sup> E.K. Adams, et al., *Transitions in Insurance Coverage from Before Pregnancy Through Delivery in Nine States, 1996-1999*, 22 *Health Aff.* 219 (2003) (a study analyzing figures from nine states during 1996-1999 found that 17-41 percent of pregnant women lacked insurance prior to pregnancy).

<sup>195</sup> *Id.* at § 2301 (2010) (codified at 42 U.S.C. § 1396d).

<sup>196</sup> *Id.* at § 2951 (2010) (codified at 42 U.S.C. § 711).

<sup>197</sup> *Id.* at § 2952 (2010) (codified at 42 U.S.C. § 712).

<sup>198</sup> *Id.* at §3114(2010) (codified at 42 U.S.C. § 1395I); *See* Sakala, *supra* note 187 (While Medicare covers only a small percentage of births, this provision will likely influence the reimbursement rates of other payers).

<sup>199</sup> *Id.* at § 4107 (2010) (codified at 42 U.S.C. § 1396d).

<sup>200</sup> *Id.* at § 10212 (2010) (codified at 42 U.S.C. § 18202).

<sup>201</sup> SB 1063, Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>202</sup> Every dollar invested in public dollars for contraception saves an estimated \$3.74 in Medicaid expenditures that otherwise would have been needed to provide pregnancy-related care (prenatal, labor, delivery and postpartum care), as well as one year of medical care for their infants. In fact, according to an employee benefits consulting firm, it costs employees 15-17 percent more not to cover contraceptives than to provide such health coverage (accounting for medical costs of pregnancy and maternity leave). See Adam Sonfield, *Contraception: An Integral Component of Preventive Care for Women*, 13 Guttmacher Policy Rev. 2 (2010).

<sup>203</sup> Maternity Care Coalition, Crossroads, *supra* note 174, at 21.

# health care system **4**

## Section B. The Impact of Sex Bias in **COMMERCIAL INSURANCE** on Women's Health

### INTRODUCTION

*The discrimination that women experience in access to and cost of health insurance, obtained through their employers (the commercial group market) or directly from insurers (the commercial individual market), negatively affects their access to health care and consequently their health. Women who obtain health insurance through the commercial group and individual markets experience gaps in insurance coverage with respect to pregnancy and maternity care, contraceptive services, and abortion care. Furthermore, sex discriminatory pricing of insurance deprives women of access to insurance altogether. These gaps cause a broad range of negative health outcomes for women, including increased risk of maternal illness, low birth rate, premature birth, infant mortality, delayed diagnoses, chronic illnesses, premature death, exposure to medical negligence, and mental health conditions. Closing the gaps will improve women's health.*



## Gaps in Women's Health Insurance Coverage

Employer-sponsored coverage is the main form of health insurance for 64 percent of women of reproductive age.<sup>1</sup> In 2011, only 60 percent of employers in the United States offered health insurance, including 99 percent of large employers (with 200 or more employees) and 59 percent of small employers (with between three and 199 employees.)<sup>2</sup> According to the 2011 Kaiser Women's Health Survey, six percent of women ages 18 to 64 purchase their own private insurance through individual policies,<sup>3</sup> and 17 percent of women ages 18 to 64 do not have health insurance.<sup>4</sup> More than 13 percent of Pennsylvania women are uninsured.<sup>5</sup> While there has been improvement in coverage of women's health care in employer-sponsored group coverage, gaps persist, largely in the coverage provided by small employers and individual policies.

### Contraceptive Coverage

Nationally, about nine out of ten group health insurance policies provide coverage for the five most commonly-used forms of FDA-approved prescription contraception.<sup>6</sup> This represents a significant increase in coverage since 1993, when only 28 percent of typical insurance plans covered the five leading reversible contraceptive methods.<sup>7</sup> However, a number of women remain without adequate coverage for contraception. Contraceptive coverage is provided less frequently and not as comprehensively by small employers and plans sold by insurers to individuals.<sup>8</sup>

Costs pose a significant barrier to access to contraception. Contraceptives are expensive, and, with the exception of condoms, most of the widely used methods require an exam and prescription from a health care provider.<sup>9</sup> Birth control pills cost between \$15-\$50 plus exam costs; Ortho-Evra (the patch) and NuvaRing (the vaginal ring) each cost about \$15-\$80 a month plus exam costs; Depo-Provera, a shot, costs \$35-\$75 per injection, plus any exam costs, and lasts three months; the diaphragm costs \$15-\$75, plus exam costs of \$50-\$200, requires spermicide, and lasts up to two years; Implanon, an implant, costs \$400-\$800 up front for implant, exam, and insertion, and lasts up to three years; an intrauterine device (IUD) costs \$500-\$1,000 up front

for IUD, exam, insertion, and follow-up visits, and lasts five to twelve years.<sup>10</sup> As a consequence, women without health insurance end up either paying high out-of-pocket costs for preventive care or going without contraception. Currently, even for some women with health insurance, high co-payments and deductibles might make contraception prohibitively expensive.<sup>11</sup>

### Abortion Coverage

Many employer-provided health insurance policies provide coverage for abortion care. A national survey of a representative sample of health insurers found that in 2002, approximately 87 percent of available employer-based health insurance policies covered abortion care.<sup>12</sup> While a 2003 survey of employers found that only 46 percent of workers with employer-based health insurance policies had coverage for abortion care, a substantial number of respondents did not know the scope of coverage provided.<sup>13</sup> This 2003 survey also found that coverage for abortion care differed substantially between small and large employers; 30 percent of small employers (3-199 employees) and 54 percent of large employers (200+ employees) had health insurance policies that covered abortion care.<sup>14</sup> After reviewing both its own survey and the Kaiser Family Foundation's research, the Guttmacher Institute

## How Much Does Contraception Cost?<sup>i</sup>

DEVICE OR PRESCRIPTION		ASSOCIATED PHYSICIAN TREATMENT	
Birth Control Pills	\$15 - \$50 a month	Doctor's visit for exam and history in order to obtain prescription	\$35 - \$250
The Patch (Ortho- Evra)	\$15 - \$80 a month	Medical exam	\$35 - \$250
Vaginal Ring (NuvaRing)	\$15 - \$80 a month	Medical exam	\$35 - \$250
Contraceptive Injection (Depo- Provera)	\$35 - \$75 per injection, given every 3 months	Medical exam	\$35 - \$250 for 1st visit; \$20 - \$40 for each subsequent visit
Diaphragm	Diaphragm costs \$15 - \$75 and lasts 2 years; Spermicide gel, jelly, or cream costs \$8 - \$17 a kit	Medical exam	\$50 - \$200
Implant (Implanon)		Medical exam, implant, and in- sertion	\$400 - \$800 every 3 years
		Removal	\$100 - \$300
Intrauterine Device (IUD)		Medical exam, IUD, insertion, and follow-up visits	\$500 - \$1,000 every 5 - 12 years, de- pending on device used

<sup>i</sup>Planned Parenthood, Birth Control, <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm> (last visited Mar. 22, 2012)

concluded that coverage of abortion by employers was probably somewhere between 46 percent and 87 percent.<sup>15</sup>

However, many women who obtain abortions either lack insurance for abortion or do not use their insurance to pay for the

procedure. In 2008, 33 percent of women who obtained abortions did not have health insurance and the remainder had some type of public or private insurance. Of those with health insurance, 57 percent paid out of pocket. Of those with private health

## **Insurance Discrimination Based on Domestic Violence**

In 2003, a Pennsylvania woman was denied health insurance because her medical records reflected care for an incident of domestic abuse. Insurers considered domestic violence to be a pre-existing condition on which they could base denial of coverage. Advocacy by the Women's Law Project and the Pennsylvania Coalition Against Domestic Violence led to the enactment of a Pennsylvania law prohibiting all insurers from taking domestic violence into account when making decisions about whom to cover, what to cover, and how much to charge.<sup>i</sup>

<sup>i</sup> 40 Pa. Stat. §§1171.3, 1171.5(a)(14) (2011).

insurance, 63 percent paid out of pocket.<sup>16</sup> These women may not have used their insurance to cover the procedure because their plan did not cover abortion, they did not know their plan covered abortion, they were afraid their employers or family members would find out about the abortion if they used their insurance, or the insurance deductible was so high that they could not use their insurance.<sup>17</sup>

### **Maternity Coverage**

Many individual health insurance policies exclude pregnancy-related care, and women are forced to either purchase expensive supplemental maternity coverage (rider), if available, or pay all pregnancy-related costs out of pocket. A 2008 study reported that in Pennsylvania, out of the 110 plans available to 30-year-old women in the individual market, only sixteen of them (14.5 percent) offered comprehensive maternity cover-

age.<sup>18</sup> Another eighteen of the plans offered maternity riders, which cost over \$100 a month in additional premiums.<sup>19</sup> One year later, a 2009 survey found that only 95 plans were available in Pennsylvania to 30-year-old women in the individual market, and only eight plans (eight percent) offered maternity coverage.<sup>20</sup> This is a dramatic gap in coverage.

### **Pre-existing Condition Rejections and Exclusions**

Health insurers' treatment of pre-existing conditions disproportionately impacts women. Insurers frequently reject women who apply for individual coverage because they have had a cesarean section, breast or cervical cancer, or medical treatment for domestic or sexual violence.<sup>21</sup> One Colorado woman was rejected by an insurance company for having previously had a cesarean section, and the company told her that she might be eligible for coverage if she were sterilized.<sup>22</sup>

### **Gender Rating**

Gender rating prevents individual women as well as employers whose workforce is predominantly female from purchasing insurance. Gender rating is the practice of charging same-aged men and women different insurance premiums; it often results in insurers charging substantially more for insurance for women than men for equal coverage.<sup>23</sup>

Individual health insurance plans charge women significantly more than men for coverage. A 2009 national study of individual health plans found that 95 percent of the surveyed best-selling plans charged a 40-year-old woman more than a 40-year old man for identical coverage.<sup>24</sup> The variations in premiums charged by gender by different insurers are so wide as to appear more arbitrary than consistent with any data demonstrating that women use more health care than men.<sup>25</sup> The fact that almost none

of the plans studied included maternity coverage, which would account in large part for higher health care usage by women, further undercuts insurer rationale for charging women more than men.<sup>26</sup> Having compared pricing for men and women of the same age for two comparable individual insurance plans listed on [www.ehealthinsurance.com](http://www.ehealthinsurance.com) for sale to Pennsylvania residents, the study found higher premiums charged for 25 and 40-year-old women as compared to men of the same age for the same coverage. 25-year-old women were charged six percent more than 25-year-old

men for policy A and 38 percent more than men for policy B. Premiums for 40-year-old women were 21 percent higher than premiums for 40-year-old men for policy A and 34 percent higher for Policy B.<sup>27</sup> The study also found that non-smoking women are frequently charged higher premiums than men of the same age who smoke. In Pennsylvania, 80 percent of the bestselling plans in the individual market charge more for a 40-year-old woman who does not smoke than for a 40-year-old man who smokes.<sup>28</sup>

## IMPACT ON WOMEN'S HEALTH

Women's lack of access to the full range of women's health care has many adverse health consequences.

### **Women with inadequate insurance coverage may not enjoy the health benefits associated with access to contraception.**

There are documented health benefits for women and infants when pregnancies are planned and intended.<sup>29</sup> Planning pregnancy enables women to improve their health and prevent a range of pregnancy complications, including gestational diabetes and high blood pressure.<sup>30</sup> Physicians may also advise women to avoid pregnancy for medical reasons because of pre-existing conditions such as diabetes, coronary artery disease, or arthritis, which could be seriously worsened by pregnancy.<sup>31</sup> Planned pregnancies enable women to engage in improved health behaviors which lead to improved birth outcomes.<sup>32</sup>

Unplanned pregnancies may bring serious health consequences to both women and infants, including increased risk of infant and maternal illness, and a greater chance that women will delay seeking prenatal care.<sup>33</sup> Women with unplanned and unin-

tended pregnancies are less likely to breast-feed, more likely to suffer poor mental health, and more likely to face physical violence during pregnancy.<sup>34</sup> Children born of unplanned pregnancies are at greater risk of negative health outcomes, including premature birth, low birth weight, poor nutrition, child abuse, and infant mortality.<sup>35</sup>

In addition to the health benefits associated with planned pregnancies, FDA-approved contraceptives are also prescribed for women's health beyond contraceptive purposes. Oral contraceptives are used for the prevention of a range of medical conditions such as endometriosis, polycystic ovary syndrome, ovarian cysts, acne, ovarian cancer, and endometrial cancer.<sup>36</sup>

### **Lack of coverage for abortion care negatively impacts women's lives in numerous ways.**

Abortion is an essential component of women's health care. It is a safe procedure—safer, in fact, than childbirth: the risk of death associated with abortion is about one-tenth of the risk associated with childbirth.<sup>37</sup> In the United States today, legally induced abortions performed by trained

physicians have a mortality rate of less than 1 per 100,000 procedures. There are two forms of abortion: surgical and medical. The risk of complications from a surgical abortion is minimal. Less than 0.5 percent of women obtaining surgical abortions experience a complication. Medical abortion, accomplished by taking Mifepristone, approved by the U.S. Food and Drug Administration in 2000, has been well established in medical literature as a safe alternative to surgical abortion.<sup>38</sup> Mifepristone is safer than acetaminophen (Tylenol), aspirin, and Viagra.<sup>39</sup>

Continuing a pregnancy endangers some women's health or even their lives. A variety of medical conditions can worsen with pregnancy, including high blood pressure, diabetes and diseases of the heart, kidneys, and blood vessels.<sup>40</sup> In addition, treatment of some medical conditions such as severe depression<sup>41</sup> or cancer<sup>42</sup> can be more difficult or pose greater risks when the patient is pregnant. For women with these conditions, abortion is a life-saving medical procedure.

Abortion may also be necessary when pregnancy results from failed contraception. Over half of women having abortions used a contraceptive method during the month they became pregnant.<sup>43</sup> In addition, rape survivors who become pregnant from rape may need abortion care.<sup>44</sup> It is a human rights violation to force a rape victim to carry a pregnancy caused by rape.<sup>45</sup>

Abortion is a medically necessary procedure for women who need to terminate an unwanted pregnancy. Abortion care permits women to direct their own lives, determine their reproductive futures, and participate equally in the economic and social life of the nation.<sup>46</sup> Making abortion care inaccessible directly interferes with a

woman's autonomy to determine her life's course, and thus to enjoy equal status as a citizen.<sup>47</sup>

When legal abortion is unavailable, some women turn to illegal procedures, which can be lethal. In the United States, prior to *Roe v. Wade*, illegal abortions were common, with estimates as high as 1.2 million per year in the 1950s and 1960s.<sup>48</sup> In 1965, illegal abortions accounted for 17 percent of all deaths attributed to pregnancy and childbirth.<sup>49</sup> Barriers to safe abortion care appear to have been responsible for recent deaths and injuries. In January 2011, West Philadelphia physician Kermit Gosnell and his staff were charged with crimes including murder and infanticide related to his illegal abortion practice which targeted low-income and immigrant women.<sup>50</sup> Grand jury and state Senate testimony indicated that women sought care from Gosnell because they could not afford to go to safe, reputable doctors.<sup>51</sup>

### **Women with inadequate insurance coverage may have unhealthy pregnancies.**

Women without maternity coverage are less likely to be taking folic acid, an important vitamin for pregnant women that prevents fetal spinal cord defects, and are less likely to receive early prenatal care.<sup>52</sup> Women who must pay for costs of doctors' visits out of pocket may under-utilize health care during pregnancy. Uninsured women who become pregnant are less likely to have had a recent pap smear and are less likely to know if they have undiagnosed diabetes or high blood pressure.<sup>53</sup>

### **Women without health insurance often suffer more than those with it.**

Being uninsured is associated with inadequate health care services and poor health outcomes:

- **Uninsured adults are less likely to receive preventive care and screenings than insured adults.**<sup>54</sup> Uninsured adults who do receive these routine services are less likely to receive them at the recommended intervals.<sup>55</sup>
- **Uninsured cancer patients are less likely to receive adequate care, and thus more likely to die prematurely.**<sup>56</sup> This increased level of mortality is likely due to delayed diagnosis.<sup>57</sup> For example, studies show that breast cancer patients who are uninsured or on Medicaid are more likely to be diagnosed at a late stage of the disease, and have a 30-50 percent greater likelihood of death than cancer patients with private insurance.<sup>58</sup>
- **Uninsured individuals with chronic illnesses are less likely to receive adequate treatment and more likely to have adverse outcomes than insured individuals.**<sup>59</sup> Effective management of chronic illnesses such as HIV, diabetes, heart disease, end-stage renal disease, and mental illness requires regular health care services and visits with health care professionals and active involvement of the patient by monitoring and attending to his or her health.<sup>60</sup> Patients without health insurance are less likely to have an ongoing relationship with a health care provider and have access to regular health care services,<sup>61</sup> and are thus at greater risk for adverse health outcomes.
- **Uninsured individuals who receive hospital care are more likely to be subject to medical negligence and more likely to die during hospitalization than insured individuals.**<sup>62</sup> This may be because uninsured persons use the hospital emergency room more frequently, where there are higher rates of



adverse events,<sup>63</sup> or because uninsured persons seek care at a later stage in their illness when they are harder to treat. Uninsured individuals who receive trauma care are less likely to be admitted to the hospital and more likely to die than insured trauma victims.<sup>64</sup>

- **Being uninsured is associated with an increased risk of premature death.**<sup>65</sup> Two separate multi-year studies that compared insured individuals with uninsured individuals found, controlling for socio demographic characteristics such as age, income, and self-reported health status, that one's status as uninsured had a significant impact on one's risk of mortality.
- **Being uninsured may take a toll on an individual's emotional health.** This is especially true for parents who are not able to provide insurance for their children, or who fear that their untreated health problems may render them unable to care for their children.

## Laws Addressing Insurer Coverage of Essential Women's Health Care

Some state and federal laws require coverage of particular elements of women's health care in both group and individual plans and prohibit sex discrimination in health benefits. However, the existing legal framework leaves gaps that need to be filled. Some discriminatory practices persist in the group market, particularly among small employers who are not subject to these laws. Women are even more vulnerable to discrimination in the individual market, as state insurance law generally imposes limited requirements on this market. In Pennsylvania, individual health insurance policies are subject to extremely limited regulation, and therefore insurers are allowed to charge substantially and unjustifiably higher premiums for individual health policies for women than for men and to exclude coverage for essential aspects of women's health care. The Patient Protection and Affordable Care Act (ACA), once fully implemented, will close many of these coverage gaps by mandating and subsidizing coverage and addressing many discriminatory practices.

### Coverage for Contraception

Title VII of the Civil Rights Act of 1964 is the federal law prohibiting sex discrimination in employment, including employee benefit plans.<sup>66</sup> It provides significant protection for contraceptive coverage in group plans offered by employers with fifteen or more employees. The Equal Employment Opportunity Commission (EEOC), which is responsible for enforcement of Title VII, has determined that the exclusion of prescription contraceptives from an employer-based health insurance plan that covers other prescription drugs and devices and preventive care generally is an unlawful employment practice that discriminates on the basis of sex and pregnancy in violation of Title VII and the Pregnancy Discrimination Act (PDA).<sup>67</sup>

Several federal courts agreed with the EEOC that excluding coverage for contraception in plans that covered a full range of preventive health services amounts to unlawful discrimination under Title VII and the PDA,<sup>68</sup> however one court, the Eighth Circuit Court of Appeals, whose opinions bind only the seven states in that circuit, rejected that view.<sup>69</sup> The EEOC maintains its interpretation of the law that the denial of contraceptive coverage from an other-

wise comprehensive employee health benefits plan is unlawful discrimination.<sup>70</sup> The Pennsylvania Human Relations Act (PHRA), which prohibits sex discrimination by Pennsylvania employers with four or more employees, prohibits sex discrimination in employer health benefit plans in the same manner as Title VII.<sup>71</sup>

Contraceptive equity laws, adopted in twenty-eight states,<sup>72</sup> require all insurance policies in both the group and individual markets<sup>73</sup> that offer prescription coverage to cover FDA-approved contraceptive drugs and devices.<sup>74</sup> Attempts to pass Pennsylvania legislation requiring insurance providers that offer prescription coverage to include prescription contraceptive drugs and devices have been unsuccessful.<sup>75</sup> In 2011, House Bill 414 was introduced in the Pennsylvania General Assembly as a renewed attempt to require insurance companies to provide contraceptive coverage equal to coverage offered for other prescription medication.<sup>76</sup> The bill is currently before the Pennsylvania House of Representatives Insurance Committee.

The Women's Health Amendment to the ACA requires the Department of Health and Human Services (HHS) to develop a

list of covered preventive health services for women.<sup>77</sup> HHS contracted with the Institute of Medicine (IOM) to develop recommendations, and IOM has received recommendations from a panel of experts, which included recommendations to include contraception.<sup>78</sup> In August 2011, HHS issued guidelines developed in conjunction with recommendations from the IOM, which require all new health insurance plans beginning on or after August 1, 2012 to cover contraception, in addition to other preventive women's health services, with no copayments or cost sharing.<sup>79</sup>

### Coverage for Abortion

Title VII requires employers to include abortion coverage in their health insurance benefits “where the life of the mother would be endangered if the fetus were carried to term” and “where medical complications have arisen from an abortion” and does not prevent employers “from providing abortion benefits or otherwise affect[ing] bargaining agreements in regard to abortion.”<sup>80</sup> Pennsylvania state insurance law does not require either group or individual health insurance policies to cover abortion, and current legislative proposals attacking insurance coverage of abortion threaten to reduce access to abortion care nationwide and in Pennsylvania.

The debate about abortion that ensued when the ACA was considered by Congress resulted in the ACA's allowing insurers and states to exclude insurance coverage for abortion care. The ACA permits insurers to decide whether to cover abortion beyond cases of life endangerment, rape, and incest and requires insurers that cover abortion to comply with strict requirements for segregation of funds, which might deter such coverage.<sup>81</sup> The ACA also explicitly allows

states to pass their own laws banning insurance coverage of abortion in exchanges.<sup>82</sup> Congress continues to debate abortion coverage; legislation has been introduced that seeks to prohibit federal funds from being used for any health benefits coverage that includes coverage of abortion, except in the case of rape, incest, or life endangerment of the woman.<sup>83</sup> In Pennsylvania, as in many other states, legislation has been introduced to ban coverage for abortion care by any health insurance plan offered through the state health insurance exchange (state-sponsored marketplace for purchase of health insurance) to be created by 2014 as part of the ACA, except in the case of rape, incest, or life endangerment of the woman.<sup>84</sup>

### Coverage for Maternity Care

Federal and state anti-discrimination laws restrict employer group plans from excluding maternity care from coverage. Title VII requires employers that offer group health insurance and have fifteen or more employees to include coverage for maternity care.<sup>85</sup> In Pennsylvania, the PHRA offers similar protection and applies to employers who employ four or more employees.<sup>86</sup> Federal and state insurance mandates also offer some protection for pregnant women. Both Federal and Pennsylvania law require all group and individual health insurance policies that include coverage for maternity care to cover a minimum of 48 hours hospital stay following a vaginal birth and 96 hours hospital stay following a cesarean section.<sup>87</sup> These provisions do not mandate maternity coverage; they just provide minimum levels required if the plan includes maternity coverage. Nor do they mandate prenatal care or post-partum care.



Beginning in 2014, the ACA will require all new insurance plans in the individual, small group, and exchange markets to include coverage for maternity and newborn care as an “essential health benefit.”<sup>88</sup> The ACA left the specific definition of maternal and newborn care up to HHS<sup>89</sup>, which has clearly not defined it.

In an attempt to provide coverage before 2014, Pennsylvania senators introduced Senate Bill 1063, which, if adopted, will require Pennsylvania insurers to include coverage for prenatal, pregnancy, and postpartum care.<sup>90</sup>

### **Pre-Existing Condition Rejections and Exclusions**

In the group market, the Health Insurance Portability and Accountability Act (HIPAA) limits pre-existing condition exclusions in group health insurance plans to a period no longer than twelve months.<sup>91</sup> HIPAA also prohibits group plans from imposing any

pre-existing condition exclusion relating to pregnancy as a pre-existing condition.<sup>92</sup> However, in the individual market, insurers are free to reject applicants entirely because of pre-existing conditions or exclude coverage for pre-existing conditions indefinitely.

Pennsylvania has been a leader in limiting pre-existing condition exclusions in the area of domestic violence. Pennsylvania law prohibits health insurers from discriminating against victims of abuse by denying them coverage, refusing to renew their coverage, cancelling their coverage, excluding or limiting benefits, or charging them higher premiums because of their status as victims of abuse.<sup>93</sup>

Federally, beginning in 2014, the ACA will prohibit insurance companies from applying pre-existing condition exclusions.<sup>94</sup> This will greatly improve women's access to insurance, as insurers will no longer be able to deny or restrict coverage based on a woman's pregnancy or prior cesarean section, or any other health condition.<sup>95</sup>

### **Gender Rating**

Most employers who offer employer-based health insurance may not, under federal and state anti-discrimination laws, charge their female employees a higher contribution toward their health insurance coverage than their male employees.<sup>96</sup> As discussed above, Title VII and the PHRA prohibit covered employers from discriminating against employees on the basis of sex with respect to health benefits,<sup>97</sup> which means that any difference in premiums charged by insurers on the basis of sex cannot be passed on to the employees. This restriction, however, only applies to employers, not the insurance companies themselves. Therefore, insurance companies who provide group coverage may legally consider the sex breakdown of the group in determining premiums, but employers may not pass on any price disparities to their

employees. This may be especially problematic for companies with a predominately female workforce, some of which may pay as much as \$2,000 more in yearly premiums per employee.<sup>98</sup>

Further, there is no legal protection against gender rating for women who purchase health insurance through the individual market. Health insurers in Pennsylvania are allowed to charge more for women than men, because there is no state or federal regulation limiting or prohibiting gender rating in the individual market.<sup>99</sup>

Pennsylvania insurers have historically been subject to little rate regulation. The Pennsylvania Accident and Health Filing Act until recently required insurers to file rates only for individual coverage and limited types of small group plans (only individual and small group Blue Cross and HMO products); it did not require filing of rates for all group plans,<sup>100</sup> nor did it require the insurance commissioner to approve or disapprove health insurance rates.<sup>101</sup> Rather, it allowed filed rates to become effective unless disapproved within 45 days of filing. Amended to comply with new ACA requirements, Pennsylvania's rate law now requires the filing of rates for small group plans as well as individual plans. However, it does not require the Insurance Department to review an insurer's rates unless the rates have increased by 10 percent or more, and it continues to permit rates to become effective unless disapproved.<sup>102</sup> Although Pennsylvania's Unfair Insurance Practices Act prohibits sex discrimination with regard to underwriting standards and practices and eligibility requirements, this prohibition does not apply to rating.<sup>103</sup>

Beginning in 2014, the ACA will prohibit insurance companies in the individual and small group markets from gender rating.<sup>104</sup> However, the ACA does not prohibit health insurers from gender rating in the large

## **Businesses Pay More for Female Employees**

Linda Bettinazzi, the president and CEO of Visiting Nurse Association of Indiana County, pays \$2000 more than the national average, per employee, for employee health insurance because nearly all of her 175 employees are women. Feeling betrayed and angry at the unfairness, Bettinazzi is, for the first time, asking employees to contribute to premiums, and the board of directors is looking at higher deductible policies.<sup>i</sup>

<sup>i</sup> Jenny Gold, *Health Care Fight Becomes a Battle of the Sexes*, Oct. 28, 2009, [http://www.msnbc.msn.com/id/33483625/ns/business-small\\_business/](http://www.msnbc.msn.com/id/33483625/ns/business-small_business/) (last visited Nov. 10, 2011).

group market, leaving a loophole that may negatively affect predominantly female workplaces.

### **Additional Women's Health Care Mandates**

Pennsylvania requires both group and individual health insurance policies to cover mammograms,<sup>105</sup> mastectomies and breast reconstruction,<sup>106</sup> annual gynecological exams,<sup>107</sup> and routine pap smears.<sup>108</sup> In addition, as of September 23, 2010, the ACA requires new plans to cover many preventive services without a copayment and without regard to any deductible, including mammograms every 1-2 years for women over age 40, cervical cancer screening, and screening and tests for pregnant women.<sup>109</sup> Further, the ACA separately guarantees that all new insurance plans will cover preventive services, including counseling, screenings, and interventions, that have received a rating of either "A" (meaning a high certainty of substantial net bene-

fit) or “B” (meaning a high certainty that the net benefit is moderate) from the United States Preventive Services Task Force.<sup>110</sup> These services, which must be covered and provided without cost-sharing, include folic acid supplements, blood pressure screening, breast feeding counseling, and many other services, and will be an enormous benefit to women.<sup>111</sup>

Recent HHS guidelines also require that health insurance plans beginning on or after

August 2012 cover, without any co-payment or cost sharing, the following services: well-women visits, screening for gestational diabetes, human papillomavirus screenings for women over thirty, sexually-transmitted infection counseling, human immunodeficiency virus screening and counseling, contraceptive methods and counseling, lactation consultation and supplies, and domestic violence screening and counseling.<sup>112</sup>

## RECOMMENDATIONS FOR REFORM

### ACA Implementation

- Pennsylvania should take all necessary steps to enact legislation and establish procedures in order to be ready to timely implement the ACA in a way that provides affordable and accessible quality health care for all Pennsylvanians, including providing for the essential health care needs of women.

### Contraceptive Coverage

- Pennsylvania should adopt legislation mandating coverage of contraceptive methods and services by all insurers and all employers, which will expand contraceptive coverage beyond the limits of current law. Under the ACA, the contraceptive coverage requirement applies only to new private health plans written on or after August 1, 2012.

### Abortion Coverage

- The state and federal governments should expand insurance coverage of abortion, including in the ACA insurance exchanges, to ensure access to safe abortion services.
- The Pennsylvania General Assembly should defeat Senate Bill 3 and permit women to use their own money to buy abortion coverage in the insurance exchanges.

### Maternity Coverage

- Pennsylvania should adopt Senate Bill 1063,<sup>113</sup> requiring all health insurance plans to cover comprehensive maternity care, including prenatal care, delivery, and post-partum care. Immediate adoption of this bill will provide necessary and essential care for women prior to the 2014 effective date of the ACA. Several states have passed laws that require all health insurance policies to cover comprehensive maternity care,<sup>114</sup> and Pennsylvania should follow suit.
- HHS should adopt a broad definition of maternity coverage as part of the essential health benefit package and Pennsylvania should implement the maternity coverage requirement to include comprehensive prenatal, delivery, and post-partum care.

### Pre-Existing Condition Coverage

- Pennsylvania should enact legislation that will prohibit insurers from rejecting applicants because of pre-existing conditions prior to the effective date of the ACA. Several states have legislation that requires insurers in the individual market to accept anyone who applies for coverage,<sup>115</sup> and Pennsylvania should adopt such a requirement.<sup>116</sup> At a minimum, Pennsylvania should enact legislation that prohibits a prior or current pregnancy, or any condition relating to a prior or current pregnancy, from being considered a pre-existing condition, a major barrier to health insurance for women.

## Gender Rating

- Congress should enact federal legislation that will prohibit gender rating in the large group insurance market. The ACA has left this loophole, which will especially hurt employers in sectors that employ a disproportionate number of women. Without such legislation, these employers might find that health insurance is prohibitively expensive, and they might require employees to pay high contributions toward their insurance coverage.<sup>117</sup>
- Pennsylvania should enact legislation that will immediately prohibit gender rating in the individual and group markets. Several states have already prohibited gender rating in the individual health insurance market,<sup>118</sup> and Pennsylvania should also prohibit gender-based rating until the ACA goes into effect.

**ENDNOTES**

- <sup>1</sup> Nat'l Conference of State Legislatures, Insurance Coverage for Contraception Laws, <http://www.ncsl.org/default.aspx?tabid=14384> (last visited Oct. 21, 2011).
- <sup>2</sup> Institute of Medicine, Essential Health Benefits: Balancing Coverage and Costs 4-9 (2011).
- <sup>3</sup> Usha Ranji & Alina Salganicoff, Kaiser Family Found., Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey 10 (2011), available at <http://www.kff.org/womenshealth/upload/8164.pdf>. Women who purchase individual policies are typically employed, but their employer or their spouse's employer does not offer insurance; because sellers of individual policies take health status into account when selling insurance, women with individual policies tend to be in better health than those who do not qualify. *Id.* at 11.
- <sup>4</sup> *Id.* at 10.
- <sup>5</sup> National Women's Law Center analysis of 2009 and 2010 health insurance data from the U.S. Census Bureau Current Population Survey's (CPS) 2010 and 2011 Annual Social and Economic (ASEC) Supplements, available at [http://www.census.gov/hhes/www/cpssc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpssc/cps_table_creator.html) in National Women's Law Center & State Partners, The Affordable Care Act Implementation in Pennsylvania 1.
- <sup>6</sup> See Mercer, Hot Topics in Health Care: Pharmacy Benefits 6 (2006), available at <http://us.select.mercer.com/ps/73410/p/133/blurb/65698/article/20066135/> (finding that 11 percent of respondents excluded coverage for contraceptives); Adam Sonfield & Rachel Benson Gold, *New Study Documents Major Strides in Drive for Contraceptive Coverage*, Guttmacher Rep. on Pub. Pol'y 4, 4 (2004), available at <http://www.guttmacher.org/pubs/tgr/07/2/gr070204.pdf>.
- <sup>7</sup> Guttmacher Inst., Testimony Submitted to the Committee on Preventive Services for Women, Institute of Medicine 16 (2011), available at <http://www.guttmacher.org/pubs/CPSW-testimony.pdf> [hereinafter Guttmacher Testimony to IOM].
- <sup>8</sup> *Id.* at 16.
- <sup>9</sup> Other less popular and less effective methods, including the sponge, spermicides, and fertility awareness-based methods, also known as natural family planning, are also available over-the-counter. Medline Plus, Over-the-Counter Birth Control, <http://www.nlm.nih.gov/medlineplus/ency/article/004003.htm> (last visited Oct. 21, 2011); Mayo Clinic, Natural Family Planning, <http://www.mayoclinic.com/health/birth-control/MY01182/DSECTION=natural-family-planning> (last visited Oct. 21, 2011).
- <sup>10</sup> Planned Parenthood, Birth Control, <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm> (last visited Oct. 21, 2011).
- <sup>11</sup> Guttmacher Testimony to IOM, *supra* note 7, at 7-8.
- <sup>12</sup> Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 Persp. on Sexual & Reprod. Health 72, 75 (2004).
- <sup>13</sup> Kaiser Family Found., Health Benefits, <http://www.kff.org/insurance/ehbs2003-10-chart.cfm#2> (last visited Oct. 21, 2011); Guttmacher Inst., Guttmacher Institute Memo on Insurance Coverage of Abortion, <http://www.guttmacher.org/media/inthenews/2009/07/22/index.html> (last visited Oct. 21, 2011).
- <sup>14</sup> *Id.*
- <sup>15</sup> Guttmacher Inst., Memo on Private Insurance Coverage of Abortion, <http://www.guttmacher.org/media/inthenews/2011/01/19/index.html> (last visited Oct. 21, 2011).
- <sup>16</sup> Rachel K. Jones et al., Guttmacher Inst., Characteristics of U.S. Abortion Patients, 2008, at 10-11 (2010), available at <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>.
- <sup>17</sup> *Id.* at 11-12.

<sup>18</sup> Nat'l Women's Law Ctr., *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* 30 (2008) [hereinafter *Nowhere to Turn*].

<sup>19</sup> *Id.*

<sup>20</sup> Nat'l Women's Law Ctr., *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* 18 (2009) [hereinafter *Still Nowhere to Turn*].

<sup>21</sup> Shriver Ctr., *30 Million Women Will Benefit from Health Care Reform*, *WomanView* 1, 2 (Aug. 2010), available at <http://www.povertylaw.org/news-and-events/woman-view/30%20Million%20Women%20Will%20Benefit%20from%20Health%20Care%20Reform.html>.

<sup>22</sup> Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, *N.Y. Times*, Mar. 29, 2010, <http://www.nytimes.com/2010/03/30/health/30women.html> (last visited Oct. 21, 2011).

<sup>23</sup> *Still Nowhere to Turn*, *supra* note 20, at 3.

<sup>24</sup> *Still Nowhere to Turn*, *supra* note 20, at 5-6.

<sup>25</sup> *Nowhere to Turn*, *supra* note 18, at 9.

<sup>26</sup> *Nowhere to Turn*, *supra* note 18, at 9; *Still Nowhere to Turn*, *supra* note 20, at 6.

<sup>27</sup> *Still Nowhere to Turn*, *supra* note 20, at 16.

<sup>28</sup> *Still Nowhere to Turn*, *supra* note 20, at 14.

<sup>29</sup> Nat'l Women's Law Ctr., *Guaranteeing Contraceptive Coverage in All New Health Insurance Plans*, <http://www.nwlc.org/resource/guaranteeing-contraceptive-coverage-all-new-health-insurance-plans> (last visited Oct. 21, 2011).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

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

<sup>33</sup> *HealthyPeople.gov*, *Family Planning*, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13#nine> (last visited Oct. 21, 2011).

<sup>34</sup> *Id.*

<sup>35</sup> Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 *Stud. Fam. Plan.* 18, 22 fig.1 (2008).

<sup>36</sup> *Ctr. for Young Women's Health*, *Medical Uses of the Oral Contraceptive Pill*, <http://www.youngwomenshealth.org/med-uses-ocp.html> (last visited Oct. 21, 2011).

<sup>37</sup> *Guttmacher Inst.*, *State Center: State Facts About Abortion: Pennsylvania* (Jan. 2011), available at <http://www.guttmacher.org/pubs/sfaa/pdf/pennsylvania.pdf>.

<sup>38</sup> Heather Boonstra, *Voicing Concern for Women, Abortion Foes Seek Limits on Availability of Mifepristone*, 4.2 *Guttmacher Rep. on Pub. Policy* 3 (2001), available at <http://www.guttmacher.org/pubs/tgr/04/2/gr040203.pdf>.

<sup>39</sup> *Ass'n of Reproductive Health Professionals*, *Clinical Fact Sheets: Mifepristone Safety Overview* (2008), available at <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/mifepristone-safety-overview>.

<sup>40</sup> F.G. Cunningham et al., *Chapter 7. Preconceptional Counseling*, *Williams Obstetrics* (McGraw-Hill Medical 2010).

<sup>41</sup> Cunningham et al., Chapter 55. Neurological and Psychiatric Disorders, *supra* note 40.

<sup>42</sup> Cunningham et al., Chapter 57. Neoplastic Diseases, *supra* note 40.

<sup>43</sup> Stanley K. Henshaw, Unintended Pregnancy in the United States, 30.1 Fam. Planning Persp. 24, 24 (1998), available at <http://www.guttmacher.org/pubs/journals/3002498.pdf>.

<sup>44</sup> Each year an estimated 25,000 U.S. women become pregnant as a result of sexual assault. See F. Stewart & J. Trussell, *Prevention of Pregnancy Resulting from Rape*, 19 Am. J. Preventive Medicine 228 (2000); see also M.M. Holmes et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 Am. J. Obstetrics & Gynecology 320 (1996) (estimating 32,000 pregnancies caused by sexual assault each year).

<sup>45</sup> Christina Zampas & Jaime M. Gher, *Abortion as a Human Right: International and Regional Standards*, 8 Human Rights L. Rev. 249 (2008).

<sup>46</sup> See *Planned Parenthood v. Casey*, 505 U.S. 833, 855-56 (1992); see also Reva Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 Emory L.J. 815 (2007).

<sup>47</sup> See *Gonzales v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting).

<sup>48</sup> Guttmacher Inst., *Lessons from Before Roe: Will Past be Prologue?*, 6 Guttmacher Rep. on Pub. 8 (2003), available at <http://www.guttmacher.org/pubs/tgr/06/1/gr060108.html>.

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

<sup>50</sup> Office of the D.A. City of Phila., *West Phila. Abortion Doctor Charged with Murder* (Jan. 19, 2011), <http://phillyda.wordpress.com/2011/01/19/west-philadelphia-abortion-doctor-charged-with-murder/> (last visited Oct. 27, 2011).

<sup>51</sup> R. Seth Williams, D.A., Report of the Grand Jury, Misc. No. 0009901-2008, at 3, available at [http://www.phila.gov/districtattorney/grandjury\\_womensmedical.html](http://www.phila.gov/districtattorney/grandjury_womensmedical.html); See Taunya English, *Women Sought Inexpensive Care at West Philly Clinic*, WHYY, Mar. 1, 2010, <http://whyy.org/cms/news/healthscience/2010/03/01/women-sought-inexpensive-care-at-west-philly-clinic/32017> (last visited Oct. 27, 2011).

<sup>52</sup> Gene Bishop, *Pregnant and Uninsured*, Phila. Inquirer, May 4, 2006, [http://articles.philly.com/2006-05-04/news/25399836\\_1\\_health-insurance-uninsured-children-high-deductible-plans](http://articles.philly.com/2006-05-04/news/25399836_1_health-insurance-uninsured-children-high-deductible-plans) (last visited Oct. 21, 2011).

<sup>53</sup> *Id.*

<sup>54</sup> Comm. on the Consequences of Uninsurance, Inst. of Med., *Care Without Coverage: Too Little, Too Late* 48 (2002) [hereinafter *Care Without Coverage*].

<sup>55</sup> *Id.* at 50.

<sup>56</sup> *Id.* at 52.

<sup>57</sup> *Id.*; Kaiser Comm'n on Medicaid & the Uninsured, Kaiser Family Found., *Sicker and Poorer: The Consequences of Being Uninsured* 18 (2002) [hereinafter *Sicker and Poorer*].

<sup>58</sup> *Care Without Coverage*, *supra* note 54, at 54.

<sup>59</sup> *Id.* at 57.

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

<sup>61</sup> See *id.* at 58.

<sup>62</sup> *Id.* at 72.

<sup>63</sup> *Id.* at 73.

<sup>64</sup> *Id.*; Sicker and Poorer, *supra* note 57, at 30-31.

<sup>65</sup> Care Without Coverage, *supra* note 54, at 81.

<sup>66</sup> 42 U.S.C. § 2000e, *et seq.*

<sup>67</sup> Coverage of Contraception, 2000 WL 33407187 (E.E.O.C. Dec. 14, 2000) (decision), *available at* <http://www.eeoc.gov/policy/docs/decision-contraception.html>.

<sup>68</sup> *See, e.g.*, *Stocking v. AT&T Corp.*, 436 F. Supp. 2d 1014 (W.D. Mo. 2006) (holding employer corporation liable under both Title VII and the PDA for excluding prescription contraception from its health plan), *overruled by* *Stocking v. AT&T Corp.*, No. 03-0421-CV-W-HFS, 2007 WL 3071825 (W.D. Mo. Oct. 22, 2007); *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001) (holding that the exclusion of contraception from a prescription drug plan failed to meet a fundamental health need regardless of whether such discrimination was intentional, and that Title VII requires employers to provide equally comprehensive coverage including additional benefits to cover women-only expenses).

<sup>69</sup> *Standridge v. Union Pac. R.R. Co.*, 479 F.3d 936, 942-43 (8th Cir. 2007). The dissent highlights the inequality of excluding contraceptive coverage, noting that such exclusion “only medically affects females, as they bear all of the health consequences of unplanned pregnancies.” *Id.* at 945 (Bye, J., dissenting).

<sup>70</sup> *See supra* note 68 and accompanying text; Ben Conery, *Catholic College Faces Lawsuit over Contraceptives*, Wash. Times, Aug. 15, 2009, <http://www.washingtontimes.com/news/2009/aug/15/catholic-college-faces-lawsuit-over-contraceptives> (last visited Oct. 21, 2011); Amanda Memrick, *EEOC Rules Belmont Abbey Discriminated Against Women and Retaliated Against Faculty Members*, Gaston Gazette, Aug. 11, 2009, <http://www.gastongazette.com/articles/college-36794-discriminated-eeoc.html> (last visited Oct. 21, 2011).

<sup>71</sup> 43 Pa. Cons. Stat. § 955 (2011); *see, e.g.*, *Lukus v. Westinghouse Elec. Corp.*, 419 A.2d 431, 449-50 (Pa. Super. Ct. 1980) (finding cognizable claim under PHRA against employer whose disability plan excluded coverage for employees disabled by pregnancy, childbirth, or related complications, reasoning that discrimination in such insurance plans was prohibited as an aspect of compensation, hire, tenure, terms, conditions or privileges of employment); *Anderson v. Upper Bucks County Area Vocational Technical Sch.*, 373 A.2d 126, 130 (Pa. Commw. Ct. 1977) (finding employer in violation of PHRA's sex discrimination prohibition where disability insurance benefit excluded disability arising out of pregnancy); *Canon-McMillan Sch. Dist. v. Pa. Human Relations Comm'n ex rel. Davis*, 372 A.2d 498, 500 (Pa. Commw. Ct. 1977) (finding a violation of PHRA's sex discrimination prohibition where employer's rules governing premium contribution for family coverage for health insurance disparately impacted female employees).

<sup>72</sup> Guttmacher Inst., *Insurance Coverage of Contraceptives 1* (2011), *available at* [http://www.guttmacher.org/statecenter/spibs/spib\\_ICC.pdf](http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf).

<sup>73</sup> Contraceptive equity laws do not, however, cover employers that are self-insured, because these plans are governed by federal law. Nat'l Women's Law Ctr., *Contraceptive Equity Laws in Your State: Know Your Rights – Use Your Rights, a Consumer Guide*, <http://www.nwlc.org/resource/contraceptive-equity-laws-your-state-know-your-rights-use-your-rights-consumer-guide-0> (last visited Oct. 21, 2011).

<sup>74</sup> *Id.*; *see, e.g.*, Ariz. Rev. Stat. Ann. § 20-2329 (2002); Del. Code Ann. tit. 18, § 3559 (2000); Iowa Code § 514C.19 (2000); N.J. Stat. Ann. § 17:48-6ee (2006); Vt. Stat. Ann. tit. 8, § 4099c (1999).

<sup>75</sup> H.R. 109, 1999 Gen. Assem., Reg. Sess. (Pa. 1999); H.R. 11, 1999 Gen. Assem., Reg. Sess. (Pa. 1999).

<sup>76</sup> H.R. 414, 2011 Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>77</sup> 42 U.S.C. § 300gg-13(a)(4) (2011).

<sup>78</sup> Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (July 19, 2011).

<sup>79</sup> U.S. Dep't of Health & Human Servs., *Press Release: Affordable Care Act Ensures Women Receive Preventive Services at No Additional Cost* (Aug. 1, 2011), <http://www.hhs.gov/news/press/2011pres/08/20110801b.html> (last visited Oct. 21, 2011) [hereinafter *Preventive Services at No Additional Cost*].

<sup>80</sup> 42 U.S.C. §§ 2000e(k), 2000e-2(a)(1) (2011); 29 C.F.R. § 1604.10(b) (2011).

<sup>81</sup> 42 U.S.C. § 18023(b)(2)(C) (2011).

<sup>82</sup> 42 U.S.C. § 18023(a)(1) (2011).

<sup>83</sup> H.R. 3, 112th Cong. (1st Sess. 2011).

<sup>84</sup> S. 3, 2011 Gen. Assem., Reg. Sess. (Pa. 2011); *See, e.g.*, Ariz. Rev. Stat. Ann. § 20-121 (2010); La. Rev. Stat. Ann. § 22:1014 (2010); Tenn. Code. Ann. § 56-26-134 (2010).

<sup>85</sup> 42 U.S.C. § 2000e(b), (k) (2011); *see also* U.S. Equal Employment Opportunity Comm'n, *Facts About Pregnancy Discrimination*, <http://www.eeoc.gov/facts/fs-preg.html> (last visited Oct. 21, 2011).

<sup>86</sup> *See supra* note 71 and accompanying text.

<sup>87</sup> 42 U.S.C. § 300gg-51 (2011); 29 U.S.C. § 1185 (2011); 40 Pa. Cons. Stat. § 1583 (2011).

<sup>88</sup> 42 U.S.C. §§ 300gg-6, 18022 (2010).

<sup>89</sup> 42 U.S.C. § 18022 (2010).

<sup>90</sup> S. 1063, 2011 Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>91</sup> 26 U.S.C. § 9801 (2011).

<sup>92</sup> 29 U.S.C. § 1181(d)(3) (2011).

<sup>93</sup> 40 Pa. Cons. Stat. § 1171.5(a)(14) (2011).

<sup>94</sup> 42 U.S.C. § 300gg-3 (2011). A restriction against pre-existing condition exclusions is already in place for children under age 19. *Id.*

<sup>95</sup> *See id.*

<sup>96</sup> Employers, however, may be charged different rates based on the gender composition of their workforce.

<sup>97</sup> *See supra* notes 66, 71 and accompanying text; 42 U.S.C. § 2000e-2 (2011) (covering employers with fifteen or more employees); 43 Pa. Cons. Stat. § 955 (2011) (covering employers with four or more employees).

<sup>98</sup> Nat'l Women's Law Ctr., *Close Insurance Company Loopholes: End Gender Rating in All Health Insurance Markets 1*, available at [http://action.nwlc.org/site/DocServer/General\\_Group\\_Market\\_Gender\\_Rating\\_UPDATED.pdf?docID=821](http://action.nwlc.org/site/DocServer/General_Group_Market_Gender_Rating_UPDATED.pdf?docID=821).

<sup>99</sup> Nowhere to Turn, *supra* note 18, at 8, 13.

<sup>100</sup> *See* 40 Pa. Cons. Stat. § 3803 (2011).

<sup>101</sup> *See* 40 Pa. Cons. Stat. § 3804 (2011).

<sup>102</sup> S. 1336, Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>103</sup> 40 Pa. Cons. Stat. § 1171.5(a)(7)(iii) (2011).

<sup>104</sup> 42 U.S.C. § 300gg (2011); *see* Shriver Ctr., *supra* note 21, at 3.

<sup>105</sup> 40 Pa. Cons. Stat. § 764c (2011).

<sup>106</sup> 40 Pa. Cons. Stat. § 764d (2011).

<sup>107</sup> 40 Pa. Cons. Stat. § 1574 (2011).

<sup>108</sup> *Id.*

<sup>109</sup> 42 U.S.C. § 300gg-13(a) (2011); U.S. Preventive Servs. Task Force, USPSTF A and B Recommendations, <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm> (last visited Oct. 21, 2011); National Women's Law Center & Partners, Access to Preventive Health Care for Women in the New Health Care Law: Frequently Asked Questions 1 (2011).

<sup>110</sup> 42 U.S.C. § 300gg-13(a)(1) (2011); grade definitions can be found at <http://www.uspreventiveservices taskforce.org/uspstf/grades.htm>.

<sup>111</sup> 42 U.S.C. § 300gg-13(a) (2011); U.S. Preventive Servs. Task Force, *supra* note 109.

<sup>112</sup> *Preventive Services at No Additional Cost*, *supra* note 79; National Women's Law Center & Partners, *supra* note 109, at 2.

<sup>113</sup> S. 1063, 2011 Gen. Assem., Reg. Sess. (Pa. 2011).

<sup>114</sup> *See, e.g.*, Or. Rev. Stat. § 743A.080 (2009); Mass. Gen. Laws Ann. ch. 176G, §§ 4C, 4I (West 2007).

<sup>115</sup> *See, e.g.*, Mass. Gen. Laws Ann. ch. 176M, §§ 1, 3(a) (West 2010); Vt. Stat. Ann. tit. 8, § 4080b(d)(1) (2009).

<sup>116</sup> It should be noted that without an individual mandate requiring everyone to obtain coverage, this would likely drive up premium costs in the individual market.

<sup>117</sup> Under the ACA, large employers are only mandated to cover 60 percent of the cost of health insurance expenses for their employees.

<sup>118</sup> *See, e.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2)(B) (2007); N.Y. Ins. Law § 3231(a) (Consol. 2011).

## Section C. The Impact of Sex Bias in **DRUG TRIALS** on Women's Health

### INTRODUCTION

*Until 1993, the Food and Drug Administration (FDA) excluded women from participating in drug treatment trials. Although women are no longer explicitly excluded from clinical drug trials, the sex breakdown of subjects paints an incomplete picture about how much is known (or unknown) about a drug's effects on women. Pregnant women especially lack information about how FDA-approved drugs will affect them or the fetus. The exclusion of women from clinical drug trials has had major repercussions throughout the years. Women have suffered severe health consequences when drugs are approved for use and prescribed without appropriate testing.*



## Sex Discrimination in Drug Trials

The importance of analyzing data from clinical drug trials by sex cannot be overstated. Both the pharmacokinetics (what the body does to the drug) and the pharmacodynamics (what the drug does to the body) of drugs are often different in men and women.<sup>1</sup> These differences can be attributed to differences in body size and composition and the effects of hormones in men and women.<sup>2</sup> Women's menstrual cycles, pregnancies, hormonal birth control, and hormone replacement therapy can also drastically alter the effects of a drug.<sup>3</sup> A 2001 General Accounting Office (GAO) report found that among new drug applications (NDAs) that reported sex-specific analyses, one-fifth reported statistically significant differences in safety between men and women, and one-half found statistically significant differences in efficacy.<sup>4</sup>

Historically, FDA policies prevented drug companies from collecting adequate data about a drug's effects on women. The 1977 FDA guidelines recommended excluding "women of childbearing potential" from clinical drug trials in order to protect fetuses,<sup>5</sup> and, although an exception was made for drugs that treated life-threatening illnesses,<sup>6</sup> this guideline amounted to an outright exclusion of women from drug trials.<sup>7</sup> In 1993, the FDA published guidelines that removed the ban on including women of childbearing potential, but these new guidelines did not include an affirmative mandate to include women in trials.<sup>8</sup> A 2000 FDA binding rule permits the FDA to place a hold on an application if the sponsor proposes to exclude participants based on reproductive potential,<sup>9</sup> but this rule does not include an affirmative mandate to recruit women or enroll a specific number of women.<sup>10</sup> Although female participation in drug trials has increased so that both sexes are now equally represented,<sup>11</sup> this

seeming equality may be insufficient, considering that the incidence and prevalence of certain conditions is greater in women than in men.<sup>12</sup>

Further, only a small portion of clinical trials analyzes the generated data by sex, and most trials are not prospectively designed to capture sex differences.<sup>13</sup> A 1988 FDA guideline called for sex-specific analyses of data in NDAs;<sup>14</sup> however, in 1993, the FDA and the GAO determined that sex-specific analyses were not being done.<sup>15</sup> The 1993 FDA guidelines reiterated the importance of analyzing data by sex.<sup>16</sup> In 1998, the FDA published a final rule that revised NDA content and format regulations to require that safety and efficacy data be presented separately by sex,<sup>17</sup> and this rule allowed the FDA to refuse to accept any application that did not analyze the data by sex.<sup>18</sup> In spite of this rule, a 2001 GAO study found that one-third of NDA summary documents submitted failed to meet the requirements for analyzing data by sex.<sup>19</sup> The study found that although all of the NDAs reviewed included enough women to indicate effectiveness in women, often there was no analysis of the data by sex.<sup>20</sup> The National Institutes of Health (NIH) also emphasizes the importance of analyzing data from clinical trials by sex, but the NIH guidelines are non-binding.<sup>21</sup> The failure to perform data analyses consistently and uniformly by sex is problematic in light of what we know about how sex differences impact drug safety and efficacy.

Although legal barriers to participation no longer exist, practical barriers may still prevent or discourage some women from participating in drug trials.<sup>22</sup> Women are often the primary caretakers in families, and are therefore less mobile and have less time to participate in drug trials.<sup>23</sup>

Another problem is that drug companies do not test drugs in pregnant women.<sup>24</sup> These companies and the FDA justify the exclusion of pregnant women from drug trials based on the duty to protect the fetus from any potential harm.<sup>25</sup> And yet doctors commonly administer drugs to pregnant women, subjecting them to unknown risks.<sup>26</sup> Although the FDA maintains a pregnancy exposure registry that compiles information about drugs' effects on pregnant women and fetuses,<sup>27</sup> this registry is too limited in scope to be a useful tool for most women.<sup>28</sup>

Further, politics may interfere with good science to the detriment of women's health. For example, when the makers of Plan B, an emergency contraception pill, applied for over-the-counter status for their drug, they assumed it would be a fairly straightforward application and approval process.<sup>29</sup> Despite the good science and solid medical evidence in favor of approving Plan B for over-the-counter use,<sup>30</sup> the pharmaceutical company encountered a series of unprecedented roadblocks.<sup>31</sup> Plan B was ultimately approved for over-the-counter use in 2006, but only after three years of repeated consideration, an unnecessary federal rulemak-



ing procedure, and a lawsuit against the FDA by the Center for Reproductive Rights.<sup>32</sup> Plan B's over-the-counter approval is more limited than other over-the-counter drugs, because it is approved only for women 17 and older and available only at health clinics and pharmacies.<sup>33</sup> In 2011, after reviewing relevant scientific data, FDA commissioner Margaret Hamburg concluded that Plan B "is safe and effective and should be approved for nonprescription use for all females of child-bearing potential."<sup>34</sup> However, in an unprecedented and unilateral move, Secretary Kathleen Sebelius of the United States Department of Health and Human Services overruled the FDA's recommendation,<sup>35</sup> leaving Plan B available by prescription-only for women under age 17.<sup>36</sup>

## Impact on Women's Health

The exclusion of women from clinical drug trials has had major repercussions throughout the years. Women have been made into guinea pigs at the medical provider's office and pharmacy, taking medications with little or no information about their safety or possible side effects. The invisibility of women and women's health permeates the pharmaceutical industry. For example, beginning in 1938, pregnant women were prescribed Diethylstilbestrol (DES) to prevent miscarriages.<sup>37</sup> Research in the 1950s showed that DES in fact did not

prevent miscarriages, but doctors continued to prescribe the drug until 1971, when the FDA published research showing that DES caused vaginal cancer in girls and women who had been exposed to DES while in the womb.<sup>38</sup> Oral contraceptives were approved by the FDA in 1957 and widely used before information about dangers associated with higher doses of estrogen came to light.<sup>39</sup> More recently, millions of menopausal women were prescribed hormone replacement therapy, until a 2002 NIH study brought to light the increased

risk of breast cancer, stroke, and heart attack associated with hormone replacement therapy.<sup>40</sup> This NIH study, which has been going on for more than twenty years, recently produced new findings indicating that in some cases, estrogen-only hormone replacement therapy actually decreased a woman's risk for breast cancer and heart attack.<sup>41</sup> This study, focusing as it does on women's health, has improved our understanding of the effect of hormones on women, demonstrating the importance of increased research dedicated to the effect of medications on women.<sup>42</sup>

Evidence supports the conclusion that the virtual exclusion of women from clinical drug testing has harmed women's health. Data show that women are more likely than men to have negative reactions to prescribed drugs.<sup>43</sup> For example, a 2001 GAO report found that prescription drugs that were taken off the market caused more adverse effects in women than in men.<sup>44</sup> The report found that eight of the ten drugs withdrawn from the U.S. market between 1997 and 2001 posed greater health risks for women than for men.<sup>45</sup> Certainly, the harms associated with inadequate clinical drug testing disproportionately fall on women.

For women, the dearth of information about safety and efficacy of medications exposes them to risks when they take those medications. There is also the risk that women will forego needed treatments because they do not have enough information about a drug to make an informed decision about whether or not to take it. These risks are especially great for pregnant women, who have virtually no information about the potential for fetal harm. For example, during the 2009 H1N1 influenza pandemic, the absence of research about the safety and efficacy of Tamiflu for pregnant women may have led doctors to prescribe inadequate doses, contributing to the higher complication rate among pregnant women.<sup>46</sup>

Finally, the exclusion of women from clinical trials has harmed women by denying them the opportunity to receive certain treatments. Clinical trials are treatments in and of themselves.<sup>47</sup> If pregnant women are unable to participate in trials, they are unable to avail themselves of possible treatment opportunities. For pregnant women who otherwise have no access to health care, exclusion from trials may deprive them of basic health care.<sup>48</sup>

## RECOMMENDATIONS FOR REFORM

### FDA

- The FDA should require that the pool of participants in the trial of a new drug reflect the prevalence in various groups of the condition the proposed drug aims to treat.<sup>49</sup> It is not enough to include an equal number of men and women in a clinical drug trial; rather, if a condition presents itself more frequently in women than in men, that should be reflected in the composition of the subjects. In addition to sex, researchers should also strive for proportionality by age, ethnicity, and any other relevant category.
- The FDA should enforce the requirement that data analyses be performed for each sex. The FDA has the power to reject NDAs that do not separate data this way, but has been reluctant to use this power. To ensure that pharmaceutical companies comply with FDA regulations in this regard, the FDA must establish and enforce consequences for noncompliance.
- The FDA should require mandatory reporting of sex differences in side effects and risks on drug labels. If the sex-specific analyses show differences in either safety or efficacy, the FDA must require that these differences be clearly marked on drug labels.<sup>50</sup>
- The FDA should expand its Pregnancy Exposure Registry program. As of December 27, 2011, only 56 pregnancy exposure registries were listed on the FDA website.<sup>51</sup> The FDA should encourage pharmaceutical companies to expand their pregnancy exposure registries by setting up registries for more drugs and medical conditions and by enrolling more women in these studies.

### Pharmaceutical Companies

- Pharmaceutical companies should offer solutions to the practical barriers to participation in clinical trials. To encourage women, especially those with caretaking responsibilities and jobs, to participate in clinical trials, the sites should be easily accessible, have extended hours, and have on-site childcare services.<sup>52</sup> Additionally, medical referrals should not be required, as referrals rule out participation by women without access to regular health care.<sup>53</sup>

### Government Officials, Pharmaceutical Companies & Researchers

- Government officials, pharmaceutical companies, and researchers should eliminate politics from drug treatment trials and decisions regarding drug availability. Decisions regarding drug treatment trials and drug availability should be based on relevant scientific data and the need for research related to women's health.

## ENDNOTES

<sup>1</sup> Ruth B. Merkatz et al., *Women in Clinical Trials of New Drugs: A Change in Food and Drug Administration Policy*, 329 New Eng. J. Med. 292, 293 (1993).

<sup>2</sup> *Id.* at 293.

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

<sup>4</sup> U.S. Gen. Accounting Office, GAO-01-754, *Women's Health: Women Sufficiently Represented in New Drug Testing, but FDA Oversight Needs Improvement* 16 (2001).

<sup>5</sup> Food & Drug Admin., Publ'n No. 77-3040, *General Considerations for the Clinical Evaluation of Drugs* 10 (1977).

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

<sup>7</sup> Jesselyn Clair S. Pe, Note, *Gender Issues in Health Research and the Impact of the Women's Health Office Act of 2005 on Women's Health*, 28 Women's Rts. L. Rep. 127, 130 (2007).

<sup>8</sup> Guideline for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs, 58 Fed. Reg. 39, 406 (1993).

<sup>9</sup> Clinical Hold for Products Intended for Life Threatening Conditions, 21 C.F.R. § 312 (2000).

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

<sup>11</sup> U.S. Accounting Office, *supra* note 4, at 3.

<sup>12</sup> Conversation with Gerianne Tringali DiPiano, President and CEO, FemmePharma Global Healthcare (Dec. 17, 2010).

<sup>13</sup> U.S. Gen. Accounting Office, *supra* note 4, at 3-4.

<sup>14</sup> Guideline for the Format and Content of the Clinical and Statistical Sections of an Application, 21 C.F.R. § 314.50 (1988).

<sup>15</sup> Guideline for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs, 58 Fed. Reg. 39,406 (1993).

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

<sup>17</sup> Investigational New Drug Applications and New Drug Applications, 63 Fed. Reg. 6854 (1998).

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

<sup>19</sup> U.S. Gen. Accounting Office, *supra* note 4, at 3.

<sup>20</sup> *Id.* at 13.

<sup>21</sup> Nat'l Inst. of Health, NIH Policy and Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research (2001), *available at* [http://grants.nih.gov/grants/funding/women\\_min/guidelines\\_amended\\_10\\_2001.htm](http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm).

<sup>22</sup> Vanessa Merton, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 Am. J. L. & Med. 369, 374 (1993).

<sup>23</sup> *Id.*

<sup>24</sup> Pe, *supra* note 7, at 132.

<sup>25</sup> *Id.*

<sup>26</sup> Merton, *supra* note 22, at 381.

<sup>27</sup> Food & Drug Admin., List of Pregnancy Exposure Registries, <http://www.fda.gov/ScienceResearch/SpecialTopics/WomensHealthResearch/ucm134848.htm> (last visited Dec. 27, 2011).

<sup>28</sup> *Id.* As of April 19, 2011, the registry website listed studies for only 38 different drugs.

<sup>29</sup> Susan F. Wood, *Schroeder Lecture: The Role of Science in Health Policy Decision-Making: The Case of Emergency Contraception*, 17 *Health Matrix* 273, 280 (2007).

<sup>30</sup> *Id.* at 286.

<sup>31</sup> *Id.* at 280-86.

<sup>32</sup> *Id.* at 285-88.

<sup>33</sup> U.S. Dep't Health & Human Servs., Memorandum: Supplemental New Drug Application (NDA 21-998/S002) (Dec. 7, 2011), available at <http://www.hhs.gov/news/press/2011pres/12/20111207a.pdf>.

<sup>34</sup> Food & Drug Admin., *Statement from FDA Commissioner Margaret Hamburg, M.D. on Plan B One-Step*, (Dec. 7, 2011), <http://www.fda.gov/NewsEvents/Newsroom/ucm282805.htm> (last visited Dec. 16, 2011).

<sup>35</sup> *Id.*; see also National Women's Law Center, *National Women's Law Center Deeply Concerned by HHS Decision on Plan B*, (Dec. 7, 2011), <http://www.nwlc.org/press-release/national-womens-law-center-deeply-concerned-hhs-decision-plan-b> (last visited Dec. 12, 2011).

<sup>36</sup> U.S. Dep't Health & Human Servs., *A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius*, (Dec. 7, 2011), <http://www.hhs.gov/news/press/2011pres/12/20111207a.html> (last visited Dec. 15, 2011); U.S. Dep't Health & Human Servs., *supra* note 33.

<sup>37</sup> Ctrs. for Disease Control & Prevention, DES History, <http://www.cdc.gov/des/consumers/about/history.html> (last visited Apr. 19, 2011).

<sup>38</sup> *Id.*

<sup>39</sup> Richard McCormick, *Keeping Women in the Dark: Lessons Not Learned and the Real Sins of the Breast Implant Manufacturers*, 17 *B.C. Third World L.J.* 413, 427 (1997) (reviewing Marcia Angell, Science on Trial: The Clash of Medical Evidence and the Law in the Breast Implant Case). Barbara Seaman's *The Doctors' Case Against the Pill* (1969) is credited with bringing about the 1970 Senate Hearings about the safety of oral contraceptives. In 2003, Seaman released *The Greatest Experiment Ever Performed on Women: Exploding the Estrogen Myth*, which detailed the potential risks of hormone-replacement therapy.

<sup>40</sup> Chi-Ling Chen et al., *Hormone Replacement Therapy in Relation to Breast Cancer*, 287 *JAMA* 734 (2002); Nat'l Inst. of Health, *Facts About Menopausal Hormone Therapy* (2005), available at [http://www.nhlbi.nih.gov/health/women/pht\\_facts.pdf](http://www.nhlbi.nih.gov/health/women/pht_facts.pdf).

<sup>41</sup> See Tara Parker-Pope, *The Women's Health Initiative and the Body Politic*, *New York Times*, Apr. 9, 2011.

<sup>42</sup> *Id.*

<sup>43</sup> Jean Hamilton & Barbara Parry, *Sex-Related Differences in Clinical Drug Response: Implications for Women's Health*, 38 *J. Am. Med. Women's Ass'n* 126 (1983), cited in Merton, *supra* note 22, at 383.

<sup>44</sup> U.S. Gen. Accounting Office, GAO-01-286R, *Drugs Withdrawn From Market* (2001).

<sup>45</sup> *Id.* at 2.

<sup>46</sup> Sara F. Goldkind, Leyla Sahin & Beverly Gallauresi, *Enrolling Pregnant Women in Research – Lessons from the H1N1 Influenza Pandemic*, 362 *New Eng. J. Med.* 2241 (2010).

<sup>47</sup> Merton, *supra* note 22, at 377-79.

<sup>48</sup> Pe, *supra* note 7, at 131.

<sup>49</sup> Conversation with Gerianne Tringali DiPiano, President and CEO, FemmePharma Global Healthcare (Dec. 17, 2010).

<sup>50</sup> See Pe, *supra* note 7, at 138.

<sup>51</sup> Food & Drug Admin., List of Pregnancy Exposure Registries, <http://www.fda.gov/ScienceResearch/SpecialTopics/WomensHealthResearch/ucm134848.htm> (last visited Dec. 27, 2011).

<sup>52</sup> See *id.*

<sup>53</sup> See *id.*