



The Coronavirus Crisis Confirms That the U.S. Health Care System Fails Women

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The coronavirus pandemic has affected everyone's lives in numerous ways, but people have and will continue to experience these challenges differently. Pandemics worsen existing gender inequities both domestically and abroad—and this one is no different.¹ While early estimates indicate that men are more likely to test positive for the virus,² there is insufficient data to determine the complete effect of the disease among different genders, races, and ethnicities.³ Still, initial data suggest that the pandemic could exacerbate existing barriers to care that women experience,⁴ particularly for women of color, women with low incomes, women with disabilities, and women living in rural areas. Additionally, as unemployment skyrockets and the stock market continues to dip, creating financial strain for millions, women⁵ and people of color⁶ may be less able to afford COVID-19-related and other health care.

Moreover, the unique health needs of women must not go unmet in the midst of the pandemic. For instance, before this current crisis, the United States was already facing an ongoing and long-standing public health crisis that has led to significantly higher maternal mortality and morbidity rates for Black women.⁷ Given the constraints placed on already overburdened hospitals and health centers, particularly those in communities of color and rural areas, the coronavirus pandemic has the potential to worsen the existing maternal health crisis. Reports have already indicated some pregnant women are looking to switch their labor and delivery out of the hospital setting, creating an urgency for access to birthing centers and home births. While the impact that COVID-19 has on pregnant people is not yet known,⁸ increased concern could lead some people to delay pregnancy—making access to contraceptives even more important. Additionally, the systemic racism that led to the maternal health crisis has already begun to result in higher rates of COVID-19 among Black communities in certain cities and states,⁹ as well as concerns about inequitable coronavirus testing within these communities. For decades, conservative lawmakers have subjected low-income women to coverage restrictions on abortion,¹⁰ and state and federal anti-choice policymakers are using the pandemic as a pretext to impose new unnecessary abortion restrictions, creating effective bans on abortion in areas where access is already limited.¹¹ This same stigma around abortion may also be impeding access to a COVID-19 vaccine or therapy.¹²

Overall, the current pandemic has revealed at least four ways the U.S. health care system fails women:

1. Many health insurance plans are not comprehensive enough to meet women's health needs.
2. Current federal and state policies are not designed to achieve health equity for women of color and their families.
3. Reproductive health services, particularly abortion, are stigmatized and thus not integrated into the health care system.
4. The health care providers whom women rely upon are underfunded or otherwise inaccessible for many.

Federal, state, and local lawmakers must act quickly to address these barriers in order to ensure women can remain healthy during this crisis as well as live sustainable, healthy lives once the pandemic is averted.

Health coverage is not robust enough to meet women's health needs

Women are more vulnerable than men to unexpected health care costs. Women experience higher rates of poverty than men as a result of discrimination and sexist policies that have led to the gender wage gap, constrained women to lower-wage jobs, and prevented nationwide policies supportive of working parents—all of which have harmed women of color the most.¹³ Due to systemic racism and sexism, poverty rates among women of color are even more stark: 22 percent of Native women, 20 percent of Black women, and 18 percent of Latinx women live in poverty, compared with 9 percent of white, non-Hispanic women.¹⁴ Transgender and immigrant women also experience multiple intersections of discrimination that result in bias limiting their income.¹⁵ While it is too soon to know the economic ramifications of this crisis, many women, particularly women of color, will likely be drastically and negatively affected given their likelihood to be employed in low-wage jobs and financial inability to withstand unexpected costs.¹⁶ Additionally, given that women are frequently the primary caretakers of their families, school closures have resulted in women taking on more domestic tasks, which might limit their ability to work outside the home or lead them to reduce the hours that they work from home.¹⁷

Income, of course, is a social determinant of health that frequently leads people to forgo necessary and preventive care. Before the pandemic, a Kaiser Family Foundation study found that a higher percentage of women than men would forgo or delay accessing health care services due to cost. Particularly relevant to this current moment, 26 percent of women, compared with 19 percent of men, delayed or went without care, and 20 percent of women, compared with 15 percent of men, did not access recommended medical test or treatments due to cost.¹⁸ Subsequently, it is important for women to have affordable health coverage to ensure they can access coronavirus diagnostic testing and care—and perhaps, one day a vaccine and treatment—as well as other necessary and preventive services, including those allowing them to plan and space pregnancies.

Everyone should have access to testing, treatment, and a vaccine

Despite recent coverage gains, not everyone will have equal access to coronavirus testing and treatment—a fact that could disproportionately affect women. On March 18, 2020, the Families First Coronavirus Response Act was signed into law. It requires most insurance plans, as well as state Medicaid programs and the Children’s Health Insurance Program (CHIP), to cover coronavirus testing with no out-of-pocket costs or medical management techniques such as prior authorization. States were also granted flexibility to provide testing under their Medicaid programs for people who are currently uninsured. And separately, the law authorizes state funding to reimburse providers for testing uninsured people.¹⁹ The administrative process for uninsured individuals to receive care and for providers treating uninsured individuals to receive payment is not yet clear and will likely vary by state. This state flexibility remains in effect during the public health emergency, as federally designated. Beyond the immediate emergency time period, most plans may be required to cover diagnostic testing pursuant to the Affordable Care Act (ACA) preventive services requirement, but a lag time is expected.²⁰

Furthermore, the Trump administration has promulgated rules that have increased the sale of junk health plans, namely short-term, limited-duration plans,²¹ as well as health care cost-sharing ministries—plans that collect monthly fees from members who share certain religious beliefs to cover medical expenses²²—which are not subject to the requirement to cover testing.²³ During this crisis, the *Miami Herald* reported that one man enrolled in a short-term plan received a bill for \$3,235 for a coronavirus test.²⁴ Under the Families First Act, states can consider those enrolled in these plans uninsured for purposes of covering coronavirus testing. However, these plans are able to exclude or price gouge people with preexisting conditions—and it remains to be seen if they will consider a coronavirus diagnosis a preexisting condition. These barriers are further compounded by the fact that these short-term plans and health care sharing ministries are not required to cover women’s preventive services, such as contraceptives, well-woman visits, and mammograms, or essential health benefits, including maternity and newborn care. These plans can also charge women more than men for similar coverage—shifting additional costs onto women during these strained health and economic times.²⁵

Furthermore, once a vaccine or treatment is developed, people may face additional costs, at least in the immediate term. First, the law does not require zero-cost-sharing coverage for a treatment or vaccine. Recent federal guidance states that small and individual insurance plans that are obligated to adhere to the ACA’s essential health benefits requirement must cover a coronavirus treatment, if developed, as well as related hospitalization and lab services, but enrollees’ cost-sharing may vary widely.²⁶ Notably, large group health plans, which provide coverage to the majority of people in the United States—nearly 160 million—are not subject to the essential health benefit requirement and thus not currently required to cover a treatment.²⁷ A recent Kaiser Family Foundation analysis assessed claims for pneumonia hospital admissions and concluded that the average out-of-pocket costs for a COVID-19 treatment for a person with employer-sponsored insurance would be greater than \$1,300.²⁸ Most plans,

pursuant to the ACA preventive services requirement, are required to cover vaccines recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices. However, even after a vaccine is developed and subsequently recommended by the committee, the preventive services requirement does not go into effect until a full year after the recommendation.²⁹ Similarly, while states have new flexibility and funding to cover diagnostic testing for uninsured individuals, the law does not afford coverage for treatment or a vaccine for the nearly 30 million uninsured individuals, of whom 44 percent are women.³⁰

Health coverage must be accessible for everyone

Losing a job, or even reducing hours to part time, can result in a loss of insurance coverage if one's insurance is based on being a full-time employee with a company or organization. Nearly 50 percent of people in the United States receive their health care coverage through an employer.³¹ Therefore, many will lose their health insurance coverage when they lose their job, which could limit their ability to access COVID-19-related preventive and treatment services, as discussed above.

Given that coverage is fragmented and not universal for everyone in the United States, lawmakers must now ensure coverage is, at least, readily available to all. Specifically, it is necessary to ensure everyone is able to enroll in coverage through a special enrollment period (SEP) on the federal and state health insurance marketplaces. While losing health care coverage creates a SEP, people who have had no change in coverage and may have previously forgone purchasing a health insurance plan may now wish to gain coverage as a result of the public health crisis. Eleven states and Washington, D.C., have created a SEP to respond to the current crisis. The federal government should follow suit,³² and the Trump administration should reverse its decision not to open a SEP to everyone.³³ In particular, lawmakers should ensure pregnant women have coverage, which means, at a minimum, creating a SEP for pregnant women. Similarly, women residing in states that have not expanded Medicaid or who otherwise do not qualify for Medicaid may be able to qualify for limited benefits as a result of their pregnancy. However, this coverage may stop at around two months after the pregnancy ends.³⁴

Simply put: Every state should expand Medicaid. But until that happens, the federal government should require every state to offer pregnancy-only Medicaid coverage for at least one year postpartum. It should also make a significant investment to ensure this coverage is meaningful, including coverage for the full scope of Medicaid benefits.

Birth control should be readily accessible

People may want to prevent pregnancies now more than ever. In response to the Zika crisis, the American College of Obstetrician and Gynecologists (ACOG) issued guidelines to OB-GYNs to encourage discussions around contraceptives and prevention. In particular, the guidelines recommended that nonpregnant women use contraceptives—and that even pregnant women use condoms or other barrier methods—if their male partner had traveled to an area with active Zika virus transmission or been exposed to the Zika virus within a certain time frame.³⁵ Similarly,

the CDC issued recommendations to consider delaying pregnancy for specified time frames based on the individual's or partner's potential exposure.³⁶ And while COVID-19 has not proven to have the same risk factors as Zika, including mother-to-infant transmission or increased susceptibility to the disease, more data are needed to rule out these concerns.³⁷ Even without guidance discouraging women from conceiving, people planning pregnancies might decide to delay a pregnancy. Notably, the American Society for Reproductive Medicine has issued guidelines calling for the suspension of new, nonurgent fertility treatments, including in vitro fertilization, given the unknowns regarding pregnancy and to reduce the risk of transmission to patients and providers from office visits.³⁸

The ACA expanded birth control coverage and required insurers to cover Food and Drug Administration (FDA)-approved contraceptives. However, insurers are only required to cover these contraceptives with a prescription—and during the COVID-19 pandemic, many will not be able to schedule appointments with a provider. The CDC has recommended, and some states have required, that providers prioritize or deliver only urgent and emergency procedures,³⁹ and people are encouraged—and in most states, required—to shelter in place.⁴⁰ Subsequently, many people will not be able to refill prescriptions. This barrier to contraception would be minimized if insurers were required to cover a 12-month supply of contraceptives and if over-the-counter contraceptives were readily available in all states. But currently, only 18 states require insurers to cover a 12-month supply of contraceptives, six require insurers to cover over-the-counter contraceptives with the same cost-sharing used for contraceptives with a prescription, and 10 allow pharmacists to prescribe contraceptives, granting over-the-counter access.⁴¹

Women of color are not treated equally in the health care system

Underlying medical conditions may put people of color at increased risk of contracting or becoming seriously ill from COVID-19.⁴² A disproportionate number of people of color have the respiratory condition asthma, placing them at a higher risk of becoming seriously ill from COVID-19.⁴³ Nearly one-quarter of American Indians and Alaska Natives, 23 percent of multiracial Americans, and 18 percent of Black Americans have asthma.⁴⁴ Black people in particular have higher rates of certain conditions that tend to weaken the immune system, making them more susceptible to becoming seriously ill from COVID-19.⁴⁵ For instance, Black or African American people accounted for 44 percent of HIV infections in 2016, despite only being around 13 percent of the U.S. population.⁴⁶ Particularly, African American women are 18.6 times more likely to have HIV progress to AIDS and around 18 times more likely to die from HIV/AIDS.⁴⁷ There are also health inequities experienced by communities of color in rates of diabetes, high blood pressure, certain cancers, and other chronic conditions, all of which are underlying risk factors for COVID-19.⁴⁸ Currently, there are insufficient data available to know the extent that health inequities will have on people of color, including women of color, but recent reports show alarmingly higher rates of infection and death from COVID-19 within the Black community.⁴⁹

An underlying driving force behind these inequities is race, with implicit and explicit bias—and outright racism—affecting care and policies. Persistent racism in the U.S. health care system may result in these communities not being diagnosed at equal rates compared with their white counterparts. Unaffordable health coverage, a lack of culturally competent health care, and sparse language access services, among other factors, have contributed to health inequities, which are compounded by structural barriers outside of the system, such as unsafe housing, food deserts, and pay disparities.⁵⁰ Also, women of color may be at increased risk of contracting the virus because they are disproportionately employed in occupations such as grocery store workers, which are considered essential, in addition to these type of jobs frequently lacking paid leave or sick days.⁵¹ The response to this pandemic has already proven that it is not immune to structural and interpersonal racism, and the newly presented problems from COVID-19 threaten to worsen existing inequities.

[Addressing the maternal health crisis must remain a priority](#)

A public health crisis affecting women of color in the United States existed before the coronavirus began to spread—specifically, the maternal health crisis that has led to Black and Indigenous women dying at three to four times the rate of white women.⁵² Despite the fact that the United States spends more on health care than any other developed country,⁵³ the maternal death rate in certain cities and states is more akin to that of underdeveloped nations.⁵⁴ And while the causes are multifaceted, race has proven to be the driving factor, given that Black and Indigenous women experience increased pregnancy-related mortality and morbidity rates even when controlling for income, education, and other factors.⁵⁵ During this crisis, hospitals have limited visitors to reduce transmissions among patients and staff. An ancillary effect has been limiting pregnant people’s ability to have full birthing teams, such as a spouse, parents, or doula, in the hospital during delivery.⁵⁶ This can have dire consequences for Black women given the studies showing that their concerns about pain are more frequently ignored, which can lead to or worsen pregnancy complications.⁵⁷ While hospitals’ intent is to reduce virus transmission, Black women having to give birth without someone in the room to advocate for them is extremely concerning.

Measures to protect individual and public health during the coronavirus pandemic must balance the need to stop the spread of the disease with safeguards that ensure efforts do not worsen existing maternal mortality and morbidity disparities. What’s more, guidelines from the World Health Organization affirm that all pregnant people should continue to be granted the right to high-quality care that includes having supportive people present during birth.⁵⁸ New York Gov. Andrew Cuomo (D) recently announced that the state would allow pregnant people to have labor support during delivery.⁵⁹ Additionally, lawmakers must prioritize other policies discussed within this issue brief that would increase access to and improve health care, including expanding pregnancy-related Medicaid coverage, ensuring a SEP for pregnancy, guaranteeing that women can access their preferred provider, and increasing coverage for comprehensive reproductive health services.

Women must have birthing and support options

The COVID-19 crisis offers proof that women need a range of accessible, affordable options for pregnancy and birth. Given that COVID-19 is treated in hospitals, coupled with the restrictions on labor support discussed above, more people may consider delivering at home or in a birthing center. During prior public health crises, including the SARS and swine flu, or H1N1 virus, outbreaks, as well as in the aftermath of Hurricane Katrina, demand for home births and midwifery care increased.⁶⁰ The ability to give birth at home or in a birthing center is frequently a luxury afforded only to some—namely, white women and women with higher incomes—in part due to women having to pay out of pocket for deliveries outside of a hospital. For instance, 33 states cover birth center deliveries,⁶¹ and only 21 states cover home births in their Medicaid program.⁶²

In the United States, midwives deliver the majority of births outside of hospital settings and can provide specialized care to women.⁶³ Studies have associated better health outcomes with the support of a midwife as well as of a doula.⁶⁴ However, these birthing assistance and pregnancy-related professionals are not integrated into the health care system, and their services are frequently covered with low reimbursement rates, if at all.⁶⁵ Additionally, states often have unnecessary scope-of-practice restrictions that prohibit midwives from practicing autonomously—again, putting services out of reach for many. Specifically, certified nurse midwives who practice in and out of hospital settings can legally practice in all 50 states and receive Medicaid coverage.⁶⁶ Certified professional midwives (CPMs) and other direct-entry midwives who practice primarily out of hospital settings face a much more complicated regulatory landscape.⁶⁷ Only 33 states have a path to licensure for CPMs, and just 13 states provide Medicaid coverage for CPMs.⁶⁸

Providers must offer culturally competent, unbiased care

It has been well documented that providers' explicit and implicit bias may cause them to disregard patient complaints or downplay symptoms.⁶⁹ Provider bias is a pronounced concern in the maternal health crisis, but bias may also affect the people in need of diagnostic testing in general. Specifically, the shortage of coronavirus tests has led providers to make decisions regarding who gets tested. At least one analysis found providers may be less likely to refer Black and African American people exhibiting COVID-19 symptoms for testing.⁷⁰ A coalition of doctors have called on the CDC to ensure the Black community is being tested equally and have flagged concerns about implicit bias where providers are making subjective decisions about testing based on presented symptoms such as fever and sore throat, which are common for a number of illnesses besides COVID-19.⁷¹ In order to address both the immediate crisis and the ongoing health crises that communities of color face, providers need to receive explicit and implicit bias as well as cultural competency training, and the health care workforce should be more racially and ethnically diverse to reflect the communities served.

Data must be disaggregated in order to achieve health equity

As mentioned above, the data are lacking when it comes to knowing the differences in diagnosis and mortality rate based on gender, race and ethnicity, or pregnancy status.⁷² There is also insufficient information available to determine whether patients are receiving equal access to testing and care based on race and ethnicity or income. This information is necessary to properly diagnose and treat patients. For instance, because there are insufficient data to know how COVID-19 affects pregnant people—including whether there is mother-to-child transmission⁷³—ACOG advises that pregnant people be treated as if they are at increased risk, particularly given the fact that they are known to be at increased risk of morbidity and mortality for other respiratory infections such as influenza and SARS.⁷⁴ Without disaggregated data, it is also possible to overlook symptoms that might be gender specific. When the HIV/AIDS epidemic began, it predominately affected men, and symptom profiles were not assessed by gender. As a result, it was many years before it was discovered that vaginal thrush is a symptom associated with HIV in women.⁷⁵

Reproductive health care services, namely abortion, are stigmatized

Abortion access has long been extremely limited for certain communities across the country, rendering *Roe v. Wade* meaningless for many in the United States; the coronavirus pandemic is exacerbating this reality. According to the Guttmacher Institute, 89 percent of U.S. counties had no clinics offering abortion care in 2017.⁷⁶ This shortage has led to both patients seeking abortions and doctors providing these services frequently needing to travel between states and even regions to receive and provide care.⁷⁷ The coronavirus pandemic has proven just how fragile the right to an abortion is in this country, given how impractical it is for many to exercise that right. Specifically, an entire state or region could lose access to abortion if even a single abortion provider is diagnosed with the coronavirus, comes into contact with a person who has been diagnosed, exhibits symptoms of COVID-19, or otherwise needs to be quarantined.⁷⁸ Additionally, the restrictions on travel have stopped or severely limited the ability of people seeking abortions to travel to an abortion health center or providers being able to travel to patients. To complicate this already limited access, anti-choice politicians seek to further stigmatize and undermine access to abortion under the guise of public health. But their actions, both before and during this pandemic, have actually proven to undermine women's health care decisions.

Abortion must be considered an essential health care procedure

Several states have issued executive orders or otherwise taken actions requiring abortion clinics to cease performing all or most abortions by declaring abortion care nonessential, pursuant to orders that nonessential businesses are must stop operations to slow the virus transmission.⁷⁹ These governors' and elected officials' actions resulted in appointments for abortion services being canceled or moved, leaving many people unsure about whether or not they can access care. Given the fluidity of the situation, it is possible that other anti-choice governors may take similar actions

soon. Litigation that was quickly filed has allowed abortions to continue, at least temporarily, in Iowa, Oklahoma, Ohio, and Alabama.⁸⁰ And while a federal judge initially suspended an executive order from Texas' governor, the court has allowed the state to halt most abortions. Currently, Texas allows abortions for people who are at least 18 weeks pregnant, but the litigation will likely continue.⁸¹

These orders fail to take into consideration very basic facts about abortion. ACOG, along with several leading health providers, issued a statement urging states to consider abortion an “essential component of comprehensive health care,” highlighting the fact that abortion is “a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible.”⁸² In other words, abortion is not a service that can be delayed; even a short delay can threaten a pregnant person's health and force them to carry the pregnancy to term, not to mention undermining their autonomy and constitutional right to an abortion.

Delaying an abortion can also increase the cost of the procedure and may require additional ancillary costs, such as travel, since only a small subset of providers perform abortions after the pregnancy has reached a certain number of weeks.⁸³ Given the current economic crisis, the financial strain could be even more harmful at this time. Similarly, experts have noted there is an increased level of anxiety during the pandemic,⁸⁴ and women denied abortions have previously experienced anxiety at increased levels compared with those who sought and received an abortion.⁸⁵

Second, these sorts of limited exceptions processes—where a politician determines what health care procedures are essential—is not based on evidence or on a consultation with medical experts. In fact, ceasing abortions will not drastically increase access to personal protective equipment or hospital beds, as claimed.⁸⁶ Most abortions are performed as an outpatient procedure; only a combined 5 percent were performed in hospitals and private physician offices, while the vast majority were performed in clinics.⁸⁷ Only one-tenth of 1 percent of abortions were transferred to a hospital for an emergency, according to a five-year observational study.⁸⁸ This means the vast majority of abortion patients are not competing for hospital beds. Furthermore, performing an abortion requires a small amount of personal protective gear, namely gloves and masks—far less than the personal protective gear needed for delivery if the pregnancy is carried to term. Notably, some of these restrictions also apply to medication abortions, which require patients to take medication at home and involve no personal protective gear. This demonstrates that these governors' true intention is to limit abortion access. Conversely, a number of states have declared that abortion is, in fact, an essential health care service that should continue to be available during the pandemic.⁸⁹

The unnecessary regulation of abortion must be considered dangerous

Even when there is no viral pandemic, the unnecessary regulation of abortion care and abortion providers threatens the lives of those seeking abortions. Particular to the COVID-19 pandemic, states that require unnecessary visits to an abortion provider's

office increase opportunities for the virus to spread. According to the Guttmacher Institute, 27 states have laws requiring a person to wait at least 24 hours after making an appointment before the person can access an abortion, necessitating multiple visits.⁹⁰ The risk created by the coronavirus compounds existing burdens that these laws impose upon women, such as forcing them to delay care, which can lead to increased costs and create more health risks as well as logistical challenges with travel, child care, and leave from work.⁹¹ Laws that impose nonevidence-based regulations on abortion should be repealed and prohibited.

Furthermore, state attempts to deem abortion nonessential, as discussed above, are made worse by gestational bans prohibiting abortions after a certain number of weeks. These bans, on top of state coronavirus executive orders, can force people to carry pregnancies to term or take unsafe measures to terminate a pregnancy. For instance, Texas, Alabama, Iowa, Kentucky, and Oklahoma all prohibit abortions after 22 weeks,⁹² and each of these states has also taken actions to halt abortions during the coronavirus.

The Hyde amendment must be permanently repealed

Conservative lawmakers have long sought to constrict access to abortion by limiting coverage for abortion. The Hyde amendment, in place since 1976, prevents the use of federal funds for abortion coverage for people enrolled in Medicaid, CHIP, and other federal health programs, with limited exceptions.⁹³ These restrictions also prohibit abortion coverage for Native Americans, federal employees, military personnel, people in federal detention, residents of Washington, D.C., and others. Medicaid alone covers nearly 50 percent of births in this country,⁹⁴ and two-thirds of the women on Medicaid are between 19 to 49 years old, which is reproductive age.⁹⁵ Due to systemic racism and sexism, Black and Hispanic women are more likely to be economically oppressed and rely upon Medicaid and other government-funded programs for their health coverage.⁹⁶ As a result, the Hyde amendment disproportionately burdens these women who are less able to absorb additional costs. Without coverage, people are coerced into carrying pregnancies to term or paying out of pocket for the services. The average abortion procedure in the United States is between \$500 to \$1,195 based on 2014 data.⁹⁷

As long as the Hyde amendment applies to some programs, extremist politicians will continue to play politics with women's health and attempt to extend the Hyde amendment to limit additional funding and programs. Here again they have used the COVID-19 pandemic to push forward their anti-choice agenda. Specifically, conservative members of Congress were able to add the Hyde amendment to the third coronavirus stimulus package, the Coronavirus Aid, Relief, and Economic Security (CARES) Act.⁹⁸ The language applies to funding to assist state, local, and tribal governments with responding to the crisis. During a public health crisis, elected officials should be focused on expanding—not limiting—health care options.

Abortion stigma should not impede medical research

In 2019, the Trump administration restricted the National Institutes of Health (NIH) from using fetal tissue for its research.⁹⁹ This move was not based on science or in pursuit of developing safe, effective treatments; in fact, fetal tissue research has led to lifesaving treatments such as vaccines for polio and measles. Instead, the discontinuation of this research was based solely on the stigma against abortion. The majority of fetal tissue is donated following an abortion, and anti-abortion forces have long sought to prohibit this research, dating back at least to the 1950s when the United States began to fund such research.¹⁰⁰ And yet the Trump-era ban holds, despite the fact that it could impede the development of a COVID-19 vaccine and/or treatment. At least one NIH researcher, a leading expert on immune responses to viral infections, complained that the ban on fetal tissue inhibits his COVID-19 research.¹⁰¹ During a time when lawmakers should focus on eradicating the virus, research processes must be informed by science, not political ideology.

Women lack access to the provider and health care support they need

Evidence-based family planning providers have already experienced funding shortages: In March 2019, the Trump administration finalized the domestic gag rule, which requires facilities in the Title X network to prohibit providers from referring patients for abortion care and to allow providers participating in the program to withhold information and counseling regarding abortion, as well as requiring a physical separation of abortion services from all other health services.¹⁰² This reduced the network's capacity by half, putting at risk health centers that 1.6 million women patients rely upon.¹⁰³ The coronavirus will exacerbate this problem as more patients turn to a social safety net that has been undermined. As a result, many women may find themselves without access to their trusted provider during this public health crisis. Notably, the majority of people who rely upon these providers are women of color and low-income women, and as a result, the health inequities discussed above could be compounded here.¹⁰⁴

Moreover, with orders to not leave the house and providers ceasing operations to reduce the spread of the coronavirus, people may not have access to their provider if the provider cannot deliver telehealth services or the patient's insurance plan will not cover those services. Additionally, given shortages in personal protective equipment, providers, particularly in lower-income and rural areas, may not have the necessary equipment to care for patients presenting with COVID-19 symptoms.

Safety-net providers must be well funded

Community health centers, as well as Title X and other family planning providers such as Planned Parenthood, provide necessary and preventive care to patients who frequently are uninsured or underinsured, and the majority of patients receiving care at these safety-net providers are Black, Latino, and low income.¹⁰⁵ In particular, family planning health centers are staffed with OB-GYNs, and the majority of women of reproductive age (18 to 44 years old) visit their OB-GYN on a more regular basis than other providers.¹⁰⁶

Subsequently, women rely upon these providers for necessary and preventive care, such as well-woman visits and contraceptives, as well as screenings for cervical cancer, sexually transmitted diseases, and other illnesses.¹⁰⁷ These providers frequently serve as patients' entry point into the health care system, connecting patients to other providers.¹⁰⁸ During this economic downturn, women will increasingly rely upon these providers for information, diagnostic screenings, and referrals for testing. Women who have not previously visited these providers will be more likely to seek the no- to low-cost services they provide. The CARES Act includes \$1.32 million in emergency funds for community health centers for 2020; however, family planning providers were largely excluded from receiving funding under the legislation.¹⁰⁹

Lawmakers must remove barriers to telehealth

As discussed above, with orders to not leave the house and providers ceasing operations to reduce the spread of the coronavirus, it is critical that barriers to telemedicine for contraception and abortion be lifted. Through the CARES Act, Congress has ramped up telehealth services and funding in an effort to encourage the public to remain at home while still receiving important health care services. Specifically, the law allows federally qualified health centers and rural health centers to operate as distant site providers during the pandemic; encourages the use of telehealth, including remote patient monitoring, to offer home health services; and reauthorizes the Health Resources and Services Administration's Telehealth Resource Center Grant Program to better serve rural and other medically underserved populations.¹¹⁰

Still, state barriers related to scope-of-practice and location requirements for providers and patients should be eased to improve access to telehealth, and Medicaid and private insurance coverage should be expanded to cover additional televisits with providers, including advanced practice clinicians, as well as additional telehealth modalities, including telephonic communications—something that is important for communities who lack consistent access to broadband services. This will allow patients to receive the prescriptions to access contraceptives and improve access to prenatal care. Additionally, the FDA should lift restrictions that require patients to visit a certified and registered drug sponsor, such as a health center or hospital, in order to access mifepristone, the medication abortion pill.¹¹¹ These restrictions prohibit pharmacies from stocking the pill and limit the ability of providers to deliver teleabortions. The FDA has already suspended such requirements for other medications, recognizing the inability of people to visit providers, and the abortion pill has proven safe to be taken at home for 20 years.¹¹² Notably, the United Kingdom also recently expanded access to medication abortion in light of the pandemic.¹¹³

Health care workers need support

Undoubtedly, the COVID-19 pandemic has placed stress upon U.S. hospitals and health systems and the women who work there. In particular, many U.S. hospitals were already operating at capacity or near capacity before the outbreak.¹¹⁴ These systems are currently experiencing a significant shortage of inpatient and intensive care beds,¹¹⁵ ventilators,¹¹⁶ and personal protective equipment such as gloves, masks, and gowns.¹¹⁷

As noted above, there is not enough data to know how these shortages are affecting certain communities, but rural hospitals¹¹⁸ and those located in communities of color frequently operate on a tight budget.¹¹⁹ The COVID-19 pandemic could stretch these systems beyond what is practical, and subsequently, the people in these communities may be underserved.

Even more, this problem significantly affects women who are front-line health care workers. Recently released data from the CDC reports that more than 9,000 health care workers have contracted the virus, demonstrating how vulnerable these workers are.¹²⁰ And while women are 41 percent of physicians and surgeons, women represent 89 percent of registered nurses, 88 percent of nurse practitioners, 71 percent of physician assistants, and 67 percent of respiratory therapists.¹²¹ A failure to protect essential health care providers is a failure to protect women.

Conclusion

The way that women's health needs are treated in the U.S. health care system has long been a public health concern. While the coronavirus did not create this problem, it has begun to exacerbate underlying problems and demonstrates that the health care system has never been equitable. As lawmakers are rightfully focused on addressing the COVID-19 pandemic—reducing the rate of transmissions and deaths from the disease—they must center women's unique health needs. Women represent around 50 percent of the population¹²² and are frequently the household decision-makers. Subsequently, satisfying women's health care needs is necessary for each individual woman's health as well as the well-being of their families.

Beyond the immediate crisis, there are ongoing public health crises that women, particularly women of color, continue to face. It is a crisis created by systemic racism, inequitable maternity care, unnecessary abortion restrictions, limited contraceptive access, and the lack of health coverage, among other factors. While these challenges affect women the most, they will also continue to impede society at large unless and until swift policy action is taken.

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Endnotes

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