CHAPTER THREE

FAMILY MATTERS

DIVORCE AND DOMESTIC VIOLENCE

DIVORCE, HEALTH, AND HEALTH INSURANCE

Laura is a happily divorced woman. Since separating from her husband, she has fulfilled a lifelong dream by going back to school, where she is about to complete her PhD. Her only regret is that she has lost her health insurance in the wake of the divorce.

Laura explains to us, "Sometimes women are forced to stay married because of insurance. That happened to a friend of mine, who's married to a man who is a bum."

"What do you mean he's a bum?" we ask.

"He's just a bum. He's a drinking bum, he's a gambling bum, he's just a no-good bum. He's someone that everyone will call 'just a bum.' And she can't get divorced from him because she needs his insurance—which he gets through his employer. And she would be uninsurable if she left him, because she has neurological problems. So she's locked into a marriage with a guy who is a real bum because she is dependent on his insurance."

Laura's perceptions are on target. With some variation by state and socioeconomic group, divorced women overall are about twice as likely to lack health insurance as married women. A recent study in Ohio found that only 8.1 percent of married women were uninsured, com-

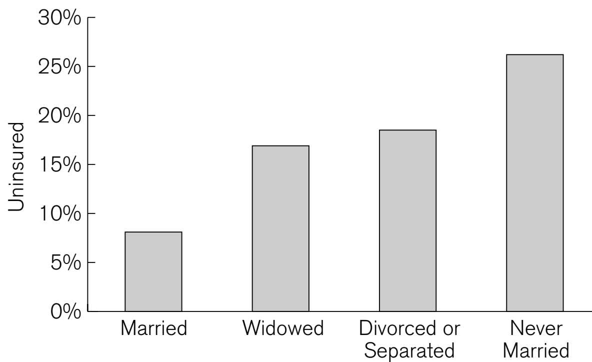

FIGURE 4. Women's marital status and lack of health insurance, Ohio, 1998. *Source:* Ohio Department of Health 2001.

pared to 18.5 percent of divorced or separated women. Widowhood had only slightly less impact than divorce on women's insurance status: 16.9 percent of widows were uninsured. Equally disturbing, 26.2 percent of never-married women were uninsured (see figure 4).

The declining likelihood that women will have health insurance if they are outside a standard marriage relationship is part of an overall picture of loss of economic protection for women at the end of marriage. In a study of women who were divorced, separated, or widowed, Leslie Morgan, author of *After Marriage Ends: Economic Consequences for Midlife Women*, reports that all three groups experienced a significant decline in family income, a decline that was sustained over time, indicating that there was no substantial recovery of income "as long as the women remained outside the boundaries of marriage." Morgan explains: "Poverty was a fairly common outcome among those who became widowed, separated, or divorced. . . . Not only do rates of poverty, per se, rise after marriage ends for women, but there are also substantial numbers of women whose households balance on the brink of poverty."

The negative experience of divorced women vis-à-vis health insurance reflects a component of the health care–employment link that is rarely noted in policy discussions: because employment-based insurance often

covers dependents (a spouse and minor children), the current system of linking health care to employment favors married people. Each member of a married couple has twice as great a chance of being insured as each individual would on his or her own. As for same-sex couples, although increasingly the largest employers are offering benefits to domestic partners, this is purely at the discretion of the employer. As a result, gay men and women are also at a disadvantage in terms of coverage.

Lenore Weitzman, author of *The Divorce Revolution*, writes: "During a marriage in which only one spouse is employed outside the home, the members of the employee's family are covered as his or her dependents and share in [health insurance] benefits. Upon divorce, the nonemployee (typically the wife) and minor children generally lose this coverage because of the traditional assumption that the rights to insurance belong only to the worker." Weitzman cites a number of examples, noting in particular the case of military wives (see Annette's story, later in this chapter), who spend years aiding their husbands' careers, only to lose their insurance benefits when now-successful husbands trade in their wives for younger models.

The family model that is institutionalized in the current link between employment and health care also favors people who live in nuclear family households—husband, wife, and children. Members of extended families are rarely covered as dependents in employment-based health insurance policies. This structure is particularly problematic in the many immigrant communities in which younger people are expected to help care for older parents and grandparents, ill siblings, and other members of the extended family who may or may not live with them at any given time.

This bias toward the nuclear family has a number of highly damaging consequences, especially for women. As chapter 4 discusses, women are far more likely than men to serve as primary caregivers for dependent family members—including those outside the nuclear family. Living with and caring for a disabled relative does not earn one the right to health insurance. And, as this chapter points out later, the link between

employment and health care and its bias toward the nuclear family can force women to remain in nasty or even violent marriages, and it can prevent women who leave abusive marriages from continuing to access the medical care they need.

ROBERTA'S STORY: TAKEN BY SURPRISE

Roberta was born into a prosperous, well-educated family in Boston. In the late 1940s, the family moved to Vermont, where her father established his own business. A bright and studious young woman, Roberta completed a master's degree in education at a prestigious midwestern university. After teaching for two years, she became a doctoral candidate in federal education policy at a large state university, and in time she took a position on the research faculty at that university.

Deeply committed to social justice, Roberta became involved in national antiwar politics and presidential campaigns in the 1960s. Her professional and personal aspirations seemed achievable in the 1970s, when she met her future husband, a psychology professor who shared many of her goals and interests.

Roberta remembers that the second time they met, he told her that he had been invited for a job interview at the University of Illinois. Her immediate reaction was to laugh and tell him that she'd never consider living in downstate Illinois. Yet, as Roberta points out, "life happens while you're making other plans," and in 1971 she and her husband moved to the University of Illinois at Urbana-Champaign.

"Given my professional background and interests, at that time I considered this a disaster because the University of Illinois was not very far along with affirmative action. I began to apply for jobs, and I was told that I didn't need a job because I was a faculty spouse," she recalls.

Over the next few years, as her husband built up a solid academic career, with a good salary and a respected professional reputation, Roberta held short-term academic positions at the university, pursued

her political interests, and undertook myriad volunteer and charitable activities in the community.

Shortly after their son was born, they took a three-year leave and moved to Washington, D.C. In the third year, Roberta took a position in the Carter administration. As things unfolded, it became clear that the future would entail making a permanent move to Washington, where the opportunities for a dual-career family were more plentiful. Roberta also was intent on finishing her dissertation and working professionally in her field, in addition to performing her roles as a wife and mother. "I was enthusiastic about the move to D.C., and I did not want to be back in Illinois at all."

As they prepared to make the permanent move from Illinois to Washington, in the late 1980s, Roberta's husband announced that he wanted a divorce. "I didn't go for a divorce. No, no, no. I was committed to the marriage and did what I could to see that we moved through the difficulties of the relationship. I'm a fairly independent and strong-minded person about things that I believe in.

"When this all happened, I was back in Illinois to prepare for the move to the D.C. area. I was devastated . . . and could not believe that my marriage was crumbling. I was probably naïve in this respect, as many women often are. In retrospect, I can only say that my husband turned fifty that summer, and I later felt that this was his midlife crisis. I felt very betrayed at the time, and it certainly took an emotional toll on me.

"When it became clear that the divorce was . . . a fait accompli, our son was in elementary school and was doing very well in school. I quickly shelved my own ambitions and made a firm decision that we were going to stay in the house in Illinois. We had friends here, a lot of social support, and, given my values, it was very important to keep my son's life stable and weather the marital storm."

Ironically, Roberta's husband soon left the University of Illinois. Roberta dug in her heels and remained in the community in which she had become active. She served on the boards of a campus religious foun-

dation and numerous other community organizations. Over the years, she has had a number of research and teaching jobs at the university, but as an adjunct faculty member, she has never had health insurance. In her current job, working for a church, she receives a medical stipend but no insurance.

"When I first was divorced, I continued to be covered by my husband's health insurance. As part of the divorce settlement, I had been given two years to become reestablished professionally, including completing my doctoral dissertation at the state university where I had started my PhD. Given the age of my son and the distance involved, this became a difficult task. When I began to experience problems with the child support provisions of the divorce settlement, I went back to court. It took over a year to get a hearing, but I was able to see us through this period, as I have always been good at managing money and squeezing blood out of a turnip if necessary!

"When the court hearing finally took place, I did receive an additional award of child support. However, I did not receive a continuance of health insurance, which I thought was totally unconscionable. After that hearing, to be very honest with you, it's a question of, do you feed your child and keep your house going, or do you insure yourself for the one time a year that you might go to the doctor because you have the flu?

"During this time, I managed to complete the payment of the mortgage on our home out of my own funds. However, I also became increasingly depressed, as the divorce had been terribly upsetting to me. I did seek out counseling and in the process received effective antidepressant medication to put my life back into perspective.

"And then it was in 1999 that I discovered that I had this lump in my breast. It was shortly after another very good friend of ours had died from breast cancer."

Roberta had spent most of her life as part of the privileged caste—she always had access to health care when she needed it (which was not often, since her health always had been excellent). Thus, her shock at discovering that she had breast cancer was compounded by the shock of

finding out what it is like to be sick and uninsured in America. As is true for all cancer patients, Roberta's days became filled with a parade of office visits—to the radiologist, the oncologist, the surgeon, and other physicians. At each step of the way, she was asked, "What insurance do you have?" and at each step her mind flashed through a series of responses that included embarrassment, anger, and anxiety.

"In the beginning, it was really hard to tell people that I [didn't] have insurance. I mean, how could this happen to me? They'd be thinking, 'Roberta was out there on every social cause, every political campaign.'"

She adds, "When I first detected the lump in my breast, I was totally proactive with every medical person who became involved in my treatment. Before we even began exams or treatment, I was explicit about lacking medical insurance. It was very humiliating for me to have to admit this, as I had always had high-option medical insurance prior to my divorce by dint of my own employment and/or marriage.

"Before my surgery, I went to all the various health care groups. I've worked as a reporter so, you know, I'll do anything. I thought about where the Illinois Department of Public Aid was. And I just went in and said, 'I would like to see someone to find out what, if anything, I am eligible for.' What you discover is that if you are totally indigent, everything is covered by the state. If you're a person who pays your bills and you basically manage within the parameters that you have, you're not eligible for a cent. And so then I just let everybody know that I had left no stone unturned, and everybody said not to worry.

"After the surgery, I went back to the hospital and said, 'Here's my situation. I would like to appeal any charges.' And I filed this incredible documentation with them. And they turned me down. So now I pay them a certain amount every month; and then I pay my primary oncologist a certain amount every month; and I applied to another hospital for coverage for the radiation oncology under their charitable giving program, and that was granted. At this point, I owe something like fifteen thousand dollars. I just pile up the bills and don't pay too much attention to them."

Roberta's annual expenses for medication (tamoxifen and other prescriptions) come to $1,427. She has no source of assistance for drug costs.

Roberta's education, community contacts, and homeownership have slowed her descent into the death spiral. Still, she lives in a county that has a particularly bad record for suing patients over medical debt and a low rate of free and charity care offered at the local hospitals.*

Although Roberta probably will not lose her house any time soon, the house will eventually need major repairs. If she is forced to declare bankruptcy because of medical debt, she will not be able to get the credit necessary to pay for the repairs. With luck (and a good economy), she'll be able to sell the house for enough money to buy a smaller place. Without luck, she will have to downgrade to a rental apartment. With a history of cancer and an uncertain income, rental payments could become an iffy proposition. Her articulate manner and expansive networking will keep her employed at least for a time. But without medical insurance at the age of fifty-five, the odds are high that her health will deteriorate, and the hustling and bustling that she does to maintain that networking will become less possible.

Despite Roberta's lifelong awareness of economic and social injustice, she is surprisingly unaware of the precariousness of her own situation. Just as she never dreamed that she would end up a single mother on a limited income or that she would be battling breast cancer without health insurance, she still cannot imagine herself falling any further down the death spiral. And, with a strong community backing her up, she might be right. But, as the experiences of Dave and Judy illustrated in chapter 1, once she starts to slip (pushed, perhaps, by being forced to sell her house, by enduring another bout with cancer, or by encountering other health problems of middle age), she will find surprisingly few handholds to grab as she goes down.

*This assessment was offered by Claudia Lennhoff, executive director of the Champaign County Health Care Consumers.

ANNETTE'S STORY: THE REPERCUSSIONS OF DOMESTIC VIOLENCE

All in all, given her solid middle-class background and her homeownership, Roberta is far luckier than many other women whose access to health care is contingent on staying in a miserable marriage. And, while her former husband certainly was not supportive of either her career or her self-esteem, at least he was not violent.

Annette wasn't so lucky.

We had arranged to meet Annette at her house at 6:00 P.M. When we rang the doorbell, we found her three children home alone; Annette had not yet returned from work. Happy to spend time with attentive adults, the two younger children climbed on our laps, drew pictures, read aloud from their books, proudly showed us the new shower curtain and toilet seat cover in the bathroom, and demonstrated their ability to climb on a chair and take ice cream from the freezer. They also told us about their own health problems: the eight-year-old, who has severe asthma, showed us his nebulizer; the fourteen-year-old, who has a congenital heart problem, wears a monitor that signals when she is experiencing cardiac stress.

Arriving home an hour late, Annette, an attractive thirty-eight-year-old African American woman, explains that she had to pay a complicated bill on the way home from work. With a household income of $15,000 a year, Annette frequently deals with complicated bills, utility shutoffs, calls from collection agencies, and kids who need clothes or school supplies that she simply cannot afford. All this she takes in stride. What she finds truly daunting are health problems.

Annette has suffered from excruciating headaches and serious visual distortions for a decade, ever since her ex-husband beat her, causing severe head injuries. Immediately after the beating, Annette was taken to the hospital. She received a CT scan, presumably to detect brain or skull injuries, and an operation was performed on her eye. At the time, her husband was in the military, and Annette had access to free medical care through the Department of Defense hospital system.

After the surgery, the doctor told her that the problem was not cured entirely and that she would continue to have some difficulties. Annette believes that the initial surgery did help somewhat, but visual problems and painful headaches continue to plague her.

Until her divorce was final (a process that took three years), Annette continued to receive health benefits through the military. She made good use of those benefits and received regular follow-up care. But once the divorce was official, she no longer had health insurance. She has never had a repeat CT scan, primarily because she no longer is eligible for benefits through the military.

We ask whether she thought about remaining married in order to keep the benefits. But Annette wisely answered, "It was not worth it." If a man beats you once, she cautions, "he would do it twice. I drove all the way from Utah to Mississippi by myself just to be free of him."

A few years ago, Annette became pregnant, which made her temporarily eligible for Medicaid. Speaking of an experience that many of us find familiar (how often do screaming children calm down as soon as they enter the doctor's waiting room?), Annette recalls: "After I got my Medicaid, my headaches stopped, eased up, and then when my Medicaid stopped, they started going bad again." We ask whether she has been back to the doctor, since the problems seem to be worsening. "I can't afford it. I had Medicaid, but they cut me off last year."

Annette continues to live with visual disturbances, which she believes have become more extreme of late. "When I look through my right eye, I see fine. But when I look at you through my left eye, you have a big old black spot on your head. All I see is everything else around you."

She also suffers from agonizing migraines, as often as twice each week.* Despite the pain she experiences when a migraine strikes, Annette

*National data suggest that migraines are more prevalent among poorer Americans. In a study of fifteen thousand households conducted by Johns Hopkins researchers (Stewart et al. 1992), prevalence of migraines was 60 percent higher among the poorest patients (those with incomes less than $10,000) than among patients who were even slightly better off (those with incomes over

must report to her job as an office manager—a job that does not provide health benefits—because if she does not show up, she will be fired. The one thing that helps the migraines is a shot she sometimes gets in the emergency room. From Annette's perspective, the most important benefit of the shot is that it allows her to "see straight."

Typically, she goes to the emergency room every month or so. The costs of the visits vary. The least she has ever paid is $250, an astronomical sum for someone living on her very limited income. The cost of the emergency room sometimes deters her from going, even when she is in terrible pain. "It was a problem last year, probably back in October. I had no job, and that was the only reason I didn't go. So I would just sit in the bed, and I would just cry and cry and cry myself to sleep. It was awful."

Annette realizes that it would be helpful for her to establish a relationship with a physician who can get to know her history and condition. Because she can't pay for office visits, however, she must rely on the emergency room, where she is seen by any of several physicians who happen to be on duty. Over the past year or so, doctors have prescribed a number of medications for her—Fioricet, Imitrex, and others. Each time she receives a new prescription, she must pay out of pocket. Unfortunately, nothing has worked so far: Fioricet seems ineffective, and she vomited after taking Imitrex.

Annette wonders whether some other sort of treatment is available: "You know, that's what I'm going to talk to the doctor [about] when I go back." She'd like something "if not as strong as Demerol, close enough to it so that when I take it, it'll put me to sleep."

In fact, a number of medications—some of them, such as beta blockers, relatively inexpensive—have been proven to reduce the frequency

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$30,000). In the majority of the two dozen families we interviewed in Mississippi, at least one member suffers from chronic or migraine headaches. In many cases, the headaches are so severe that they require trips to the emergency room and lead to missed days of work. The financial consequences of both these situations—the minimum cost of an ER visit typically exceeds $200, and lost work days mean lost income—certainly add to the already stressful lives of women like Annette.

and severity of migraine attacks. But they must be managed and prescribed by a doctor who sees the patient regularly, thus putting them out of Annette's reach.

Like many women who have suffered from domestic violence, Annette seems to be prone to frequent illnesses. During the past year, she has gone to doctors at least half a dozen times for colds, earaches, the flu, headaches, and bronchitis. Each doctor visit costs $61, plus whatever medication is prescribed. Relying on urgent care and walk-in clinics, she rarely sees the same doctor more than once. Last year, she was diagnosed with an ulcer and took medication for it for a short while. (She no longer remembers the name of the medication and couldn't afford to purchase it even if she could.)

Annette is a bright woman. She is a high school graduate, and her dearest dream is that her fourteen-year-old daughter will go to college, get a degree, and "do better than what I'm doing." According to Annette, she "has potential. She's gifted, she's very intellectual." In many ways, Annette has done a good job at making a life for herself and her family. Her children are sweet and friendly, and she herself works at a reasonably good job.

Yet, as we spend more time with Annette and her family, it becomes increasingly clear that she is at the end of her tether. She is coping not only with her own health problems but also with those of her children and with their collective trauma in the wake of brutal domestic violence. The eight-year-old has a noticeable speech impediment and reads far below his grade level. Since the divorce, Annette has been involved in relationships with two other men, one who also became violent and another who ran up large bills in her name. The house is in disarray—when Annette comes home from work, she often collapses on her bed with a migraine.

HEALTH CARE AND THE ECONOMICS OF DOMESTIC VIOLENCE

Unfortunately, Annette's experiences are not unusual. American women face the greatest risk of assault from those with whom they are intimate,

particularly male partners. Estimates indicate that a minimum of two million women and possibly as many as four million are severely assaulted by male partners each year in the United States and that between 21 percent and 34 percent of all U.S. women will be physically attacked by a male partner during adulthood.

Injuries sustained by women in these attacks range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, loss of hearing or vision, scars from burns or knife wounds, and even death. Survivors of domestic and sexual violence frequently experience long-term reactions of fearfulness, anxiety, and confusion; chronic fatigue, sleep disturbances, phobias, depression, substance abuse, feelings of powerlessness, and a variety of somatic symptoms are also common. Overall, women with a history of suffering rape and other abuse perceive their health less favorably than other women and report more symptoms of illness across virtually all body systems.

Because of the ongoing and injurious nature of violence by male partners, abused women often visit physicians repeatedly, with increasingly severe physical traumas. Even with repeated trips to physicians, however, inquiries are rarely made into the cause of the injuries, and the history of victimization underlying the physical trauma may never be identified. This is clearly the case in Annette's experience. Despite frequent trips to the emergency room with severe head pain, she has received no counseling, no offers of support groups for victims of domestic violence. No one has expressed interest in trying to figure out why she has these excruciating headaches or in coming up with a plan to reduce their frequency or severity.

Abused women like Annette make substantially greater use of medical and mental health services than women who have not faced abuse. Women with a history of suffering sexual assault are likely to make twice as many visits to physicians each year as women who have not been assaulted. The outpatient medical expenses incurred by the most severely victimized women can be more than twice as high as expenses incurred

by nonvictimized women. One watershed study reports that "victimization severity was the single most powerful predictor of total yearly physician visits and outpatient costs, exceeding the predictive power of age, ethnicity, self-reported symptoms, and morbidity-related injurious health behaviors." Although it is crucial for women who have experienced domestic or sexual violence to be assured of ongoing access to health care, as Annette's experience shows, the opposite may be the case: as a result of domestic violence, women can lose access to health insurance.

For all these reasons, the welfare policies of the TANF program, discussed in chapter 2, have particularly negative consequences for women who are at risk for, or who have been victims of, domestic violence. Because the long-term physical and emotional effects of abuse often create a greater need for welfare, cutbacks in public aid hit victims of domestic violence especially hard. Across the nation, research shows that women on welfare report shockingly high rates of past domestic violence. For example, a 1997 study commissioned by the Massachusetts Governor's Commission on Domestic Violence found that one-fifth of the participants in the state's Transitional Aid to Families with Dependent Children program had been abused by a current or former husband or boyfriend during the preceding year; and nearly two-thirds had been abused at some point in their lives. That survey also revealed that, compared to other women, abused women had lower self-esteem, greater emotional distress, and more physical disabilities.

Most women deal with abuse by trying to leave, but these efforts can be hampered by economic deprivation. Abused women typically flee with very little money because abusive partners tend to control bank accounts. Financial support, such as welfare payments, enables women to leave their abusers—but without such economic support, victimized women may stay in, or return to, abusive relationships.

Since abusers often demand that their victims remain socially isolated, abused women may lack the occupational and social resources necessary to begin working and keep a job. Moreover, the kinds of emotional and

physical injuries abused women may have suffered can make them less employable. Battered women tend to miss days of work because of their injuries and may lose their jobs because of the abusers' disruptive behavior. Thus, whether women are on welfare or not, domestic violence can jeopardize employability and, consequently, accessible health care.

In the Massachusetts study, abused women were much more likely than nonabused women to report that a current or former husband or boyfriend opposed their attempts to attend school or hold down a job. The study concludes: "Welfare reform may unintentionally serve to keep some women from leaving an abusive situation or may cause some to return to it. The requirement for finding work or a workfare placement within two months of receipt of assistance (for women whose youngest child is school age) may not be safe for current or recent victims of domestic violence and may not be achievable for severely traumatized victims of domestic violence."

Unfortunately, many battered women who have left their abusers are compelled to return because of economic distress. They are more likely to be ill and to be only marginally employable, in jobs that are less likely to offer health care benefits. Thus, they are less able to access the medical services that could help them become more employable. In this way, the death spiral forces women back into violent marriages, where their health and employability may deteriorate further, trapping them ever more firmly in its pull.