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THE IMPACT OF HEALTH CARE REFORM ON ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER SURVIVORS OF DOMESTIC VIOLENCE

OVERVIEW

41-61% of Asian Americans report experiencing domestic violence during their lifetime.[1] Nationally, the cost of domestic violence, including rape, physical assault and stalking, exceeds $5.8 billion each year, with two-thirds accounting for health care costs alone.[2] Asian American, Native Hawaiian and Pacific Islander survivors of domestic violence face numerous barriers to care including lack of health insurance coverage, limited access to health care or obtaining linguistically and culturally appropriate care, immigration restrictions, and the role of culture and stigma.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. PPACA made several reforms to the nation's health care system, and contains numerous provisions that will improve access to affordable health care and provide coverage for many essential services needed by AA and NHPI survivors of violence. While PPACA expands access to care for survivors of domestic violence, barriers to care remain. As the law moves into the implementation phase, there are numerous opportunities for advocacy by providers serving these communities.

IMPROVED ACCESS TO HEALTH CARE

PPACA expands both public and private health insurance options. Some of these provisions went into effect on September 23, 2010, offering consumers improved access to care. Many of these changes will help survivors of domestic violence gain coverage, including the creation of the Pre-existing Condition Plan (also known as the High-Risk Pools), the expansion of Medicaid, and key insurance market reforms that prohibit insurance companies from engaging in discriminatory practices. These changes will also help survivors of violence increase access to essential testing and treatment services.

Ending of Discrimination on the Basis of Pre-existing Conditions, Gender and Health Status: In 2014, private insurers will be prohibited from taking into account a person's health status or pre-existing condition such as domestic violence as a basis for barring individuals from coverage or charging higher premiums. In the individual and small group markets, insurance providers will no longer be able to charge women higher premiums on account of their gender.

Creation of Pre-existing Condition Insurance Plans: Survivors of domestic violence can apply for coverage under the "Pre-existing Condition Insurance Plans." The requirements for eligibility are:

- United States citizenship, or lawful presence in the country
- Lack of insurance for past six months
- Inability to obtain insurance because of a pre-existing condition

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[1] This range is based on studies of women's experiences of domestic violence conducted among different Asian ethnic groups in the U.S. The low end of the range is from a study by A. Raj and J. Silverman, Domestic violence against South-Asian women in Greater Boston Journal of the American Medical Women's Association. 2002; 57(2): 111-114. The high end of the range is from a study by M. Yoshihama, Domestic violence against women of Japanese descent in Los Angeles: Two methods of estimating prevalence. Violence Against Women. 1999; 5(8):869-897.

[2] Costs of Domestic violence Against Women in the United States, Atlanta, GA, Centers for Disease Control and Prevention and National Center for Injury Prevention and Control, March 2003.

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Creation of Health Insurance Exchanges (HIE): Beginning in 2014, each state will create its own HIE, or the federal government will operate one for them. The HIE will serve as a one-stop marketplace for purchasing insurance coverage, with subsidies available for individuals up to 400% of FPL. The HIE will allow women and their families access to more affordable coverage and is especially important given women are less likely to have employer sponsored coverage, and more likely to be covered as dependents, and therefore more likely to loose coverage. All plans in the HIE must contain an Essential Benefits Package setting forth the minimum benefits to be provided. These benefits will be defined by the Secretary of the Department of Health and Human Services and must include:

- Emergency services and hospitalization
- Mental health services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Prescription drugs
- Laboratory services

Expansion of Medicaid: Medicaid will be expanded to cover eligible individuals and families with incomes below 133% of FPL, including childless adults. Medicaid is a major source of coverage for family planning services and supplies for low-income women of reproductive age. Women in abusive relationships often have less resources and income, and must rely on public benefit programs to receive care. In addition, States have the option of expanding coverage to childless adults as early as 2011. States can optionally use CHIP funds to cover pregnant women up to 185% FPL, and already have the option to remove the 5-year waiting period on lawfully residing immigrant pregnant women and children.

Sexually Transmitted Disease (STD) and HIV Screening: Starting September 23, 2010, all new plans must cover, without cost-sharing, all services rated an "A" or "B" by the United States Preventive Services Task Force (USPSTF). Covered services include HIV and STD screening for adults and adolescents at increased risk.[3] Violence increases a woman's risk for STD infection due to their inability to engage in voluntary sexual activity or practice safe sex. Providers serving battered women should understand this interaction between reproductive health and violence and the effect on treatment interventions.

Investments in Reducing Domestic Violence and Sexual Assault: PPACA also contains numerous provisions targeted at lessening the impact of domestic violence on communities. Starting in 2014, states can fund teen pregnancy prevention initiatives through the Personal Responsibility Education Program (PREP), in which all programs must address at least three adulthood preparation subjects such as building healthy relationships. In addition, over the next ten years, the Secretaries of Health and Human Services and Department of Education will award competitive grants totaling $25 million to address the needs of young women and pregnant teens. These grants can be used to fund programs combating violence and provide support services such as housing, childcare and health care.

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[3] Increased risk is defined as engaging in high-risk sexual practices, including all women who are sexually active and younger than age 25 for chlamydia, gonorrhea, and syphilis. Physicians are encouraged to consider community and population differences in determining whether a patient is at increased risk for HIV or an STD. USPSTF Recommendations for STI Screening, United States Preventive Services Task Force, March 2008. Available at http://www.uspreventiveservicestaskforce.org/uspstf08/methods/stinfections.htm.

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BARRIERS TO CARE

While PPACA contains numerous provisions increasing access to health insurance coverage, expanding options for obtaining affordable care and providing improved coverage of STD and HIV screening, barriers to care remain for AA and NHPI battered women. Only United States citizens and "lawfully present" immigrants are eligible to purchase health insurance plans offered in the Health Insurance Exchanges and/or participate in the Medicaid expansion. Verifying immigration status for eligibility purposes poses significant barriers for Asian and Pacific Islander survivors of domestic violence who may not have access to their immigration documents. In addition, coverage of STD and HIV screening and testing under Medicaid is limited and coverage for abortion services under Medicaid and the health insurance exchanges is restricted.

Barriers in Medicaid

- **Emergency Contraception:** States are required to cover family planning services and supplies, though there is diversity in the types of services covered by each state in the Medicaid program. In a recent Kaiser Health Foundation survey, only 26 of 44 states surveyed routinely covered emergency contraception as a family planning benefit.[4]
- **STD and HIV Testing:** Most states do not consider STD and HIV screening to be a routine family planning benefit, and only 11 states cover STD and HIV screening in all cases.[5] Most states cover STD treatment.[6]

Screening for domestic violence: The United States Preventive Services Taskforce (USPSTF) recommendation on screening for family violence is rated "I," as the USPSTF has found insufficient evidence to recommend for or against routine screening of domestic violence.

Abortion coverage: Coverage of abortion is restricted in Medicaid, the health insurance exchanges and the pre-existing condition insurance plans. Women in abusive relationships are at risk for reproductive coercion, a method of battering involving control over a woman's reproductive health and autonomy.[7] Reproductive coercion can result in forced or coerced pregnancies, due to tampering with or preventing the use of contraceptives, and can lead to further violence and/or pregnancy-related complications such as miscarriage and low-birth weight.[8]

- Medicaid: The Hyde Amendment currently bans the use of federal funds to pay for abortion, except in the case of rape, incest, or where the life of the mother would be in danger. States can elect to use their own, non-federal, funds to cover medically necessary abortions.
- Health Insurance Exchanges: Plans are not required to cover abortions and states may elect to ban abortion from the exchanges in their state. States that allow abortion coverage under their exchanges must ensure payment for abortion coverage is separated from the general premium.
- Pre-exiting Condition Insurance Plans: Federal Hyde restrictions apply. The effect is that women enrolled in these plans must pay providers directly for abortion services.

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[4] State Medicaid Coverage of Family Planning Services: Summary of State Findings, Kaiser Family Foundation and The George Washington University Medical Center School of Public Health and Health Services, November 2009. Available at: http://www.kff.org/womenshealth/8015.cfm.
[5] Id.
[6] Id.
[7] The Facts on Adolescent Pregnancy, Reproductive Risk, and Exposure to Dating and Family Violence, The Family Violence Prevention Fund, February 2010. Available at http://www.endabuse.org/ .
[8] Id.

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RECOMMENDATIONS FOR ADVOCATES AND SERVICE PROVIDERS

1. Inform clients about the private and public healthcare expansion and assist them in the application process. Encourage eligible persons to enroll in the Pre-Existing Condition Insurance Plans.
2. Inform domestic violence survivors about coverage of STD and HIV testing and treatment under Medicaid (depending on your state) and under all new private plans.
3. Advocate for the USPSTF to revise its recommendations on screening for domestic violence as early interventions can save the lives of AA and NHPI women and families.
4. Urge the Institute of Medicine (IOM) to recommend that all health plans cover, without cost-sharing, all FDA approved contraceptives, family planning services and products as these interventions are central to the physical, emotional and economic well being of women who have survived domestic violence.
5. Urge your state to allow insurance plans covering abortion to participate in the health insurance exchanges. Advocate for a system of separate payments for abortion coverage that is least burdensome for enrollees.
6. Encourage your state to take up the option to remove the 5-year waiting period on lawfully residing immigrant pregnant women and children in Medicaid and CHIP.
7. PPACA contains provisions aimed at expanding the use of electronic health records and online enrollment systems. Providers and advocates should be aware that survivors of violence have unique privacy concerns and their privacy and confidentially should be respected at all times.

DEFINITIONS

Domestic Violence: Domestic violence is a pattern of physical, sexual, emotional and economic abuses in romantic or intimate relationships.

Pre-existing condition: An injury, disease, or other medical illness that occurred before an individual applies for a health plan. Generally, the condition bars the individual from gaining health coverage, or raises the premium for coverage. Health care reform laws seek to change this over time, through the Pre-existing Condition Insurance Plan.

Pre-existing Condition Insurance Plan: This is the government insurance plan that allows individuals with pre-existing conditions to gain coverage until 2014, when public and private plans will have to offer coverage to all individuals, regardless of health status.

Federal Poverty Level (FPL): Income levels set by federal agencies to determine whether individuals are eligible for federal benefits.

Essential Benefits Package (EBP): The minimum benefits an insurance plan within the state-based health insurance exchange must provide. The EBP will be defined by the Secretary of HHS in 2014.

Eligible individuals: The eligibility of an individual varies by program. Hence, the term "eligible individual" does not have one, fixed meaning.

For more information about the health care reform law, please visit our Health Care Reform Resource Center at www.apiahf.org.

For more information about domestic violence, please visit the Asian and Pacific Islander Institute on Domestic Violence www.apiidv.org or the Family Violence Prevention Fund at www.endabuse.org/.

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