

**LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS
BRANCH****PUBLIC
SUBMISSION**

As of: September 20, 2010
Received: September 17, 2010
Status: Posted
Posted: September 20, 2010
Tracking No. 80b522ba
Comments Due: September 17, 2010
Submission Type: Web

Docket: IRS-2010-0017

Requirement for Group Health Plans and Health Insurance Issuers to Provide Coverage of Preventive Services under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0017-0002

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services; etc.

Document: IRS-2010-0017-0028

Comment on FR Doc # 2010-17242

Submitter Information

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Washington, DC,

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Organization: Family Violence Prevention Fund

General Comment

See attached file(s)

Attachments

IRS-2010-0017-0028.1: Comment on FR Doc # 2010-17242

Family Violence Prevention Fund

www.endabuse.org

September 16, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIO-9992-IFC,
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Secretary Sebelius:

In a notice published in the *Federal Register* on July 19, 2010 (Vol. 75, No. 137, pp. 41726–41760), the Departments of Health and Human Services (DHHS), Labor, and the Treasury issued an interim final rule (IFR) to implement a section of the Patient Protection and Affordable Care Act (PPACA) that requires group health plans and health insurance issuers in the group and individual markets to provide benefits, without cost-sharing, for a series of preventive services.

On behalf of the Family Violence Prevention Fund, a nonprofit organization dedicated to having violence prevention efforts become self-sustaining, and transforming the way health care providers and others address violence, I am pleased to submit the following comments on this IFR. We believe that this provision, codified as Sec. 2713 of the Public Health Services Act and entitled Coverage of Preventive Health Services, and particularly Sec. 2713(a)(4), known as the Women's Health Amendment (WHA) and sponsored by Sen. Barbara Mikulski of Maryland, should include assessment for intimate partner violence (IPV) and lifetime exposure to violence and abuse.

The Family Violence Prevention Fund (FVPF) is one of the world's leading violence prevention agencies. With a 30-year history and offices in San Francisco, Boston and Washington, D.C., and partners around the world, the FVPF develops innovative strategies to prevent domestic, dating and sexual violence, and child abuse. The FVPF serves as the nation's clearinghouse for information on the health care response to domestic violence and provides training and technical assistance to thousands of people each year. As part of that effort, the FVPF offers model strategies and tools to health professionals and domestic violence/sexual assault programs to address and prevent the chronic health issues and injuries associated with exposure to abuse. We work closely with professional health associations and public health departments to produce policy guidelines for health care professionals responding to domestic violence. We provide technical assistance, training, health policy recommendations, and materials and respond to thousands of requests for technical assistance annually. We are approved by ACCME to provide continuing medical education for providers on family violence.

Under Sec. 2713, beginning on September 23, 2010, all new health plans must cover, without cost-sharing, preventive services described in several sets of federally supported recommendations and guidelines, including recommendations from the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and

guidelines on pediatric preventive care beyond those recommended by the USPSTF, as delineated by guidelines supported by HRSA. The guidelines needed to implement the WHA will be written by a panel of the Institute of Medicine (IOM) under a contract with DHHS.

We have a few areas of consideration regarding this IFR, relating to the WHA specifically. These thoughts are detailed below.

Identifying Women's Preventive Services

The central question for implementing the WHA is the identification of the specific women's preventive services to be included. Approximately one in five women are uninsured today and women are more likely to neglect care or treatment because of cost. Victims of domestic violence utilize health services at more than double the rate of their peers, yet often are not linked to supportive services. Intimate partner violence is one of the most common, preventable threats to women's health with one out of four women and one in seven men reporting some form of lifetime IPV victimization.

IPV elevates health care costs, not only among women currently experiencing trauma, but also among women for whom the abuse has ceased. The Centers for Disease Control and Prevention (CDC) has documented a link between IPV and a number of chronic health conditions and health risk behaviors; IPV has been associated with a range of significant short-term negative mental and physical health outcomes, including health risk behaviors such as binge drinking, and reproductive health issues including sexually transmitted disease and HIV transmission, miscarriages, unplanned pregnancy and more. Long-term, IPV is linked to chronic health conditions that can include asthma, arthritis, and stroke. Unfortunately, health providers can often fail to recognize the association between violence and abuse and many chronic conditions. The Women's Health Amendment was intended to ensure coverage of annual well-woman visits¹ and assessment for intimate partner and family violence² and we join with other comments on the Interim Final Rule to ensure that Section 2713(a)(4), when fully implemented, meets the full range of women's preventive health needs.

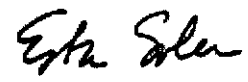
To that end, we urge the Department to clarify that the HRSA-supported guidelines for children and for women by definition include office visits for the purpose of providing preventive services delineated in those guidelines, including well-woman visits and assessment for lifetime exposure to violence and abuse, including IPV. *The final list of protected services should be based on and informed by current, reputable scientific evidence of the benefits and drawbacks of specific services for women's health; by the legislative history of the amendment; and by precedents in federal law and policy.* The panel should consult with and be guided by the current clinical guidelines, standards and opinions of federal agencies and mainstream national medical societies with an expertise in women's health, such as the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, and it should pay heed to statements from supporters of the amendment during the Senate floor debate.

Again, we urge the final regulations include a process that results in complete recommendations for women. Thank you again for the opportunity to comment on these important regulations. We look forward to working with you in the future as you continue to implement the Affordable Care Act.

¹ S12027 CONG. REC. H.R. 3590 (daily ed. Dec. 1, 2009) (statement Sen. Shaheen); S12059 CONG. REC. H.R. 3590 (daily ed. Dec. 1, 2009) (statement Sen. Cardin).

² S12025 CONG. REC. H.R. 3590 (daily ed. Dec. 1, 2009) (statement Sen. Boxer,); S12027 CONG. REC. H.R. 3590 (daily ed. Dec. 1, 2009) (statement Sen. Gillibrand); S12059 CONG. REC. H.R. 3590 (daily ed. Dec. 1, 2009) (statement Sen. Cardin).

Sincerely,

A handwritten signature in black ink, appearing to read "Esta Soler". The script is fluid and cursive, with the first name "Esta" and last name "Soler" clearly distinguishable.

Esta Soler
President and Founder