



NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

September 17, 2010

Secretary Kathleen Sebelius
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on **OCHIO-9992-IFC**, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act

Dear Secretary Sebelius:

The National Latina Institute for Reproductive Health (NLIRH) is a social justice organization that represents Latina women and families throughout the United States. NLIRH appreciates the opportunity to submit these comments on the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act (PPACA). We offer our strong support for the requirements that insurers cover preventive services without cost-sharing requirements. We also offer recommendations for strengthening the rules, including a recommendation to eliminate unnecessary and unreasonable delays in the extension of these critical protections to women's preventive services, such as contraception, for which there is clear evidence, and a strong medical consensus in support of their importance as a competent of the standard of preventive care.

The mission of NLIRH is to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy. We know that Latinas face a unique and complex array of reproductive health and rights issues that are exacerbated by poverty, gender, racial and ethnic discrimination and xenophobia. These circumstances make it especially difficult for Latinas to access reproductive health care services, including the full range of available reproductive health technologies and abortion services.

We believe that in order to substantially improve the reproductive health of Latinas and protect their rights to exercise reproductive freedom, NLIRH must locate reproductive health and rights issues within a broader social justice framework that seeks to bring an end to poverty and discrimination and affirms human dignity and the right to self-determination. NLIRH is cognizant that women of color, particularly Latinas, have had very limited access to the institutions and officials responsible for setting and

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implementing policies that directly affect the lives of many Latinas. For this reason, NLIRH is committed to serving as an advocacy engine or vehicle by which Latinas can voice their concerns and make their demands known.

Introduction

The Importance of No-Cost Preventive Services for Latina Women

Preventive health services are an essential component of health care; however, extra cost prevents many low-income women and women of color from seeking critical preventive treatment.

A May 2009 report by the Commonwealth Foundation found that more than half of women delayed or avoided preventive care due to cost. Low-income women and women of color are disproportionately affected by the high cost of preventive health care, creating disparities in mortality rates of diseases that are highly treatable with early diagnosis, such as cervical and breast cancer. The incidence of cervical cancer for Latina women in the United States is almost twice as high as non-Latina white women. Latina women have the 2nd highest mortality rate from cervical cancer (after black women). Cervical cancer is very preventable. 85% of women who die from cervical cancer never had a pap smear.

Not only is no-cost preventive care the right decision for individual low income and minority women, but making preventive care possible for everyone is also the best financial decision for the general public. Increasing access to preventive care encourages individuals to seek treatment that they otherwise could not afford, which will decrease the general public's health care burden by decreasing costs associated with preventable conditions.

Recommendations:

1-Contraception Should be Treated as Preventive Care

Unintended pregnancy is an area of reproductive health where women of color face significant disparities. The rate of unintended pregnancy among Latinas is 75% higher than among non-Hispanics,¹ and Latinas are three to four times more likely than white women to use no method of contraception.² In addition, while overall rates of contraception use increased in the 1990s, since 2002 rates have started to decline due to rising nonuse among low-income women of color.³ In 2006, the teen pregnancy rate rose for the first time since 1991, and the racial group with the largest increase was young African American women.⁴ Almost half of unintended pregnancies in the United States end in abortion.⁵

¹ HEATHER D. BOONSTRA ET AL., ABORTION IN WOMEN'S LIVES 28 (Guttmacher Inst., May 2008).

² Nat'l Ctr. for Health Stat., *Fertility, Family Planning and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth*, 23 VITAL & HEALTH STAT. No. 25, at 101 (2005).

³ BOONSTRA, ABORTION IN WOMEN'S LIVES, *supra* note 15, at 25-26.

⁴ Ctrs. for Disease Control, *Births: Preliminary Data for 2006*, 56 NAT'L VITAL STATISTICS REP. No. 7, 1-2 (2007).

⁵ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 90-96, 90 (2006).

Contraception is an important preventative measure that allows women to plan for pregnancies and their own reproductive health. Access to contraception allows women to prevent pregnancy complications as well as lowers abortion rates. In fact, abortion rates increase when contraception is less accessible to low-income women.⁶ Women of color, who have less access to contraception and have more unintended pregnancies than white women, choose to terminate their pregnancies more often. Due to disparities in preventive contraception use, since 1991, the abortion rate for African American women has remained three times higher than that for white women.⁷

Section 2713(a)(4) expands the prevention requirements to include preventative care and screenings for women as recommended by guidelines supported by the Health Resources and Services Administration (HRSA). The fact that Congress understood the debate on PPACA to include family planning is on record. In addition, public health officials and organizations agree that contraception is an essential tool in preventing health outcomes that devastating for women and children. Congress as well as the public expect contraceptive care to be among the women's preventative health services detailed in the HRSA guidelines that mandate no-cost sharing coverage by insurance.⁸

In the most recent version of the *Healthy People* series, family planning is not only listed as a priority area, but also specifically calls for increased insurance coverage of contraceptive supplies and services. Medicaid and the Sec. 330 Health Center program both require family planning and label it preventive care (Medicaid exempts it from cost-sharing), and states have long used funding from the Maternal and Child Health Block Grant for these services as well. The support for contraceptive supplies and services does not stop there. Large employers were urged by the National Business Group on Health to offer the full range of contraceptive methods and services at no cost-sharing in order to improve maternal and child health.

The final rule should not be influenced by political controversy over abortion. Contraception as preventative care is in line with science-based recommendations for reproductive health, as well as advances in technology and changing clinical practices. The public health value of comprehensive contraceptive services for maternal and infant health demands that there is no delay in this medically straightforward issue.

2-Preventative services at non-cost sharing should be available to all those who require screening, regardless of the gender stated in the patient's insurance policy

Transgender or gender non-conforming persons are also at risk of cervical cancer if they are sexually active and have not removed the cervix. In fact, transgender persons who have not surgically removed breasts, uterus or ovaries are at risk for cancer in these organs,⁹ and must undergo screenings recommended for these cancers; so too, trans women's health care should include screenings for prostate cancer when appropriate. Because these screening procedures are so heavily gendered, however, even transgender

⁶ Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 231 (2002).

⁷ Ctrs. for Disease Control, *Abortion Surveillance—United States, 2003*, 55 MORBIDITY & MORTALITY WEEKLY REP. SS-11 6-7 (2006).

⁸ <http://www.nwlc.org/resource/opinion-survey-reproductive-health-coverage-health-reform>

⁹ Top 10 things transgender persons should discuss with their healthcare provider. Available at: http://www.glma.org/_data/n_0001/resources/live/Top%20Ten%20Trans.pdf [Accessed September 17, 2010].

persons who have the resources to see a physician may forgo such screenings due to an inability to find a competent provider, and cases of transgender persons with reproductive cancers being refused treatment have been documented.¹⁰

It is absolutely critical that the preventive services that will be covered under the women's health amendment be offered with full coverage to all those who require screening, regardless of the gender stated in the patient's insurance policy. Anyone who has a cervix, for example, must be eligible to have Pap tests covered regardless of stated gender. Latinas are disproportionately affected by cervical cancer, a disparity that is no doubt connected to high rates of uninsurance and lack of coverage.¹¹, ¹² If we are to make headway in diminishing health disparities, it is pivotal to take this factor into account.

3-Eliminate unnecessary and unreasonable delays in extending these critical protections to women

NLIRH stands with Raising Women's Voices for the Health Care We Need and other organizations representing diverse women, families and communities throughout the United States and have signed-on to a separate **OCHIO-9992-IFC** comment letter indicating such. We reiterate those recommendations here for emphasis:

If the Department proceeds as outlined in the Rules, insurers will not be required to comply with the HRSA guidelines for women's preventive health services until January 2013, meaning that the protection from cost-sharing will not be extended to women's preventive health care until two years after the rest of the Sec. 2713 protections go into effect. This plan and timeline impose unnecessary and unreasonable delays on the extension of these critical protections to women, and we are urging HHS to revise the Rules to eliminate those delays.

The Rules state that the Department of Health and Human Services (HHS) is developing the HRSA guidelines for women's preventive health services to be covered and exempted from cost-sharing under this provision of the law. HHS has elaborated on this plan, explaining that HRSA is contracting the Institute of Medicine (IOM) to make recommendations about which women's preventive health services should be included in the HRSA guidelines. With respect to timing, the Rules state that HHS expects to issue the HRSA guidelines no later than August 1, 2011 and that when new guidelines are included in the recommended preventive services, insurers do not have to change coverage or cost-sharing requirements until the first plan year beginning on or after the date that is one year after the guideline went into effect.

We recognize the importance of producing the HRSA guidelines for women's preventive health services according to an evidence-based process that has scientific integrity, however, the timeline that HHS has laid out in the Interim Final Rules for creating the HRSA guidelines and for bringing insurers into compliance with the requirement to extend the protections of the law to women's preventive health care is

¹⁰ Kate Davis. *Southern Comfort.*; 2001.

¹¹ Theresa L. Byrd, Rafaelita Chavez, Katherine M. Wilson. Barriers and facilitators of cervical cancer screening among Hispanic women. *Ethnicity & Disease.* 2007;17:129-134.

¹² Leighton Ku, Timothy Waidmann. *How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population.*. The Henry J. Kaiser Family Foundation; 2003.

not acceptable. We propose the following revisions to the Rules to tighten the timeline of the process without undermining medical legitimacy of the HRSA guidelines.

- A. Establish a two-step process for the IOM. We appreciate the selection of the IOM to evaluate the evidence and make recommendations to HHS. The IOM is a well-respected body whose members include top practitioners of all medical specialties, and it unquestionably has the expertise to evaluate research in this area. In light of the urgency of extending the Section 2713 protections to women, we recommend that HHS ask the IOM to establish a two-step process for making its recommendations. In the first step, IOM will review the evidence and convene a panel of experts. The experts will identify two categories of women's preventive health services: services for which the mainstream medical and public health communities recognize the service to be a part of the standard of care, with clear evidence supporting its inclusion in the list of services protected from cost-sharing; and services for which the evidence is less strong or services for which there is a difference of opinion within the public health and/or mainstream medical community regarding the strength of the evidence. The IOM will immediately forward a list to HRSA of services which fall into the first category, and HRSA will create an interim guideline mandating coverage of, and prohibiting cost-sharing for, those services.

In the second step of the process, the IOM will complete its review and develop recommendations regarding the second category of services according to the timeline contemplated in the Interim Final Rules. This process will ensure that IOM is able to bring the full strength and integrity of its review to the recommendations without imposing an unnecessary and unreasonable delay in the timeline for implementing the women's preventive health provision of the law.

- B. Put insurers on a faster timeline for compliance. The Rules unnecessarily apply a one-year interval between when the women's preventive health guidelines are completed and when they will become effective for new plans. Again in light of the compelling public health value of bringing the benefits of the provision to women, HHS should set a shorter interval of one month for compliance with the guidelines. Should the IOM process be amended as recommended above, the shorter interval would apply for both HRSA's interim and final guidelines. It is reasonable to establish a faster timeline for implementation of these protections because the broader requirements of Section 2713 will already be in effect, and insurers will already have a system in place for protecting preventive health services from cost-sharing. They will simply be adding a new bundle of services to the existing system to extend the protections to women's preventive health care. HHS should require insurers to act swiftly so that women will be relieved of the burden of cost-sharing as soon as practically feasible.

4-Establish processes to monitor, enforce and encourage compliance

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the United States and have signed-on to a separate **OCHIO-9992-IFC** comment letter indicating such. We reiterate those recommendations here for emphasis:

The Rules are silent as to enforcement and oversight of insurers' compliance with Section 2713 requirements. We recommend that regulations include processes to monitor, enforce and encourage compliance with these important requirements. Those processes should allow consumers to issue complaints and make appeals when insurers, providers or pharmacies do not adhere to the law and consumers are inappropriately denied access to preventive health services or required to absorb some of the cost of protected services and supplies. To encourage compliance, HHS should provide technical assistance and education to health plans, health care providers, pharmacies and the public.

5-Define “not recommended” to clarify that it applies to services that receive a USPSTF grade of D

NLIRH stands with Raising Women's Voices for the Health Care We Need and other organizations representing diverse women, families and communities throughout the United States and have signed-on to a separate **OCHIO-9992-IFC** comment letter indicating such. We reiterate those recommendations here for emphasis:

The law provides, and the Rules reflect, that insurers may deny coverage for preventive health services that are not recommended by the USPSTF. But neither the law nor the Rules provide more detail about the definition of “not recommended.” The Rules should clarify that this means insurers can deny coverage for preventive health services that receive a grade of D from the USPSTF, which the Task Force defines to mean that it has “found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.” This additional fleshing out is necessary to make clear that insurers may not deny coverage altogether, let alone protections from cost-sharing, for recommended screenings that are simply not addressed by the USPSTF.

6-Establish a process for periodic updates to the HRSA guidelines based on science and evidence

NLIRH stands with Raising Women's Voices for the Health Care We Need and other organizations representing diverse women, families and communities throughout the United States and have signed-on to a separate **OCHIO-9992-IFC** comment letter indicating such. We reiterate those recommendations here for emphasis:

The law and the Rules fail to articulate a process that HHS can use to update the women's preventive health services guidelines. As research progresses, it will be important that the guidelines be updated to reflect advancing knowledge about the services that evidence supports for women's preventive health care. The Rules should establish a process that ensures that the list of covered services is periodically updated to reflect the most current evidence available, as well as advances in technology and changes in clinical practices. This process must ensure that determinations and updates to the guidelines are based on science and evidence.

We know the PPACA will be of tremendous benefit for Latinas if appropriate range of vital and preventative services is included. We look forward to working with you during the implementation process of the PPACA.

Sincerely,

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