FIGHTING DOMESTIC VIOLENCE THROUGH INSURANCE: WHAT THE AFFORDABLE CARE ACT DOES AND CAN DO FOR SURVIVORS

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Domestic violence survivors and their families have faced discrimination from the insurance industry for many years. Even when state legislation has prohibited such discriminatory practices, the insurance industry has found ways to circumvent the law and continue to set high premiums or deny insurance altogether to these survivors. This discrimination causes financial challenges for survivors that restrict their ability to leave their abusive partners and makes life much more difficult when they do leave those partners. The Patient Protection and Affordable Care Act (ACA) contains several provisions aimed at ending discrimination against survivors and their families while promoting prevention of domestic violence. These provisions, however, risk becoming entirely toothless without proper implementation. This article proposes recommendations to strengthen the ACA’s domestic violence provisions in order to reduce the incidence of abuse and combat domestic violence assumptions and stereotypes.

INTRODUCTION

Domestic violence survivors have continuously faced discrimination by insurance companies through denial of coverage or through expensive premiums. For example, insurance companies use a history suggestive of domestic violence to justify higher premiums for those in abusive relationships or those who experienced relationship violence in the past. Moreover, healthcare practices tend to be ill-equipped to respond to such discrimination—doctors do not typically screen for domestic violence during a standard appointment, shutting down an avenue for preventing and uncovering abuse. Additionally, counseling for domestic violence is typically outside the scope of most current insurance plans, rendering necessary medical care too expensive for most survivors.

The Patient Protection and Affordable Care Act (ACA) has been a hotly contested political issue since its introduction. Even after the United

1. I chose to predominantly use the term domestic violence in lieu of other terms, such as interpersonal violence, because of the phrasing of the ACA statutory language.
3. Id.
States Supreme Court upheld the Act’s constitutionality,6 2012 Republican candidates frequently vowed to repeal the law. However, the GOP failed to win either the presidency or enough seats in Congress to overturn the ACA, allowing it to continue protecting domestic violence survivors.

The ACA contains two provisions that have the potential to ease discrimination among insurance companies. First, the ACA makes it illegal for insurance companies—and the government through Medicaid or other public health programs—to consider a history of domestic violence when setting premium rates.7 Second, the ACA requires domestic violence screenings and counseling to be covered by all insurance plans without copay.8 These provisions, when paired with the individual mandate requiring Americans either to have insurance or to face a tax,9 could pave the way toward better insurance and better treatment for survivors.

Unfortunately, unless strong and informed guidelines are put into place to realize this potential, these provisions will likely fail to make any lasting changes. If implementation is done right, however, these little-discussed aspects of the ACA can become valuable tools in the fight against domestic violence in America.

I. Financial Challenges Facing Domestic Violence Survivors in Accessing Healthcare

Generally, domestic violence is recognized as a serious problem in society10 and is no longer considered a private family matter.11 Moreover, men are being increasingly recognized as also being victims of violence.12 While the recognition of this abuse as a societal problem has had many benefits—for example, in the form of federal legislative responses13—there

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10. See, e.g., Michelle J. Mandel, Ensuring That Survivors of Domestic Abuse are Not Discriminated Against in the Insurance Industry, 29 McGEOGE L. REV. 677, 678 (1998) (discussing the proactive steps that California has taken to reform its insurance laws to prohibit denial of coverage to survivors of domestic violence on the grounds that domestic violence is a lifestyle choice).
11. Historically, domestic violence was a private family matter and remained within the sphere of the household. See Bradley v. State, 1 Miss. 156, 157 (1824) (upholding the right of a husband to assault and batter his wife).
has also been a downside to these changing attitudes, especially in regard to insurance coverage. More survivors seeking medical treatment and help from the police for domestic violence means increasing documentation of abuse which insurance companies can use as a basis for discriminating against survivors. These economic consequences are exacerbated by the fact that the availability of domestic violence screenings and counseling covered by insurance is limited, resulting in extremely high out-of-pocket expenses.

A. Insurance Discrimination

Insurance companies frequently use evidence of domestic violence in deciding whether to offer an applicant insurance coverage and at what cost. While some states have enacted laws prohibiting the use of domestic violence information in insurance determinations, these laws have not provided an adequate remedy to the problem.

Although the increasing numbers of survivors seeking medical care is a positive development, an inescapable consequence of this treatment is insurance companies’ access to the medical documents and records resulting from that care. When survivors file complaints in response to abuse, insurance companies have access to public records, such as protective orders, police reports, and court documents that result from that reporting. Some states even require medical professionals to report domestic violence, creating a policy problem and contributing to documentation of abuse.

Insurance companies justify their use of this information on the grounds that they believe the survivors are living “risky” lifestyles. The companies’ representatives claim that survivors chose to be in an abusive relationship and insurance companies should not be held responsible for

14. See Mandel, supra note 10, at 678.
15. Tulchin & O’Neil, infra note 5.
18. See Mandel, supra note 10, at 678.
19. Hoskins, supra note 2, at 953.
covering the injuries that result from that "choice." These same companies, however, have been unable to produce any statistical evidence to justify their claim that domestic violence survivors cost more to insure. A State Farm representative conceded that the company had no empirical evidence to back up such a claim and admitted that the classification was "just sort of a logical conclusion."

Further, even in states that have limited this practice by law, insurance companies can find ways around the prohibition. State statutes frequently prohibit insurance companies from making coverage decisions "solely" or "only" on a history of domestic violence. Despite these statutes, insurance companies are still allowed to use a history of domestic violence in setting premiums. The companies can examine preexisting medical conditions that suggest a history of domestic violence, or simply consider the violence in conjunction with other undefined factors. By using these documents to make coverage determinations, "companies have abused the information obtained for the purpose of benefiting and protecting survivors of domestic violence by using that information for discriminatory purposes."

B. Inability to Access Domestic Violence Screenings and Counseling

The initial economic consequences caused by insurance denials and high premiums are exacerbated by the fact that the availability of domestic violence screenings and counseling covered by insurance is very limited, resulting in extremely high out-of-pocket expenses.

1. Screenings

Insurance companies are largely silent on physicians' providing (or not providing) screenings, but the Department of Health and Human Services (HHS) projects that many survivors can access screenings only through out-of-pocket or cost-sharing means. Adding to this problem,

22. Id.
24. Id. at 212.
25. Id. at 213.
26. Id.
27. Id. at 214.
28. Tulchin & O'Neil, supra note 5.
physicians themselves seem reluctant to screen their patients for domestic violence regardless of insurance concerns. In a nationwide survey of over 5,000 women, “only 7 percent said a health professional had ever asked them about domestic or family violence.”

A detailed survey of pediatricians and family care physicians in Connecticut concerning domestic violence screenings revealed similar statistics, finding that only a “minority of Connecticut . . . physicians routinely screen mothers for domestic violence.”

In a column published in The New York Times, Dr. Erin Marcus, a physician and associate medical director of the Institute for Women’s Health at the University of Miami Miller School of Medicine, explained why many physicians feel uncomfortable screening patients for abuse. Among these reasons, Dr. Marcus lists the frustration doctors feel with patients who do not immediately leave their abusive relationships. In addition, physicians see domestic violence as a criminal justice issue, and in general doctors “take umbrage at being expected to delve into a difficult, messy topic.”

2. Counseling

Insurance coverage for general counseling, let alone counseling for domestic violence, varies considerably across insurance plans and many plans do not cover any type of counseling at all. For those few who do have plans including this benefit, insurance companies usually limit the coverage to insured parties that demonstrate a specific mental disorder. Survivors without the requisite mental disorders still need extensive treatment for stress and general mental health needs but do not qualify for insurance coverage.

As stated, survivors are frequently either denied insurance altogether or offered more expensive, less comprehensive plans because they were abused. Because of this, obtaining a plan that includes coverage for

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32. Marcus, supra note 4.
33. Id.
34. Id.
36. Id.
37. Hoskins, supra note 2, at 959.
general counseling is more difficult for survivors when compared to the rest of the population. Without adequate coverage, the financial hurdles to accessing treatment are steep. The National Directory of Marriage & Family Counseling explains that counseling costs range from $75 to $200 an hour. An average six- to twelve-session treatment can cost upwards of $1,200. For those struggling to start a life away from their abusive partners, the cost of healing will often simply be too high.

II. The Pronounced Harm to Survivors Created by Barriers to Healthcare

The difficulty in obtaining care (due to insurance discrimination, high costs of care, and current medical professionals’ discomfort with engaging on this topic) means that survivors without financial means—or financial freedom from their partners—are unable to access needed treatment.

A. Insurance Denials and High Premiums

Insurance discrimination contributes significantly to the cycle of abuse because of the resulting economic sanctions against survivors. Abusers frequently have financial control over their survivors. The result of this control is well documented in contexts outside of healthcare. For example, shelters typically limit the time survivors and their children may stay, and many survivors report feeling forced to return to or stay with their partners because they cannot pay rent or buy a home after being forced to leave a shelter. A lack of reasonably priced insurance for these survivors has the same effect. Because insurance is either unavailable or too expensive, survivors become more dependent on their partners to meet their—and their children’s—healthcare needs. And when survivors are aware of the effects that calling the police or seeking medical help may have on their ability to buy insurance, they will be even more unlikely to leave the relationship and find help.

39. Id.
40. See Sarah M. Buel, Fifty Obstacles to Leaving, a.k.a., Why Abuse Survivors Stay, 28 Colo. Lawyer 19, 20 (1999) (noting the “[f]inancial despair [that] quickly takes hold when the victim realizes that she cannot provide for her children without the batterer’s assistance”).
41. Id.
42. Mullikin, supra note 23, at 224.
B. Cost Prohibitive Domestic Violence Screening and Counseling

Difficulty in accessing screenings and counseling emphasizes the problem created by insurance companies’ unwillingness to insure survivors. The high cost of these services paired with the infrequency in which they are offered keeps many survivors from receiving the care they need to leave and permanently recover from their abusive relationships.

1. Screening

Survivors are forced to pay out-of-pocket for screening services causing greater difficulty in identifying individuals in need of help. By choosing not to screen regardless of coverage, or only screening irregularly, medical professionals are allowing important opportunities to combat domestic violence lapse as well. Significant evidence demonstrates that domestic violence screenings as part of an annual checkup could have a strong preventative impact on domestic violence.43 Further, the director of the Center for Health Improvement and Prevention Studies explains that even a medical professional’s discussion about domestic violence can plant the seed for change.

On an initial level, because of their discomfort with the subject, physicians may not screen their patients for domestic violence at all; these physicians risk failing to detect abuse patients may be willing to discuss. No matter whether an individual volunteers information at the time of the screening, the Center for Health Improvement and Prevention Studies’ director explained, even a physician’s simply asking about domestic violence can plant the seed for change.44 However, physicians who screen, but do so only selectively, present an additional problem. A study demonstrated how the majority of the physicians who irregularly screen for domestic violence did so only for “certain” patients they viewed as “at-risk.”45 In contrast, physicians who had any sort of domestic violence training in the past were much more likely to screen regularly for such


44. Marcus, supra note 4.

45. Lapidus et al., supra note 31, at 335. The survey did not explore what characteristics of patients motivated a physician’s decision whether or not to screen.
abuse and not make such assumptions.\textsuperscript{46} Because of the pervasive cultural bias about the “type” of people who are abused—uneducated and impoverished women\textsuperscript{47}—physicians who engage in selective screenings are likely to screen only those patients who fit these characteristics.\textsuperscript{48} Because of similar biases, those people may be likely to be overlooked by other outreach efforts as well.

2. Counseling

Similar to screenings, the lack of coverage for counseling has severe consequences. Counseling can interrupt the cycle of abuse inherent in domestic violence for those who enter into therapy while in the abusive relationship.\textsuperscript{49} Moreover, effective counseling helps survivors recover after being in an abusive relationship.\textsuperscript{50} The need for counseling can be pronounced: “[T]he psychological trauma of abuse can be so severe that twenty-five percent of all suicide attempts and twenty-six percent of all suicide attempt-related injuries treated . . . are attributable to an abusive relationship.”\textsuperscript{51}

C. Those Most Affected

The difficulty in obtaining affordable care, brought on through insurance discrimination and current practices in screening and counseling, means that survivors without financial means—or financial freedom from their partners—are kept from treatment that could empower them to leave their partners.

Many studies suggest that, despite the need for holistic screening methods, the fact remains that those suffering most frequently from abusive relationships are low-income women.\textsuperscript{52} The evidence on this point is pronounced—“Women receiving TANF [Temporary Assistance for Needy Families] are current survivors of domestic violence at rates about ten times

\textsuperscript{46} Id.

\textsuperscript{47} See, e.g., Buel, supra note 40 (discussing different stereotypes surrounding survivors of domestic abuse); Deborah A. Widiss, Domestic Violence and the Workplace: The Explosion of State Legislation and the Need for a Comprehensive Strategy, 35 FLA. ST. U. L. REV. 669, 692 n.71 (2008) (discussing the need for training and education to address such bias against battered women).

\textsuperscript{48} Marcus, supra note 4.

\textsuperscript{49} Mullikin, supra note 23, at 225 n.237 (describing one woman’s statement that the availability of counseling covered by her insurance helped her leave her abuser).

\textsuperscript{50} Id.

\textsuperscript{51} Hoskins, supra note 2, at 959.

\textsuperscript{52} See generally NATIONAL INSTITUTE OF JUSTICE, Selected Research Results on Violence Against Women, http://nij.gov/topics/crime/violence-against-women/Pages/selected-results.aspx.
higher than women in the general population."

Gender of the survivors aside, "[households] with incomes between $7,500 and $25,000 experience nearly three times the amount of domestic violence as those with incomes above $50,000." For those with incomes below $7,000, that rate rises to five times as much.

Regardless of the socioeconomic status of the survivor, abusers frequently have financial control over their victims. Even for those survivors from higher income brackets, financial dependence on abusive partners causes some survivors to stay in abusive relationships. Abused persons who live under the financial control of their abuser are no more able to access care if they live in a mansion as opposed to a shack. "Without the financial means to establish a permanent residence, many survivors fear becoming homeless and either never leave their abusive partners or return to their abusive partners."

Insurance agencies, through their discriminatory practices and lack of coverage for necessary treatment, contribute to survivors staying in abusive relationships. In addition, medical professionals' discomfort with the subject furthers the isolation of domestic violence survivors in the healthcare system. However, the ACA has provisions addressing both prongs of this problem.

III. How the ACA Could Help Ease the Challenges Domestic Violence Survivors Face

Some of the ACA has gone into effect, but beginning in 2014, all the major provisions—including the provision requiring Americans to carry health insurance—will become effective. As a result, many survivors who previously lacked insurance will be enrolled in coverage and able to access medical care more frequently. Additionally, the ACA has two provisions that specifically address domestic violence. First, it prohibits insurance companies from considering the abuse in their coverage determinations. Second, insurance must cover screenings and counseling.

54. Id. at 367.
55. Id.
56. See Buel, supra note 40.
57. See id. (discussing various financial obstacles survivors face in leaving abusers).
58. Hoskins, supra note 2, at 957.
for domestic violence without copayment. These provisions demonstrate a growing consciousness towards the need for reform but continue to remain problematic.

A. How the ACA Will Increase the Number of Survivors Eligible for Care

Beginning at the start of 2014, the individual mandate will take effect and all Americans will be required to have health insurance or face a penalty in the form of a tax. As a way to ensure all Americans have health insurance in 2014, the ACA has enacted several provisions to lessen the burden of buying health insurance.

First, insurance through an employer can satisfy the ACA health insurance requirement. Moreover, states will be able to expand eligibility for Medicaid starting in 2014. In addition to the Medicaid expansion, subsidies to buy insurance will be available to individuals with financial hardship who cannot otherwise afford insurance. Further, a new way of obtaining insurance will be available through insurance exchanges. Individuals who could not access insurance because of cost will now be eligible for affordable healthcare through these initiatives—likely leading to a greater number of survivors eligible for Medicaid and enrolling in insurance plans.

B. Prohibition of Insurance Discrimination

The ACA specifically prohibits insurance companies from discriminating against domestic violence survivors. The applicable language reads:

SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

61. See U.S. DEP’T HEALTH AND HUMAN SERVICES, supra note 8.
62. This explanation is intended only as a brief summary of how the domestic violence provisions in the ACA will be put into effect and does not seek to provide an overview of the many different approaches, difficulties, criticisms, and concerns about implementation.
63. Healthcare Timeline, supra note 59.
64. Id.
65. Id.
66. Id.
67. Id.
68. Id.
IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(7) Evidence of insurability (including conditions arising out of acts of domestic violence). 69

On its face, this section of the ACA does not present any insurmountable problems. The phrase “conditions arising out of acts of domestic violence” is broad enough that the prohibition could dodge the problems that plague some of the more limited state laws. Instead of only prohibiting discrimination against those that an insurance company can clearly label from medical or police records, the provision could be understood to prevent discrimination against survivors on the basis of a medical history suggestive of abuse or through the other, more creative means insurance companies have developed over the years. At the same time, while the language is promising it does not itself mandate this interpretation of the law.

C. Insurance Coverage of Domestic Violence Screening and Counseling

On August 1, 2012, all insurance plans 70 were required to begin covering a host of women’s preventative services without copayment. 71 Two of the preventative services covered are domestic violence screenings and counseling. 72 While requiring screening and counseling to be covered is a good start, this provision includes more holes and problematic areas than the insurance discrimination provision does.

With regard to screening and counseling, the law gives little guidance on when these services should be conducted, and in what form. Additionally, the law gives no guidance as to what physicians must do with the records that are produced from these services. Further, the provision is only a required service for women’s preventative health. Unless this categorization is corrected, women in abusive relationships will be covered, but men will not. Finally, “counseling” is not defined, leaving open a variety of questions about exactly what type of counseling is intended to be covered.

70. At the moment, there is an exception for plans that were grandfathered in, but almost all plans are likely to lose their grandfathered status by 2014.
71. See U.S. DEP’T HEALTH AND HUMAN SERVICES, supra note 8.
72. Id.
IV. Recommendations on How to Best Implement the Domestic Violence Provisions

The domestic violence insurance provisions have created a foundation for ridding discrimination, but guidelines that better define the provisions, clarify the requirements of medical professionals, and expand provisions past the current guidelines must be enacted at either a state or federal level.

A. Goals for Implementation

With robust implementation of the law, domestic violence survivors will be able to access the healthcare services they need. The primary goal of the recommendations that follow is to ensure more survivors become less financially dependent on their abusers and receive the physical and mental treatment they need to heal from the abuse. But a secondary goal exists as well within these recommendations. If broad and proper implementation is successful, the provisions of the ACA focused on domestic violence have the potential to promote awareness of the prevalence of domestic violence in America and help combat dangerous stereotypes of survivors. Four basic steps, instituted through federal or state guidance, could help achieve these goals.

B. Necessary First Steps

First, HHS must specifically define the discrimination provision to prohibit practices insurance companies have used to avoid similar state prohibitions. Second, either HHS or state officials must expand the screening and counseling provision to men. Third, HHS must require screenings and brief counseling during a patients’ yearly checkup. Finally, to ensure medical professionals are able to carry out the screenings and counseling effectively, states must require training for medical professionals on domestic violence, and the federal government should issue a best-practices guide for those providing the services.

1. Define Insurance Discrimination Broadly

HHS should enact guidelines better defining the phrase “conditions arising out of” to mean injuries suggestive of domestic violence for all insurance plans in all states. If HHS remains inactive, insurance companies are likely to interpret the requirement narrowly and stop discriminating only against those survivors who can be labeled as such through specific language in police and medical reports. Insurance companies will continue
to deny coverage for those who have any documentation of medical or personal conditions suggestive of domestic violence.

2. Expand Provision to Apply to Men

A major problem with the screening and counseling provision is that it is listed only under “women’s preventative health” instead of under the general preventative health section which applies to all patients. While women are the majority of survivors, they are not the only people abused. It is extremely important for men to be screened for domestic violence as well; heterosexual and homosexual men are, for a variety of reasons, reporting abuse by their partners in increasing numbers, and screening and counseling will give men an additional safe place for reporting abuse. Congress should fix this problem through legislation. If, however, political gridlock on a federal level proves insurmountable, states could include these services for men as part of their own benchmark plans.

Screenings for men, however, would do more than simply find more survivors who need help—an important goal that alone would explain the recommendation—but it would also promote awareness of domestic violence. If hearing questions about domestic violence at every annual visit becomes a normal part of every person’s health checkup, less people will be able to dismiss domestic violence as a marginal problem. Screening will aid in preventing domestic violence, along with, perhaps, starting a cultural shift in the way domestic violence is viewed—as part of life that can affect anyone.

3. Define When Screenings and Counseling Will be Covered

Screenings and counseling should be covered as a required part of all annual checkups—for everyone—and medical professionals must be trained in these practices. Doing so will remove the problem of healthcare providers’ opting not to address domestic violence. These services are not currently required to be covered annually, though regulations open the door for screenings to be included in the annual well-woman visits also required to be covered without copayment: “This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines.” This is not a controversial proposal: the Institute of Medicine supports domestic violence screening and counseling as a part of

73. See U.S. DEP’T HEALTH AND HUMAN SERVICES, supra note 8.
75. U.S. DEP’T HEALTH AND HUMAN SERVICES, supra note 8.
every checkup. As with expanding the provisions to apply to men, setting this standard will ensure more survivors are reached and demonstrate to the public that domestic violence is not a problem contained to one gender or one socioeconomic group.

While brief counseling after an initial screening conducted by any medical professional can be beneficial, it can hardly be comprehensive enough to help patients with all the feelings and issues they may have regarding their abusive relationships. In-depth counseling conducted by trained professionals for domestic violence should be covered under the ACA as part of the extended mental health services package. Care should be taken to specifically define counseling for domestic violence as a covered service, allowing survivors coverage even though they are unable to present a specific mental health disease as the law currently requires.

4. Prepare Professionals to Frequently Conduct Screenings and Counseling

States must take proactive steps to ensure all medical professionals in their state are equipped to effectively provide these services as they become more common. Studies demonstrate that physicians with past domestic violence training already institute the most effective screening policies for their practices and are less likely to judge certain patients as “at-risk.” Only a few states, however, require training of medical professionals on domestic violence.

States can require such training in a variety of ways. For example, some states, recognizing the benefits of domestic violence training for all medical professionals, have instituted training programs mandatory for state employees or certain types of state-sponsored medical programs. And every state could easily require such training as part of the license renewal process, similar to Connecticut and Florida. Doing so will ensure that medical professionals have a better understanding of the

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77. Hoskins, supra note 2, at 959.
78. See Lapidus et al., supra note 31, at 335 (noting that physicians with domestic violence training are significantly more likely to institute screening practices).
80. Id. at 16, 28.
widespread nature of domestic violence and help to ensure that they do not selectively screen patients based on stereotypes as a default.

Finally, states and the HHS should set baseline “best practices” for the brief screenings and counseling that would occur during checkups—these materials also must help medical professionals address the limits of patient confidentiality in regard to domestic violence. While states could prepare such materials, HHS should develop a nationwide guide to complement work the federal government has already started.

HHS has not explained through official guidelines how exactly the screening and counseling should be conducted, but has released a joint memo on the topic with Futures Without Violence, a national advocacy group engaged in raising awareness and prevention of domestic violence. This joint memo summarizes effective screening practices that would fit the timeframe of an annual checkup. While comprehensive, detailed screenings are unlikely to be implemented during an annual visit because of time constraints, even a short screening and directed counseling can be effective. The memo hardly amounts to a detailed script, but does include sound advice—including phrasing questions with validating statements and having an established relationship with a local advocate. At a minimum, health professionals should be clear and sensitive in their administration of these services while following these steps: “[A]sk, affirm, offer harm reduction strategies, document, and refer.” And all medical settings should have documents on hand to provide the patient with guidance and resources. Because of HHS’s obvious endorsement of the memo, it would not be out of the question for the Department to expand on its provisions to create an official guide for practitioners.

The same type of guidance should be developed in regard to addressing confidentiality constraints. Because of the mandatory reporting laws referenced above, many advocacy groups recommend that medical professionals discuss the limits of their confidentiality before screening their patients because state laws vary considerably on the mandatory reporting requirements in healthcare settings. Medical professionals in

83. Id.
85. Id.
86. Id.
87. See id. at 4 (noting that “[r]esearch has shown that brochure based interventions are effective).
88. See Futures Without Violence, Mandatory Reporting of Domestic Violence to Law Enforcement by Health Care Providers 4, http://www.healthcaresaboutipv.org/wp-
states that require reporting should be upfront with the patient before screening and respect a patient’s decision to decline screening. In that situation, the medical professional should give the patient literature listing domestic violence resources. Even if patients do not want the full screening and counseling, materials made available for use at a later date may be effective on their own.89

CONCLUSION

Insurance discrimination and inadequate practices in regard to screening and counseling can amount to a denial of treatment that could be vital to a survivor’s decision to leave an abusive relationship and ability to heal afterward. The Affordable Care Act’s domestic violence provisions provide the skeleton framework that could be used to help these individuals obtain better and more complete insurance coverage, while also promoting awareness and prevention. Officials, however, still must take many proactive steps to bring these provisions to life in a way that can create long-lasting change.

89. Memorandum, supra note 84.
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