Analysis of California Assembly Bill 2843 Rape and Sexual Assault

APRIL 16, 2024

California Health Benefits Review Program (CHBRP)
Office of Research, University of California, Berkeley

www.chbrp.org

KEY FINDINGS

Analysis of California Assembly Bill 2843 Rape and Sexual Assault

Summary to the 2023–2024 California State Legislature, April 16, 2024

Summary

California Assembly Bill (AB) 2843 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a rape or sexual assault.

In 2025, approximately 21.4 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 2843. However, 100% of Medi-Cal beneficiaries in DMHC-regulated plans have coverage without cost sharing, thus their coverage would not be impacted by this bill.

Utilization: At baseline, CHBRP estimates 402 enrollees utilize sexual assault services without an emergency department (ED) visit, and 644 enrollees utilize these services with an ED visit. CHBRP assumes AB 2843 would result in a 3% increase in utilization of services due to new users, and a 5% increased utilization of services by enrollees who used them at baseline. Thus, postmandate, CHBRP estimates 415 enrollees would use sexual assault services without an ED visit, and 663 enrollees would use services with an ED visit. AB 2843 would not exceed essential health benefits (EHBs).

Medical Effectiveness: CHBRP found *insufficient evidence* to assess how cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency and follow-up services for sexual assault. There is a *preponderance of evidence* that behavioral health treatment is effective at reducing symptoms of post-traumatic stress disorder (PTSD), depression, anxiety, and internalizing behavior when compared to no or minimal treatment. CHBRP also concluded there is a *preponderance of evidence* that some behavioral health treatments are more effective than others at reducing mental health symptoms among adults and children/adolescents who have experienced sexual assault.

Cost Impacts: CHBRP estimates AB 2843 would result in an increase of $600,000 (0.0004%) in total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $1,051,000 increase in premiums paid by employers and enrollees, and an estimated $451,000 reduction in cost sharing. Postmandate, CHBRP estimates an average decrease in cost sharing of $170 for enrollees without an ED visit, and $594 for those with an ED visit.

Public Health Impacts: In the first year postmandate, although a small increase in utilization of emergency and follow-up services among enrollees is expected, the public health impact of AB 2843 is *unknown* due to insufficient evidence regarding the impact of cost sharing on enrollees' utilization of these services. However, at the person-level, enrollees who seek care at the ED following a sexual assault may have impactful reductions in out-of-pocket costs due to having no cost sharing postmandate, in addition to health and quality of life improvements.

Context

Sexual assault is a common experience. Most victims of sexual assault know their perpetrators (acquaintances, intimate partners, and family members).[1] Sexual assault is under-reported, and the recorded estimates of incidence and prevalence of sexual assault are lower than the true number due to barriers to victims reporting, disclosing, or seeking medical care after an assault. Most sexual assaults are not reported to police or healthcare providers. In the United States, about 34% of

[1] See full report for references.

all sexual assaults were reported to the police in 2019 and 21% of female sexual assault victims seek medical care following an assault.

Cost may be a barrier for sexual assault victims who do not wish to pay out-of-pocket for services that are not covered in a medical exam, or they choose not to undergo a forensic medical examination (FME). CHBRP found no evidence to quantify the amount of cost or cost-sharing that would be a barrier to seeking medical care for sexual assault victims. Fewer than two in five victims follow up with a primary care provider 6 weeks after sexual assault, and one in four victims who visit primary care providers after sexual assault do not disclose the assault to the providers.

Additional barriers related to emergency and follow-up services after sexual assault include not recognizing that medical care is needed, consequences of seeking medical care such as stigmatization and retaliation from the perpetrator or not wanting sexual assault diagnosis on medical record and insurance explanation of benefits, and inability to access care.

Bill Summary

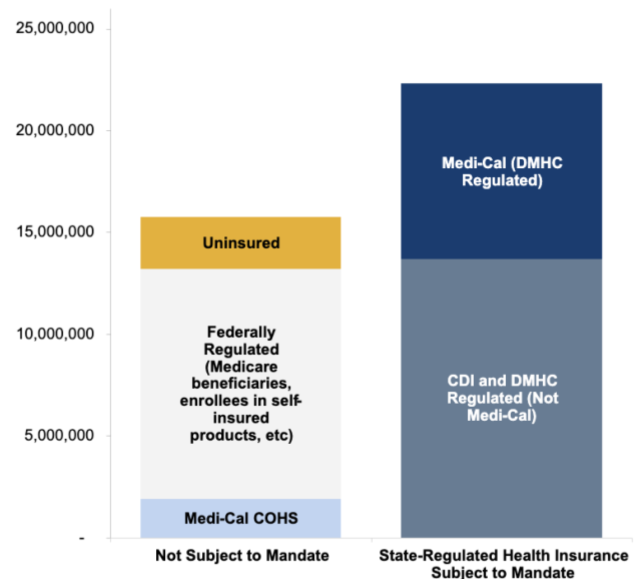
AB 2843 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a rape or sexual assault.

AB 2843 specifies that health plans and insurers are prohibited from conditioning coverage on factors related to criminal charges, convictions, and reporting to police.

The bill also states that its provisions do not authorize coverage for rape or sexual assault services provided by an out-of-network provider, unless the services are not available in a health plan's network and a health plan makes arrangements for them to be provided by an out-of-network provider.

Figure A notes how many Californians have health insurance that would be subject to AB 2843.

Figure A. Health Insurance in CA and AB 2843



Source: California Health Benefits Review Program, 2024.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

Impacts

Medical Effectiveness

To assess the impact of cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency and follow-up services after sexual assault, CHBRP examined *health care utilization* (e.g., emergency department visits, visits for mental health services) as the outcome of interest.

To assess the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health, CHBRP examined *physiological, behavioral, functional, and quality of life* measures (e.g., PTSD symptoms, anxiety, depression, social functioning) as outcomes of interest.

CHBRP found there is *insufficient evidence* to assess how cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency room medical care and follow-up treatment for sexual assault. This does not indicate that these requirements do not have an impact; solely that no evidence was located.

There is a *preponderance of evidence* that behavioral health treatment is effective at reducing symptoms of post-traumatic stress disorder (PTSD) and depression among adults who have experienced sexual assault, as well as reducing symptoms of PTSD, anxiety, depression, and internalizing behavior[2] among children and adolescents who have experienced sexual assault, when compared to no or minimal treatment.

There is a *preponderance of evidence* that some behavioral health treatments are more effective at reducing mental health symptoms among adults and children/adolescents who have experienced sexual assault.

- Trauma-focused interventions yield significant reductions in PTSD and depression symptoms at three-months post-treatment compared to non–trauma-focused interventions among adults who have experienced sexual assault.
- Cognitive behavioral therapy is more effective than child-centered therapy[3] at reducing symptoms of PTSD, anxiety, depression, and social functioning as well as internalizing behavior and sexualized behavior, among children and adolescents who have experienced sexual assault.
- Interpersonal therapy[4] is more effective at reducing symptoms of PTSD than prolonged exposure or relaxation therapy[5] for adult victims of sexual assault.

Utilization and Cost

Utilization

At baseline, CHBRP estimates 402 enrollees utilize sexual assault services without an ED visit, and 644 enrollees utilize these services with an ED visit. CHBRP assumes AB 2843 would result in a 3% increase in utilization of services due to new users, and a 5% increased utilization of services by enrollees who used these services at baseline. Thus, postmandate, CHBRP estimates 415 enrollees would use sexual assault services without an ED visit, and 663 enrollees would use services with an ED visit. AB 2843 would not exceed essential health benefits (EHBs).

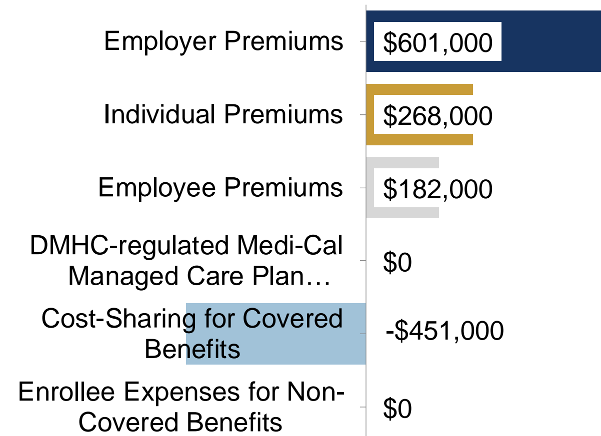
Expenditures

CHBRP estimates AB 2843 would result in an increase $600,000 (0.0004%) of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure B). This is due to a $1,051,000 increase in premiums paid by employers and enrollees, and an estimated $451,000 reduction in cost sharing.

Cost Sharing

At baseline, CHBRP estimates enrollees who receive sexual assault services without an ED visit are responsible for, on average, $170 in cost sharing, and those with an ED visit are responsible for, on average, $594 in cost sharing. Postmandate, all enrollees would have $0 in cost sharing, regardless of whether their services were delivered in an ED.

Figure B. Expenditure Impacts of AB 2843



Source: California Health Benefits Review Program, 2024.
Key: DMHC = Department of Managed Health Care.

Medi-Cal

Although the insurance of Medi-Cal beneficiaries in DMHC-regulated plans is subject to AB 2843, if enacted, the bill would not impact their insurance. At baseline, Medi-Cal beneficiaries in DMHC-regulated plans have

[2] Internalizing behaviors are those directed inwards towards oneself, such as worry, somatic symptoms, avoidance, and suicide.
[3] Child-centered therapy focuses on enabling the child to identify their feelings by providing them with the opportunities to recognize, clarify, and express those feelings (e.g., through play).
[4] Interpersonal therapy focuses on improving interpersonal relationships and social functioning.
[5] Relaxation therapy focuses on muscle and mental relaxation (e.g., through listening to relaxation tapes).

100% coverage without cost sharing for sexual assault services.

CalPERS

For enrollees associated with the California Public Employees' Retirement System (CalPERS) in DMHC-regulated plans, CHBRP estimates that AB 2843 would increase premiums for employer-sponsored and CalPERS employer insurance premiums by about $34,000 (0.0005%) postmandate.

Covered California – Individually Purchased

CHBRP estimates that AB 2843 would result in an increase in premiums for enrollees of individually purchased Covered California plans of about $268,000 (0.0013%). The reduction in cost sharing per user in these plans would be $250 and $1,200 for those without an ED visit and with an ED visit, respectively.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2843.

Public Health

In the first year postmandate, although a small increase in utilization of emergency and follow-up services among enrollees is expected, the public health impact of AB 2843 is *unknown* due to insufficient evidence regarding the impact of cost sharing on enrollees' utilization of these services. Please note that the absence of evidence is not "evidence of no effect." It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

However, at the person level, enrollees who seek care at the ED following a sexual assault may have impactful reductions in out-of-pocket costs due to no cost sharing postmandate. Also, at the person level, AB 2843 would likely yield health and quality of life improvements such as reduced symptoms of mental health disorders.

Long-Term Impacts

CHBRP estimates that after the initial 1-year postmandate period, annual cost-sharing savings to enrollees would likely be similar to the first year. It is possible that long-term utilization for follow-up services for sexual assault would increase with the elimination of cost sharing due to AB 2843. With regard to behavioral health follow-up care, CHBRP notes that there is a significant supply-side barrier with a shortage of behavioral health professionals that may not be able to meet any increased demand for follow-up mental health care for sexual assault.

There could be a potential for improved mental health for enrollees for whom cost was a barrier at baseline to receiving services if in the longer term, they choose to continue receiving behavioral health services due to the elimination of cost sharing as a barrier.

If the reduced cost barriers resulting from AB 2843 enables better access to behavioral health services following a sexual assault for enrollees, it could potentially reduce the risk of developing PTSD and subsequent long-term mental health consequences for those enrollees.

Essential Health Benefits and the Affordable Care Act

AB 2843 would not require coverage for a new state benefit mandate that exceeds the definition of essential health benefits in California.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at **www.chbrp.org**.

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Policy Context

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[6] conduct an evidence-based assessment of the medical, financial, and public health impacts of AB 2843, Rape and Sexual Assault, as introduced on February 15, 2024.

Bill-Specific Analysis of AB 2843, Rape and Sexual Assault

Bill Language

AB 2843 would require DMHC-regulated plans and CDI-regulated policies to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a rape or sexual assault.

AB 2843 specifies that health plans and insurers are prohibited from conditioning coverage on the occurrence of any of the following:

- An enrollee/insured to file a police report on the assault.
- Charges to be brought against the assailant.
- An assailant to be convicted of rape or sexual assault.

California Regulatory Agencies

DMHC: California Department of Managed Health Care

CDI: California Department of Insurance

The bill also specifies that its provisions do not authorize coverage for rape or sexual assault services provided by an out-of-network provider, unless the services are not available in a health plan's network, and a health plan makes arrangements for them to be provided by an out-of-network provider.

The full text of AB 2843 can be found in Appendix A.

Definitions

AB 2843 defines "rape" and "sexual assault" through references to the California Penal Code. Briefly, California statute[7] defines these terms as follows:

- **Rape:** the act of sexual intercourse accomplished under certain circumstances, including: if it is accomplished against a person's will (by force, threat of retaliation, or threat of use of public official to incarcerate, arrest, or deport); if a person is prevented from resisting by an intoxicating substance; if a person is unconscious; if done under false pretenses of the person's identity; or if a person who is not the spouse of the person committing the act is incapable, because of a mental disorder or disability, of giving legal consent.
- **Sexual assault:** includes nonconsensual sexual intercourse, sodomy, oral copulation, sexual penetration,[8] or rape.

[6] CHBRP's authorizing statute is available at www.chbrp.org/about/faqs.
[7] See Appendix A for full text of AB 2843 with relevant California statutory references to rape and sexual assault.
[8] Sexual penetration is defined as "the act of causing the penetration, however slight, of the genital or anal opening of any person or causing another person to so penetrate the defendant's or another person's genital or anal opening for the purpose of sexual arousal, gratification, or abuse by any foreign object, substance, instrument, or device or by any unknown object." A foreign object, substance, instrument, or device includes "any part of the body, except a sexual organ." California Penal Code Section 289(k).

Relevant Populations

If enacted, AB 2843 would apply to the health insurance of approximately 21.4 million enrollees. This represents those who have commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans. However, as described in the *Benefit Coverage, Utilization, and Cost Impacts* section, Medi-Cal beneficiaries enrolled in DMHC-regulated plans have full coverage for emergency and follow-up services for sexual assault at baseline and do not generally have cost sharing; therefore, AB 2843 would not impact this population.

Analytic Approach and Key Assumptions

CHBRP uses the following terminology throughout this analysis:

- **Cost sharing:** copayments, coinsurance, and/or deductibles associated with covered health insurance benefits. Cost sharing does not include premium expenses. See the *Cost Sharing* section for more information.
- **Emergency services**: to describe "emergency room medical care," as written in AB 2843. Includes any medical services[9] related to an emergency department visit, including prescription drugs.
- **Follow-up services**: to describe "follow-up health care treatment," as written in AB 2843. Includes any medical nonemergency services related to a sexual assault, i.e., those services that are not associated with an emergency department visit, including prescription drugs. Examples include testing for sexually transmitted infections (STIs), pregnancy testing, behavioral health counseling, ongoing prescription drugs, and any pregnancy care that may occur outside of the emergency department.
- **Sexual Assaul**t: in reference to both rape and sexual assault, as defined in AB 2843.
- **Sexual Assault Service**s: all medical emergency and non-emergency services that are associated with a sexual assault diagnosis.
- **Victim**: a person who has been raped or sexually assaulted.[10]

CHBRP assumes that if AB 2843 is enacted, the elimination of cost sharing for emergency and follow-up services related to sexual assault would only occur for those enrollees with health insurance claims that include a diagnosis for sexual assault. CHBRP's analytical approach is therefore based on data that consider all emergency and follow-up services that include a diagnosis for sexual assault.[11]

Sexual assault victims may choose to receive medical, counseling, and other support services in places of service other than their primary care physician's office, the emergency department, or other hospital settings. For example, they may prefer to receive services at a rape crisis center or other independent sexual assault service providers. Many of these organizations offer free medical or behavioral health services to victims of sexual assault and may be able to provide patients with privacy that they may not otherwise receive if they used services through health insurance. For instance, the victim may be a minor who does not wish to disclose the sexual assault to a parent due to shame, or they may be a victim of intimate partner violence and fear retaliation. CHBRP assumes many enrollees who receive sexual assault services at rape crisis centers and other locations outside their primary health insurance network may continue to do so, even if AB 2843 was enacted, due to personal reasons unrelated to cost.

[9] Medical services include those for physical and behavioral health.
[10] CHBRP recognizes that the term "survivor" is also applicable. The Rape, Abuse & Incest National Network (RAINN) typically uses the term "victim" in reference to a person who was recently affected by sexual assault, and the term "survivor" in reference to a person who has gone through the recovery process (RAINN, 2024). AB 2843 is concerned with services and treatment related to those of a recent sexual assault, therefore CHBRP uses the term "victim" throughout the report.
[11] There are multiple diagnoses related to sexual assault. See Appendix C for more details.

One of the services a victim of sexual assault may choose to receive is a sexual assault forensic medical exam (FME). FMEs are designed to provide health care services and collect evidence of the sexual assault. Under existing law, all sexual assault victims are entitled to an FME from a trained medical professional, free of charge, regardless of whether they choose to report the assault to the police. Follow-up services are not covered. As discussed in the *California Policy Landscape* section, all FMEs conducted by any qualified health care professional are reimbursable through local law enforcement agencies. Therefore, CHBRP assumes that services associated with an FME would be reimbursed by the local law enforcement agency, so CHBRP does not include those costs or services in this analysis. See the *Background on Sexual Assault* section for additional information on FMEs.

Interaction With Existing State and Federal Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

Federal Policy Landscape

Federal Laws and Legislation

Victims of Crime Act

Federal law also established the Victims of Crime Act (VOCA), which provides state funding for victim assistance and compensation programs, such as California Victims Compensation Board (CalVCB), that offer support and services to those impacted by violent crimes (OVC, 2023). The Office of Justice Programs, a bureau of the Department of Justice, Office for Victims of Crime, is currently proposing regulations that would amend the guidelines for the Victims of Crime Act Victim Compensation Program and update and codify requirements for the VOCA Victim Compensation Formula Grant Program. The intent of the proposed regulations is to clarify and streamline policies and definitions, and to make it easier for states to seek reimbursements for costs associated with recovery efforts (recovery payment amounts via restitution and subrogation) (OJP, 2024).

Violence Against Women Act

In 1994, the federal government enacted the Violence Against Women Act (VAWA), which addressed criminal penalties, and authorized grants to state, local, and tribal law enforcement entities to investigate and prosecute violent crimes against women (CRS, 2023). Since its original enactment, the VAWA has been reauthorized four times, its provisions amended with each iteration to address congressional concerns related to violence against women. The most recent (2022) reauthorization extended the program until 2027 and expanded some portions of the law, including increasing services and support for victims/survivors in underserved and marginalized communities. It also enacted the Fairness for Rape Kit Backlog Survivors Act, which requires state victim compensation programs to waive deadlines for sexual assault victims to file for compensation in cases where a victims failed to meet deadlines due to a backlog in the testing of rape kits (CRS, 2023).

Funding authorized under VAWA is administered primarily through the U.S. Department of Justice's Office on Violence Against Women (OVW). The OVW administers discretionary (i.e., OVW establishes program parameters, eligibility, qualifications, and deliverables) and formula (i.e., noncompetitive, based on criteria specified in legislation) grant programs related to sexual assault. The current formula grant programs include the Sexual Assault Services Formula Grant Program (SASP), State and Territorial Sexual Assault and Domestic Violence Coalitions Program, Services Training Officers Prosecutors (STOP) Violence Against Women Formula Grant Program, and Tribal Domestic Violence and Sexual Assault Coalitions Program (OVW, 2024). The formula grant programs assist in supporting some of CalOES's sexual assault programs. For example, CalOES uses funds from the STOP Violence Against Women program to support its Campus Sexual Assault Program, and to reimburse law enforcement for FMEs of those sexual assault victims who are

undecided about reporting to law enforcement or who have decided not to submit a report to law enforcement (CalOES, 2022, 2023). CalOES uses SASP funding to partially fund its Rape Crisis Program (CalOES, 2023).

OVW administers several discretionary grant programs that address different specific populations of victims of sexual assault, including those with disabilities, those assaulted at an institute of higher education, those in rural areas, and those in transitional housing, among others (OVW, 2024).

California Policy Landscape

California law and regulations

Existing law requires all public and private general acute care hospitals to comply with certain standards for the examination and treatment of victims of sexual assault and attempted sexual assault, including child abuse. Hospitals that cannot comply with these standards must adopt a protocol for the immediate referral of these victims to a local hospital that is able to do so.[12] The minimum standards include: notification of law enforcement authorities;[13] use of statutory protocols if conducting an FME; consent for a physical examination, treatment, and collection of evidence; taking a history of sexual assault; and, for those adults and minor victims of sexual assault that consent to an FME, a physical examination and collection, preservation, and disposition of evidence through specified protocols.[14]

With regard to costs of medical services and treatments related to sexual assault, existing law states that an any costs incurred by a qualified health care professional, hospital, clinic, sexual assault FME team, or other emergency medical facility examination related to an FME are prohibited from being charged directly or indirectly to the sexual assault victim. These costs must be treated as a local cost and charged to and reimbursed within 60 days by the local law enforcement agency in whose jurisdiction the alleged sexual assault was committed. Existing law further clarifies that the costs for FMEs may be reimbursed regardless of whether a victim chooses to report the sexual assault to law enforcement.[15] See the *Background on Rape and Sexual Assault* section for additional information on FMEs. It should be noted that if a sexual assault victim chooses not to undergo an FME, under existing law, any medical services received by the victim as a result of the sexual assault may be subject to cost sharing.

California law also requires county hospitals to provide victims of sexual assault with testing for venereal disease and pregnancy without charge, as well as information regarding assistance available from the California Victim Compensation Board.[16] See *State Resources for Victims of Sexual Assault* for more information.

State Resources for Victims of Sexual Assault

California Victims Compensation Fund

The California Victims Compensation Board (CalVCB) is a state program established to provide reimbursement for crime-related expenses to eligible victims who suffer physical injury or the threat of physical injury as a result of a violent crime. Several crimes are covered, including child abuse, rape, sexual assault, and sexual battery. Expenses eligible for reimbursement include medical and dental treatment, and mental health treatment or counseling, among others.[17] CalVCB is the payer of last resort, and therefore only pays for expenses that are not reimbursed by any other source, such as health insurance (CalVCB, 2024a). To qualify for reimbursement, victims must meet certain criteria, including cooperating with police and court officials to arrest and prosecute the offender, and filing the application within certain time limits. The time limits are either within 7 years of the crime, 7 years after the direct victim turns 21 years of age, or 7 years from when the crime could have been discovered, whichever is later (CalVCB, 2024b). Applications must be approved by CalVCB prior to disbursement of funds.

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[12] Health and Safety Code (HSC) 1281.
[13] If enacted, AB 2843 would not impact the mandatory reporting requirement of hospitals; it would state that health plans could not require the enrollee to file a police report as a condition of coverage without cost sharing.
[14] Penal Code (PEN) 13823.11 and 13823.5.
[15] PEN 13823.95.
[16] HSC 1491-1492.
[17] Government Code § 13957.

CalOES Programs

The California Governor's Office of Emergency Services (CalOES) administers several programs to assist victims of sexual assault, such as the Rape Crisis Program and Campus Sexual Assault Program. Several of these programs rely on both state funds and federal formula grants, including those discussed in the Federal Policy Landscape section, and award funding to nonprofit, nongovernmental organizations that provide free or low-cost medical and behavioral health services to sexual assault victims regardless of their health insurance status (CalOES, 2023).

Similar requirements in other states

At least five states (Maryland,[18] Nebraska,[19] North Carolina, Ohio, and Oregon) prohibit providers from billing a victim's private insurance or billing the victim directly for an FME and follow-up services (AEquitas, 2012). Providers must bill the appropriate state program for reimbursement. Two states, Illinois and Vermont, have laws that require private insurance and/or the state to cover the cost of medical services, including cost sharing, for victims of sexual assault.

Illinois requires reimbursement to hospitals or other health care facilities or providers for emergency contraception, follow-up health care including laboratory services and pharmacy services rendered within 180 days of the initial visit, and appropriate medications including post-exposure prophylaxis (PEP). Providers are required to furnish the services without charge to the victim, and instructions for payment vary based on the victim's insurance status. The provider is able to bill the victim's private insurance for the delivered services, and then any amounts that would be charged to the victim because of cost sharing or denials of claims could be submitted to the Illinois Sexual Assault Emergency Treatment Program (SAETP) of the Department of Healthcare and Family Services. Follow-up care is only billed to the SAETP and is not billed to the victim's insurance.[20]

In Vermont, specified services include treatment of the patient's injuries; providing care for sexually transmitted infections; assessing pregnancy risk; discussing treatment options, including reproductive health services, screening for HIV, and prophylactic treatment when appropriate; and providing instructions and referrals for follow-up care. If, as a result of an FME, the victim has been referred for mental health counseling, the State shall bear any costs of such examination not covered by the victim's health insurance coverage. Additionally, if the victim has not yet met their deductible, the insurer is required to refer any amount due to the State for payment.[21]

CHBRP did not identify any states with pending legislation on cost sharing associated with sexual assault emergency and follow-up services. Some states have proposed legislation on the subject of sexual assault; however, the bills do not relate directly to payment for medical services or prescription drugs and are therefore not included in this section.

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 2843 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[22,23]

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[18] **Md. Code Regs. 10.12.02.05.**

[19] Nebraska Attorney General's Office. 2020. Nebraska Medical Sexual Assault Protocol. Available at: **https://ago.nebraska.gov/sites/ago.nebraska.gov/files/doc/May%202020%20-%20Nebraska%20Medical%20Sexual%20Assault%20Protocol%20FINAL_0.pdf**. Accessed on March 29, 2024.

[20] In order for any services, including follow-up care, to be billed to the SAETP, victims present a "sexual assault services voucher" to the respective provider or facility, which they receive at their initial visit for sexual assault services.

[21] Vermont S.60 (Act 34).

[22] The ACA requires non-grandfathered small-group and individual market health insurance – including, but not limited to, qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: **www.chbrp.org/other-publications/issue-briefs**.

[23] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

Essential Health Benefits

In California, nongrandfathered[24] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[25] In 2025, approximately 11.5% of all Californians will be enrolled in a plan or policy that must cover EHBs.[26]

States may require state-regulated health insurance to offer benefits that exceed EHBs.[27,28,29] Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. However, state benefit mandates specifying provider types, cost sharing, or other details of existing benefit coverage would not meet the definition of state benefit mandates that could exceed EHBs.[30,31]

AB 2843 would not exceed the definition of EHBs in California.

Cost Sharing

This section provides an overview of the cost-sharing structures used for health insurance benefits.

Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[32]). There are a variety of cost-sharing mechanisms that can be applicable to covered benefits Figure 1). Some health insurance benefit designs incorporate higher enrollee cost sharing in order to lower premiums. Reductions in allowed copayments, coinsurance, and/or deductibles can shift the cost to premium expenses or to higher cost sharing for other covered benefits.[33]

Annual out-of-pocket maximums for covered benefits limit annual enrollee cost sharing (medical and pharmacy benefits). After an enrollee has reached this limit through payment of coinsurance, copayments, and/or deductibles, insurance pays 100% of the covered services. The enrollee remains responsible for the full cost of any tests, treatments, or services that are not covered benefits.

An enrollee who receives services following a sexual assault may experience multiple forms of out-of-pocket expenses. If an enrollee has a plan with a deductible, and the enrollee has not yet met the deductible, the enrollee would be responsible for the full cost of care until that deductible is met. Once an enrollee has met their deductible, the enrollee would be responsible for the copayment or coinsurance associated with services for medical care, including behavioral

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[24] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." Available at: **www.healthcare.gov/glossary/grandfathered-health-plan**.

[25] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*, available at **www.chbrp.org/other-publications/issue-briefshttps://chbrp.org/other_publications/index.php**.

[26] See CHBRP's resource, *Sources of Health Insurance in California,* available at **www.chbrp.org/other-publications/resources**.

[27] ACA Section 1311(d)(3).

[28] State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: **www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf**.

[29] However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

[30] Essential Health Benefits. Final Rule. A state's health insurance marketplace would be responsible for determining when a state benefit mandate exceeds EHBs, and qualified health plan issuers would be responsible for calculating the cost that must be defrayed. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: **www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf**.

[31] Both Massachusetts and Utah currently pay defrayment costs for exceeding EHBs. For more information about defrayal, refer to CHBRP's issue brief *Essential Health Benefits: Exceeding EHBs and they Defrayal Requirement*, available at: **www.chbrp.org/other-publications/issue-briefs.**

[32] Premiums are paid by most enrollees, regardless of their use any tests, treatments, or services. Some enrollees may not pay premiums because their employers cover the full premium, they receive premium subsidies through the Covered California, or they receive benefits through Medi-Cal.

[33] Plans and policies sold within Covered California are required by federal law to meet specified actuarial values. The actuarial value is required to fall within specified ranges and dictates the average percentage of health care costs a plan or policy covers. If a required reduction in cost sharing impacts the actuarial value, some number of these plans or policies might have to alter other cost-sharing components of the plan and/or premiums in order to keep the overall benefit design within the required actuarial value limits.

health services, for injuries and conditions following a sexual assault. Should an enrollee's out-of-pocket expenses meet the annual out-of-pocket maximum, the enrollee would no longer be responsible for cost-sharing responsibilities.

Out-of-pocket expenses for victims of sexual assault may include copayments and coinsurance for services not included in an FME and for follow-up services after an FME is conducted. Victims may also be responsible for out-of-pocket expenses if they choose to not undergo an FME, which is covered with no cost sharing by California law (see *California Policy Landscape*), and/or they do not apply for reimbursement through the CalVCB. Ambiguities among hospital billing and health insurance regarding the party responsible for the medical charges may also lead to out-of-pocket expenses for the victim (Ramaswamy et al., 2022).

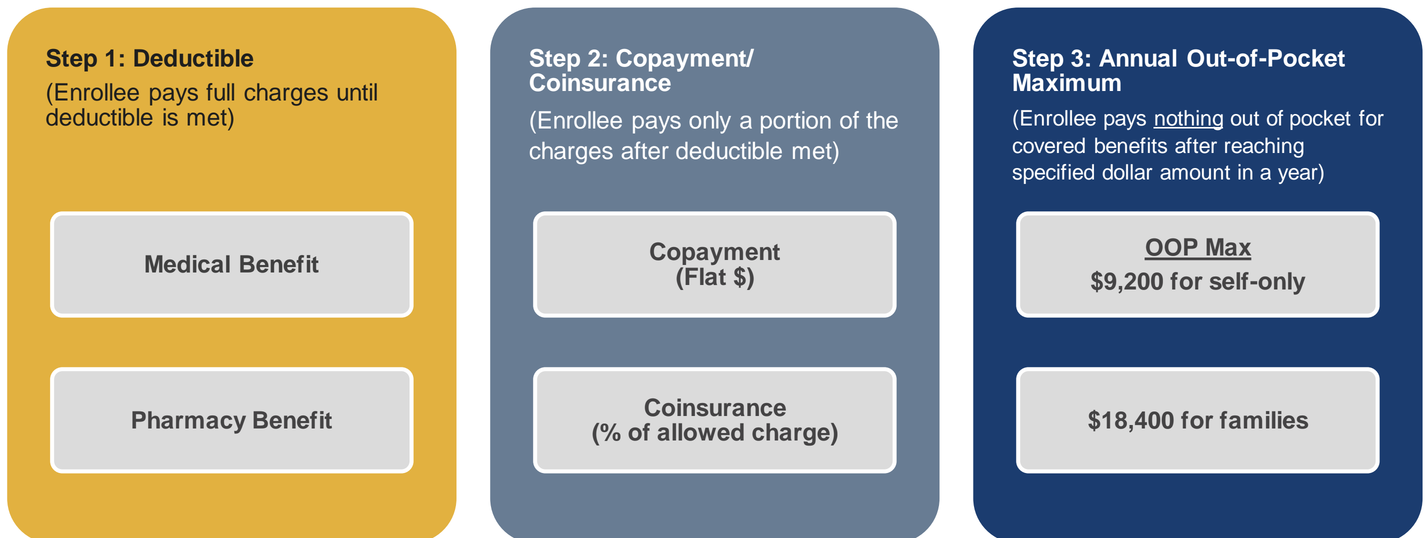
AB 2843 would prohibit cost sharing for emergency and follow-up services for enrollees/insureds treated for a sexual assault.

Out-of-Pocket Costs

Sexual assault victims in California may be charged for out-of-pocket costs for the following reasons:

- victims do not undergo an FME;
- services are not covered by an FME;
- ambiguity among hospital billing and insurance and who gets charged for the exam;
- victims do not apply for reimbursement through CalVCB;
- victims' applications to CalVCB's victim compensation fund are rejected for reimbursement for medical treatment;
- victims need services not included in an FME (Ramaswamy et al., 2022).

Figure 1. Overview of the Intersection of Cost-Sharing Methods Used in Health Insurance



Source: California Health Benefits Review Program, 2024; CMS, 2023.
Note: Steps 1 and 2 are not mutually exclusive. Under certain circumstances (i.e., preventive screenings or therapies), enrollees may pay coinsurance or copayments prior to their deductible being met; also copayments and coinsurance may be applied against the deductible in some circumstances. The figure assumes that the enrollee is in a plan with a deductible. If no deductible, then enrollee pays a coinsurance and/or a copayment beginning with the first dollar spent (Step 2). The annual out-of-pocket maximums listed in Step 3 increase each year according to methods detailed in CMS's Notice of Benefit and Payment Parameters (CMS, 2023).
Key: OOP Max = annual out-of-pocket maximum.

High deductible health plans

Both DMHC-regulated plans and CDI-regulated policies may be designated high deductible health plans (HDHPs).[34] HDHPs are a type of health plan with requirements set by federal regulation.[35] As the name implies, these plans include a deductible – but they are not allowed to have separate medical and pharmacy deductibles. For the 2024 plan year, the Internal Revenue Service (IRS) defines an HDHP as any plan with a deductible of at least $1,600 for an individual and $3,200 for a family.[36] Annual out-of-pocket expenses for coverage of in-network tests, treatments, and services, which would result from cost sharing[37] applicable after the deductible is met, are not allowed to be more than $8,050 for an individual and $16,100 for a family.[38]

In the context of AB 2843, under existing law, enrollees in HDHPs who have not yet reached their deductible may be responsible for a large portion, or all, of their out-of-pocket expenses related to sexual assault services as compared with enrollees with low deductible plans. HDHPs are typically designed to have lower monthly premiums, however enrollees are required to pay a higher amount (deductible) before their health plan/insurer will cover any costs. If AB 2843 was enacted, enrollees in HDHPs may see a greater reduction in their out-of-pocket expenses associated with sexual assault services than those with plans or policies with lower deductibles.

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[34] For enrollment estimates, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*, available at **www.chbrp.org/other-publications/resources**.
[35] HealthCare.gov, Glossary: High Deductible Health Plan (HDHP). Available at **www.healthcare.gov/glossary/high-deductible-health-plan/**. Accessed March 5, 2021.
[36] IRS Revenue Procedure 2023-23, available at **www.irs.gov/pub/irs-drop/rp-23-23.pdf**.
[37] Such as copays and coinsurance applicable to the covered test, treatment, or service.
[38] There is no annual out-of-pocket expenses limit for coverage of out-of-network tests, treatments, and services.

Background on Sexual Assault

This section discusses the lifetime prevalence of sexual assault in California, barriers associated with sexual assault care and access to sexual assault services, the health outcomes related to sexual assault, and disparities in sexual assault prevalence and access to sexual assault services.

Sexual assault is a common experience. Most victims of sexual assault know their perpetrators (acquaintances, intimate partners, and family members) (Basile et al., 2022). Sexual assault involves "a wide range of unwanted sexual behaviors" that are attempted or completed without the consent of the victim and includes rape (Linden, 2011; NIJ, 2010). Rape definitions vary by state, but most statutes define rape as "nonconsensual oral, anal, or vaginal penetration of the victim by body parts or objects using force, threats of bodily harm, or by taking advantage of a victim" without consent (NIJ, 2010) (see the *Policy Context* section for a discussion of California penal codes). AB 2843 would require coverage without cost sharing for emergency and follow-up services for enrollees/insured who are victims of sexual assault.

Estimating Sexual Assault Prevalence

Sexual assault is under-reported, and the recorded estimates of incidence and prevalence of sexual assault are lower than the true number due to barriers to victims reporting, disclosing, or seeking medical care after an assault. Most sexual assaults are not reported to police or health care providers (Feldhaus et al., 2000). In the United States, about 34% of all sexual assaults were reported to the police in 2019 (Morgan and Truman, 2020), and 21% of female sexual assault victims seek medical care following an assault (Zinzow et al., 2012).

Sexual Assault Lifetime Prevalence in California

Between 2016 and 2017 in California, the lifetime prevalence of rape among women was estimated to be 37% and among men was estimated to be 3% (Smith et al., 2023).

Sexual Assaults Reported to Law Enforcement in California

In 2022, 14,346 completed and attempted rapes (36.8 rapes per 100,000 persons) were reported to law enforcement in California (CADOJ, 2024).

Emergency Department Visits for Sexual Assault

In the United States, 3% of emergency department (ED) visits due to violence are for sexual assault; sexual assault accounted for 0.24% of all injuries treated at the ED (Loder and Robinson, 2020). The ED is often the first point of contact for victims and provides evaluation and treatment for injuries related to sexual assault (Avegno et al., 2009; Vogt et al., 2022) (see Appendix C for International Classification of Diseases [ICD-10-CM] for sexual assault).

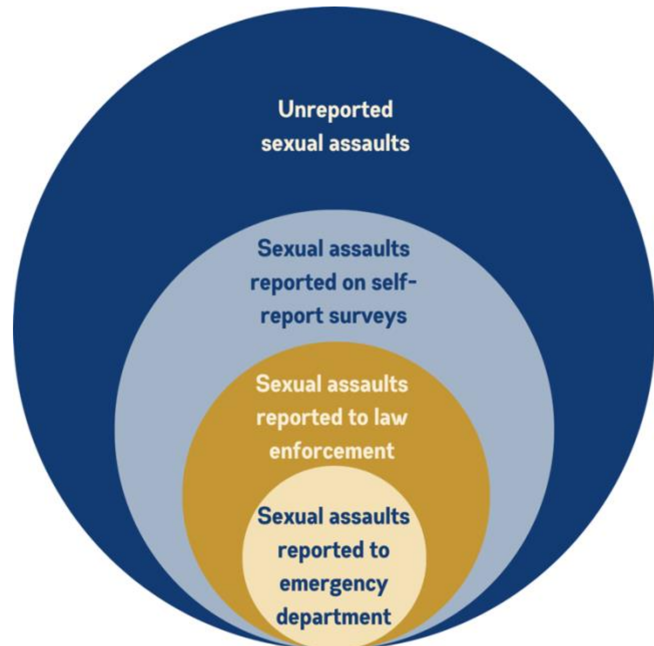

Figure 2. Conceptual Framework of Sexual Assault Reporting in the United States

Source: California Health Benefits Review Program, 2024; Vogt et al., 2022; Basile et al., 2022; National Intimate Partner and Sexual Violence Survey (Basile et al., 2022; Smith et al., 2023).

The California Department of Public Health monitors and tracks data[39] related to ED visits in California. In 2022, there were 1,360 nonfatal ED visits for adult and child sexual assaults (confirmed and suspected) among privately insured Californians (CDPH, 2023). 90% of the victims identified as female and 10% identified as male, and most victims were White (40%) or Latino (36%) followed by Black (11%) and Asian (4%) (CDPH, 2023). See the *Benefit Coverage, Utilization, and Cost* section for additional details for CHBRP's projections of utilization among enrollees related to AB 2843.

Barriers to Accessing Sexual Assault Services

Barriers to reporting to law enforcement, emergency medical and follow-up services, and behavioral health services after sexual assault exist in the United States and California.

Barriers to Reporting to Law Enforcement

Victims of sexual assault, especially those with perpetrators who are known to the victim, may choose not report to the police because of stigma or embarrassment, fear of the assailant, fear of other people finding out about the attack, not wanting the perpetrator to be prosecuted (mandatory reporting requirements), financial dependence on the perpetrator, fear of not being believed, not understanding that a crime has occurred and they can seek forensic evidence collection, and lack of resources to obtain help (cultural and language barriers) (Feldhaus et al., 2000; McCauley et al., 2019; Sable et al., 2006).

Reasons Why Victims Do Not Seek Out Sexual Assault Services

- Not recognizing medical care is needed
- Minimizing violence and health risks
- Lack of privacy and control
- Stigmatization
- Self-blame
- Retaliation from perpetrator
- Retraumatizing medical treatment
- Limited access to medical care independently
- Lack of social support
- Multiple visits for behavioral health services
- Difficulty finding a behavioral health provider

Buchbinder et al., 2021; Donne et al., 2018; Gilmore et al., 2021; Kamke et al., 2023; Logan et al., 2005; Ramaswamy et al., 2022; Short et al., 2021

Barriers to Emergency and Follow-Up Services`

Cost and cost sharing may be barriers for sexual assault victims who do not wish to pay out-of-pocket for services that are not covered in a medical exam, or they choose not to undergo an exam that includes evidence collection (FME) (Ramaswamy et al., 2022). CHBRP found no evidence to quantify the amount of cost or cost sharing that would be a barrier to seeking medical care for sexual assault victims. Fewer than two in five victims follow up with a primary care provider 6 weeks after sexual assault, and one in four victims who visit primary care providers after sexual assault do not disclose the assault to the providers (Short et al., 2021).

Additional barriers related to emergency and follow-up services after sexual assault include not recognizing that medical care is needed, consequences of seeking medical care such as stigmatization and retaliation from the perpetrator or not wanting sexual assault diagnosis on medical record and insurance explanation of benefits (OVC, 2024),[40] and inability to access care (Kamke et al., 2023) See the *Public Health* section for further discussion of barriers related to emergency medical services.

[39] ICD-10-CM Codes: T7421 for adult sexual abuse, confirmed T7422 for adult sexual abuse, suspected, T7621 for child sexual abuse, confirmed, and T7622 child sexual abuse, suspected. (CDPH, 2023).
[40] Communication with S. Metz, March 2024.

Barriers to Behavioral Health Services

Most victims of sexual assault, especially victims who experience sexual assault from an intimate partner, do not receive follow-up mental health care after an FME (Gilmore et al., 2021a). 38% of female sexual assault victims that visit the ED follow up with a behavioral health provider within 6 weeks after the assault (Short et al., 2021).

The relationship between mental health outcomes and sexual assault is complex due to the variations in help-seeking, disclosure of the assault, and other factors (e.g., previous sexual assault, child abuse, age) (Ullman, 2007). Sexual assault victims may encounter barriers in seeking behavioral health care, including access to care, challenges of finding a provider, and individual level barriers such as self-blame and embarrassment (Buchbinder et al., 2021; Donne et al., 2018; Gilmore et al., 2021b; Logan et al., 2005; Short et al., 2021) (see the *Public Health* section for further discussion of barriers related to behavioral health services and sexual assault). Factors that increase victims' use of behavioral health services include prior traumatic and stressful life events, prior use of mental health services, prior use of alcohol abuse treatment, having private insurance, having Medicaid or Medicare, and increased score on the Beck Depression Inventory[41] (Price et al., 2014; Ullman and Brecklin, 2002).

Increased Risk of Sexual Assault

Persons with the following background or characteristics have higher rates of sexual assault: cultural/ethnic groups such as Latina and Black women adolescents, college students, women in active-duty military, physically or mentally disabled persons, persons with active post-traumatic stress disorder (PTSD), persons experiencing homelessness, persons living in poverty, persons who engage in sex work, and persons who live in prisons or institutions (Acierno et al., 1999; Basile et al., 2022; Farahi and McEachern, 2021; Mellins et al., 2017; Tomsa et al., 2021; USDOD, 2020) (see the *Disparities* section for further discussion).

Health Outcomes and Consequences of Sexual Assault

Sexual assault is a complex public health concern that has lifelong impacts. There are many health outcomes associated with sexual assault. These include the following (Basile et al., 2021, 2022; CDC, 2022; Rothman et al., 2019):

- **Immediate impacts:** including concern for safety (67% female victims, 50% male victims), fear (65% female victims, 50% male victims), sexually transmitted infections (STIs) (16% female victims), physical injury (37% female victims), and pregnancy (15% female victims) (Basile et al., 2022).
- **Physical health consequences**: including injuries (body trauma, genital injuries, attempted strangulation, defensive injuries, lacerations, abrasions, bruising, bite marks), STIs, human immunodeficiency virus (HIV) infection, and pregnancy (Basile et al., 2021, 2022; Linden, 2011).
- **Mental health consequence**s: including depression, anxiety, suicidal thoughts, and PTSD (Basile et al., 2022; Dworkin, 2020; Dworkin et al., 2022). See the *Post-traumatic stress disorder and sexual assault* section for more details.
- **Chronic health conditions:** including nonspecific chronic pain, functional gastrointestinal disorders, psychogenic seizures, chronic pelvic pain, frequent headaches, asthma, HIV, PTSD, and alcohol misuse (Amstadter et al., 2008; Basile et al., 2021, 2022; Linden, 2011; Paras et al., 2009; Ullman, 2003).
- **Impaired romantic relationships and higher risk sexual behavior:** (Basile et al., 2020; Rothman et al., 2019).

[41] The Beck Depression Inventory is a 21-item, self-report rating inventory that measures symptoms of depression (Beck et al., 1961).

PTSD and sexual assault

PTSD is a long-term consequence of sexual assault. Sexual assault victims are at increased risk of mental health consequences including PTSD, depression, anxiety, and substance abuse disorders (Ades et al., 2019). 36% of sexual assault victims report a lifetime prevalence of PTSD, which is a persistent condition that can endure even with treatment (Breslau, 2009; Dworkin, 2020). Individuals with a history of depression or anxiety are at increased risk of developing PTSD after a trauma exposure (Breslau, 2009). About one third of victims who receive an FME after a sexual assault get follow-up behavioral health services (Gilmore et al., 2021a). Those with the most severe mental health symptoms are more likely to seek follow up behavioral health services (Gilmore et al., 2021b) (see the *Public Health* section for the long-term impact of sexual assault and PTSD).

Emergency and Follow-Up Services Following Sexual Assault

Emergency Services

Victims of sexual assault may seek medical care to assess injuries related to the assault, for STI and pregnancy testing, for mental health concerns, and to report the assault and receive an FME. After an assault, sexual assault victims make decisions about whether to seek medical care immediately (e.g., ED, urgent care, primary care clinic, Planned Parenthood, federally qualified health center), contact a crisis hotline, seek medical or behavioral services from a rape crisis or sexual assault service center, or to report the incident to the police (Zweig et al., 2021). There are many implications to seeking care for sexual assault, and victims may need time to decide whether to seek medical care at all and whether they want to have forensic evidence collected (Zweig et al., 2021). See the *Barriers* section for more information.

Under current law in California, when victims with insurance present to the ED for medical care, they are responsible for copayments associated with ED care if they do not consent to evidence collection through an FME. Collection of forensic evidence is typically conducted within the first 96 hours following a sexual assault (CAOCJP, 2001).

Follow-Up Services

Experts recommend that sexual assault victims receive follow-up care for medical needs and emotional support (e.g., behavioral health services) after an assault-related emergency department or health care visit. Primary care physicians can provide care including follow-up pregnancy, STI and HIV testing, follow-up care for pregnancy if a pregnancy test is positive, follow-up treatment for STI or HIV if these tests are positive, follow-up care of physical injuries, and referrals for behavioral health services. Pregnancy testing is recommended at 4 weeks following an assault HIV testing is recommended to be repeated at 4 to 6 weeks, 3 months, and 6 months after the sexual assault (Buchanan, 2023).

Preventative treatment may be needed for persons who are at risk of pregnancy or infection following a sexual assault (e.g., exposure to blood or bodily fluids through nonintact skin). Treatments may include antibiotics, vaccines, prophylaxis medication for HIV, and emergency contraception (Buchanan, 2023).

Behavioral health services

Many victims of sexual assault experience mental health disorders (depression, anxiety, suicidal thoughts, and PTSD) following an assault (Basile et al., 2022; Dworkin, 2020; Dworkin et al., 2022). Experts recommend that sexual assault victims follow up with behavioral health providers to initiate treatment for mental health disorders (Buchanan, 2023). Behavioral health services include counseling, psychotherapy, behavioral therapy, and medications (antidepressants or antianxiety medications) (Buchanan, 2023). Rape crisis centers can provide support such as confidential counseling and assistance with legal services (Linden, 2011). See the *Medical Effectiveness* section for further discussion of behavioral health services and outcomes.

Forensic Medical Exams

Among victims in the United States who do seek medical care, about 60% consent to forensic evidence collection (Feldhaus et al., 2000). Victims that consent to forensic collection of evidence receive an FME that is performed by trained providers to collect and document evidence after sexual assault (Ramaswamy et al., 2022). The evidence collected is stored and provided to law enforcement authorities. Consent for forensic exam can be withdrawn at any time before the evidence is given to law enforcement. The evidence collected includes photographs of injuries, collection of specimens such as pubic or head hair, blood and/or saliva for typing, and blood and/or urine for toxicology analysis (CAOCJP, 2001). Forensic exams are covered under the VAWA, but follow-up care (primary care visits and behavioral health care) after a sexual assault is not covered.

Disparities[42] in Sexual Assault Prevalence and Outcomes

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

CHBRP found literature identifying disparities by race/ethnicity, age, gender identity/sexual orientation, and income regarding experiences with sexual assault.

Race or Ethnicity

Disparities exist by race and ethnicity among women who reported rape in their lifetime in the United States.

American Indian/Alaskan Native and multiracial women, as reported on the NISVS 2016/2017, experienced sexual assault disproportionally compared to other ethnic/racial groups. Almost 44% of American Indian/Alaska Native women, 48% of multiracial women, 29% of Black women, 28% of Latina women, 28% of White women, and 17% of Asian or Native Hawaiian/Pacific Islander women reported rape in their lifetime (Basile et al., 2022). Among men in the United States, 6.3% of multiracial men reported rape in their lifetime compared to 3% of Latino men, 3% of Black men, and 4% of White men (Basile et al., 2022).

Black female victims of sexual assault have been less likely to report victimization because of cross-cultural barriers such as negative attitudes toward victims of sexual assault and culture-specific barriers such as stereotypes about Black women's sexuality, sexual and economic oppression, and protection of Black male perpetrators (Bryant-Davis et al., 2010).

Barriers to medical care and FMEs following a sexual assault disproportionally impact racial/ethnic groups that are minoritized. Non–English-speaking victims of sexual assault have difficulty obtaining FMEs (Bach et al., 2021), and Black women and American Indian women access sexual assault services fewer times than White women, who report the highest rates of medical care (Amstadter et al., 2008; Bach et al., 2021).

Age

The prevalence of sexual assault varies by age in the United States. Adolescents and young adults report more sexual assaults than any other age group. More than 80% of female and male victims of sexual assault reported that the first time they were victimized occurred before age 25 in the United States (Basile et al., 2022).

[42] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

In California (2016/2017), about 15% of women experienced rape for the first time before age 18 years (Smith et al., 2023). Children who are victims of sexual assault are at increased risk of physical and psychological consequences that span the lifetime and increased risk of future victimizations (Briere et al., 2020).

Gender[43]

Gender disparities exist among persons who report lifetime rape in the United States. Almost 27% of women in the United States reported rape (completed or attempted) in their lifetime, and about 4% of men reported rape (completed or attempted) in their lifetime (Basile et al., 2022). Ninety-four percent of female victims reported rape by male perpetrators in their lifetime, and almost 77% of male victims reported rape by a male perpetrator in their lifetime in the United States (Basile et al., 2022).

Transgender college students in the United States have significantly higher odds of sexual assault compared to cisgender men and women (Coulter et al., 2017). Sexual assault victims identifying as sexual/gender minorities experience unique barriers to medical care. Lack of knowledge about sexual/gender minorities, decreased cultural sensitivity towards sexual/gender minorities, and discrimination by health care providers impact victims' decisions to seek medical care (Bach et al., 2021).

Sexual Orientation[44]

Disparities exist between sexual orientation and prevalence of sexual assault in the United States. Prevalence data suggest that gay, lesbian, and bisexual persons are at increased risk for lifetime sexual assault compared to heterosexual persons in the United States (Mellins et al., 2017). The prevalence of lifetime sexual assault[45] ranges from about 16%-85% (median 43%) for lesbian and bisexual women and about 12%-54% (median 30%) for gay and bisexual men (Rothman et al., 2011).

Income

Disparities exist between income and prevalence of sexual assault in the United States. Almost 10% of women and men with household income $25,000 or less and 6% of women and men with household income $25,000 to $55,0000 reported rape, physical violence, or stalking by an intimate partner in 2010 compared to 3% of women and men with household incomes $50,000 to $75,000 and 3% of women and men with household incomes of $75,000 or greater in the United States (Breiding et al., 2014).

Societal Impact of Rape and Sexual Assault in California

Sexual assault in California has direct and indirect economic and societal costs. It is estimated that in California, direct costs related to medical[46] and mental health care, property damage, victim services, and investigation and sanctioning exceeded $9 billion in 2012. Indirect costs due to sexual violence throughout the lifespan including lost work productivity, loss of earnings, and decreased quality of life were estimated at over $130 billion in 2012 in California. Please note, the societal impact discussed here is relevant to a broader population than that impacted by AB 2843 which would affect the health insurance of a subset of Californians (see the *Policy Context* section). See the *Benefit Coverage, Utilization, and Cost Impacts* section for estimates of direct cost impacts for the specific population targeted by AB 2843.

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[43] CHBRP uses the National Institutes of Health (NIH) distinction between "sex" and "gender": "'Sex' refers to biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles. 'Gender' refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time." (NIH, 2019).
[44] CHBRP defines gender identity as one's internal sense of one's own gender, or the gender in which a person identifies, whether it be male, female, or nonbinary. Gender identity and sexual orientation are different facets of one's identity; an individual's gender does not determine a person's sexual orientation (i.e., a person's emotional, romantic, or sexual attraction to other people) (ACOG, 2022; CDC, 2022).
[45] These data are from a systematic review of 75 articles of sexual assaults among gay or bisexual men and lesbian or bisexual women in the United States (Rothman et al. 2011).
[46] Medical care includes treatment for direct medical costs, STIs, pregnancy, suicide acts, and substance abuse (CALCASA, 2018).

Medical Effectiveness

As discussed in the *Policy Context* section, AB 2843 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a sexual assault.

AB 2843 specifies that health plans and insurers are prohibited from requiring any of the following to occur as a condition of coverage:

- An insured to file a police report on the sexual assault;
- Charges to be brought against an assailant; or
- An assailant to be convicted of an offense.

AB 2843 states that an enrollee be prohibited from receiving coverage for sexual assault services provided by an out-of-network provider unless these services are not available in a health plan's network and a health plan makes arrangements for them to be provided by an out-of-network provider.

The full text of AB 2843 can be found in Appendix A.

The medical effectiveness review summarizes findings from evidence[47] from 1985 to present on how cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency room medical care and follow-up treatment for sexual assault. CHBRP also reviewed evidence on the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health outcomes.

Although follow-up health care treatment for sexual assault may include other services, such as pregnancy testing, STI testing and follow up treatment, HIV testing and follow-up, and follow-up care of injuries, this medical effectiveness review does not discuss these services because health plans and insurers are already required to cover them. In addition, this medical effectiveness review does not include medications typically prescribed as part of follow-up health care treatment for sexual assault because such medications are routinely covered by health plans and insurers.

Research Approach and Methods

Studies were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, and the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Agency for Healthcare Research and Quality (AHRQ), the International Network of Agencies for Health Technology Assessment (INAHTA), the National Institute for Health and Clinical Excellence (NICE), the Scottish Intercollegiate Guideline Network (SIGN), U.S. Preventive Services Task Force (USPSTF), and the World Health Organization (WHO).

A total of four studies were included in the medical effectiveness review for this report. Two of these studies were systematic reviews conducted by Cochrane that synthesized findings from multiple individual studies. The other articles were eliminated because they did not focus on persons who experienced sexual assault, were of poor quality, did not report findings from clinical research studies, or were included in one of the Cochrane reviews.

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[47] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence in the Medical Effectiveness Analysis and Research Approach document (posted at www.chbrp.org/about/analysis-methodology/medical-effectiveness-analysis), in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

The search was limited to studies published from 2021 to present. CHBRP relied on two Cochrane reviews published in 2023 for findings from studies published from 1985 to 2021. Two additional studies not included in the reviews, published in 2012 and 2017, were identified through additional searches and reviewing citations of identified articles.

A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[48] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. Does cost sharing affect enrollees' use of emergency and follow-up services for a sexual assault?
2. Does the requirement of filing a police report and/or charges be brought against an assailant and/or an assailant be convicted of an offense affect enrollees' use of emergency and follow-up services for sexual assault?
3. Does the restriction on receiving emergency and follow-up services for sexual assault from only a participating ("in-network") provider, unless arranged otherwise by a health plan, affect enrollees' use of emergency and follow-up services for sexual assault?
4. What is the effectiveness of follow-up behavioral health treatment following a sexual assault on enrollees' mental health?

Methodological Considerations

CHBRP did not identify any studies on the impact of cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers on enrollees' use of emergency room medical care and follow-up treatment after sexual assault.

CHBRP identified several limitations of the literature on the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health. First, no studies assessed the long-term effectiveness of behavioral health treatment on enrollees' mental health after sexual assault. Second, many studies had small sample sizes. Third, some studies focused on specific subpopulations of persons who experience sexual assault (e.g., women enrolled in college, veterans with PTSD related to military sexual trauma), which may limit the generalizability of findings to other populations.

Outcomes Assessed

To assess the impact of cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency and follow-up services after sexual assault, CHBRP examined *health care utilization* (e.g., emergency department visits, visits for mental health services) as the outcome of interest.

To assess the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health, CHBRP examined *physiological, behavioral, functional, and quality of life* measures (e.g., PTSD symptoms, anxiety, depression, social functioning) as outcomes of interest.

[48] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. For more information on CHBRP's use of grey literature, visit www.chbrp.org/about/analysis-methodology/medical-effectiveness-analysis.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence on the impact of cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers on enrollees' use of emergency and follow-up services for sexual assault, as well as the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

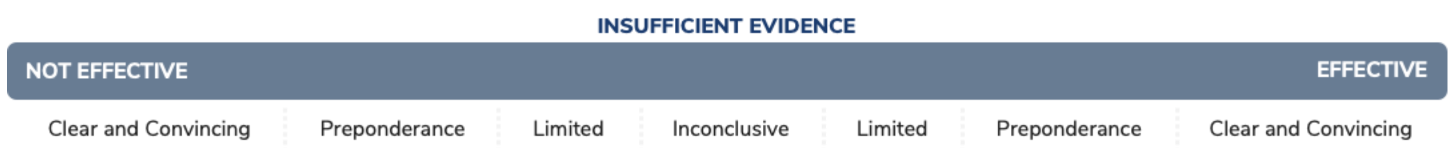
More information is available in Appendix B.

Impact of Cost Sharing on Enrollees' Use of Emergency and Follow-up Services for Sexual Assault

CHBRP did not identify any literature that directly examines the impact of cost sharing on enrollee's use of emergency and follow-up services for a sexual assault. However, it is well established in literature that persons who face higher cost sharing use fewer services than persons with lower cost sharing (CHBRP, 2020; Effros et al., 2009).

Summary of findings regarding the impact of cost sharing on enrollees' use of emergency and follow-up services for sexual assault*:* CHBRP found *insufficient evidence* on the impact of cost sharing on enrollees' use of emergency and follow-up services for sexual assault.

Figure 3. Impact of Cost Sharing on Enrollees' Use of Emergency and Follow-Up Services for Sexual Assault

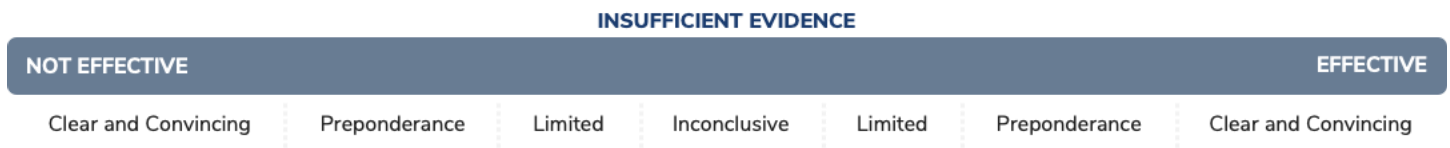


Impact of Criminal Justice Involvement Requirements on Enrollees' Use of Emergency and Follow-Up Services for Sexual Assault

CHBRP did not identify any literature that addresses the impact of requirements to file a police report, have charges brought against an assailant, or have an assailant be convicted on enrollees' use of emergency and follow-up services for sexual assault. However, the absence of evidence does not indicate that requirements for criminal justice involvement have no effect on enrollees' use of emergency and follow-up services for sexual assault.

Summary of findings regarding the impact of criminal justice involvement requirements on enrollees' use of emergency and follow-up services for sexual assault: CHBRP found *insufficient evidence* on the impact of requirements to file a police report, have charges brought against an assailant, or have an assailant be convicted on enrollees' use of emergency and follow-up services for sexual assault.

Figure 4. Impact of Criminal Justice Requirements on Enrollees' Use of Emergency and Follow-Up Services for Sexual Assault

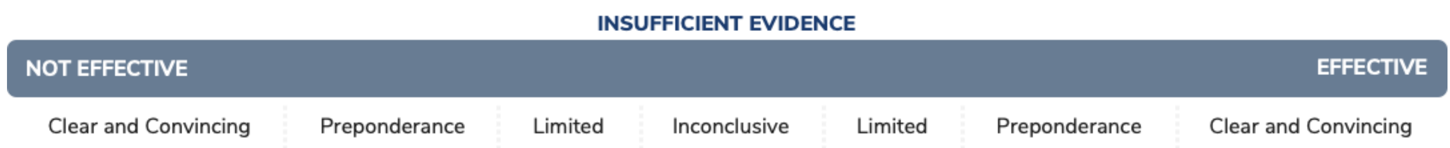


Impact of Restricting Coverage to In-Network Providers on Enrollees' Use of Emergency and Follow-Up Services for Sexual Assault

CHBRP did not identify any literature that addresses the impact of restricting coverage to in-network providers on enrollees' use of emergency and follow-up services for sexual assault. However, the absence of evidence does not indicate that restricting coverage to in-network providers has no effect on enrollees' use of emergency and follow-up services for sexual assault.

Summary of findings regarding the impact of restricting coverage to in-network providers on enrollees' use of emergency and follow-up services for sexual assault: CHBRP found *insufficient evidence* on the impact of restricting coverage to in-network providers on enrollees' use of emergency and follow-up services for sexual assault.

Figure 5. Impact of Restricting Coverage to In-Network Providers on Enrollees' Use of Emergency and Follow-Up Services for Sexual Assault



Effectiveness of Follow-Up Behavioral Health Treatment Following Sexual Assault on Enrollees' Mental Health

CHBRP identified two Cochrane reviews, one randomized control trial (RCT), and one quasi-experimental study that examined the effectiveness of follow-up behavioral health treatment after sexual assault on mental health outcomes.

A Cochrane review by O'Doherty et al. (2023) evaluated the efficacy of behavioral health interventions designed for recovery from sexual assault on adult participants' mental health outcomes. RCTs that assigned participants or clusters of participants to interventions and compared no or minimal intervention, usual care, wait-list, pharmacological only, or other

behavioral health intervention(s) were reviewed. Thirty-six studies (3,992 participants) published from 1991 to 2021 were included. The review evaluated the following psychotherapies: cognitive behavioral therapy[49] (CBT, 32 studies), behavioral interventions[50] (10 studies), integrative therapies[51] (three studies), humanist[52] (three studies), other psychologically oriented interventions (five studies), and other psychosocial interventions (seven studies). Sixteen studies compared one active intervention to a control group, seven studies compared either two or three active interventions and a control group, while the remaining 13 compared active interventions to each other.

A Cochrane review by Caro et al. (2023) assessed the effectiveness of behavioral health interventions for children and adolescents (under 18 years of age) who have experienced sexual assault. Twenty-two RCTs (1,478 participants) published from 1985 to 2004 were included. The review evaluated the following psychotherapies: cognitive behavioral therapy (CBT; 14 studies), psychodynamic therapy[53] (two studies), family therapy[54] (two studies), child-centered therapy[55] (CCT; eight studies), and eye movement desensitization and reprocessing[56] (EMDR; two studies). Interventions were compared to other treatments or no treatments at post-treatment, 6-month follow-up, and 12-month follow-up using network meta-analyses and pairwise meta-analyses[57].

Comparison of follow-up behavioral health treatment versus no or minimal treatment after sexual assault

O'Doherty et al. (2023) pooled studies that assessed the same mental health outcome and compared an active behavioral health intervention to a control. The authors found that active behavioral health intervention was significantly more effective in reducing PTSD symptoms post-treatment.[58] Active behavioral health intervention was also more effective than the controls in reducing depression symptoms post-treatment.[59] However, the difference in PTSD symptoms at 3 months post was not significant–possibly because only seven studies could be pooled. The difference in depression symptoms at 3 months post was also not significant, but only three studies were pooled. For both analyses, the quality of evidence was rated with low confidence because removing studies at high risk of bias reduced the estimated impact of active behavioral health intervention, and because there was variability in how interventions were delivered, sample sizes, and time since sexual assault; effect estimates are therefore uncertain and imprecise.

Caro et al. (2023) conducted network and pairwise meta-analyses to compare different behavioral health treatments with management as usual or being placed on a waiting list.[60] The authors found that *cognitive behavioral therapy delivered only to the child* reduced PTSD symptoms at post-treatment and at 6-month follow-up relative to management as usual (network and pairwise meta-analyses), as well as reduced depression symptoms at post-treatment relative to management as usual and reduced PTSD and anxiety symptoms at post-treatment relative to being placed on a waiting list (pairwise meta-analyses). *Cognitive behavioral therapy delivered to the child and their caregiver* reduced PTSD symptoms at 6 and 12 months relative to management as usual (network meta-analyses) and reduced PTSD symptoms at post-treatment relative to being placed on a waiting list (pairwise meta-analysis). *Child-centered therapy delivered to the child and their caregiver* reduced PTSD symptoms at post-treatment relative to management as usual (network meta-

[49] Cognitive behavioral therapy (CBT) focuses on identifying negative thought patterns, then challenging and replacing them with more positive, realistic thoughts or ideas that result in behavioral change (American Psychological Association, 2017).
[50] Behavioral therapies as defined by Cochrane Depression, Anxiety and Neurosis (CCDAN) and Cochrane Common Mental Disorders (CCMD) Groups include relaxation techniques and Eye Movement Desensitization and Reprocessing (O'Doherty et al., 2023).
[51] Integrative therapies as defined by Cochrane Depression, Anxiety and Neurosis (CCDAN) and Cochrane Common Mental Disorders (CCMD) Groups include interpersonal therapy and blends of different approaches or traditions (O'Doherty et al., 2023).
[52] Humanist therapies as defined by Cochrane Depression, Anxiety and Neurosis (CCDAN) and Cochrane Common Mental Disorders (CCMD) Groups include Gestalt, experiential approaches, and supportive and non-directive therapy following the work of Rogers and others (O'Doherty et al., 2023).
[53] Psychodynamic therapy focuses on self-awareness and understanding how the past manifests in present behavior (Center for Substance Abuse Treatment, 1999).
[54] Family therapy focuses on reducing distress and conflict by improving interactions between family members (Varghese et al., 2020).
[55] Child-centered therapy focuses on enabling the child to identify their feelings by providing them with the opportunities to recognize, clarify, and express those feelings (e.g., through play) (Caro et al., 2023).
[56] Eye movement desensitization and reprocessing (EMDR) focuses on processing disturbing memories of the traumatic experience, the triggers that elicit disturbance, and identifying coping mechanisms for the future (Caro et al., 2023).
[57] Network meta-analyses allow for the comparison of more than two interventions and allows for comparisons between interventions that have not been directly compared in a randomized control trial. Traditional pairwise meta-analyses compare two interventions by pooling head-to-head data (Watt et al., 2019).
[58] The standardized mean difference post-treatment in posttraumatic stress disorder (PTSD) symptom scores (16 studies, 1130 participants) was −0.83 (95% CI −1.22 to –0.44), favoring the active behavioral health intervention.
[59] The standardized mean difference post-treatment in depressive symptom scores (12 studies, 901 participants) was −0.82 (95% CI −1.17 to −0.48), favoring the active intervention group.
[60] Point estimates and confidence intervals for these findings are available in Table 7 of Appendix C.

analysis). *Eye movement desensitization and reprocessing* reduced internalizing behavior[61] at post-treatment (network and pairwise meta-analyses) and reduced symptoms of PTSD, depression, and anxiety at post-treatment (pairwise meta-analyses) relative to being placed on a waiting list. The quality of evidence was rated with low confidence for all findings in the review by Caro et al. (2023) due to low numbers of studies included in the meta-analyses, small sample sizes, and variability in how interventions were delivered; effect estimates are therefore uncertain and imprecise.

One RCT (Rothbaum et al., 2012) randomly assigned 137 adult participants to receive either three sessions of an early intervention beginning in the emergency department or an assessment-only control. The intervention was a modified prolonged exposure[62] with imaginal exposure to the trauma memory, processing of traumatic material, and in vivo and imaginal exposure homework. Thirty-seven participants had experienced sexual assault. The prolonged exposure intervention reduced PTSD symptoms significantly more than the control after 4 weeks and 12 weeks.[63]

Summary of findings regarding the effectiveness of follow-up behavioral health treatment compared to no or minimal treatment following sexual assault: There is a *preponderance of evidence* that behavioral health treatment reduces symptoms of PTSD and depression among adults who have experienced sexual assault, and reduces symptoms of PTSD, anxiety, depression, and internalizing behavior among children and adolescents who have experienced sexual assault, when compared to no or minimal treatment, based on two Cochrane reviews and one RCT.

Figure 6. Impact of the Effectiveness of Follow-Up Behavioral Health Treatment Compared to No or Minimal Treatment Following Sexual Assault on Enrollees' Mental Health

Comparison of different follow-up behavioral health treatments after sexual assault

O'Doherty et al. (2023) pooled studies to compare trauma-focused behavioral health interventions to non–trauma-focused interventions. Although the authors found no difference in the effect on PTSD symptoms immediately post-treatment, there was a significant reduction 3 months afterwards in the trauma-focused group.[64] However, the difference between the trauma-focused and non–trauma-focused groups was no longer significant at 6 months. Similarly, the authors found no difference in the effect on depression symptoms immediately post-treatment, but there was a significant reduction 3 months afterwards in the trauma-focused group.[65] However, the difference between the trauma-focused and non–trauma-focused groups was no longer significant at 6 months.

Caro et al. (2023) conducted network and pairwise meta-analyses to compare different behavioral health treatments.[66] The authors found that *cognitive behavioral therapy delivered only to the child or to the child and their caregiver* was associated with larger reductions in symptoms of PTSD, depression, anxiety, and social functioning, as well as internalizing behavior and sexualized behavior than child-centered therapy delivered only to the child or to the child and their caregiver. *Eye movement desensitization and reprocessing* reduced internalizing behavior at post-treatment relative to family therapy (network meta-analysis). Again, the quality of evidence was rated with low confidence for all findings in the review by Caro et al. (2023) due to low numbers of studies included in the meta-analyses, small sample sizes, and variability in how interventions were delivered; effect estimates are therefore uncertain and imprecise.

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[61] Internalizing behaviors are those directed inwards towards oneself, such as worry, somatic symptoms, avoidance, and suicide (Liu et al., 2011).
[62] Prolonged exposure (PE) therapy is a type of cognitive behavioral therapy where individuals recount the traumatic event(s) aloud, listen to the audio recording, and discuss the details of the trauma to reduce anxiety, fear, and other distressing emotions related to the trauma (Miles et al., 2023).
[63] Persons in the intervention group were assessed by blinded assessors to have significantly lower PTSD symptom scores than the control group at both week four (M = 20.10, SE = 2.38 vs M = 30.45, SE = 2.73) and week twelve (M = 16.63, SE = 3.05 vs. M = 25.04, SE = 3.37).
[64] The standardized mean difference post-treatment in PTSD symptom scores (8 studies, 584 participants) was −0.33 (95% CI −0.49 to –0.16), favoring the trauma-focused interventions.
[65] The standardized mean difference post-treatment in depressive symptom scores (7 studies, 535 participants) was −0.56 (95% CI −0.97 to −0.15), favoring the trauma-focused interventions.
[66] Point estimates and confidence intervals for these findings are available in Table 8 of Appendix C.

Markowitz et al. (2017) conducted a quasi-experimental study that compared PE therapy with interpersonal therapy[67] and relaxation therapy[68] for 14 weeks. In total, there were 110 adult participants, approximately 35% (39) of whom reported having experienced sexual assault. Among the victims of sexual assault, there were large effect sizes[69] for interpersonal therapy versus prolonged exposure, and interpersonal therapy versus relaxation therapy for the PTSD measure.[70] There was a small effect size for prolonged exposure versus relaxation therapy. These findings indicate that interpersonal therapy showed greater benefit than prolonged exposure or relaxation therapy for victims of sexual assault.

Summary of findings regarding the effectiveness of different follow-up behavioral health treatments after sexual assault: There is a *preponderance of evidence* that some behavioral health treatments are more effective at improving mental health symptoms among adults and children/adolescents who have experienced sexual assault based on two Cochrane reviews and one quasi-experimental study. Evidence suggests that there are significant reductions in PTSD and depression symptoms at 3 months post-treatment with trauma-focused interventions among adults who have experienced sexual assault when compared with non–trauma-focused interventions. There is evidence that cognitive behavioral therapy is more effective than child-centered therapy at reducing symptoms of PTSD, anxiety, depression, and social functioning as well as internalizing behavior and sexualized behavior, among children and adolescents who have experienced sexual assault. Research also indicates that interpersonal therapy is more effective at reducing symptoms of PTSD than prolonged exposure or relaxation therapy for adult victims of sexual assault.

Figure 7. Impact of the Effectiveness of Different Follow-Up Behavioral Health Treatments Following Sexual Assault on Enrollees' Mental Health

Harms from behavioral health treatment following sexual assault

The meta-analysis by O'Doherty et al. (2023) compared adverse events and withdrawal rates between active interventions and the controls, and trauma-focused and non–trauma-focused interventions. The authors found an increased rate of patient withdrawal rates for trauma-focused interventions.[71] No other statistically significant differences were found. However, the absence of a statistically significant effect does not indicate that adverse effects did not occur. Other studies reviewed did not report adverse effects or withdrawal rates.

Summary of Findings

There is *insufficient evidence* to assess how cost sharing, requirements of criminal justice involvement, and requirements to use in-network providers impact enrollees' use of emergency room medical care and follow-up treatment for sexual assault. This does not indicate that these requirements do not have an impact; solely that no evidence was located.

There is a *preponderance of evidence* that behavioral health treatment is effective at reducing symptoms of PTSD and depression among adults who have experienced sexual assault, as well as reducing symptoms of PTSD, anxiety, depression, and internalizing behavior among children and adolescents who have experienced sexual assault, when compared to no or minimal treatment.

There is a *preponderance of evidence* that some behavioral health treatments are more effective at reducing mental health symptoms among adults and children/adolescents who have experienced sexual assault. Trauma-focused

[67] Interpersonal therapy (IPT) focuses on improving interpersonal relationships and social functioning (Miles et al., 2023).
[68] Relaxation therapy (RT) focuses on muscle and mental relaxation (e.g., through listening to relaxation tapes) (Markowitz et al., 2017).
[69] Effect size reflects the magnitude of differences between two intervention groups and is reported using Cohen's *d*, which classifies effect sizes as small (d = 0.2), medium (d = 0.5), and large ($d \geq 0.8$) (Cohen, 1988).
[70] The effect sizes are as follows: interpersonal therapy versus prolonged exposure (d = 1.30); interpersonal therapy versus relaxation therapy (d = 1.68); prolonged exposure versus relaxation therapy (d = 0.38).
[71] Risk ratio of 1.43 (95% CI 1.08 to 1.87), higher risk for trauma-focused interventions.

interventions yield significant reductions in symptoms of PTSD and depression at three months post-treatment compared to non–trauma-focused interventions among adults who have experienced sexual assault. Cognitive behavioral therapy is more effective than child-centered therapy at reducing symptoms of PTSD, anxiety, depression, and social functioning, as well as internalizing behavior and sexualized behavior, among children and adolescents who have experienced sexual assault. Interpersonal therapy is more effective at reducing symptoms of PTSD than prolonged exposure or relaxation therapy for adult victims of sexual assault.

Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, AB 2843 would require health plans and health policies regulated by the Department of Managed Health Care (DMHC) or the California Department of insurance (CDI) to provide coverage without cost sharing for emergency and follow-up services following sexual assault. AB 2843 further states that an enrollee be prohibited from receiving coverage for rape or sexual assault services provided by an out-of-network provider unless the services are not available in a health plan's network and a health plan makes arrangements for them to be provided by an out-of-network provider.

As noted in the *Policy Context* section, AB 2843 would impact CalPERS enrollees' benefit coverage, but not that of Medi-Cal beneficiaries in DMHC-regulated health plans. Medi-Cal beneficiaries enrolled in DMHC-regulated plans have full coverage for emergency and follow-up services for sexual assault at baseline, and do not generally have cost sharing, thus AB 2843 would not impact this population.

This section reports the potential incremental impacts of AB 2843 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

CHBRP used Milliman's proprietary 2021 and 2022 Consolidated Health Cost Guidelines™ Sources Database (CHSD) to obtain data on emergency and follow-up services, including drugs, following sexual assault. CHBRP tabulated medical and pharmacy claims that had at least one diagnosis code that was associated with sexual assault. These diagnoses codes were chosen based on prior work conducted on costs to sexual assault victims in the published literature (Dickman et al., 2022) and under consultation with CHBRP's content expert (see Appendix C for list of diagnosis codes). Given the notable differences in costs to enrollees based on whether or not they first visited an emergency department (ED) to receive services for the sexual assault,[72] CHBRP presents quantitative estimates in this section for those who had an ED visit and for those who did not have an ED visit.

General Cost Assumptions

CHBRP uses the following assumptions for the cost analysis of AB 2843:

- If AB 2843 is enacted, the elimination of cost sharing for emergency and follow-up services related to sexual assault would only occur for those enrollees with health insurance claims that include a diagnosis for sexual assault. Note the term "sexual assault services" used throughout is inclusive of emergency and follow-up services and medications. See the *Policy Context* section for definitions.
- Pharmacy costs associated with sexual assault services include any medications that are associated with the sexual assault. Under consultation with CHBRP's clinician expert, CHBRP reviewed the medications of enrollees with a medical claim that had a sexual assault diagnosis code. CHBRP categorized the drugs that could be prescribed for sexual assault into two categories based on therapeutic class: drugs that are prescribed for sexual assault and drugs that are sometimes prescribed for sexual assault. All drugs prescribed for sexual assault and one third of the drugs that are sometimes prescribed were included in the tabulation and estimates of utilization and costs of services for sexual assault (see Appendix C for more detail).
- AB 2843 is concerned with sexual assault services covered under the medical *and* pharmacy benefit.

[72] Emergency services for sexual assault often includes treatment for physical injuries, which can be costly depending on degree of trauma.

- All medical services associated with a forensic medical exam (FME) would be reimbursed by the local law enforcement (see the *Policy Context* section for more details). CHBRP does not include FME-related costs in this analysis.

- Health savings account (HSA) qualified high deductible health plans are required by the Internal Revenue Service (IRS) to have first dollar deductible cost sharing for services with few exceptions. CHBRP excluded enrollees in HSA-qualified high deductible health plans from the analysis.

Assumptions for Utilization and Cost at Baseline

At baseline, all enrollees in commercial or CalPERS health insurance regulated by DMHC and CDI and Medi-Cal beneficiaries enrolled in DMHC-regulated plans have full coverage for health care services, both emergency and follow-up, after a sexual assault. Enrollees in DMHC-regulated health plans and CDI-regulated policies, including CalPERS but excluding Medi-Cal beneficiaries in DMHC-regulated plans, do have cost sharing for emergency and follow-up services for sexual assault; thus, they would be the groups impacted by AB 2843.

Assumptions for Utilization and Cost Postmandate

As described in the *Medical Effectiveness* section, CHBRP found insufficient evidence of the impact of the removal of cost sharing, removal of criminal justice involvement requirements, or the restriction of using an in-network providers on enrollee's use of emergency care and follow-up services for sexual assault. CHBRP notes, however, there is some evidence that suggests generally (i.e., not specific to sexual assault), follow-up care for specialist visits, radiology, and mental health can be responsive (i.e., price elastic) to cost changes (Ellis et al., 2017). CHBRP assumes there could be two main ways utilization for follow-up services might increase postmandate due to the removal of cost sharing by AB 2843: 1) by those who accessed services at baseline (i.e., those who were coded with the sexual assault diagnosis at baseline could have more use of follow-up services); and 2) by new users of emergency and follow-up services as a result of the removal of cost sharing. Under consultation with CHBRP's content expert,[73] CHBRP assumed: 1) a 5% increase in utilization of services postmandate among enrollees who accessed services at baseline; and 2) a 3% increase in new users who utilize emergency and follow-up sexual assault services postmandate. These assumed increases in utilization are inclusive of both medical services and pharmacy.

CHBRP notes all estimates shown here could be higher or lower depending on the degree to which the removal of cost sharing for sexual assault services becomes known to enrollees, and the degree to which both enrollees and providers respond.

CHBRP assumes the unit cost of services and drugs would not change postmandate.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Baseline and Postmandate Benefit Coverage

[73] Communication with S. Metz, March 28, 2024.

Table 1 provides estimates of how many Californians have health insurance that would have to comply with AB 2843 in terms of benefit coverage.

Table 1. Impacts of AB 2843 on Benefit Coverage, 2025

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,297,000	22,297,000	0	0%
Total enrollees with health insurance subject to AB 2843 (b)	21,378,000	21,378,000	0	0%
Number of enrollees with coverage for sexual assault services	21,378,000	21,378,000	0	0%
Number of enrollees with coverage for sexual assault services without cost sharing	8,609,000	21,378,000	12,769,000	148.32%

Source: California Health Benefits Review Program, 2024.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[74]
(b) Excludes enrollees in Health Savings Account (HSA)-qualified High Deductible Health Plans (HDHPs) plans.
(c) Sexual assault services include all emergency and follow up services and medications that are associated with a sexual assault diagnosis. See Appendix C for list of diagnosis codes.
(d) 40% represents Medi-Cal beneficiaries enrolled in DMHC-regulated plans who have full coverage for emergency and follow-up services for sexual assault without cost sharing at baseline.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

At baseline, 21,378,000 enrollees have health insurance subject to AB 2843, and 8,609,000 of these enrollees have coverage for sexual assault without any cost sharing. Postmandate, CHBRP estimates all 21,378,000 of enrollees subject to AB 2843 would have coverage for sexual assault services without cost sharing, which is equivalent to an increase of 148% postmandate.

Baseline and Postmandate Utilization and Unit Cost

Below, Table 2 provides estimates of the impacts of AB 2843 on utilization and unit cost of sexual assault.

Table 2. Impacts of AB 2843 on Utilization and Unit Cost, 2025

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Enrollees using sexual assault services				
Number of enrollees using services	1,046	1,078	32	3%
Enrollees without an ED visit	402	415	13	3%
Enrollees with an ED visit	644	663	19	3%
Average annual cost per user of sexual assault services				
Without ED visit	$1,676	$1,760	$84	5%
With ED visit	$7,959	$8,357	$398	5%

[74] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Average annual cost sharing per user of sexual assault services				
Without ED visit	$170	$0	−$170	−100%
With ED visit	$594	$0	−$594	−100%

Source: California Health Benefits Review Program, 2024.
Notes: (a) Within this average, unit costs range from $1 to $100.
Key: ED = emergency department.

At baseline, 1,046 enrollees with health insurance subject to AB 2843 utilized services for sexual assault. The majority, 644 enrollees, had an emergency department (ED) visit for the sexual assault, and 402 enrollees did not have an ED visit. As explained in the cost assumptions above, CHBRP applied a 3% increase in utilization of all services postmandate due to the removal of cost sharing by AB 2843. Thus, postmandate, the number of users would increase for ED and non-ED services by 19 and 13 enrollees, respectively. CHBRP also assumed a 5% increase in utilization of sexual assault services by existing users at baseline. This increase in utilization gets translated into an increase in annual cost per user of sexual assault services. Thus, the annual costs per user of services increases by $398 for enrollees who had an ED visit and by $84 for those who did not use the ED.

At baseline, the average cost of sexual assault services per enrollee is $1,676 without an ED visit and $7,959 with an ED visit. CHBRP further examined the breakdown of average costs per enrollee by service category. For enrollees who did not visit an ED, about 39% of their costs were for behavioral health visits, 23% for medications, 17% for maternity care, 11% for other care, and 10% for office visits. For enrollees who visited an ED, about 68% of their costs stemmed from the ED visit, 18% for medications, 5% for maternity care, 5% for other care, and 4% for behavioral health. See Appendix D for more detail and a visual breakdown.

The average cost sharing for sexual assault services per enrollee is $170 for those without an ED visit and $594 for those with an ED visit at baseline (Table 2). As AB 2843 would eliminate cost sharing for sexual assault services, cost sharing postmandate would be $0 for enrollees, resulting in a 100% change in cost sharing.

Baseline and Postmandate Expenditures

Below, Table 3 provides estimates of the impacts of AB 2843 on expenditures, which include premiums and enrollee cost sharing.

Table 3. Impacts of AB 2843 on Expenditures, 2025

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$64,203,365,000	$64,203,932,000	$567,000	0.0009%
CalPERS employer (b)	$6,974,311,000	$6,974,345,000	$34,000	0.0005%
Medi-Cal (excludes COHS) include	$30,043,243,000	$30,043,243,000	$0	0%
Enrollee premiums				
Enrollees, individually purchased insurance	$20,751,015,000	$20,751,283,000	$268,000	0.0013%
Outside Covered California	$5,089,510,000	$5,089,575,000	$65,000	0.0013%

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Through Covered California	$15,661,505,000	$15,661,708,000	$203,000	0.0013%
Enrollees, group insurance (c)	$20,397,418,000	$20,397,600,000	$182,000	0.0009%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copays, etc.)	$15,689,351,000	$15,688,900,000	−$451,000	−0.0029%
Expenses for noncovered benefits include (d)	$0	$0	$0	0%
Total expenditures	$158,058,703,000	$158,059,303,000	$600,000	0.0004%

Source: California Health Benefits Review Program, 2024.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five (20.8%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
include Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of $0 million for Medi-Cal beneficiaries enrolled in COHS managed care.
(c) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
include Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(d) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

For DMHC-regulated plans and CDI-regulated policies, AB 2843 would increase total premiums paid by employers and enrollees for newly covered benefits. Premiums for employer-sponsored and CalPERS employer insurance premiums would increase by about 0.001% postmandate, and enrollee premiums for individually purchased insurance and for group insurance would increase by about 0.001% postmandate. Enrollee out-of-pocket expenses from cost sharing for sexual assault services, which are covered benefits, would decrease by 0.003%. This would result in an increase of $600,000 (0.0004%) of the total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

Premiums

At the end of this section, Table 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of AB 2843 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 5, and Table 6), with health insurance that would be subject to AB 2843.

The increase in premiums across all the different commercial plans due to AB 2843 would be about 0.001% or less, and any small differences between plans would be marginal and do not compel any further comment here. For enrollees associated with CalPERS in DMHC-regulated plans, the increase in premiums postmandate would be 0.0005%. Note there would be no impact for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Enrollee Expenses

AB 2843-related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see

Table 3, Table 5, and Table 6) with health insurance that would be subject to AB 2843 expected to use the relevant tests, treatments, or services due to sexual assault during the year after enactment.

Changes to enrollee expenses postmandate stem directly from the removal of cost sharing for services associated with sexual assault due to AB 2843. The decrease in cost sharing per member per month (PMPM) for enrollees in commercial market plans are less than $0.01 PMPM, and any differences by type of plan are marginal and do not compel further comment here. For enrollees associated with CalPERS in DMHC-regulated plans, the decrease in enrollee expenses due to removal of cost sharing is $0.0005 PMPM. As stated above, note there is no impact for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Average enrollee out-of-pocket expenses per user

Enrollees using sexual assault services without an ED visit would experience an estimated average decrease in cost sharing of $170 (Table 2). Table 6 below shows how this decrease varies by coverage type. Enrollees in individual plans would experience the greatest reductions in annual out-pocket-costs if using sexual assault services without an ED visit ($250).

For enrollees using sexual assault services with an ED visit for sexual assault the estimated average decrease in cost sharing for sexual assault services would be $594 (Table 2). The decrease in out-of-pocket costs varies widely by type of plan (Table 4), with the largest annual impact for enrollees in individual plans (−$1,200) and small-group plans (−$940). Because ED visits for sexual assault often includes treatment for physical injuries, costs tend to be higher. Enrollees in plans with higher cost sharing for services due to higher copays, deductibles, and coinsurance would have the greatest reductions in out-of-pocket expenses postmandate.

Table 4. Impact of AB 2843 on Average Annual Enrollee Out-of-Pocket Expenses Per User

	Large Group	Small Group	Individual	CalPERS	Medi-Cal (a)
Impact for enrollees with out-of-pocket expenses due to AB 2843 (b)	0.008%	0.008%	0.008%	0.008%	N/A
Avg. annual out-of-pocket expenses impact for enrollees without an ED visit	$140	$240	$250	$70	N/A
Avg. annual out-of-pocket expenses impact for enrollees with an ED visit	$380	$940	$1,200	$80	N/A

Source: California Health Benefits Review Program, 2024.
Notes: Average enrollee expenses include cost sharing (e.g., deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.
(b) Not including impacts on premiums.
Key: ED = emergency department.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies would remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP notes that when cost sharing is shifted to the health plans and policies, administrative expenses are applied

because it is added to the premium. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 3, Table 5, and Table 6), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 2843.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 2843.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

As described in the *Policy Context* and *Background* sections, there are state resources for victims of sexual assault, such as CalVCB, which may be used to obtain reimbursement for services related to sexual assault under certain circumstances. Private charities may also provide financial help for those who do not have the financial means to pay for health care services after a sexual assault. It is possible that with the enactment of AB 2843, individuals would be more likely to access services for sexual assault through their own health insurance rather than seeking reimbursement for services under such programs. CHBRP is unable to provide a quantifiable estimate of the number of people who would seek care through their health insurance rather than using other payers postmandate. CHBRP notes that this potential impact could be attenuated by the fact that enrollees generally have limited understanding of their health insurance benefits (Yagi et al., 2022), may not be aware of cost sharing changes postmandate, and may be reluctant to use health insurance benefits for sexual assault for fear that family members might find out about their assault or use of services (see the *Background* section for more on barriers to utilization of sexual assault services).

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) include*		*Large Group*	*Small Group*	*Individual*	**Total**
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (c)	7,864,000	2,161,000	2,378,000	894,000	7,791,000	818,000	293,000	62,000	36,000	22,297,000
Total enrollees in plans/policies subject to AB 2843	7,342,000	1,972,000	2,267,000	894,000	7,791,000	818,000	213,000	45,000	36,000	21,378,000
Premiums										
Average portion of premium paid by employer include	$527.59	$461.25	$0.00	$650.10	$263.09	$554.83	$585.36	$533.03	$0.00	$101,220,919,000
Average portion of premium paid by enrollee	$138.26	$193.80	$716.04	$133.99	$0	$0	$215.50	$174.12	$736.61	$41,148,433,000
Total premium	**$665.85**	**$655.05**	**$716.04**	**$784.09**	**$263.09**	**$554.83**	**$800.87**	**$707.15**	**$736.61**	**$142,369,352,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$48.82	$146.52	$209.79	$56.41	$0	$0	$119.25	$246.95	$203.25	$15,689,351,000
Expenses for noncovered benefits (d)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total expenditures	**$714.67**	**$801.57**	**$925.82**	**$840.51**	**$263.09**	**$554.83**	**$920.12**	**$954.10**	**$939.86**	**$158,058,703,000**

Source: California Health Benefits Review Program, 2024.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five (20.8%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
include Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(c) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[75]
include In some cases, a union or other organization – or Medi-Cal for its beneficiaries.

[75] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at www.chbrp.org/other-publications/resources.

(d) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2025

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			Total
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) include* *Under 65*	*65+*	*Large Group*	*Small Group*	*Individual*	
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (c)	7,864,000	2,161,000	2,378,000	894,000	7,791,000	818,000	293,000	62,000	36,000	22,297,000
Total enrollees in plans/policies subject to AB 2843	7,342,000	1,972,000	2,267,000	894,000	7,791,000	818,000	213,000	45,000	36,000	21,378,000
Premiums										
Average portion of premium paid by employer include	$0.0042	$0.0059	$0.0000	$0.0032	$0	$0	$0.0035	$0.0041	$0.0000	$602,000
Average portion of premium paid by enrollee	$0.0011	$0.0025	$0.0093	$0.0006	$0	$0	$0.0013	$0.0014	$0.0097	$450,000
Total premium	$0.0054	$0.0083	$0.0093	$0.0038	$0	$0	$0.0048	$0.0055	$0.0097	**$1,051,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	−$0.0018	−$0.0041	−$0.0054	−$0.0005	$0	$0	−$0.0028	−$0.0040	−$0.0062	−$451,000
Expenses for noncovered benefits (d)	$0.0000	$0.0000	$0.0000	$0.0000	$0	$0	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0036	$0.0042	$0.0038	$0.0033	$0	$0	$0.0020	$0.0015	$0.0035	**$600,000**
Percent change										
Premiums	0.001%	0.001%	0.001%	0.0005%	0%	0%	0.001%	0.001%	0.001%	0.001%
Total expenditures	0.0005%	0.0005%	0.0004%	0.0004%	0%	0%	0.0002%	0.0002%	0.0004%	0.0004%

Source: California Health Benefits Review Program, 2024.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents.
include Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.

(c) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[76]
include In some cases, a union or other organization – or Medi-Cal for its beneficiaries.
(d) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[76] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*, available at **www.chbrp.org/other-publications/resources**.

Public Health Impacts

As discussed in the *Policy Context* section, AB 2843 would require health plans regulated by the Department of Managed Health Care and policies regulated by the California Department of Insurance to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a sexual assault.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact of AB 2843 on eliminating cost sharing for emergency and follow-up services after a sexual assault and the potential impact on disparities. See the *Long-Term Impacts* section for discussion of economic loss and access to behavioral health services.

Estimated Public Health Outcomes

Outcomes relevant to AB 2843 include the elimination of cost sharing as a barrier to emergency and follow-up services after a sexual assault and the potential to improve mental health outcomes for victims who receive behavioral health services.

As presented in the *Medical Effectiveness* section, there is *insufficient evidence* on the impact of cost sharing on enrollees' use of emergency and follow-up services for sexual assault. There is a *preponderance of evidence* that behavioral health services are effective at alleviating mental health symptoms (symptoms of PTSD and depression among adult victims and symptoms of PTSD, depression, anxiety, and internalizing behavior among child and adolescent victims) for enrollees following sexual assault compared to no or minimal treatment.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, all enrollees subject to AB 2843 would have coverage with no cost sharing for sexual assault emergency and follow-up services postmandate. CHBRP estimates a 5% increase in utilization of emergency and follow-up services postmandate among enrollees who accessed services at baseline and a 3% increase in utilization among enrollees who would be new users of emergency and follow-up services postmandate.

Enrollees that seek sexual assault services will benefit from AB 2843 with the elimination of cost sharing and reduction of out-of-pocket costs for sexual assault services. For enrollees who visit the emergency department for sexual assault medical care, there will be an estimated average reduction in out-of-pocket costs of $594, and for enrollees who seek follow-up services, there will be an estimated reduction in out-of-pocket costs of $170. There will be some benefit to enrollee victims of sexual assault who experience elimination of out-of-pocket costs due to AB 2843.

In the first year postmandate, the public health impact of AB 2843 is *unknown* due to insufficient evidence regarding the impact of cost sharing on enrollees' use of emergency and follow-up services for sexual assault and a small, estimated increase in utilization of emergency and follow-up services among enrollee victims (estimates based on health care utilization with no cost sharing for other medical care). Please note that the absence of evidence is not "evidence of no effect." It is possible that an impact – desirable or undesirable – could result, but current evidence is insufficient to inform an estimate.

However, at the person level, enrollees who seek care at the emergency department following a sexual assault may have impactful reductions in out-of-pocket costs due to no cost sharing postmandate. Also, at the person level, AB 2843 would likely yield health and quality of life improvements such as reduced mental health symptoms among the additional 5% of enrollees who would use emergency and follow-up services at baseline and 3% of enrollees who would be new users of emergency and follow-up services postmandate.

Barriers and Sexual Assault Services

AB 2843 would not affect barriers related to seeking sexual assault services except for victims who experience cost sharing as a barrier. As discussed in the *Background on Sexual Assault* section, there are several barriers related to receiving sexual assault services. Victims of sexual assault make decisions about seeking sexual assault services following an assault. These decisions may be influenced by the victim's previous experiences with the health care system or law enforcement and by individual characteristics of the victim and the environment. The barriers related to emergency and follow-up services after sexual assault include not recognizing that medical care is needed (lack of understanding of health concerns, minimizing violence and health risks), the consequences of seeking medical care (lack of privacy and control, stigmatization, violence victimization, retaliation from perpetrator, retraumatizing medical treatment, and sexual assault diagnosis in medical record), and inability to access care (limited access to medical care independently, lack of social support, and perpetrator prevents access to medical care) (Kamke et al., 2023).[77]

Lack of insurance and having symptoms of PTSD are associated with greater barriers in seeking behavioral health services (Gilmore et al., 2021b). Sexual assault victims may encounter additional barriers in seeking behavioral health services, including access to care (needing multiple visits a month, lack of sufficient reimbursement, and knowledge of services), challenges of finding a provider (long waitlists and lack of sensitivity), and individual level barriers (emotional difficulty following through with care, self-blame, embarrassment, PTSD symptoms, and alcohol abuse) (Buchbinder et al., 2021; Donne et al., 2018; Gilmore et al., 2021b; Logan et al., 2005; Short et al., 2021). In California, there continues to be ongoing needs for increased access to behavioral health services despite legislation that mandates parity in coverage from mental and physical illnesses (CHCF, 2022). There is a projected shortage of behavioral health providers in California (Coffman et al., 2018). Victims of sexual assault may not seek behavioral health services immediately following the assault, but many access associated behavioral health services later in life (Ullman, 2007). There are also additional sources of support for sexual assault victims (crisis counselors and victim advocates at rape crisis centers, rape crisis hotlines, community mental health agencies, and family) (Ullman, 2007).

Additional barriers related to formal help-seeking[78] after sexual violence from an ecological framework include individual-level barriers (being a member of an oppressed or minoritized group, lack of acknowledgment of the sexual victimization, self-stigma, and previous help-seeking experiences) microsystem-level barriers (negative reactions to assault disclosure, fear of perpetrator, relationship and dependence on perpetrator, and socioeconomic status), mesosystem- and exosystem-level barriers (lack of resources and access, distrust in formal services, laws that impede help-seeking, and cultural norms), and macrosystem-level barriers (cultural mistrust and disclosure reactions) (Zinzow et al., 2022). These additional barriers are not affected by AB 2843.

AB 2843 would alleviate barriers related to cost sharing for enrollees who wanted to seek behavioral health services following a sexual assault but did not seek services or did not continue services due to out-of-pocket costs. For enrollees in high deductible plans (HDHPs), AB 2843 may have a greater financial impact by eliminating high out-of-pocket costs associated with outpatient behavioral health services. See the *Policy Context* section for more information on AB 2843 and HDHPs.

Impact on Disparities[79]

As described in the *Background on Sexual Assault* section, disparities among victims of sexual assault exist by race/ethnicity, age, sex, gender identity/sexual orientation, and income. Within the first 12 months postmandate, CHBRP estimates that the impact of AB 2843 on alleviating disparities related to accessing sexual assault services is unknown due to insufficient evidence on the impact of cost sharing and the use of emergency and follow-up services postmandate. CHBRP found no evidence on the impact of eliminating cost sharing for sexual assault services by race/ethnicity, age,

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[77] Communication with S. Metz, March 2024.
[78] Formal help-seeking includes mental health services, social services, sexual assault recovery services, and law enforcement reporting (Zinzow et al., 2022).
[79] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document here: **http://chbrp.com/analysis_methodology/public_health_impact_analysis.php**.

sex, gender identity/sexual orientation, and income. (For a discussion of potential impacts beyond the first 12 months of implementation, see the *Long-Term Impacts* section.)

Impact on Racial or Ethnic Disparities

Although CHBRP did not find direct evidence that eliminating cost sharing for sexual assault services is effective at increasing utilization, CHBRP did find relevant literature on care for Black women who experience sexual assault. Black women report lower rates of mental health treatment following sexual assault than White women (Alvidrez et al., 2011). Black women experience barriers to behavioral health services including stigma, financial inequities, inaccessible location, transportation problems, availability of services, and mistrust of providers (Ward et al., 2009). AB 2843 would have no impact on the additional barriers experienced by Black women are victims of sexual assault.

The impact of AB 2843 on reducing disparities among racial and ethnic groups is unknown. CHBRP found insufficient evidence on the impact of cost sharing on the use of emergency and follow-up services among racial and ethnic groups. However, AB 2843 would eliminate cost as a barrier for enrollees, and there is evidence that Black women experience financial inequities to behavioral health services; AB 2843 does have the potential to reduce disparities in behavioral health outcomes for Black women who experience sexual assault.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of AB 2843, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

It is possible that long-term utilization for follow-up services for sexual assault would increase with the elimination of cost sharing due to AB 2843. With regards to behavioral health follow-up care, CHBRP notes that there is a significant supply-side barrier with a shortage of behavioral health professionals that may not be able to meet any increased demand for follow-up mental health care for sexual assault. Coffman et al. (2018) project that assuming current trends continue: "California will have 50% fewer psychiatrists than will be needed to meet both current patterns of demand and unmet demand for behavioral health services. California will have 28% fewer psychologists, licensed marriage and family therapists (LMFTs), licensed professional clinical counselors (LPCCs), and licensed clinical social workers (LCSWs) combined to meet both current patterns of demand and unmet demand for behavioral health services" by 2028.

Cost Impacts

CHBRP estimates that after the initial 1-year postmandate period, annual cost-sharing savings to enrollees will likely be similar to the first year.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

In the case of AB 2843, CHBRP estimates a 3%-5% increase in utilization of emergency and follow-up services for enrollee victims of sexual assault. Cost would no longer be a barrier for enrollees who seek services for emergency and follow-up services including behavioral health services following a sexual assault. There could be potential for improved mental health symptoms for these enrollees in the longer term, if they choose to continue receiving behavioral health services for a longer period of time due to the elimination of cost sharing as a barrier.

Secondary prevention for sexual assault victims can be effective at reducing and mitigating symptoms of PTSD and associated conditions after sexual assault (Short et al., 2020). As discussed in the *Background* section, PTSD is a long-term consequence of sexual assault and can have lifelong consequences on mental health, physical health, and functioning. The *Medical Effectiveness* review found that behavioral health treatments are effective at reducing symptoms of PTSD. Victims who seek behavioral health services within 3 months after the assault may see reduction in the development of PTSD and related disorders (Short et al., 2020). Therefore, for enrollees who seek behavioral health services following a sexual assault, AB 2843 may benefit those who would not otherwise be able to access behavioral health services due to cost sharing; if the reduced cost barriers resulting from AB 2843 enables increased access to behavioral health services following a sexual assault for enrollees, it could potentially reduce the risk of developing PTSD and subsequent long-term mental health and psychosocial consequences for those enrollees.

Impacts on Economic Loss

Economic loss associated with disease is generally presented in the literature as an estimation of the value of the years of potential lost life (YPLL) in dollar amounts (i.e., valuation of a population's lost years of work over a lifetime). In addition, morbidity associated with the disease or condition of interest can also result in lost productivity by causing a worker to miss days of work due to illness or acting as a caregiver for someone else who is ill.

As discussed in the *Background on Sexual Assault* section, the per-victim lifetime cost of rape is estimated $122,461, and the economic burden for the United States is estimated around $1.2 trillion in medical costs, $1.6 trillion in lost productivity from victims and perpetrators, $234 billion in criminal justice activities, and $36 billion in other costs (Peterson et al., 2017). Although AB 2843 does not prevent rape or sexual assault victimization, reducing cost sharing for emergency and follow-up services related to sexual assault could reduce the economic burden and lifetime costs for enrollee victims.

Appendix A. Text of Bill Analyzed

On February 16, 2024 the California Assembly Committee on Health requested that CHBRP analyze AB 2843, as introduced on February 15, 2024.

ASSEMBLY BILL **NO. 2843**

Introduced by Assembly Member Petrie-Norris
(Coauthor: Assembly Member Addis)

February 15, 2024

An act to add Section 1367.37 to the Health and Safety Code, and to add Section 10123.211 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2843, as introduced, Petrie-Norris. Health care coverage: rape and sexual assault.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Existing law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault.

This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency and follow-up services for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(e) The Center for Disease Control and Prevention's National Intimate Partner and Sexual Violence Survey published in 2017 reported that one in four American women reported they were subjected to a completed or attempted rape at least once in their life. One in three women are injured during their assault. About 1 in 26 American men reported being subjected to a completed or attempted rape in their lifetime.

(b) In 2022, the New England Journal of Medicine reported that only 20 percent of sexual assault survivors seek medical care, which includes the collection of forensic evidence via rape kits. Survivors may not seek care or report because they know their attacker and fear retribution, or because they may feel shame. Many do not seek medical care because of the high cost of emergency room visits, despite the fact that forensic evidence collection and other services are provided without cost to the survivor.

include Findings indicate that indigenous people are more likely to experience rape or sexual assault. Findings also notes that transgender students experience higher rates of rape or sexual assault than nontransgender students.

(d) In 2022, the Journal of the American Medical Association reported that sexual assault survivors from the lowest income quartile by zip code were overrepresented in emergency department visits. Survivors 18 to 25 years of age accounted for 41.2 percent to 48.6 percent of emergency department visits following rapes and sexual assaults.

include The average costs for medical care following a rape or sexual assault is $3,673. For pregnant survivors, those costs average closer to $4,500.

(f) Insured survivors pay about 14 percent of emergency room costs out of pocket.

(g) High-cost medical care expenses not only discourage sexual assault reporting, but the lack of reporting also prevents a survivor from seeking justice and prevents law enforcement from obtaining the evidence necessary to bring an assailant to justice.

(h) Moreover, without the evidentiary tools to remove sexual predators from society, serial rapists are enabled to continue to commit violent, traumatic crimes against individuals.

(e) According to the Rape, Assault and Incest National Network (RAINN), only 25 perpetrators out of every 1000 rapes will serve time for their crime.

SEC. 2. Section 1367.37 is added to the Health and Safety Code, to read:

1367.37. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, excluding a specialized health care service plan contract, shall provide coverage for emergency and follow-up services for an enrollee who is treated following a rape or sexual assault, as defined in Sections 261, 261.6, 263, 263.1, and 288.7 of the Penal Code, without imposing cost sharing, including copayments and deductibles.

(b) A health care service plan shall not require any of the following to provide coverage under this section:

(e) An enrollee to file a police report on the rape or sexual assault.

(2) Charges to be brought against an assailant.

(3) An assailant to be convicted of an offense listed in subdivision (a).

include (1) This section does not authorize an enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) A plan shall arrange for the provision of services required by this section from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.

(d) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee other than premium or share of premium.

SEC. 3. Section 10123.211 is added to the Insurance Code, to read:

10123.211. (a) A health insurance policy that is issued, amended, or renewed on or after January 1, 2025, excluding a specialized health insurance policy, shall provide coverage for emergency and follow-up services for an insured who is treated following a rape or sexual assault, as defined in Sections 261, 261.6, 263, 263.1, and 288.7 of the Penal Code, without imposing cost sharing, including copayments and deductibles.

(b) A health insurer shall not require any of the following to provide coverage under this section:

(e) An insured to file a police report on the rape or sexual assault.

(2) Charges to be brought against an assailant.

(3) An assailant to be convicted of an offense listed in subdivision (a).

include (1) This section does not authorize an insured to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, except as specified in paragraph (2).

(2) A health insurer shall arrange for the provision of services required by this section from providers outside the insurer’s network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 10133.54.

(d) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

include This section does not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Appendix B. Literature Review Methods

This appendix describes methods used in the literature review conducted for this report.

Studies of the impact of cost-sharing, requirements of criminal justice involvement, and requirements to use in-network providers on enrollees' use of emergency room medical care and follow-up treatment for sexual assault, as well as the effectiveness of behavioral health treatment following sexual assault on enrollees' mental health were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, and the Cumulative Index of Nursing and Allied Health Literature. The search was limited to abstracts of studies published in English and published from 2021 to present. CHBRP relied on two systematic reviews published in 2023 for findings from studies published from 1991 to 2021.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Medical Effectiveness Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis Research Approach*.[80] To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome.

[80] Available at: www.chbrp.org/about/analysis-methodology/medical-effectiveness-analysis.

Appendix C. Findings from Cochrane Reviews

Table 7. Findings From Cochrane Review by Caro et al. (2023) – Comparison of Follow-Up Behavioral Health Treatment Versus No or Minimal Treatment After Sexual Assault[81]

Intervention	Comparison	Network Meta-Analysis		Pairwise Meta-Analysis	
		Findings	Standard Mean Difference and 95% CI	Findings	Standard Mean Difference and 95% CI
Cognitive behavioral therapy delivered only to the child	Management as usual	Intervention reduced **PTSD symptoms** at post-treatment and 6 mos.	Post: −0.96 (95% CI −1.72 to −0.20)[1] 6 mos.: −0.94 (95% CI −1.64 to −0.25)[1]	Intervention reduced **PTSD symptoms** at post-treatment and 6 mos., and **depression symptoms** at post-treatment	PTSD post: −0.96, (95% CI −1.68 to −0.24)[1] PTSD 6 mos.: −0.88 (95% CI −1.59 to −0.17)[1] Depression: −0.73 (95% CI −1.42 to −0.05)[1]
	Being placed on a waiting list			Intervention reduced **PTSD and anxiety symptoms** at post-treatment	PTSD: −1.59 (95% CI −2.45 to −0.72)* Anxiety: −1.24 (95% CI −2.45 to −0.04)*
Cognitive behavioral therapy delivered to the child and their caregiver	Management as usual	Intervention reduced **PTSD symptoms** at 6 mos. And 12 mos.	6 mos.: −0.72 (95% CI −1.42 to −0.02)[1] 12 mos.: −0.75 (95% CI −1.45 to −0.05)[1]		
	Being placed on a waiting list			Intervention reduced **PTSD symptoms** at post-treatment	−1.21 (95% CI −2.21 to −0.21)[1]
Child-centered therapy delivered to the child and their caregiver	Management as usual	Intervention reduced **PTSD symptoms** at post-treatment	−0.87 (95% CI −1.64 to −0.10)*		
Eye movement desensitization and reprocessing	Being placed on a waiting list	Intervention reduced **internalizing behavior** at	−0.75 (95% CI −1.50 to −0.01)*	Intervention reduced **PTSD, depression, and anxiety**	PTSD: −1.24 (95% CI −2.03 to −0.45)[1] Depression: −1.30 (95% CI −2.10 to −0.51)[1]

[81] Findings from Cochrane Review by Caro et al. (2023)

	post-treatment	**symptoms**, and **internalizing behavior**, at post-treatment	Anxiety: −0.88 (95% CI −1.63 to −0.12)[1] Internalizing behavior: −0.75 (95% CI −1.50 to −0.01)[1]

Source: California Health Benefits Review Program, 2024.
Key: * = number of studies included in analyses unknown; [1] = 1 study

Table 8. Findings From Cochrane Review by Caro et al. (2023) – Comparison of Different Follow-Up Behavioral Health Treatments After Sexual Assault[82]

Intervention	Comparison	Network Meta-Analysis		Pairwise Meta-Analysis	
		Findings	Standard Mean Difference and 95% CI	Findings	Standard Mean Difference and 95% CI
Cognitive behavioral therapy delivered only to the child	Child-centered therapy delivered only to the child	Intervention reduced **PTSD symptoms** at 6 mos.	−0.92 (95% CI −1.45 to −0.39)*		
	Child-centered therapy delivered to the child and their caregiver	Intervention reduced **depression symptoms** at 6 mos.	−0.74 (95% CI −1.42 to −0.06)*		
Cognitive behavioral therapy delivered to the child and their caregiver	Child-centered therapy delivered only to the child			Intervention reduced **PTSD symptoms** at 6 mos.	−0.92 (95% CI −1.45 to −0.39)[1]
	Child-centered therapy delivered to the child and their caregiver	Intervention reduced **PTSD symptoms** at 6 and 12 mos.; **depression symptoms** at 6 mos.; **internalizing behavior** at post-treatment; and **sexualized behavior** at 12 mos.	PTSD 6 mos.: −0.45 (95% CI −0.73 to −0.17)* PTSD 12 mos.: −0.33 (95% CI −0.59 to −0.07)* Depression: −0.27 (95% CI −0.53 to −0.01)* Internalizing behavior:	Intervention reduced **PTSD symptoms** at post-treatment, 6 mos., and 12 mos.; **depression symptoms** at post-treatment and 6 mos.; **anxiety symptoms** at post-treatment and 6 mos.; **internalizing behavior** at post-treatment and 12 mos.; **sexualized behavior** at post-treatment and 12 mos.; and **social functioning symptoms** at post-treatment	PTSD post: −0.40 (95% CI −0.65 to −0.16)* PTSD 6 mos.: −0.46 (95% CI −0.74 to −0.17)[1] PTSD 12 mos.: −0.33 (95% CI −0.59 to −0.07)* Depression post: −0.43 (95% CI −0.68 to −0.19)* Depression 6 mos.: −0.27 (95% CI −0.53 to −0.01)* Anxiety post: −0.25 (95% CI −0.49 to −0.01)* Anxiety 6 mos.: −0.32 (95% CI −0.58 to −0.06)[2] Internalizing behavior post: −0.40 (95% CI −0.68 to −0.12)* Internalizing behavior 12 mos.: −0.26 (95% CI −0.50 to −0.02)[3]

[82] Findings From Cochrane Review by Caro et al. (2023).

			−0.39 (95% CI −0.62 to −0.16)* Sexualized behavior: −0.41 (95% CI −0.77 to −0.05)*		Sexualized behavior post: −0.28 (95% CI −0.49 to −0.07)* Sexualized behavior 12 mos.: −0.41 (95% CI −0.77 to −0.05)* Social functioning: −0.25 (95% CI −0.47 to −0.04)[3]
Eye movement desensitization and re-processing	Family therapy	Intervention reduced **internalizing behavior** at post-treatment	−1.59 (95% CI −3.09 to −0.09)*		

Source: California Health Benefits Review Program, 2024.
Key: * = number of studies included in analyses unknown; [1] = 1 study; [2] = 2 studies; [3] = 3 studies

Appendix D. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc, the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[83] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses are available on CHBRP's website.[84]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Health Cost Guidelines

The Health Cost Guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

[83] CHBRP's authorizing statute, available at www.chbrp.org/about/faqs, requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[84] See method documents posted at www.chbrp.org/about/analysis-methodology/cost-impact-analysis; in particular, see *Cost Analyses: Data Sources, Caveats, and Assumptions*.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

Methodology and Assumptions for Identification of Sexual Assault

- CHBRP identified the annual rates of California enrollees using sexual assault services using Milliman's proprietary 2021 and 2022 Consolidated Health Cost Guidelines™ Sources Database (CHSD). Enrollees were categorized as those with a related emergency department visit and those without a related emergency department visit based on the Milliman Health Cost Guidelines' definition of an emergency department visit.
- Sexual assault services were identified as claims with an ICD-10 diagnosis code designating victims of sexual violence as outlined in a *New England Journal of Medicine* study on uncovered medical bills after sexual assault (Dickman et al., 2022).
    - Sexual assault ICD 10 diagnosis codes: T7421XA, T7421XD, T7421XS, T7422XA, T7422XD, T7422XS, T7621XA, T7621XD, T7621XS, T7622XA, T7622XD, T7622XS, O9A411, O9A412, O9A413, O9A419, O9A42, O9A43, Z0441, Z0442
- CHBRP categorized outpatient drugs for enrollees with sexual assault services into the following two categories:
    - Drugs classes that are prescribed for sexual assault – includes drugs to treat infections (bacterial, fungal, viral, and other), manage HIV/AIDS, prevent pregnancy, and diagnose or monitor diseases.
    - Drug classes that are sometimes prescribed for sexual assault – includes drugs to manage pain, treat depression and anxiety and other related behavioral health conditions, and relax muscles.
- For drug classes that are sometimes prescribed for sexual assault, CHBRP assumed that only one third of the annual usage for these drugs would be prescribed for sexual assault and included in the analysis. This assumption was based on the clinical expertise of a CHBRP-contracted clinician.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- It was determined that services included in emergency and follow-up services for an enrollee or insured who is treated following sexual assault would be considered medically necessary care. Furthermore, these services are deemed essential health benefits. Therefore, CHBRP assumes all plans included in this analysis are currently required to cover sexual assault services and all plans cover these services at typical cost sharing.
- CHBRP excluded enrollees in health savings account (HSA) qualified high deductible health plans from the analysis. HSA qualified high deductible health plans are required by the IRS to have first dollar deductible cost sharing for services with few exceptions. Please see CHBRP's resource document on deductibles for more information. https://www.chbrp.org/sites/default/files/2024-02/Deductibles%20in%20State-Regulated%20Health%20Insurance%20%28projecting%202025%29%20021424.pdf

Methodology and Assumptions for Baseline Utilization

Using the methodology described above, utilization rates of enrollees using sexual assault services with or without a related emergency department visit were calculated. These rates were applied to each line of business.

Methodology and Assumptions for Baseline Cost

- Using the methodology described above, CHBRP calculated the average annual medical and outpatient drug cost of sexual assault claims per enrollee.
- CHBRP summarized the annual cost of all sexual assault claims for each enrollee using sexual assault services by enrollees with and without a related emergency department visit.
- CHBRP calculated the average cost sexual assault claims per enrollee in each line of business including considering the proportion of enrollees with outpatient drug coverage.
- The average costs for emergency room services was trended from 2021 and 2022 to 2025 using a 10.0% annual trend. All other services were trended from 2021 and 2022 to 2025 using a 6.0% annual trend. These trends are based on trends from the 2023 Milliman Health Cost Guidelines.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP created non-HSA sample plan designs, including deductible, coinsurance, and out-of-pocket maximum, for each metal level and deductible level by line of business and regulator.
    - The large-group and grandfathered plan carrier survey results are by medical deductible ranges. CHBRP relied on results from the 2023 KFF Employer Health Benefit Survey and actuarial judgment for coinsurance and out-of-pocket maximums.

      https://www.kff.org/report-section/ehbs-2023-section-7-employee-cost-sharing

        - For plans with no deductible, CHBRP assumed a medical deductible of $0, a coinsurance of 5%, and an out-of-pocket maximum of $2,500.
        - For plans in the $1 to $1,399 deductible range, CHBRP assumed a medical deductible of $750, a coinsurance of 10%, and an out-of-pocket maximum of $3,500.
        - For plans in the $1,400 to $2,999 deductible range, CHBRP assumed a medical deductible of $2,200, a coinsurance of 20%, and an out-of-pocket maximum of $4,500.
        - For plans in the $3,000 to $3,499 deductible range, CHBRP assumed a medical deductible of $3,250, a coinsurance of 20%, and an out-of-pocket maximum of $5,500.
        - For plans in the $3,500 to $3,999 deductible range, CHBRP assumed a medical deductible of $3,750, a coinsurance of 20%, and an out-of-pocket maximum of $6,500.
        - For plans with a $4,000 or greater deductible, CHBRP assumed a medical deductible of $5,150, a coinsurance of 30%, and an out-of-pocket maximum of $8,000.
    - For non-grandfathered small-group plans, CHBRP reviewed the 2024 Covered California plan offerings and assumed the average non-HSA medical deductible, coinsurance, and out-of-pocket maximum for each metal tier.

  - For non-grandfathered individual plans, CHBRP reviewed the 2024 Covered California plan offerings and assumed the non-HSA medical deductible, coinsurance, and out-of-pocket maximum at each metal tier.
  - For CalPERS, CHBRP used the plan design from the HMO with the highest enrollment offered with a medical deductible of $0, a coinsurance of 0%, and an out-of-pocket maximum of $1,500. CHBRP also applied one $50 copay for emergency department visits.
  - CHBRP assumed an effective 20% coinsurance for copay services for all sample plans based on the average copayments and coinsurance for physician office visits from the 2023 KFF Employer Health Benefit Survey.
- CHBRP created sample outpatient pharmacy plan designs, including deductible, generic copayment, brand copayment, and specialty maximum or specialty copayment. For all plans with specialty maximums, CHBRP assumed the maximum would be reached for each script.
  - For large group and grandfathered plans, CHBRP relied on results from the 2023 KFF Employer Health Benefit Survey for deductibles and copays.
    - For DMHC-regulated large-group plans, CDI-regulated large-group grandfathered plans, small-group grandfathered plans, and individual grandfathered plans, CHBRP assumed no outpatient pharmacy deductible, a $15 generic copay, a $36 brand copay, and a $110 specialty copay.
    - For CDI-regulated large-group non-grandfathered plans, CHBRP assumed a $250 outpatient pharmacy deductible, a $15 generic copay, a $36 brand copay, and a $110 specialty copay, with all drugs subject to the deductible.
  - For nongrandfathered small-group plans, CHBRP reviewed the 2024 Covered California plan offerings and assumed the average non-HSA outpatient pharmacy deductible and copay benefits at each metal tier.
  - For nongrandfathered individual plans, CHBRP reviewed the 2024 Covered California plan offerings and assumed the average non-HSA outpatient pharmacy deductible and copay benefits at each metal tier.
  - For CalPERS, CHBRP used the plan design from the HMO with the highest enrollment offered. It had an outpatient pharmacy deductible of $0, a $5 generic copay, a $20 brand copay, and a $20 specialty copay.
- CHBRP calculated the allowed cost of enrollees with sexual assault services by service type in Milliman's proprietary 2021 and 2022 CHSD.
  - Services were split into sexual assault services and nonsexual assault services following the methodology above.
  - Services were also split into services where deductible and coinsurance typically apply and services where only copays typically apply.
    - Copay services were services identified as office visits, urgent care visits, vision exam, hearing exams, and professional outpatient behavioral health visits.
    - All other services were classified as deductible and coinsurance services.
  - Preventive services were excluded.
- For both medical services alone and medical services plus outpatient drugs combined, CHBRP applied the sample plan designs to the annual cost of sexual assault and nonsexual assault claims by enrollee to develop total baseline cost sharing for each sample plan. CHBRP then reapplied sample plan designs to the non-sexual assault services only. The difference is the average cost sharing for sexual assault services by sample plan.

- The average cost sharing by line of business was calculated by blending annual cost sharing for each metal level and deductible level by line of business, brand and generic outpatient drug coverage, and regulator by enrollment.

Methodology and Assumptions for Postmandate Utilization

- CHBRP assumed an additional 3% of enrollees would utilize sexual assault services postmandate.[85]

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed a 5% increase in utilization of services postmandate among enrollees who accessed services at baseline.[86] This was calculated as a 5% increase in the average annual cost of sexual assault services per enrollee.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed there would be no cost sharing for sexual assault services postmandate.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

[85] Communication with S. Metz, March 28, 2024.
[86] Communication with S. Metz, March 28, 2024.

Appendix E. Sexual Assault Services Cost Breakdown

As discussed in the *Benefit Coverage, Utilization, and Cost Impacts* section, at baseline, the average cost of sexual assault services per enrollee is $1,676 without an emergency department (ED) visit and $7,959 with an ED visit. CHBRP further examined the breakdown of average costs per enrollee by service category. A visualization is provided in the figures below.

Figure 8. Estimated Cost by Service Category for Enrollees Without Emergency Services

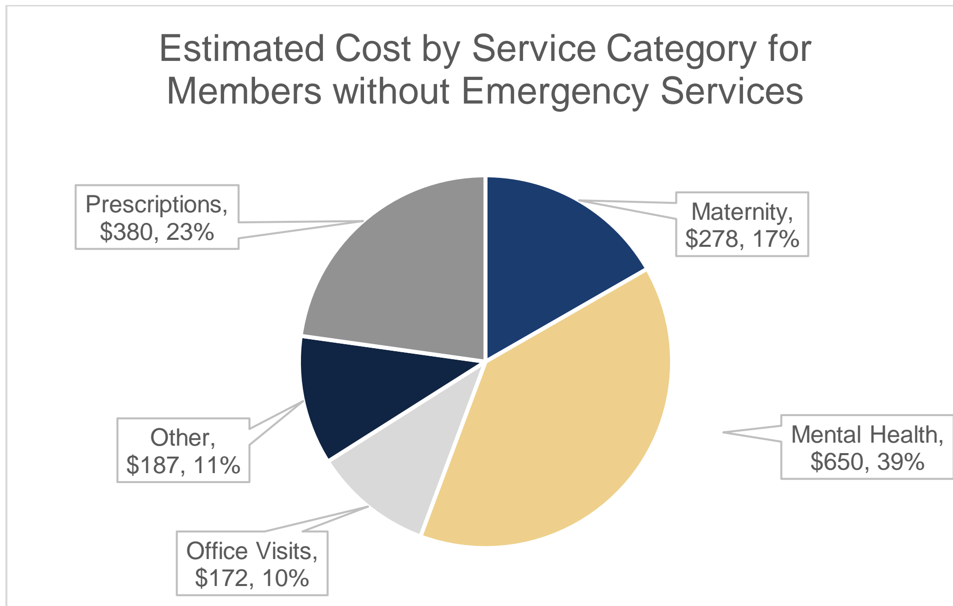
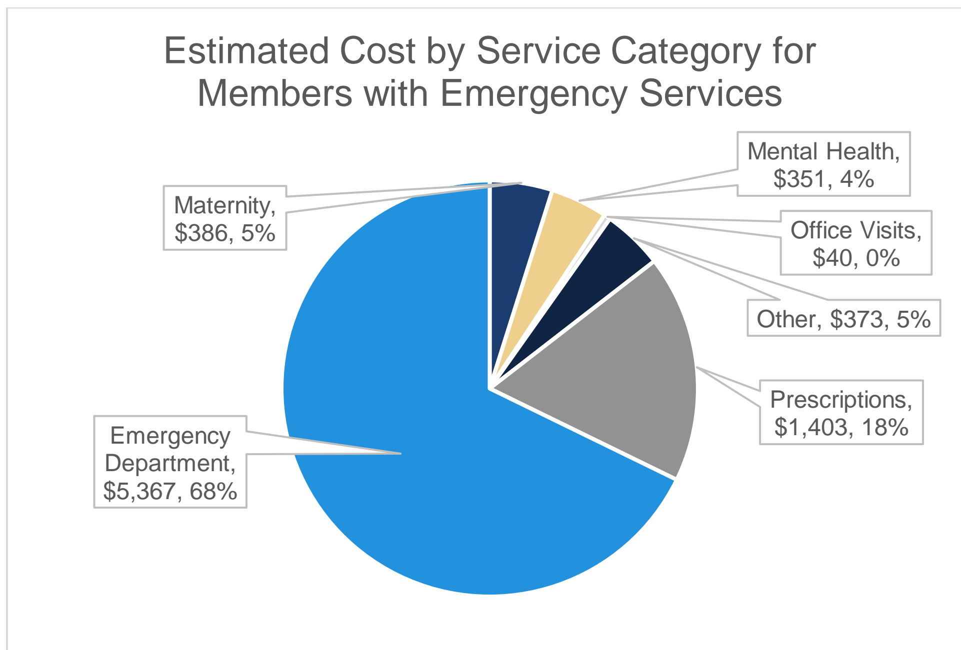


Figure 9. Estimated Cost by Service Category for Members With Emergency Services



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A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The National Advisory Council provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at **www.chbrp.org**.

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Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or **www.chbrp.org**.

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