

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

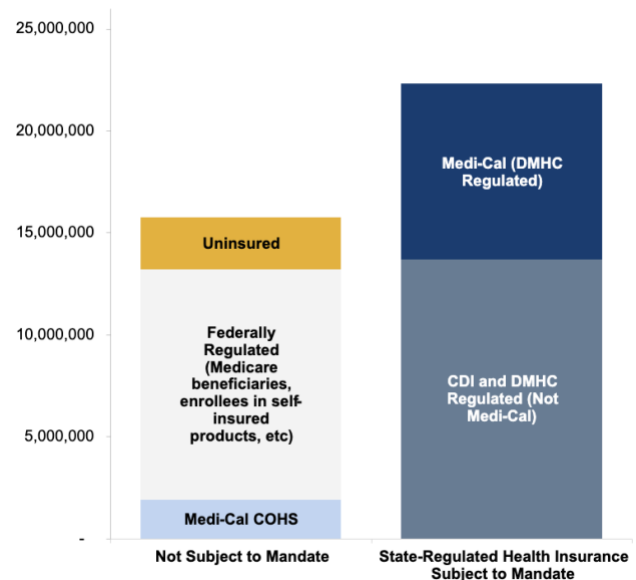
AB 2843 would require health plans regulated by the Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI) to provide coverage without cost sharing for emergency and follow-up services for enrollees/insureds treated following a rape or sexual assault.

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 behavior² 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 therapy³ 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 therapy⁴ is more effective at reducing symptoms of PTSD than prolonged exposure or relaxation therapy⁵ 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).

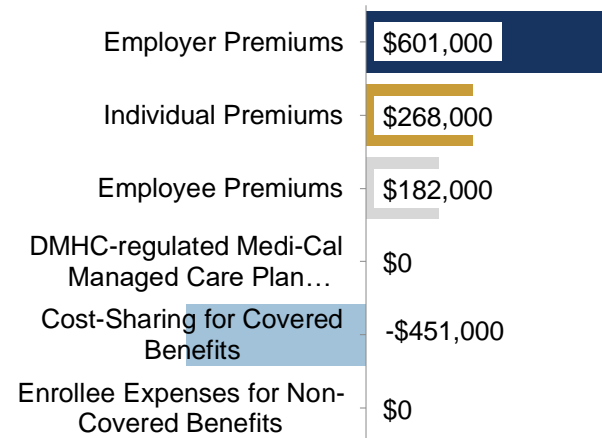
Expenditures

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.