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**#METOO MEETS THE EMERGENCY ROOM: PROVIDING AND
PAYING FOR CARE AFTER A SEXUAL ASSAULT**

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ABSTRACT

Sexual assault continues to be a major public health problem in the United States. Compounding the problem, survivors of sexual assault all too often face challenges of obtaining and paying for sexual assault forensic exams (SAFEs), commonly referred to as a “rape kit,” and related medical services. Sexual assault survivors who do seek medical care in the emergency department (ED) are often turned away for several reasons, such as EDs determining that sexual assault is not an emergency medical condition, failing to carry SAFEs, or refusing to treat survivors who lack proof of insurance. Denial of care can further traumatize survivors, deter medically necessary treatment, result in loss of forensic evidence, and cause non-physically apparent medical needs to be overlooked. Federal laws, such as the Violence Against Women Act (VAWA) and the Emergency Medical Treatment and Labor Act (EMTALA), offer only limited remedies to compel and cover care for survivors of sexual assault. Consequently, federal and state legislative, regulatory, and enforcement action is needed to ensure that sexual assault survivors receive appropriate care and that such care is covered.

This article provides overviews of sexual assault in the United States and the appropriate follow-up health care services that survivors need. It also identifies the barriers to accessing and affording appropriate health care services following a sexual assault and applicable laws governing provision and payment for such services. It analyzes potential remedies for survivors who are denied access to SAFEs and related services, and it provides recommended actions at both the state and federal levels that will better ensure access to and coverage of SAFEs and related services.

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I. INTRODUCTION

Dinisha had been out with her friends celebrating her new job when she was drugged, taken to a hotel room, and raped by a stranger.¹ When she finally made it home the following morning, still dizzy and confused, her fiancé Daniel immediately took her to the nearest emergency department (ED).² Daniel told the ED receptionist that Dinisha had been raped and needed a sexual assault forensic exam (SAFE), commonly referred to as a “rape kit.”³ The receptionist asked for proof of insurance.⁴ When she could not produce her insurance card, Dinisha was turned away.⁵ She was then turned away by another hospital before finally receiving treatment—nine hours later—at a third hospital.⁶ Dinisha later recounted, “I was equally victimized by this system as I was by the guy [who raped me] . . . I tried to handle the situation responsibly, but it was out of my hands. I had no control.”⁷

In 2013, Erin was sexually assaulted.⁸ Unlike Dinisha, Erin received a SAFE at an ED.⁹ Unfortunately, six years later and despite having moved 1,000 miles away from the ED, she still receives calls from a collection agency demanding that she pay for those services despite laws that required such exams to be provided at no cost.¹⁰ Every call retraumatizes Erin. She explains: “[w]hen I get that phone call, it’s still so raw. I’m shaking.”¹¹

Dinisha’s and Erin’s stories represent the challenges that survivors of sexual assault face in accessing and affording emergency care following an assault. Denial of care can further traumatize survivors, deter further treatment, result in loss of forensic evidence, and cause non-physically apparent medical needs to be overlooked.¹² As the national momentum behind the #MeToo movement has

1. Jillian Keenan, *Why Did it Take 9 Hours and 3 Emergency Rooms for This Woman to Get a Rape Kit?*, COSMOPOLITAN (Aug. 23, 2016), <https://www.cosmopolitan.com/politics/a58941/dinisha-ball-rape-kit-texas-emergency-room/>.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Keenan, *supra* note 1.

7. *Id.*

8. Michelle Andrews, *Years After Sexual Assault, Survivors Hounded to Pay Bills for the Rape Kit Exam*, NPR (July 10, 2019), <https://www.npr.org/sections/health-shots/2019/07/10/739925186/years-after-sexual-assault-survivors-hounded-to-pay-bills-for-the-rape-kit-exam>.

9. *Id.*

10. Andrews, *supra* note 8. *See also* Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109-162, § 101(f), 119 Stat. 2960, 2974 (2006) (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)).

11. Andrews, *supra* note 8.

12. *See generally* Kennan, *supra* note 1. *See also* Lindsay White, *How We Care for Sexual Assault Survivors*, MEDSTAR (Aug. 2, 2017), <https://blog.medstarwashington.org/2017/08/02/sexual-assault-sane-nurses/> (discussing how medical providers care for sexual assault victims).

begun to break the culture of silence surrounding sexual assault, survivors are beginning to feel more empowered to come forward.¹³ Yet, survivors still face significant hurdles to care, including obtaining and paying for SAFEs and related medical services despite laws that are intended to compel and cover care.¹⁴

Enacted in 1994 and later amended, the Violence Against Women Act (VAWA) required states that receive certain federal funds to pay the full cost of SAFEs on behalf of sexual assault survivors.¹⁵ VAWA's implementing regulations define a SAFE¹⁶ as an examination of a survivor by medical personnel to gather evidence of a sexual assault in a manner suitable for use in court.¹⁷ A SAFE includes, at a minimum, "[g]athering information from the patient for the forensic medical history; [h]ead-to-toe examination of the patient; [d]ocumentation of biological and physical findings; and [c]ollection of evidence from the patient."¹⁸ "The inclusion of additional procedures (e.g., testing for sexually transmitted diseases) may be determined by the State[...]in accordance with its current laws, policies, and practices."¹⁹

While VAWA made noble strides to improve access to SAFEs, sexual assault survivors often require additional medical services, such as diagnosis and treatment for physical injuries and mental health problems.²⁰ Such services can also include extended inpatient stays and access to prescription drugs, all of which can be costly.²¹ While some of these costs are covered by health insurance, many survivors are still responsible for large out-of-pocket costs.²² To address this issue, several states have enacted their own laws that implement

13. Kelly Wallace, *After #MeToo, More Women Feeling Empowered*, CNN HEALTH (Dec. 27, 2017), <https://www.cnn.com/2017/12/27/health/sexual-harassment-women-empowerment/index.html>.

14. Carolyn Crist, *Rape Victims in U.S. Made to Pay Part of the Medical Bill*, REUTERS: HEALTH NEWS (Apr. 20, 2017), <https://www.reuters.com/article/us-health-rape-usa-costs/rape-victims-in-u-s-made-to-pay-part-of-the-medical-bill-idUSKBN17M2KU>.

15. See Violence Against Women Act of 1994, Pub. L. No. 103-322, § 40121, 108 Stat. 1796, 1915 (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)); Violence Against Women and Department of Justice Reauthorization Act of 2005 § 101(f); Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, § 101(2)(M), 127 Stat. 54, 69 (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)).

16. See Violence Against Women Act of 1994 § 40121 (showing that VAWA uses the term "forensic medical examination"); 28 C.F.R. § 90.2 (2019) (showing that VAWA's implementing regulations use and define the term "forensic medical examination").

17. 28 C.F.R. § 90.2(c).

18. *Id.* § 90.2(c)(1).

19. *Id.* § 90.2(c)(3).

20. See, e.g., Joan C. Chrisler & Sheila Ferguson, *Violence Against Women as a Public Health Issue*, ANNALS N.Y. ACAD. SCI., Nov. 2006, at 235, 237–38, 242 (detailing the physical and mental injuries experienced by domestic sexual assault victims).

21. See *id.* at 237; Ashlee M. Tennessee et al., *The Monetary Cost of Sexual Assault to Privately Insured US Women in 2013*, 107 AM. J. PUB. HEALTH 983, 985 (2017).

22. Tennessee et al., *supra* note 23, at 985.

additional protections and guarantees.²³ However, VAWA expired in early 2019, leaving survivors to navigate the complex and confusing patchwork of state laws without a consistent federal standard.²⁴ Consequently, federal and state legislative, regulatory, and enforcement action is needed to ensure that sexual assault survivors receive appropriate care and that such care is covered.

Part II of this article provides overviews of sexual assault in the United States and the appropriate follow-up health care services that survivors need. It also identifies the barriers to accessing and affording appropriate health care services following a sexual assault and applicable laws governing provision and payment for such services. Part III analyzes potential remedies for survivors who are denied access to SAFEs and related services, including Emergency Medical Treatment and Labor Act (EMTALA). Part IV provides recommended actions at both the state and federal levels that will better ensure access to and coverage of SAFEs and related services.

II. BACKGROUND

Sexual assault continues to be a major public health problem in the United States²⁵ Despite this prevalence, survivors of sexual assault all too often face challenges accessing and affording quality health care following an assault.

A. *Defining Sexual Assault and Appropriate Treatment*

Sexual assault occurs when a person forces unwanted sexual contact on another, including actual or attempted sexual intercourse, child molestation, oral or anal sexual actions, incest, or fondling.²⁶ Force may be exerted through physical actions, threats, coercion, substances, or deception.²⁷ Anyone may become a survivor of sexual assault regardless of age, race, gender, or

23. See, e.g., CAL. PENAL CODE § 13823.95 (West 2019); MISS. CODE ANN. § 99-37-25(1) (2019); N.J. STAT. ANN. § 52:4B-52 (West 2019).

24. *Violence Against Women Act Reauthorization Threatened*, AM. B. ASS'N (May 16, 2019), https://www.americanbar.org/advocacy/governmental_legislative_work/publications/washington_letter/may2019/vawa_update/.

25. Am. Coll. of Obstetricians & Gynecologists, *ACOG Committee Opinion Number 777*, 133 OBSTETRICS & GYNECOLOGY e296, e297 (2019), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Sexual-Assault?IsMobileSet=false>. See also ASS'N FOR THE TREATMENT OF SEXUAL ABUSERS, SEXUAL ABUSE AS A PUBLIC HEALTH PROBLEM 1 (2011) (discussing sexual abuse as a public health problem).

26. *About Sexual Abuse*, NAT'L CTR. FOR VICTIMS CRIME, <http://victimsofcrime.org/our-programs/dna-resource-center/untested-sexual-assault-kits/about-sexual-assault> (last visited Mar. 6, 2020).

27. See *id.*

socioeconomic class, and most assaults happen by someone the survivor knows.²⁸ The legal definition of sexual assault varies from state to state.²⁹

Unfortunately, sexual assault is highly prevalent in the United States. According to the U.S. Department of Justice (DOJ), 734,630 instances of sexual assault were reported in 2018.³⁰ The actual number of sexual assaults that occur each year is likely much higher because sexual assaults are largely underreported.³¹

Survivors of sexual assault are an extremely vulnerable population that have been subjected to physical and emotional trauma.³² At a minimum, treatment following a sexual assault should include a SAFE with treatment of injuries that require immediate attention and any necessary follow-up care, such as preventive treatment for sexually transmitted infections (STIs).³³ Yet, survivors may require additional related services in addition to a SAFE, including specialized trauma-sensitive medical care that adequately treats physical injuries; screens for pregnancy, internal bleeding, and STIs; and care for psychological needs.³⁴ Acute traumatic injuries may include minor injuries, such as scratches, bruises, and welts, as well as more extensive injuries, such as fractures, head and facial trauma, lacerations, bullet wounds, or even death.³⁵ Injuries to sex organs may be severe enough to require surgical intervention.³⁶ Other medical consequences include STIs; mental health conditions, such as

28. *Id.*

29. Am. Coll. of Obstetricians & Gynecologists, *supra* note 25, at e296. See 34 U.S.C. § 12291(a)(29) (2018) (defining sexual assault as “any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent.”).

30. RACHEL E. MORGAN & BARBARA A. OUDEKERK, U.S. DEP’T OF JUSTICE, CRIMINAL VICTIMIZATION, 2018, at 4 (2019).

31. Cameron Kimble & Inimai M. Chettiar, *Sexual Assault Remains Dramatically Underreported*, BRENNAN CTR. FOR JUST. (Oct. 4, 2018), <https://www.brennancenter.org/our-work/analysis-opinion/sexual-assault-remains-dramatically-underreported>.

32. See KATIE BUSH, EMERGENCY NURSES ASS’N & INT’L ASS’N OF FORENSIC NURSES, ADULT AND ADOLESCENT SEXUAL ASSAULT PATIENTS IN THE EMERGENCY CARE SETTING 1 (2016).

33. See, e.g., U.S. DEP’T OF JUSTICE, OFFICE ON VIOLENCE AGAINST WOMEN, A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS: ADULTS/ADOLESCENTS (2d ed. 2013) (“Despite variations, however, it is critical that every kit meets or exceeds minimum guidelines for contents: broadly including a kit container, instruction sheet and/or checklist, forms, and materials for collecting and preserving all evidence required by the applicable crime laboratory. Evidence that may be collected includes, but is not limited to, clothing, foreign materials on the body, hair (including head and pubic hair samples and combings), oral and anogenital swabs and smears, body swabs, blood and urine samples for possible alcohol and/or toxicology testing, and a blood or saliva sample for DNA analysis and comparison.”). *What Is a Rape Kit?*, RAPE, ABUSE & INCEST NAT’L NETWORK, <https://www.rainn.org/articles/rape-kit> (noting the importance of follow-up care for STIs, pregnancy, and treatment for trauma) (last visited May 11, 2020).

34. BUSH, *supra* note 32, at 1.

35. Am. Coll. of Obstetricians & Gynecologists, *supra* note 25, at e297.

36. *Id.*

posttraumatic stress disorder; and risk of unintended pregnancy.³⁷ As such, medical experts recommend that survivors of sexual assault seek medical attention as soon as possible.³⁸

B. Identifying Barriers to Treatment

Several factors have contributed to the lack of access to and coverage of appropriate care for survivors of sexual assault.

1. No Provision of Treatment

The DOJ's Office on Violence Against Women (OVW) notes that there is a lack of thorough knowledge of how many survivors seek medical care and what services are rendered.³⁹ Nonetheless, it is clear that a significant number of sexual assault survivors do not seek medical treatment.⁴⁰ In fact, a 2012 survey published in the *American Journal of Preventive Medicine* found that only twenty-seven percent of survivors sought medical attention.⁴¹

Sexual assault survivors who do seek medical care in the ED are often turned away for several reasons. For instance, hospitals may lack properly trained professionals to administer a SAFE.⁴² Best practices generally recommend that

37. *Id.* at e296.

38. *See, e.g., id.* at e296 (“Sexual violence continues to be a major public health problem affecting millions of adults and children in the United States Obstetrician–gynecologists and other women’s health care providers play a key role in the evaluation and management of sexual assault survivors and should screen routinely for a history of sexual assault. When sexual violence is identified, individuals should receive appropriate and timely care.”); Carol K. Bates, *Patient Education: Care After Sexual Assault (Beyond the Basics)*, UPTODATE (Apr. 4, 2019), <https://www.uptodate.com/contents/care-after-sexual-assault-beyond-the-basics/print> (noting that after a sexual assault, survivors should “[s]eek medical care. If possible, [survivors should] not change clothes, bathe, douche, or brush [their] teeth until evidence is collected. A complete medical evaluation includes evidence collection, a physical examination, treatment, and/or counseling. You do not have to do any part of this evaluation that you do not want to do.”); *Receiving Medical Attention*, RAPE, ABUSE & INCEST NAT’L NETWORK, <https://www.rainn.org/articles/receiving-medical-attention> (“After a sexual assault, you may wish to seek medical attention to treat any possible injuries and to check for injuries you may not be able to see.”) (last visited May 11, 2020).

39. U.S. DEP’T OF JUSTICE, OFFICE ON VIOLENCE AGAINST WOMEN, S.T.O.P. PROGRAM 2010 REPORT 64 (2010), (“Although it is not possible to know exactly what services were provided to sexual assault survivors, subgrantees [which include SANEs and related forensic medical staff] did report that 18,921 victims/survivors were accompanied to the hospital; those hospital visits are often for forensic exams for sexual assault victims/survivors.”).

40. Heidi M. Zinzow et al., *Receipt of Post-Rape Medical Care in a National Sample of Female Victims*, 43 AM. J. PREVENTIVE MED. 183, 185 (2012) (reporting that of the 3,001 survivors of rape surveyed, only twenty-seven percent sought medical attention, with the chances of seeking care increasing with concerns of STI or pregnancy).

41. *Id.*

42. NURSING@GEORGETOWN, *Improving Health Care Access for Survivors of Sexual Assault*, GEO. U. (Nov. 4, 2019), <https://online.nursing.georgetown.edu/blog/access-to-sexual-assault-care/>.

hospitals employ a sexual assault nurse examiner (SANE) who has undergone training and received a certification to provide emergency medical, psychological, and forensic care for sexual assault survivors.⁴³ Yet, less than fourteen percent of hospitals actually employ a SANE.⁴⁴ Many hospitals find that providing access to a SANE is too financially burdensome and resource intensive because it requires four to six hours to effectively administer a SAFE.⁴⁵ Additionally, hospitals often turn survivors away because they do not deem sexual assault to be an emergency medical condition, do not carry SAFE kits, or do not treat survivors without proof of insurance.⁴⁶ Denial of care can re-traumatize survivors, deter further treatment, result in loss of forensic evidence, and cause non-obvious medical needs to be overlooked.⁴⁷

2. VAWA Was Not Reauthorized

VAWA established a federal grant program in which state, tribal, or local governments or nongovernmental survivor services organizations could apply for a Services, Training, Officers, and Prosecutors (STOP) Violence Against Women grant to improve law enforcement, prosecution, or survivor service capacities in the state.⁴⁸ As a condition of receiving STOP funding, states were

43. *See generally* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-334, SEXUAL ASSAULT: INFORMATION ON TRAINING, FUNDING, AND THE AVAILABILITY OF FORENSIC EXAMINERS 5–8 (2016) (stating that the “DOJ, IAFN [International Association of Forensic Nurses], and the American College of Emergency Physicians (ACEP) recommend that sexual assault forensic exams be performed by specially trained medical providers—or sexual assault forensic examiners” which includes SANEs). *See also* White, *supra* note 12, at 5–6 (discussing the value of SANEs).

44. *SANEs in Level 1 and 2 Trauma Centers Policy Paper*, INT’L ASS’N FORENSIC NURSES (2017), https://cdn.ymaaws.com/www.forensicnurses.org/resource/resmgr/position_papers/sanes_in_trauma_centers_poli.pdf.

45. *See generally* Caitlin Flynn, *America Has a Rape Kit Crisis*, DAME (Mar. 4, 2019), <https://www.damemagazine.com/2019/03/04/america-has-a-rape-kit-crisis/>.

46. *Id.* Keenan, *supra* note 1.

47. *See generally* Srikala Subramanian & Jennifer S. Green, *The General Approach and Management of the Patient Who Discloses a Sexual Assault*, 112 MO. MED. 211, 211–17 (2015); White, *supra* note 12, at 6.

48. *See* Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, § 2005, 108 Stat. 1796, 1910 (codified as amended at 34 U.S.C. § 10449(b) (2018)) (“A State, Indian tribal government, or unit of local government shall be deemed to incur the full out-of-pocket cost of forensic medical exams for victims of sexual assault if any government entity—(1) provides such exams to victims free of charge to the victim; (2) arranges for victims to obtain such exams free of charge to the victims; or (3) reimburses victims for the cost of such exams.”); Martha Burt et al., *The Violence Against Women Act of 1994: Evaluation of the STOP Block Grants to Combat Violence Against Women*, URB. INST. 8 (1996), <https://www.urban.org/sites/default/files/publication/70186/306621-Evaluation-of-the-STOP-Block-Grants-to-Combat-Violence-Against-Women-Act-of—The-Violence-Against-Women-Act-of—Report-.PDF> (discussing how the DOJ implemented grant funding referenced in VAWA 1994 to establish formula grants known as “STOP grants”); Violent Crime Control and Law Enforcement Act of 1994 § 2001(b) (“Grants under this part shall provide personnel, training, technical assistance, data collection and other equipment for

required to cover the full out-of-pocket cost of SAFEs.⁴⁹ Full out-of-pocket costs included “any expense that may be charged to a victim in connection with a [SAFE] forensic medical examination for the purpose of gathering evidence of a sexual assault,” such as the full cost of the examination, insurance deductible, or fees established by the facility that has conducted the SAFE.⁵⁰ States could use their own revenues, other discretionary federal funds, or STOP grant funding to cover additional services.⁵¹

States that did not apply for grants were under no obligation to provide free SAFEs.⁵² However, all fifty states, the District of Columbia, and all five U.S. territories had received STOP funding.⁵³ A majority of states paid for SAFEs through their victims’ compensation funds, with a minority of states using prosecution or law enforcement funds.⁵⁴ Other states have employed different payment models, such as requiring the state departments of health to establish funding to pay for SAFEs or by allocating funding for SAFEs per county.⁵⁵ Surprisingly, STOP funds have not typically been used to cover the cost of SAFEs.⁵⁶

VAWA discouraged states from billing a survivor’s health plan.⁵⁷ A state could only bill a survivor’s private insurance for a SAFE if it did not use STOP program funds to pay for the cost of the exams.⁵⁸ In addition, the state or one of

the more widespread apprehension, prosecution, and adjudication of persons committing violent crimes against women.”).

49. Violent Crime Control and Law Enforcement Act of 1994 § 2005.

50. 28 C.F.R. § 90.14 (2019) (providing that if an individual is covered by insurance, the full out-of-pocket costs are any costs that the insurer does not pay).

51. Janine Zweig et al., *Who Pays for Sexual Assault Medical Forensic Exams? It Is Not the Victim’s Responsibility*, URB. INST. 1, 1–4 (May 2014), <https://www.urban.org/sites/default/files/publication/32581/413122-Who-Pays-for-Sexual-Assault-Medical-Forensic-Exams-It-Is-Not-the-Victim-s-Responsibility.pdf> (discussing different models states employ to allocate a combination of state and federal funds to cover services mandated by VAWA and additional related services).

52. *Id.* at 1.

53. FY 2019 OVW Grant Awards by State, U.S. DEP’T JUST. (Oct. 16, 2019), <https://www.justice.gov/ovw/awards/fy-2019-ovw-grant-awards-by-state>. See also Burt et al., *supra* note 48, at vi, 27.

54. Zweig et al., *supra* note 51, at 1–2 (“Victim compensation funds are by far the largest designated source of funds to pay for medical forensic exams across the United States, and compensation fund administrators are most likely to be the designated paying agency (whether using compensation funds or a special funding source). Two-thirds of states use compensation funds to pay for at least some exams, and more than one-third use *only* these funds to pay for exams. No other funding source is tapped so heavily for this purpose.”).

55. *Id.* at 2.

56. *Id.* at 1 (finding that “STOP funds are the funding source least likely to be designated to cover exams. STOP administrative offices are the least likely to pay bills. This is surprising, because the state’s STOP program eligibility is at stake when the VAWA 2005 requirement is not met.”).

57. See 28 C.F.R. § 90.14 (2019).

58. See *id.* § 90.14.

its governmental entities were required to pay for any portion of the SAFE that the insurer did not cover; the survivor could not be billed for those expenses.⁵⁹

In each new version of VAWA, Congress determined how many years to reauthorize the law, it made appropriations, and it made additional substantive changes to the law.⁶⁰ For example, the 2005 reauthorization required all states and local governmental entities to certify that they have protocols in place to comply with requirements that SAFEs be provided at no cost as a condition to qualify for STOP grants.⁶¹ The 2005 reauthorization also stated that STOP grantees were prohibited from “requir[ing] a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam [SAFE], reimbursement for charges incurred on account of such exam, or both.”⁶² Notably, although VAWA expired in 2011, its programs continued to receive appropriations for both fiscal years 2012 and 2013 before the law was reauthorized again in 2013.⁶³ This demonstrates that programs created under VAWA can still receive appropriations even if the law has not been reauthorized.

By the end of 2018, VAWA had become entrenched in political controversy over whether to include a provision that would limit access to firearms for dating partners who were not legally married and had been convicted of abuse or were under a restraining order.⁶⁴ Consequently, VAWA expired on February 15, 2019

59. *Id.*

60. *See* Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, § 1701(k), 108 Stat. 1796, 1810–11 (“The authority under subsection (a) of this section to make grants for the hiring and rehiring of additional career law enforcement officers shall lapse at the conclusion of 6 years from the date of enactment.”); Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109-162, § 101, 119 Stat. 2960, 2974 (2006) (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)); Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, 127 Stat. 54 (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)). *See also* CONG. REVIEW SERV., THE VIOLENCE AGAINST WOMEN ACT (VAWA): HISTORICAL OVERVIEW, FUNDING, AND REAUTHORIZATION 1 (2019) (discussing the history of VAWA’s reauthorizations and appropriations).

61. Violence Against Women and Department of Justice Reauthorization Act of 2005 § 101(f). *See also* *Certification of Compliance with the Statutory Eligibility Requirements of the Violence Against Women Act as Amended, STOP Formula Grant Program*, U.S. DEP’T JUST., <https://www.justice.gov/ovw/page/file/1144416/download> (last visited May 11, 2020).

62. Violence Against Women and Department of Justice Reauthorization Act of 2005 § 101(f).

63. CONG. REVIEW SERV., *supra* note 60, at 16.

64. Jordain Carney, *Senate Talks on Stalled Violence Against Women Act Reauthorization Unravel*, HILL (Nov. 8, 2019), <https://thehill.com/homenews/senate/469635-senate-talks-on-stalled-violence-against-women-act-reauthorization-unravel> (“The bill would eliminate the so-called boyfriend loophole by expanding a current ban on firearm purchases for spouses or formerly married partners convicted of abuse or under a restraining order to include dating partners who were never legally married. More than 30 House Republicans voted for the measure. But the opposition from most House Republicans, as well as the NRA, made it unlikely it would pass the GOP-controlled Senate.”).

and has not been reauthorized as of May 2020.⁶⁵ Without VAWA in place, it is unclear whether states will still offer sufficient protections or allocate any funds to guarantee access to and coverage of care for survivors of sexual assault.

3. Hospitals Bill Survivors Incorrectly

Even when VAWA was authorized, hospitals still charged many survivors large sums of money for SAFEs, and survivors were sometimes harassed for years by collection agencies.⁶⁶ In 2014, advocacy groups from thirteen states reported that many hospitals or providers had billed patients directly rather than billing the state.⁶⁷ A June 2017 study in the *American Journal of Public Health* revealed that hospitals do not have separate billing procedures for privately-insured survivors of sexual assault and privately-insured patients who do not present for sexual assault.⁶⁸ As such, patients who present for sexual assault are billed directly for services that they receive at the hospital, regardless of laws that are or were in place to prohibit billing for certain medical treatment for sexual assault.⁶⁹

Not only could the billing and collections process retraumatize survivors, but sending bills to a survivor's house creates a chance that others in the house could learn of the sexual assault or that the survivor received care.⁷⁰ The perpetrator could be a partner or spouse who lives in the same house as the survivor, so sending such a bill could put the survivor in danger.⁷¹

4. Additional Treatment and Services Are Cost Prohibitive

While survivors may need access to the treatments and services identified above, VAWA only required that state, tribal, and other local governments cover

65. *Violence Against Women Act Reauthorization Threatened*, *supra* note 24. See also Search Results list for “violence against women act”, CONGRESS.GOV, <https://www.congress.gov/search?q={%22source%22:%22legislation%22,%22search%22:%22violence%20against%20women%20act%22}&searchResultViewType=expanded&KWICView=false> (last visited May 25, 2020) (a search of Congress.gov shows multiple attempts at introducing bills to authorize VAWA, and none have passed).

66. Andrews, *supra* note 8.

67. Kris Van Cleave, *For Some Sex Assault Victims, Ordeal Carries Price Tag*, CBS NEWS (Nov. 12, 2014), <https://www.cbsnews.com/news/for-some-sex-assault-victims-rape-kits-come-at-a-price/>.

68. Ashley M. Tennessee et al., *The Monetary Cost of Sexual Assault to Privately Insured US Women in 2013*, AM. J. PUB. HEALTH 983, 983–86 (2017) (“The average rape cost was \$6737, of which 86%, or \$5789, was paid by the insurance provider and 14%, or \$948, was paid by the victim.”).

69. *Id.*

70. See Steve DeVane, *Cape Fear Valley Apologizes for Billing Rape Victims for Tests*, FAYETTEVILLE OBSERVER (Jan. 21, 2020), <https://www.fayobserver.com/news/20200121/cape-fear-valley-apologizes-for-billing-rape-victims-for-tests>.

71. *Id.*

the full out-of-pocket costs of SAFE as a condition of receiving STOP grant funding.⁷² These costs extend only to the cost of the SAFE itself.⁷³ Any payment for related services, such as STI screenings, was up to the state or other governmental entity that is responsible for furnishing payment.⁷⁴ Yet, hospital billing procedures often include more services than those associated with the SAFE alone, such as for pain medication or STI and pregnancy tests.⁷⁵ Therefore, survivors often faced significant out-of-pocket costs for these additional services.

III. ANALYSIS

Without VAWA providing sufficient protections for survivors of sexual assault, other legal theories should be explored so that harmed survivors can seek remedies if hospitals turn them away or inappropriately charge them for care.

A. *Potential Remedies Under EMTALA*

Sexual assault survivors who seek care at EDs after their assault and are denied access to appropriate medical treatment may be able to seek relief under EMTALA.

1. Overview of EMTALA

Historically, hospitals have acted as centers of care for indigent, disabled, elderly, incompetent, and other vulnerable members of the community.⁷⁶ While the economics of the medical industry have changed, the expectation that a person will receive dignified care at the ED nonetheless remains.⁷⁷ Yet, hospitals have an economic incentive to transfer patients who are uninsured or indigent, and often medically unstable, from a private hospital to a public hospital.⁷⁸ This “patient dumping” occurs when a medical practice denies care in a discriminatory manner, such as refusing to treat a patient based on economic,

72. See 28 C.F.R. § 90.14(a) (2019).

73. See *id.*

74. *Id.* §§ 90.14(c), 90.2.

75. Tennessee et al., *supra* note 68, at 984–85 (explaining that “[h]ospital billing procedures for privately insured victims of rape across the United States are not separate from billing procedures for privately insured nonrape patients. This standardized procedure leads hospitals to bill victims directly for services not paid under the victims’ insurance policy.”); See, e.g., Assurance of Discontinuance at 3, Brooklyn Hosp. Ctr. (N.Y. Att’y Gen. 2017) (No. 17-184) (noting in the facts that the survivor received a bill from Brooklyn Hospital combining the cost of the SAFE and related physician services).

76. Hannah R. Sullivan, *Hospital’s Obligations to Address Social Determinants of Health*, 21 *AMA J. ETHICS* 248, 248 (2019).

77. See *id.*

78. Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 *AM. U.L. REV.* 173, 181–82 nn.31–32 (2002).

racial, or mental health status.⁷⁹ Moreover, hospitals, like physicians, only have a common-law duty to treat individuals with whom they undertake a doctor-patient contractual relationship.⁸⁰ As such, EDs previously were able to turn patients with emergency medical conditions away so long as no doctor-patient relationship was formed.⁸¹

In 1986, Congress enacted EMTALA, a federal law that requires anyone who presents at a hospital with a dedicated ED, to be stabilized and treated regardless of whether the patient has insurance or is able to pay for treatment.⁸² The primary purpose of this law was to stop EDs from patient dumping in emergency situations.⁸³ EMTALA applies to hospitals that participate in the Medicare program and operate a dedicated ED.⁸⁴ This accounts for approximately eighty-seven percent of hospitals in the U.S.⁸⁵

Though EMTALA has helped to increase access to emergency care for indigent patients, the law is narrow in scope.⁸⁶ The law requires EDs to provide

79. *Id.* at 175–76.

80. *See id.* at 184–87 nn.60–62.

81. *See* Childs v. Weis, 440 S.W.2d 104, 107 (Tex. App. 1969) (stating that “[s]ince it is unquestionably the law that the relationship of physician and patient is dependent upon contract, either express or implied, a physician is not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical or surgical assistance provided that the relation of physician and patient does not exist at the time the call is made or at the time the person presents himself for treatment.”).

82. Ryan M. McKenna et al., *Examining EMTALA in the Era of the Patient Protection and Affordable Care Act*, 5 AIMS PUB. HEALTH 366, 367 (2018); 42 U.S.C. § 1395dd (2018).

83. *See* Gionis et al., *supra* note 78, at 177.

84. 42 C.F.R. § 489.24 (2019) (A dedicated ED includes “any department or facility of the hospital” that either: (1) is “licensed by the State in which it is located” as an ED; (2) “is held out to the public...as a place that provides” emergency medical care; or (3) “provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment” during the previous calendar year). *See generally* 42 U.S.C. § 1395dd; Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,230 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, and 489) (explaining that certain urgent care centers may fall within the scope of EMTALA as long as they meet the criteria of a dedicated emergency department under the law).

85. This figure was calculated by dividing 5,326, the number of hospitals with Medicare billing privileges that also have an emergency room, by 6,146 the total number of hospitals in the U.S. as reported by the American Hospital Association. *See Hospital General Information*, DATA.MEDICARE.GOV, <https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/xubh-q36u> (last visited May 25, 2020); *Fast Facts on U.S. Hospitals, 2020*, AM. HOSP. ASS’N, <https://www.aha.org/statistics/fast-facts-us-hospitals> (last visited May 25, 2020). It is important to note that this number does not include urgent care facilities, which CMS has also stated may fall within the scope of EMTALA. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. at 53,231.

86. McKenna et al., *supra* note 82.

screening, stabilization, and appropriate transfer services.⁸⁷ Under the screening requirement, a hospital must provide an appropriate medical screening⁸⁸ to any patient who presents at the ED and requests an examination or treatment to determine if he or she has an emergency medical condition (EMC).⁸⁹ EMTALA defines an EMC as a medical condition that presents as

[A]cute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy, . . . serious impairment to bodily functions, or . . . serious dysfunction of any bodily organ or part.⁹⁰

EMTALA does not set a standard for what qualifies as an appropriate screening.⁹¹ However, any material departure from the hospital's standard screening procedures, regardless of the motive, constitutes a violation of the screening requirement.⁹²

If the screening indicates that the patient has an EMC, then the ED must stabilize the EMC, unless the patient meets certain conditions to be transferred to another medical facility.⁹³ Stabilizing care must assure, within a reasonable medical probability, that no material deterioration of the condition is likely to occur.⁹⁴ The ED may not transfer a patient whose EMC has not been stabilized unless the patient requests the transfer in writing, or a physician or qualified medical person has signed a certification that the medical benefits of transfer outweigh the increased risks to the individual.⁹⁵ If a patient's EMC has been stabilized, transfer is permissible under EMTALA if the receiving facility has the capability to treat a patient, the new facility has agreed to accept the patient,

87. 42 U.S.C. § 1395dd(a)–(c).

88. *See generally id.* § 1395dd(a)–(i) (showing that EMTALA does not define appropriate medical screening).

89. *Id.* § 1395dd(a).

90. *Id.* § 1395dd(e).

91. Alicia K. Dowdy et al., *The Anatomy of EMTALA: A Litigator's Guide*, 27 ST. MARY'S L.J. 463, 476 (1996). *See also* 42 U.S.C. § 1395dd(a)–(i).

92. *See Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (“In our view, then, a hospital fulfills the ‘appropriate medical screening’ requirement when it conforms in its treatment of a particular patient to its standard screening procedures. By the same token, any departure from standard screening procedures constitutes inappropriate screening in violation of the Emergency Act. The motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him or her by subsection 1395dd(a).”); 42 U.S.C. § 1395dd(a).

93. 42 U.S.C. § 1395dd(b)–(c)(2) (establishing conditions that must be met in order to transfer, including that the receiving facility must have space and agree to receive the patient, and that the transferring hospital must send all the patient's medical records to the receiving facility and arrange for appropriate transportation).

94. *Id.* § 1395dd(e)(3)(A–B) (defining “to stabilize” and “stabilized”).

95. *Id.* § 1395dd(c)(1).

the transferring hospital provides all of the patient's medical records to the receiving facility, and appropriate and safe transportation services and discharge procedures are used.⁹⁶

Violating EMTALA's screening, stabilization, or transfer requirements exposes both the hospital and treating physician to vast civil liability.⁹⁷ Individuals who suffer a direct personal harm as a result of the violation may bring a private cause of action under EMTALA to recover equitable and monetary remedies, in addition to any personal injury claim under state law that they may have.⁹⁸ The U.S. Department of Health and Human Services (HHS) may also issue civil monetary penalties or terminate the physician's or hospital's provider agreement with Medicare.⁹⁹

2. Potential Provision of Treatment for Survivors of Sexual Assault Under EMTALA

Whether sexual assault constitutes an EMC under EMTALA's narrow statutory language must be determined on a case-by-case basis.¹⁰⁰ Only conditions severe enough to place the patient at risk of death, cause serious impairment to bodily function, or result in serious dysfunction of any bodily organ qualify as EMCs.¹⁰¹ This is a high standard to meet. However, sexual assault can be incredibly forceful and violent, resulting in serious physical injuries, such as internal bleeding, strangulation, or broken bones.¹⁰² Survivors may also be suicidal or catatonic and in need of immediate psychological treatment.¹⁰³ In such cases, these injuries could rise to the level of an EMC under EMTALA. In other cases, the lack of immediate medical treatment may not put a person's health in severe jeopardy or pose a likely risk of impairment or loss of bodily function.¹⁰⁴ Absent other serious injury, the post-trauma of sexual assault by itself may fall outside of EMTALA's protections.

96. *Id.* § 1395dd(c)(1)–(2).

97. *Id.* § 1395dd(d)(1).

98. 42 U.S.C. § 1395dd(d)(2)(A).

99. *Id.* § 1395dd(d)(3).

100. CTRS FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL: APPENDIX V – INTERPRETIVE GUIDELINES – RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES 47 (2019).

101. 42 U.S.C. § 1395dd(e)(1)(A).

102. See Marilyn S. Sommers et al., *Injuries from Intimate Partner and Sexual Violence: Significance and Classification Systems*, 19 J. FORENSIC & LEGAL MED. 250, 250–58 (July 2012).

103. See, e.g., Sarah E. Ullman, *Sexual Assault Victimization and Suicidal Behavior in Women: A Review of the Literature*, 9 AGGRESSION & VIOLENT BEHAV. 331, 332–33 (2004); DOUGLAS G. JACOBS ET AL., AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF PATIENTS WITH SUICIDAL BEHAVIORS 106–07 (2003); Elizabeth C. Neilson et al., *Sexual Assault Severity and Depressive Symptoms as Longitudinal Predictors of the Quality of Women's Sexual Experiences*, 43 J. SEX & MARITAL THERAPY 463, 464, 472–74 (2017).

104. See generally 42 U.S.C. § 1395dd(e)(1) (outlining the statutory requirements for an EMC).

In *Schramm v. Montage Health*, for example, the plaintiff arrived at the defendant hospital after suspecting that she was drugged and raped the night before.¹⁰⁵ She appeared gravely disoriented, she complained of severe pain in her neck and abdomen, and her legs were covered in scratches and bruises.¹⁰⁶ Providers at the hospital did not administer a toxicology exam to test for the presence of a “date-rape drug,” check for STIs, or administer a SAFE.¹⁰⁷ When the plaintiff attempted to leave the hospital in hopes of finding treatment elsewhere, the hospital staff physically restrained and formally detained her, claiming that she posed a danger to herself and others as a result of mental health disorder.¹⁰⁸

The plaintiff filed suit against the defendant hospital, claiming that the hospital violated EMTALA’s screening and stabilization requirements by denying her request for a SAFE.¹⁰⁹ The defendant argued that the plaintiff could not state a claim for relief under EMTALA because “sexual assault is not a medical condition manifesting itself by acute symptoms of sufficient severity.”¹¹⁰ However, the U.S. District Court for the Northern District of California found that it did not need to determine whether sexual assault was an EMC because the plaintiff had adequately pleaded that, based on her physical injuries, she arrived at the hospital with a qualifying condition.¹¹¹

Once a survivor has established that their sexual assault qualifies as an EMC, he or she then will need to establish that the hospital failed to provide an appropriate screening or did not stabilize the EMC to prevail on an EMTALA claim.¹¹² A survivor of sexual assault may be able to establish a violation of EMTALA’s screening and stabilization requirements if he or she can prove that ED staff deviated from their internal standards.¹¹³

While EMTALA does not define “appropriate medical screening,” courts have found that this language requires a hospital to provide each patient with a medical screening similar to one that it would provide to any other patient.¹¹⁴ In *C.M. v. Tomball*, for example, the mother of a fifteen-year-old girl sought medical care from the defendant hospital on the day following her daughter’s

105. See *Schramm v. Montage Health*, No. 17-cv-02757-HRL, 2018 WL 1156894, at *1 (N.D. Cal. Mar. 5, 2018).

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Schramm*, 2018 WL 1156894, at *4.

111. *Id.*

112. See 42 U.S.C. § 1395dd(a)–(b) (2018) (describing the statutory requirements in place for hospitals).

113. *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (stating that “any departure from standard screening procedures constitutes inappropriate screening”).

114. See, e.g., *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Gatewood*, 933 F.2d at 1041; *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 272 (6th Cir. 1990).

sexual assault, explaining that her daughter was in severe pain following a sexual assault.¹¹⁵ The hospital's manual had procedures in place for medical "investigations in cases of suspected sexual assault" that required detailed "procedures to be conducted by the hospital staff upon a victim's arrival."¹¹⁶ The manual stated that the purpose of these procedures was "to provide for the medical detection and emotional support of a person who has been the victim of a sexual assault to include provision of immediate safety, evidence collection, comfort, privacy, preventative and emergency medical treatment and referral services."¹¹⁷ When the head nurse learned that the daughter had bathed after the alleged sexual assault, he insinuated that he did not believe she had been assaulted, and stated "[w]e do not like to deal with rape victims, especially after they have taken a bath or a shower or anything."¹¹⁸ Subsequently, the hospital staff did not take the daughter's vital signs, did not ask for her medical history, and did not perform a physical examination.¹¹⁹ The staff performed the screening in the ED waiting room rather than in a private room.¹²⁰ The U.S. Court of Appeals of Texas found that summary judgment was improper because the evidence raised an issue of material fact as to whether the defendant hospital conducted an appropriate medical screening under EMTALA.¹²¹

A screening that fails to identify or misdiagnoses an EMC does not constitute a violation of EMTALA's screening requirement as long as the screening is reasonably designed to detect an EMC.¹²² In *Schramm v. Montage Health*, the court dismissed both of the plaintiff's screening and stabilization claims, noting that the scope of both provisions is narrow.¹²³ The court explained that "[a] hospital need only conduct a screening that is reasonably designed to identify whether the patient is suffering from an [EMC]."¹²⁴ Further, "[e]ven if a hospital negligently 'fails to detect or... misdiagnoses an [EMC], it does not violate EMTALA."¹²⁵ As such, the court held that the hospital did not violate the screening requirement because it did screen and diagnose an EMC, as

115. *C.M. v. Tomball Reg'l Hosp.*, 961 S.W.2d 236, 238–40 (Tex. App. 1997).

116. *Id.* at 241.

117. *Id.*

118. *Id.* at 242.

119. *Id.* at 240.

120. *Tomball*, 961 S.W.2d at 240.

121. *Id.* at 242.

122. *Schramm v. Montage Health*, No. 17-cv-02757-HRL, 2018 WL 1156894, at *5 (N.D. Cal. Mar. 5, 2018).

123. *Id.* See also *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1167 (9th Cir. 2002) (holding that EMTALA's stabilization requirement "normally ends when an individual is admitted for inpatient care." Consequently, because it admitted the patient for inpatient care, the hospital did not violate EMTALA).

124. *Schramm*, 2018 WL 1156894, at *5.

125. *Id.*

evidenced by its detention of the plaintiff and her subsequent hospital stay.¹²⁶ So, although the hospital may have identified the “wrong emergency,” and may not have responded to plaintiff’s rape allegation “adequately,” the hospital did not violate EMTALA.¹²⁷ The court also held that EMTALA’s stabilization requirement “ends when an individual is admitted for inpatient care.”¹²⁸ Consequently, because it admitted the patient for inpatient care, the hospital did not violate EMTALA.¹²⁹

Therefore, survivors who present at an ED and do not receive adequate care may be able to assert a claim for relief under EMTALA if they can successfully argue that the sexual assault or accompanying injuries constituted an EMC and that the hospital failed to properly screen and stabilize this EMC. Even so, a hospital still would not be obligated to include employing SANEs or providing SAFEs in its policies or by-laws. EMTALA was never meant to establish a national standard of care.¹³⁰ Thus, seeking to compel EDs to offer SAFEs and train SANE personnel is likely outside the scope of the law. Moreover, the law only obligates hospitals to treat patients until they are stable for transfer.¹³¹ As such, EMTALA’s transfer provisions may allow hospitals to continue to transfer stable survivors to hospitals that do provide SAFEs and employ SANEs, as long as the transferring hospital complies with the appropriate transfer requirements.¹³² Therefore, while EMTALA offers some potential protections, stronger protections are needed to ensure that survivors have access to care following an assault.

B. State Laws Offering Protections to Sexual Assault Survivors

Over the years, many states have enacted their own laws to expand access to health care for sexual assault survivors.¹³³ Without a federal standard currently in place, survivors of sexual assault must rely on this patchwork of state protections. Yet, a lot of the problems that plagued VAWA also plague states.

126. *Id.*

127. *Id.*

128. *Id.* (citing *Bryant*, 289 F.3d at 1167).

129. *Schramm*, 2018 WL 1156894, at *5.

130. *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708, 713 (4th Cir. 1993) (“EMTALA does not create liability for malpractice based on a breach of national or community standard of care.”).

131. 42 U.S.C. § 1395dd(c) (2018).

132. *See C.M. v. Tomball Reg’l Hosp.*, 961 S.W.2d 236, 241 (Tex. App. 1997) (stating that EMTALA “does not define ‘appropriate medical screening.’ . . . Thus, a hospital fulfills its ‘appropriate medical screening’ requirement when it conforms to its standard screening procedures.”) (first citing *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); and then citing *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 268 (6th Cir. 1990)).

133. *See, e.g.*, N.M. STAT. ANN. § 24-10D-3 (2020); MINN. STAT. § 609.35 (2019); DEL. CODE ANN. tit. 11 § 9023 (2020); CAL. HEALTH & SAFETY CODE § 1491 (West 2020); CONN. GEN. STAT. § 19a-112a (2018).

While many states have expanded access to free care for sexual assault services, they also commonly place restrictions¹³⁴ on the funding used to cover that care, including restrictions on whom qualifies as a survivor.¹³⁵ Some states exclude those who have previously been convicted of a felony, have recently been on parole, were using drugs during the time of their assault, or may have acted in a way the state determines may have “contributed” to the assault.¹³⁶ The New Mexico Sexual Assault Survivors Emergency Care Act defines a “sexual assault survivor” as only a female who presents as a patient at a hospital, excluding male survivors of sexual assault from its scope.¹³⁷

Other states place restrictions on which services are covered. Many, but not all, states mandate coverage of STI and pregnancy testing of survivors who present at the ED following a sexual assault.¹³⁸ Other states, such as Arkansas, limit coverage to health care services related to evidence collection following a sexual assault.¹³⁹ New Mexico law requires hospitals that provide emergency care for sexual assault survivors to provide emergency contraception, but the law includes no other requirements for emergency care for survivors.¹⁴⁰

When hospitals violate state law by improperly billing survivors, state regulatory authorities must take enforcement action against them to ensure compliance and set an example. New York, in particular, has taken an active role to ensure sexual assault survivors have access to affordable care.¹⁴¹ New York

134. See, e.g., Clifton Adcock, *Majority of Claims by Sexual Assault Survivors to State Crime Victim Program Are Denied, Data Shows*, FRONTIER (July 10, 2019), <https://www.readfrontier.org/stories/more-claims-by-sexual-assault-victims-to-state-program-for-compensation-are-denied-data-shows/> (showing that payment for SAFEs and related services may also be denied for procedural reasons. “Nearly two-thirds of sexual assault victims who applied for funds from Oklahoma’s Victim’s Compensation Program between Jan. 1, 2014 and Dec. 31, 2018 were denied, according to the data. Most of the denials are because the applicants could or did not submit a bill to reimburse an expense, victims advocates said, often because they could not pay for services up front” and then wait for reimbursement).

135. See, e.g., Zweig et al., *supra* note 51 (“Victim compensation funds are by far the largest designated source of funds to pay for medical forensic exams across the United States, and compensation fund administrators are most likely to be the designated paying agency (whether using compensation funds or a special funding source). Two-thirds of states use compensation funds to pay for at least some exams, and more than one-third use *only* these funds to pay for exams. No other funding source is tapped so heavily for this purpose.”).

136. Elizabeth Nolan Brown, *Where Rape Victims Are Forced to Pay for Their Own Forensic Exams*, REASON (October 9, 2014), <https://reason.com/2014/10/09/rape-victims-charged-for-forensic-tests>,

137. N.M. STAT. ANN. § 24-10D-2.

138. See, e.g., MINN. STAT. § 609.35; DEL. CODE ANN. tit. 11 § 9023; CAL. HEALTH & SAFETY CODE § 1491; CONN. GEN. STAT. § 19a-112a.

139. ARK. CODE ANN. § 12-12-401 (2020).

140. N.M. STAT. ANN. § 24-10D-3.

141. See Jen Chung, *At Least Eight NY Hospitals Caught Illegally Billing Sexual Assault Victims for Rape Kits*, GOTHAMIST (Nov. 30, 2018), <https://gothamist.com/news/at-least-eight-ny-hospitals-caught-illegally-billing-sexual-assault-victims-for-rape-kits>.

law prohibits hospitals, providers, and programs that administer SAFEs from billing survivors directly for SAFE exams.¹⁴² Exams may only be billed to the state's Office of Victim's Services unless the survivor voluntarily agrees to assign any insurance benefits to the service provider, in which case the health plan may be billed.¹⁴³

Between 2017 and 2018, New York's attorney general conducted a large-scale investigation of hospitals that allegedly improperly billed sexual assault survivors for SAFEs.¹⁴⁴ The investigation began when the attorney general received a complaint alleging that Brooklyn Hospital and a collection agency attempted seven times to collect payment from a survivor for a SAFE and related physician services, leading the survivor to file a complaint with the attorney general.¹⁴⁵

After conducting an audit of Brooklyn Hospital's billing procedures, the attorney general concluded that eighty-five of the eighty-six SAFEs had been improperly billed to patients directly or to the patient's insurance plan without advising the patient of his or her options.¹⁴⁶ Brooklyn Hospital agreed to settle prior to the attorney general commencing civil proceedings.¹⁴⁷ The hospital agreed to provide restitution to sexual assault survivors who were improperly billed, implement billing procedures with safeguards to ensure survivors are not billed, train all relevant employees annually on SAFE billing practices, and submit an initial compliance report and follow-up reports, as requested.¹⁴⁸

Subsequently, the investigation turned into a statewide probe that uncovered that at least 200 SAFEs were improperly billed, ranging from \$46 to \$3,000 each.¹⁴⁹ As a result, the attorney general entered into similar settlement agreements with at least eight other New York hospitals.¹⁵⁰

142. N.Y. EXEC. LAW § 631(13) (McKinney 2020).

143. *Id.*

144. Chung, *supra* note 141.

145. Assurance of Discontinuance, *supra* note 75, at 6–11.

146. *Id.* at 12.

147. *Id.* at 21.

148. *Id.* at 23–25.

149. Chung, *supra* note 141.

150. See Michael R. Sisak, *New York Hospitals to Repay Victims Charged for Rape Kits*, ASSOCIATED PRESS (Nov. 29, 2018), <https://apnews.com/debb5ace52cd483a994c94507d4df6e4>; Carl Campanile, *Seven Hospitals Settle with AG after Illegally Billing for Rape Kits*, N.Y. POST (Nov. 29, 2018), <https://nypost.com/2018/11/29/seven-hospitals-settle-with-ag-after-illegally-billing-for-rape-kits/>; Press Release, NY Attorney Gen., Attorney General James Announces Settlement with Hospital for Illegally Billing Rape Survivors for Rape Exams (Feb. 5, 2019). The hospitals that settled included: Brookdale University Hospital Medical Center and New York-Presbyterian/Brooklyn Methodist Hospital in Brooklyn; St. Barnabas Hospital and BronxCare in the Bronx; New York-Presbyterian/Columbia University Irving Medical Center in Manhattan; Richmond University Medical Center in Staten Island; Montefiore Nyack Hospital in Rockland County; and Columbia University. See Sisak, *supra* note 150; Campanile, *supra* note 150; Press Release, *supra* note 150.

IV. RECOMMENDATIONS TO IMPROVE ACCESS TO CARE

While survivors may be able to employ current federal and state laws to gain access to and coverage of health services, there are still many deficiencies in the system, and survivors should not be left to traverse a complex and unpredictable legal system in the aftermath of trauma. Stronger laws, regulations, and enforcement mechanisms are necessary to ensure that hospitals provide and pay for SAFEs and related health services.

A. *Reauthorize VAWA's Protections*

Congress should reauthorize VAWA. However, in light of the political controversies surrounding the provisions of the 2018 VAWA reauthorization pertaining to firearms, Congress could also choose to enact a new bill that includes only VAWA's provisions aimed at increasing access to free SAFEs and related health care services. These provisions are not controversial and would improve the quality of health care provided to sexual assault survivors. Regardless of whether Congress were to reauthorize VAWA in its entirety or only the provisions regarding access to health services, the future legislation should incorporate stronger enforcement and oversight mechanisms and expand the scope of services required to be covered.

First, grants under VAWA have historically only required state, tribal, and territorial governments to cover the out-of-pocket costs of SAFEs.¹⁵¹ This narrow provision left gaps that allowed survivors to be billed for necessary related health services that may cost the survivor significant sums of money following an assault.¹⁵² Future reauthorizations of VAWA should expand the scope of SAFEs to include related services, such as services associated with treating physical injuries resulting from a sexual assault, mental health services, screening for pregnancy, internal bleeding exams, and STI testing, and the reauthorizations should also require governmental STOP grant recipients to cover the out-of-pocket costs related to such services.

Second, future VAWA reauthorizations should establish stronger compliance, oversight, and enforcement mechanisms. As noted above, VAWA required STOP grantees to certify that they have protocols in place to ensure that hospitals within their jurisdiction provide free SAFEs to survivors as a condition

151. See Violence Against Women Act of 1994, Pub. L. No. 103-322, § 2000(b), 108 Stat. 1796, 1910 (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)); Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109-162, § 101(f), 119 Stat. 2960, 2974 (2006) (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)); Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, §101, 127 Stat. 54, 69 (codified as amended at 42 U.S.C. §§ 13701–14040 (2018)).

152. See Andrews, *supra* note 8 (discussing variations states have taken surrounding billing).

for funding.¹⁵³ OVW should conduct independent investigations of STOP grantees' compliance protocols. To improve oversight, OVW should then submit an annual or biannual report to Congress on whether STOP grantees are following certification requirements and ensuring that hospitals within their jurisdiction are not illegally or unfairly billing survivors. If systematic noncompliance in a state or local government is identified, then OVW should discontinue STOP funding support. Such oversight and enforcement mechanisms would help improve the likelihood that survivors who seek care receive it at no cost, as VAWA intended.

B. *Essential Health Benefits*

Under VAWA and state laws, state and federal funding supported medical services for sexual assault survivors. However, insurers could also provide such services at little or no cost to survivors. Such services could be added to the emergency services category of essential health benefits (EHBs) under the Patient Protection and Affordable Care Act (ACA).

The ACA established a set of ten categories of services that all non-grandfathered individual and small group health plans sold in the marketplace must cover.¹⁵⁴ EHBs include ambulatory patient services, mental health and substance use disorder services, and hospitalization, among other benefits.¹⁵⁵ Each state may clarify which services are covered within each EHB category.¹⁵⁶ All non-grandfathered individual and small group plans must offer, at a minimum, the coverage provided by the benchmark plan selected by each state.¹⁵⁷ HHS may also implement new categories of EHBs if necessary.¹⁵⁸ Additionally, the ACA restricts what limitations that health plan may place on EHB services, including limitations on cost sharing, prior authorization, and out-

153. *Certification of Compliance with the Statutory Eligibility Requirements of the Violence Against Women Act as Amended, STOP Formula Grant Program*, *supra* note 61.

154. 42 U.S.C. § 18022(b)(1) (2018) (listing the ten minimum EHB categories as: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).

155. *Id.*

156. Ian Spatz & Michael Kolber, *The Future of Essential Health Benefits*, HEALTH AFF. (Feb. 14, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170214.058765/full>.

157. *Information on Essential Health Benefits (EHB) Benchmark Plans (2020)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb> (last visited May 13, 2020).

158. 42 U.S.C. § 18022(b)(1)–(2) (granting authority to the HHS Secretary to determine and periodically review and revise EHB coverage, “except that such benefits shall include at least the following general [ten] categories and the items and services” listed in the statute).

of-network fees.¹⁵⁹ Notably, certain EHB services, such as preventive services, must be covered with no cost-sharing, including copay requirements.¹⁶⁰

EHBs remain a key point of contention in the health care reform debate.¹⁶¹ Many reformers point to EHBs as driving up the costs of insurance premiums and reducing insurance companies' ability to tailor plans to individuals who desire lower coverage.¹⁶² Given the current political nature of the ACA¹⁶³ and health care at large, adding a new category of EHB under federal law is likely too costly, both politically and economically, to be a feasible option. However, states could issue regulations clarifying that SAFEs and related services fall within the preexisting EHB category for emergency services. States could also select a benchmark plan that provides such services free of charge. Alternatively, states with legislatures that are more favorable to coverage expansion could designate SAFEs and related services as a separate EHB category required to be covered for plans sold within their state.

159. *Id.* § 18022(b)–(c).

160. *See Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, KAISER FAM. FOUND. 1–3 (Aug. 2015), <http://files.kff.org/attachment/preventive-services-covered-by-private-health-plans-under-the-affordable-care-act-fact-sheet>. *See also* 42 U.S.C. § 300gg–13(a) (providing that preventive services for women, preventive services for children, immunizations, and evidence-based screenings and counseling must be covered at no cost to insureds).

161. *See* Amanda Cassidy, *Essential Health Benefits: States Have Determined the Minimum Set of Benefits to be Included in Individual and Small-Group Insurance Plans. What's Next?*, HEALTH AFF. 1, 1 (May 2, 2013), https://www.healthaffairs.org/doi/10.1377/hpb20130502.454771/full/healthpolicybrief_91.pdf; Julia Belluz, *The Republican Attack on "Essential Health Benefits," Explained*, VOX (May 4, 2017), <https://www.vox.com/2017/3/23/15031322/the-fight-over-essential-health-benefits-explained>; Matthew Fiedler, *Allowing States to Define "Essential Health Benefits" Could Weaken Protections Against Catastrophic Costs for People with Employer Coverage Nationwide*, USC-BROOKINGS SCHAEFFER ON HEALTH POL'Y (May 2, 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/05/02/allowing-states-to-define-essential-health-benefits-could-weaken-aca-protections-against-catastrophic-costs-for-people-with-employer-coverage-nationwide/>.

162. Spatz & Kolber, *supra* note 156.

163. *See Texas v. United States*, 945 F.3d 355, 369 (5th Cir. 2019) (holding that the ACA's "individual mandate is unconstitutional because it can no longer be read as a tax" and remanding the case to the lower court to determine which sections of the ACA should be struck down); Katie Keith, *Texas at the Supreme Court: The Latest*, HEALTH AFF. (Feb. 21, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200221.66921/full/> (noting that the Supreme Court has granted certiorari on *Texas v. United States*. The entire ACA is currently in jeopardy awaiting the Court's decision).

C. *States Should Enact Laws to Improve Access to SAFEs and Related Services*

Considering the turbulent nature of the federal health care reform, states may have more flexibility and political power to systematically reform the treatment of survivors within their jurisdiction.

1. Provision of Services

States should enact laws that require all hospitals to implement a protocol to offer SAFEs and related services by a SANE or other specially trained medical professional. Additional related services should include adequately treating physical injuries; screening for pregnancy, internal bleeding, and STIs; and providing care for psychological needs. The law should also require hospitals to have a protocol in place to ensure that the survivor receives services, even in situations in which a SANE or other qualified professional is not readily available. Such protocols can be implemented through telehealth services connecting untrained staff to a SANE or through programs that coordinate between facilities to provide mobile SAFEs.¹⁶⁴

2. Payment of Services

To ensure that services are paid for, state law should require that all hospitals and health care providers who choose to perform SAFEs provide these exams at no cost to the survivor. As such, the state should designate victim's compensation funds to compensate hospitals or health care providers for administering the SAFE and related services. Moreover, in the event that a survivor is billed in violation of the law, the law should require the health care provider to reimburse the survivor for any unauthorized charge in timely manner.

State law should also ensure that funding designated to pay for SAFEs and related services is not restricted based on substantive or procedural requirements. For example, such services should not be restricted to just women who are sexually assaulted. Likewise, states should not exclude survivors who have been convicted of a felony, have recently been on parole, were using drugs during the time of their assault, or may have acted in a way the state determines may have "contributed" to the assault. As such, state laws that currently impose

164. See Wendy A. Walsh et al., *Using Telehealth for Sexual Assault Forensic Examinations: A Process Evaluation of a National Pilot Project*, 15 J. FORENSIC NURSING 152–162 (July 2019) (discussing the current and potential use of telehealth to assist in the provision of SAFEs and related services). See generally MD. CODE ANN., HEALTH–GEN. § 19-310.2 (West 2014); PLANNING COMM. TO IMPLEMENT IMPROVED ACCESS TO SEXUAL ASSAULT MED. FORENSIC EXAMINATIONS IN MD., MD. DEP'T OF HEALTH & HYGIENE, REPORT TO THE GOVERNOR, THE SENATE FINANCE COMMITTEE, AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE 3 (2015).

such restrictions will need to be amended and expanded to remove arcane restrictions.

3. Oversight and Enforcement

States should establish reporting requirements for hospitals to ensure that they are in compliance with the law. For instance, states may require hospitals to report data on how many patients presented at the ED for sexual assault; how many were either admitted and treated, turned away, or transferred; general rationale for turning away or transferring patients; and how patients who received treatment were billed. Alternatively, billing documentation that shows that the provider billed the state victims' compensation fund or obtained voluntary consent from a survivor to assign his or her insurance benefits to the health care provider could be submitted to an appropriate designated agency, such as a state medical board, department of health, or the attorney general.¹⁶⁵ Reporting mechanisms will need to be consistent with patient privacy laws, such as Health Insurance Portability and Accountability Act (HIPAA) and incorporate adequate patient privacy protections. Under HIPAA, protected health information¹⁶⁶ may be disclosed to a health oversight authority¹⁶⁷ for oversight activities that have been authorized by law. Even so, laws that implement reporting requirements should take care to limit the disclosure of individually identifiable information of sexual assault survivors. Reporting requirements should require the redaction of personal health information that is not necessary to ensure compliance with the law.

States should require the designated agency to conduct oversight of hospitals and health care providers to 1) ensure compliance through routine and

165. See Assurance of Discontinuance, *supra* note 75, at 22, 24(a-c) (instituting record keeping and routine reporting requirements on Brooklyn Hospital to increase compliance with New York laws governing the billing of survivors).

166. 45 C.F.R. § 164.512 (2019). See *id.* § 160.103 (“Protected health information means individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information: (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; (ii) In records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); (iii) In employment records held by a covered entity in its role as employer; and (iv) Regarding a person who has been deceased for more than 50 years.”). See also *id.* § 164.501 (“Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.”).

167. 28 C.F.R. § 90.13(e) (2018).

randomized audits, and 2) identify and take enforcement action against those who violate the law. States should also ensure that their laws contain penalties that are steep enough to compel compliance. Penalties should include both restitution to survivors and significant fines to deter noncompliance.

4. Increase Awareness of Provision and Payment of Services

Finally, many survivors may not be aware that they are entitled to medical services following a sexual assault. While VAWA required states or other governmental entities responsible for paying the cost of SAFEs to coordinate with health care providers to notify survivors of the availability of free sexual assault services,¹⁶⁸ oftentimes survivors do not receive such notification. As such, the creation and distribution of educational materials or programs for survivors is critical in ensuring that survivors are aware of their options for care, and, when available, that they are entitled to such care at no cost. Such materials should also provide information on how to file a complaint with the appropriate state regulatory authority if a hospital turns a survivor away or if a survivor receives an erroneous bill so that they are fully aware of how to exercise their legal rights.

V. CONCLUSION

The momentum brought by the #MeToo movement made important strides in cracking the culture of silence surrounding sexual assault and empowering survivors to seek justice, if they so choose. Survivors must now be equally empowered to promptly seek care, and the health system must be reformed to guarantee that those who do seek such care receive it at little to no cost. True accessibility requires both coverage reform as well as actions to incentive hospitals to offer the services. To truly begin to move toward justice for survivors, the health system must change.

168. 28 C.F.R. § 90.13(e).

