ROB BONTA
ATTORNEY GENERAL

LETITIA JAMES
ATTORNEY GENERAL

July 28, 2021

Via Federal eRulemaking Portal

The Honorable Xavier Becerra
Secretary of the U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244–8016
Attention: CMS-9906-P

RE: Notice of Proposed Rulemaking: "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond"
[RIN: 0938-AU60; file code CMS-9906-P]

Dear Secretary Becerra and Administrator Brooks-LaSure:

The undersigned Attorneys General of California, New York, Colorado, Illinois, Maine, Maryland, Massachusetts, Oregon, Vermont, Washington, and the District of Columbia (the States) write in support of the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services' (collectively HHS) Proposed Rule seeking to reverse the Trump Administration's so called "Program Integrity Rule" of 2019, better known as the Separate Abortion Billing Rule, which impacted the compliance requirements of Section 1303 of the Affordable Care Act (ACA).[1] The Separate Abortion Billing Rule (or the 2019 Rule) required issuers (insurance companies) to send consumers two separate premium bills for their health coverage: one bill for at least $1 for abortion coverage and another bill for a consumer's remaining health benefits. Under the 2019 Rule, should a consumer fail to pay the $1, the consumer would lose their *entire* health coverage. The 2019 Rule did nothing to protect the

[1] 86 Fed. Reg. 35,156 (July 1, 2021) at https://www.govinfo.gov/content/pkg/FR-2021-07-01/pdf/2021-13993.pdf.

integrity of the ACA Exchanges, but instead threatened our residents' health coverage and placed excessive and unnecessary burdens on our State agencies and health insurance markets.[2]

We support HHS's reversal of the 2019 Rule and believe the Proposed Rule can strengthen one of the core purposes of the ACA—to make healthcare more accessible and affordable for consumers. The Proposed Rule recognizes the overwhelming evidence of consumer harm that the Trump Administration ignored in its 2019 Rule and addresses those harms by removing burdensome requirements that threatened to exacerbate health disparities and jeopardize public health. Over the past year, these existing health disparities were brought into sharp focus by the ongoing COVID-19 pandemic. At a time when public confidence is most fragile and health insurance more necessary than ever, the Proposed Rule fully appreciates that the public interest is advanced by reducing consumer confusion, eliminating barriers to coverage, and mitigating the administrative costs of resource-taxed State agencies.

The States successfully challenged the legality of the 2019 Rule and retain a strong interest in ensuring no future administration attempts to usurp Section 1303's requirements in a manner that impedes the States' policies to advance women's reproductive health.[3] The States commend HHS for its Proposed Rule and respectfully request that HHS consider the comments below.

A. The Trump Administration's 2019 Rule Harmed Consumers and Threatened Women's Healthcare

Through various comments, during the 2019 Rule's public comment period and via the various letter campaigns following, the States[4] and many others alerted the Trump Administration to the unreasonableness of the 2019 Rule's implementation and its unjustifiable outcome of coverage termination for any nonpayment of $1.[5] Coverage termination would lead

---

[2] As the Proposed Rule confirms, the 2019 Rule did not further Section 1303's aims, and "is ultimately nonessential to…issuer compliance." 86 Fed. Reg. at 35,178.

[3] *See California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992 (N.D. Cal. July 20, 2020) (holding that the 2019 Rule constituted arbitrary and capricious agency action, in violation of the APA); *Washington v. Azar*, 461 F. Supp. 3d 1016 (E.D. Wash. 2020) (finding that the 2019 Rule was in conflict with and did not preempt Washington's "Single-Invoice Statute," 85 Wash. Rev. Code § 48.43.074). The States of Illinois and Massachusetts were not parties to either litigation but nevertheless join in support of this multistate comment.

[4] The States of Illinois and Massachusetts were not signatory States to the previous comment letter campaigns but nevertheless join in support of this multistate comment.

[5] *See* Attorneys General (AG) Multistate Coalition Comment of January 08, 2019 on the Proposed Rule "Patient Protection and Affordable Care Act; Exchange Program Integrity CMS-9922-P," 83 Fed. Reg. 56,015 (Nov. 09, 2018) (docket available at https://www.regulations.gov/docket/CMS-2018-0135) (hereinafter "Comments on the 2019 Rule"); *id.* at American Academy of Family Physicians (AAFP); *id.* at American Academy of Pediatrics (AAP); *id.* at American College of Obstetricians and Gynecologists (ACOG); *id.* at American College of Physicians (ACP); *id.* at American Medical Association (AMA); *id.* at the American Psychiatric Association (APA); *see e.g.,* April 07, 2021 Multi-state Letter to HHS "Attorney General Becerra Co-leads Letter Urging Trump Administration to Safeguard Americans' Healthcare Coverage, Halt Implementation of Their Abortion Separate Payment Rule" available at

to several adverse consequences—including increased number of uninsured residents, increased healthcare costs, and decreased quality health coverage—that impact the States. Citing the Rule's own administrative record, the States showed that consumers would be confused by the separate billing requirements and likely not pay their separate bill, resulting in a credible threat of health coverage termination.[6] As the States explained, such coverage termination would increase the number of uninsured residents.[7] The States warned HHS that any rise in uninsured rates will cause individuals to seek emergency care rather than timely and preventive care. States bear the brunt of rising uninsured rates or gaps in health coverage in the form of uncompensated costs for hospital care.[8] As commenters stressed, termination of coverage will "decrease the size of the risk pool and increase the cost of uncompensated care, which will drive medical costs and health insurance rates higher, further limiting access to coverage."[9] An increase in uncompensated costs harms the quality of care that is possible when hospitals have "regular and reliable source[s] of payment," causing poorer health outcomes.[10]

As HHS now recognizes, historically underinsured communities, such as black, indigenous and other people of color, are most vulnerable to poorer health outcomes, including those living in rural areas lacking reliable access to the internet, living with a disability, and who are members of the LGBTQ community.[11] These vulnerable groups already face disparities in access to healthcare and the 2019 Rule created additional barriers that would "exacerbate these disproportionate burdens," particularly among those "with lower health insurance literacy."[12]

Most evident in the 2019 Rule are the barriers erected to harm women's ability to exercise their constitutional right to access abortion services in our States. The costs to women and

---

https://oag.ca.gov/news/press-releases/attorney-general-becerra-co-leads-letter-urging-trump-administration-safeguard; *see also* July 07, 2020 Multi-state Comment in response to the Interim Final Rule—"Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" available at https://www.oag.ca.gov/system/files/attachments/press-docs/FINAL%201303%20IFR%20Multistate%20Comment%20Letter_07-07-2020.pdf.

[6] Comments on the 2019 Rule by the AG Multistate.

[7] *Id.*

[8] *Id.*

[9] Comments on the 2019 Rule by the State of Oregon, Department of Consumer and Business Services; *id.* at AG Multistate Coalition (the rule will interfere with gains in enrollment rates and the insurance risk pool) and the New York State of Health Comment (the rule will "reverse recent reductions in uncompensated care").

[10] Comment on the 2019 Rule by the New York State of Health.

[11] *See* 86 Fed. Reg. 35,179 (recognizing that the 2019 Rule's logistical barriers would "disproportionately burden communities who already face barriers to accessing care, such as individuals with limited English proficiency (LEP), individuals with disabilities, rural residents, those with inconsistent or no access to the internet, those with low levels of health care system literacy, and individuals within other marginalized communities"); *see also* Comments on the 2019 Rule by the National Family Planning & Reproductive Health Association (NFPRHA); *id.* at National Latina Institute for Reproductive Health (NLIRH); The National LGBTQ Task Force.

[12] Comment on the 2019 Rule by the Jacobs Institute of Women's Health.

individuals with reproductive capacities who may lose abortion coverage remain excessive and unreasonable. Indeed, not having coverage can delay a person's ability to obtain an abortion, a time sensitive procedure, which can increase out-of-pocket costs or result in individuals being forced to carry unwanted pregnancies to term. Numerous commenters reminded HHS that abortions are costly (albeit less costly than a pregnancy and delivery), and without insurance many women cannot afford the out-of-pocket costs ranging from $400 to $1,650.[13] Those who cannot access abortion due to lack of coverage and are forced to carry pregnancies to term have a higher likelihood of falling into cycles of poverty and reliance on public assistance programs.[14] Any gaps in health insurance coverage can have dire consequences for women who experience an unintended pregnancy outside of open enrollment periods.

B. The Proposed Rule Will Protect Health Insurance Coverage When Consumers Need It Most

The Proposed Rule's changes safeguard the health coverage gains made possible by the States and the federal government's extensive efforts to roll out Special Enrollment Periods during the public health crisis of the COVID-19 pandemic.

1. States Have Made Significant Coverage Gains Through Special Enrollment Periods

Recognizing the importance of health insurance coverage, at the onset of the pandemic, many of our States opened ACA-authorized Special Enrollment Periods through their respective health insurance markets.[15] Since then, States have continued to roll out Special Enrollment Periods to meet consumer needs.

In California, for example, Covered California, the State's Exchange, extended its Special Enrollment Period through the end of December 2021 and has reached new enrollment records of 1.6 million, including 139,000 who signed up for quality health coverage since lower premiums

---

[13] Comment on the 2019 Rule by Planned Parenthood Federation of America; *see also* Sarah C.M. Roberts, et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues (2014), available at https://pubmed.ncbi.nlm.nih.gov/24630423/.

[14] *See* Comments on the 2019 Rule by the Asian & Pacific Islander American Health Forum (APIAHF) (discussing health harms, "women who are denied access to an abortion have been found to suffer adverse physical and mental health consequences."); *id.* at the American Public Health Association (APHA) ("women denied abortions are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy"); *id.* at Equality North Carolina (individuals "assigned female at birth have the same need for sexual and reproductive health services").

[15] *See* July 07, 2020 Multi-state Comment in response to the Interim Final Rule—"Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" available at https://www.oag.ca.gov/system/files/attachments/press-docs/FINAL%201303%20IFR%20Multistate%20Comment%20Letter_07-07-2020.pdf.

became available through the American Rescue Plan.[16] Vermont similarly instituted an additional Special Enrollment Period running until October 1, 2021.[17] The State of New York also extended its Open Enrollment Period through the end of December 2021.[18] More than 111,000 New Yorkers are newly enrolled in health coverage through the State's Exchange, and more than 140,000 people are benefiting from the lower premiums made available through the American Rescue Plan.[19] To meet the needs of families in need of coverage immediately, the District of Columbia established a Coronavirus Special Enrollment Period that allows residents to be insured the same month they enroll.[20] Others, including Colorado, Maryland, and Washington, announced Special Enrollment Periods open until August 15, 2021, which aligns with the recent federal extension for those using the federal marketplace dashboard.[21] States have continued to witness a significant rise in enrollments. Colorado has signed up 205,813 Coloradans to date, documenting a "sustained level of sign-ups—at least 1,000 per week over the past five months," demonstrating the real need for affordable health insurance.[22]

---

[16] *Covered California*, "Covered California Sets New Enrollment Record as Thousands Get Lower Premiums From the American Rescue Plan as June Deadline Approaches" (June 21, 2021), at https://www.coveredca.com/newsroom/news-releases/2021/06/21/covered-california-sets-new-enrollment-record-as-thousands-get-lower-premiums-from-the-american-rescue-plan-as-june-deadline-approaches/.

[17] *Vermont Health Connect*, "Enrollment FAQ" at https://info.healthconnect.vermont.gov/how-apply/enrollment-faq.

[18] *New York State of Health*, "On 11th Anniversary of the Affordable Care Act's Signing, Governor Cuomo Announces Expanded Eligibility for Financial Assistance in New York," Press Release (Mar. 23, 2021), at https://info.nystateofhealth.ny.gov/news/press-release-11th-anniversary-affordable-care-acts-signing-governor-cuomo-announces-expanded.

[19] *New York State of Health*, "Press Release: NY State of Health Enrollment Continues to Climb, More New Yorkers than Ever Benefitting from Affordable Health Coverage; New Yorkers Save Money on Health Coverage with American Rescue Plan Enhanced Tax Credits" (July 16, 2021), at https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-enrollment-continues-climb-more-new-yorkers-ever-benefitting.

[20] *DC Health Link*, "Coronavirus (COVID-19) and Enrolling in Health Insurance for Individuals and Families" (accessed on July 19, 2021), at https://dchealthlink.com/coronavirus/faqs.

[21] *See Connect for Health Colorado*, "Colorado's Health Insurance Marketplace Maintains Enrollment" (July 08, 2021), at https://connectforhealthco.com/colorados-health-insurance-marketplace-maintains-enrollment-momentum/; *Maryland Health Benefit Exchange*, "Gov. Hogan Announces Extension Of State Health Insurance Special Enrollment Period Until Aug. 15" (March 26, 2021), at https://www.marylandhbe.com/wp-content/uploads/2021/05/2021-C-SEP-Extension-Press-Release_03262021.pdf; *Washington Health Benefit Exchange*, "Washington Healthplanfinder is extending special enrollment period for Washingtonians seeking health coverage through August 15, 2021" (Mar. 31, 2021), at https://www.wahbexchange.org/washington-healthplanfinder-is-extending-special-enrollment-period-for-washingtonians-seeking-health-coverage-through-august-15-2021/; *see also* U.S. Dep't of Health and Human Servs., News (June 14, 2021), at https://www.hhs.gov/about/news/2021/06/14/four-ten-new-consumers-spend-10-or-less-month-healthcaregov-coverage-following-implementation-american-rescue-plan-tax-credits.html.

[22] *Connect for Health Colorado*, *supra* note 21.

Through these Special Enrollment Periods, millions of individuals across the States were able to secure health coverage. To date, over two million Americans have signed up for coverage through the various COVID Special Enrollment Periods.[23]

2. The 2019 Rule Jeopardized These Health Coverage Gains

These health coverage gains remained at risk of termination under the 2019 Rule. New health insurance coverage is conditioned on the consumer's ability to make their "binder payment"—the first month's premium payment in full.[24] Absent this binder payment, coverage cannot be initiated. The 2019 Rule would have required all binder payments to include a separate bill for abortion coverage. Thus, failure to pay the separate bill for abortion coverage, due to consumer confusion, could then lead to a complete loss of health coverage because the premium would not have been paid in full such that coverage would not have been initiated.[25]

Initiating health insurance coverage is more important than ever as the country continues to battle the COVID-19 virus and its various iterations. Health coverage allows people to access services and treatment for the virus and related medical complications. Protecting that coverage is crucial, as the pandemic continues to shed light on the significant healthcare disparities in historically uninsured communities. As discussed above, health equity demands eliminating risks for consumer confusion that may lead to coverage termination.

As many continue to enroll in health insurance through new open enrollment periods, the Proposed Rule will ensure that their coverage is not again put at risk. Increased affordability and expansion of access to the ACA's marketplaces will better support enrollment in comprehensive health insurance coverage, improving access to healthcare during and beyond the COVID-19 public health emergency.

C. The Proposed Rule's Reversal of the 2019 Rule is Consistent with Commonsense Billing Practices and the Public Interest

The 2019 Rule was unreasonable and burdensome because it attempted to implement a billing scheme completely at odds with standard industry practices, which would have cost an exorbitant amount to implement and impeded our States' ability to regulate healthcare.

No issuer manages its billing through separate transactions, and multiple consumer advocate groups stressed numerous reasons to prefer single, or bundled, billing in the health

[23] *See* U.S. Dep't of Health and Human Servs., News (June 14, 2021), at https://www.hhs.gov/about/news/2021/07/14/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-of-aug-15-deadline.html.

[24] *See* Comments on the 2019 Rule by the AG Multistate Coalition; *see also id.* at Access Health Connecticut, Blue Cross Blue Shield Association (BCBSA), and American Health Insurance Plans (AHIP) (reiterating the same risks).

[25] *Id.*

insurance industry.[26] The California Insurance Commissioner explained that, "[c]onsumers are accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items."[27] This billing practice is intentional in healthcare as "[c]onsumers purchase a *package* of medical benefits" to "ensure health coverage markets work efficiently and are affordable for everyone."[28] For example, when issuers cover benefits, such as substance use disorder treatment or maternity care, "consumers do not have the option [to] pay only a portion of the premium because they do not use—or expect to use—those services."[29] Ultimately, "[i]f consumers were able to selectively purchase only benefits and services they knew they would use, the associated premiums for those coverage products would quickly become unaffordable due to adverse selection."[30]

The Proposed Rule furthers the States' interest by streamlining already complex billing practices within the healthcare industry. Requiring separate transactions for the payment of health insurance coverage places irrational burdens on State agencies and regulators. As demonstrated in the States' litigation, in order to implement the 2019 Rule, the States would have been burdened with significant increases in call center inquiries, resolving new enrollment system issues, redirecting the allocation of resources from consumer outreach to mitigation of the risk of coverage terminations, and issuing new regulatory and guidance packages to ensure compliance.[31] For example, the District of Columbia's Health Benefit Exchange expected the 2019 Rule's implementation to result in a 50% increase in inadvertent terminations due to: 1) miscommunication; 2) confusion; 3) non-payment of premiums; 4) partial payment of premiums; or 5) misapplication of paid premiums.[32] The 2019 Rule forced State regulators and Exchanges to spend additional resources and personnel time to devise implementation plans that ultimately reaped zero benefits and led to costly administrative responses necessary to mitigate its attendant consumer harms.

The 2019 Rule also came with an exorbitant price tag. HHS itself conceded that to bring all affected issuers (94 total) across the country into compliance and implement the necessary technical changes would require over 2.9 million hours of work and cost approximately $385 million for all issuers.[33] HHS estimated that the 2019 Rule would cost approximately

[26] *See* Comment on the 2019 Rule by the Western Center for Law and Poverty (to "itemize the cost of, or separately bill for specific benefits that are incorporated in a comprehensive benefit plan…go against standard practice in the insurance industry.").

[27] Comment on the 2019 Rule by the California Department of Insurance.

[28] Comment on the 2019 Rule by AHIP.

[29] *Id.*

[30] *Id.*

[31] *See* Mot. Summ. J. at ECF No. 36-1-16 declarations of Doug McKeever Decl. ¶¶ 13-15; Donna Frescatore Decl. ¶ 8; David Patterson Decl. ¶¶ 8, 11; Mila Kofman Decl. ¶¶ 8-11, 13-14; Michelle Eberle Decl. ¶¶ 10-12; Carmina Flowers Decl. ¶ 8; Adaline Strumolo Decl. ¶¶ 16-17; Bruce Hinze Decl. ¶¶ 9-10 (e.g., 1,739 extra hours of workload, amounting to an excess of $85,000 per year); and Sara Ream Decl. ¶¶ 11-13, *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992 (N.D. Cal. July 20, 2020) (No. 3:20-CV-00682).

[32] *Id.* at Kofman Decl. ¶ 9.

[33] 84 Fed. Reg. 71,697.

$9 million for the twelve state-based Exchanges that permit the sale of plans offering abortion coverage, and ongoing costs of $2.4 million for 2020 alone.[34] The ongoing costs to the States would approximate $36 million for plan years 2020 to 2024.[35] Notably, these costs did not account for consumers' personal administrative burdens of understanding the separate billing requirements, which HHS estimated to be about $35.5 million in the first year alone.[36]

To protect consumers and ensure public resources are used wisely, the State of Washington requires health insurance carriers to bill enrollees with a single monthly invoice. Wash. Rev. Code § 48.43.074(2)(a). The law requires all issuers, including issuers of qualified health plans to "[b]ill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan."[37] In enacting this law, Washington codified the state's standard practice of requiring issuers to bill enrollees with a single invoice and segregate into a separate account the premium attributable to abortion services, thereby ensuring "maximum access to reproductive…coverage for all people" in the State.[38] Washington's single invoice statute reflects the State's strong commitment to reproductive healthcare and consumer protection, and is consistent with Section 1303's recognition of the States' authority to regulate healthcare with respect to abortion care.

HHS's policy reversal is not only imperative during the current public health crisis, but also provides a reasonable way of complying with Section 1303 in the only manner that serves the public interest.

D. The Proposed Rule Reflects Congress's Vision of Exchange Diversity

The States support the Proposed Rule's recognition of the flexibility embedded in the ACA and made possible through Section 1303. The ACA gave States operational discretion to design their platforms to meet their unique public health priorities, 42 U.S.C. § 18041, including the ability to mandate additional essential health benefits required or allowed by state laws, 42 U.S.C. § 18031(d)(3)(B)(i). Section 1303 gave the States explicit authority to allow coverage for abortion services as a covered health benefit offered by qualified health plans participating in their respective Exchanges.[39]

Through Section 1303, Congress recognized that where required by State law, issuers would cover abortion services in their health plans. And States that prioritized women's health

[34] *Id.* at 71,705.
[35] *Id.* at 71,707.
[36] *Id.*
[37] Wash. Rev. Code § 48.43.074(2)(a).
[38] Wash. House Amendment, 2019 Reg. Sess. S.B. 5602.
[39] 42 U.S.C. § 18023(a)(1).

chose to either allow or require issuers to provide abortion coverage. Indeed, several of the States have laws that generally require health plans to cover abortion services.[40]

To achieve State flexibility, Congress did not require separate billing transactions but rather the establishment of *accounting practices* to guarantee federal funds are segregated from a policyholder's out-of-pocket funds for abortion services, ensuring compliance with federal funding restrictions. Since Section 1303's enactment a decade ago, states have imposed separate accounting and transparency requirements for coverage of abortion services provided by qualified health plans sold through the individual Exchanges.[41] And each year issuers "submit annual filings with respect to the premium segregation plan" that provide sufficient assurances of compliance with Section 1303.[42] Segregation plans are complete with separate financial accounting systems, monthly reconciliation processes, and internal controls to ensure that issuers are in compliance with federal regulations.[43] The 2019 Rule did not produce any evidence that issuers are *not* in compliance with federal regulations. Absent any good reason for requiring such drastic and burdensome regulatory changes, the 2019 Rule was merely a solution in search of a compliance problem.

The Proposed Rule guarantees that the States can continue to operate their Exchanges as Congress intended and without unnecessary logistical and administrative obstacles that disrupt their insurance markets or intrude on their authority to regulate healthcare. By contrast, the 2019 Rule included an opt-out provision—giving enrollees the option of changing their plan, and opting out of abortion coverage, by choosing not to pay the premium attributable to abortion services.[44] Allowing policyholders the ability to selectively eliminate abortion coverage in a health plan, for all enrollees (those covered under the policyholder's plan) and at any time during a plan year, would render meaningless the purpose of the "open enrollment" period's one-year contracts of 45 C.F.R. § 155.410-420 and jeopardize the stability of the insurance market in that State. Therefore, the ability to change one's coverage under the 2019 Rule, or any rule like it, is contrary to the ACA and the States' laws requiring certain coverage benchmarks that include abortion benefits. Allowing issuers to send single or itemized bills for health coverage—like the Proposed Rule does—aligns with the statutory authority Congress granted to the States under Section 1303.

---

[40] *See* Cal. Health & Safety Code § 1340 *et seq*. (California); N.Y. Comp. Codes R. & Regs. tit. 11, § 52.16 (New York); Wash. Rev. Code 48.43.073 (Washington); Reproductive Health Equity Act (RHEA), HB 3391; O.L. 2017, Ch.721 (Oregon).

[41] *See* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1303, 124 Stat. 119, 896; 42 U.S.C. § 18023 (2019); *see also* Executive Order No. 13535, 75 Fed. Reg. 15,599 (Mar. 29, 2010) ("maintaining current Hyde restrictions on abortion services and extending those restrictions to the newly created health insurance Exchanges").

[42] *See* Mot. Summ. J. at ECF No. 36-1-16 declarations of Al Redmer Decl. ¶ 7; Andrew Stolfi Decl. ¶¶ 7-8; Eric Cioppa Decl. ¶ 9; Ruth Greene Decl. ¶ 5, *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992 (N.D. Cal. July 20, 2020) (No. 3:20-CV-00682).

[43] *Id.* at Hinze Decl. ¶ 7.

[44] 84 Fed. Reg. 71,686.

E. The Proposed Rule Should Make Explicit That Sending Consumers Separate Bills for Abortion Coverage Is Contrary to Section 1303

The States urge HHS to finalize a rule that is consistent with Section 1303's central prohibition on disaggregating the charge for abortion coverage contained in consumer premium bills. To that end, the final rule should eliminate the option offered under the 2015 regulations, of "sending a separate monthly bill for [abortion] services," because it is 1) prohibited by the statute, 2) consistent with the purpose of Section 1303, and 3) supported by the record and common industry practice.

First, under 42 U.S.C. § 18023(b)(3)(B) ("Rules relating to payments") any notice regarding payments "shall provide information *only with respect to the total amount of the combined payments for services*" covered by the plan. (emphasis added). This restriction suggests that bills regarding abortion should only bill "the total amount of the combined payments." Presenting issuers again with this null option contained in the 2015 regulations risks contradicting the statute's rules relating to payments restriction on separating the abortion charge from the total health premium.

Second, eliminating the separate billing option is also consistent with the purpose of Section 1303—to regulate issuers by requiring the segregation of funds into separate allocation accounts, after collection of payment. Compliance with Section 1303 falls on the issuers, not the consumers. The negative consequences of sending bills through separate transactions—increasing consumer confusion without any real benefit and the risk of coverage termination—underscore the significance of Section 1303's prohibition on disaggregating the abortion coverage charge contained in consumer premium bills or notices. The Northern District of California also rejected the notion "that [Section 1303] requires separate billing from issuers or separate transactions from enrollees."[45] Highlighting the notice provisions, the court stated that "the statute does not require or even suggest separate billings by issuers or separate transaction-payments by consumers."[46] The Court's opinion also aligns with HHS's view that Section 1303's requirements are primarily for ensuring "that no public funding is utilized for coverage of… abortion services, including requiring issuers to collect separate payments for this portion of the premium, to segregate the funds, and deposit such funds into separate allocation accounts."[47] As the Proposed Rule correctly demonstrates, separate bills and payments do not further this goal.

Third, as HHS recognizes, no issuer utilizes the option of sending separate bills, and no such evidence of its use was presented in the 2019 Rule's administrative record or subsequent litigation. The Proposed Rule itself anticipates that,

---

[45] *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992, 1002 (N.D. Cal. 2020).

[46] *Id.* ("the statute's notice provisions require notice to enrollees of the plan's inclusion of abortion coverage 'only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.'") (quoting 42 U.S.C. § 18023(b)(3)(A)).

[47] 86 Fed. Reg. 35,177.

> "most issuers covering abortion services…will decline to send two separate monthly bills, and will choose to collect separate payments by one of the other proposed acceptable methods, as those alternatives minimize administrative complexity for issuers, align with industry billing practice, are less costly and administratively burdensome, and promote a more seamless consumer billing and payment experience."[48]

Thus, eliminating the option is clearly supported by the overwhelming evidence before HHS. *See also* Sections A-B. As stated above, it is standard industry practice for issuers to sell health coverage plans as a package of benefits, and this practice reduces consumer confusion.

For these reasons, the States urge HHS to use this opportunity to clarify that Section 1303 itself does not, in practice, contemplate an option of sending separate bills to consumers.

* *

The States applaud HHS's swift actions to undo the Trump Administration's 2019 Rule. The States further encourage HHS to prohibit separate billing transactions altogether. These regulatory changes are in the public interest and will guarantee that abortion care is seen for what it is—healthcare, an integral part of the package of health benefits in our States.

Sincerely,

ROB BONTA
Attorney General of California

LETITIA JAMES
Attorney General of New York

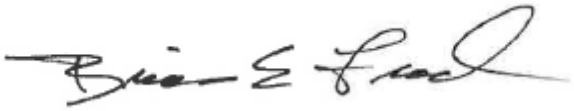
PHILIP J. WEISER
Attorney General of Colorado

KARL A. RACINE
Attorney General for the District of Columbia

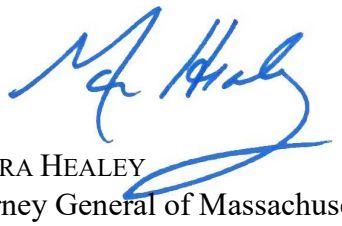
KWAME RAOUL
Attorney General of Illinois

AARON M. FREY
Attorney General of Maine

[48] *Id.* at 35,178.



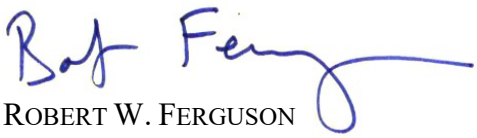
BRIAN E. FROSH
Attorney General of Maryland



MAURA HEALEY
Attorney General of Massachusetts

ELLEN F. ROSENBLUM
Attorney General of Oregon

THOMAS J. DONOVAN, JR.
Attorney General of Vermont



ROBERT W. FERGUSON
Attorney General of Washington