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January 8, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9922-P
P.O. Box 8016
Baltimore, MD 21244-8010

**Re: CMS-9922-P, Patient Protection and Affordable
Care Act; Exchange Program Integrity NPRM**

Dear Administrator Verma:

We appreciate the opportunity to provide written comments on the proposed rule, "Patient Protection and Affordable Care Act; Exchange Program Integrity."¹

The National Health Law Program is a public interest law firm working to advance access to quality health care. Founded in 1969, we protect and advance the health rights of low-income and underserved individuals and families by advocating, educating, and litigating at the federal and state levels.

Our specific comments are provided on the following pages.

¹ See Patient Protection and Affordable Care Act; Exchange Program Integrity, Proposed Rule, 83 Fed. Reg. 56015 (Nov. 9, 2018).

Sections 155.320, 155.330 – Verification process related to eligibility for insurance affordability programs; Eligibility redetermination during a benefit year

We have a number of concerns with the proposed changes to this section. First, we are concerned that this section allows an Exchange to terminate QHP coverage if the individual is "eligible for or enrolled in other qualifying coverage." Knowing that transitions between QHPs and Medicaid can be challenging, particularly with SBEs that do not have integrated eligibility systems, we are concerned the NPRM allows for QHP termination when *eligibility* is verified, i.e. before MEC *enrollment* is necessarily secured. And for individuals eligible for Medicare, QHP coverage could be terminated before the individual enrolls in Medicare Part B. Also, Exchange/Medicaid eligibility determinations are sometimes wrong and terminating QHP coverage when the correct coverage option is still being determined/appealed would disrupt coverage and care. For example, we have heard of some individuals enrolled in limited family planning Medicaid coverage being found ineligible for QHP coverage because the data matching indicates Medicaid enrollment, even though the enrollment is in a limited scope Medicaid category that does not preclude QHP enrollment.

Second, we are concerned that the proposed language in 155.320 could allow a state to perform periodic data matching more than two times per year. We believe twice a year, as currently done by CMS for healthcare.gov enrollees, is the correct balance between program integrity and consumer protection. Allowing states to perform data matching more than twice per year, especially with the problems we have sometimes seen when data matching is done (especially in states without integrated eligibility systems), could result in consumers erroneously losing their coverage without a legitimate increase in program integrity.

Third, we are concerned that CMS does not appear to adequately consider how its proposal to terminate Marketplace coverage for certain enrollees with dual coverage would impact people with Medicare and those approaching Medicare eligibility.

While we agree with CMS's stated goal of ensuring people are in the "most appropriate type of coverage," we disagree with CMS's proposal to automate this process.² Allowing the Marketplaces to terminate coverage for those who are eligible for or enrolled in Medicare Part A would create harmful gaps in coverage, as the affected individuals would not have seamless, immediate access to the Medicare coverage option of their choice. As a result, they would be forced to go without needed coverage—putting their

² <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-rule-improve-integrity-exchange>.

health and economic security at risk. Instead of abruptly eliminating their access to critical medical care, we strongly urge CMS to assist dual enrollees in making timely, optimal coverage decisions.

Currently, some people over 65 years old have Marketplace coverage but are not yet fully enrolled in Medicare. Some of these people may not have Part B because they mistakenly delayed or declined enrollment when first eligible, in favor of Marketplace coverage that may have been more affordable. Others may have been automatically enrolled in Part A—but not Part B—when they began receiving Social Security. Still others may be deferring Social Security benefits, along with Medicare coverage, a group whose numbers are likely only to grow as the population ages and people work later in life. At the same time, others with Marketplace coverage are approaching Medicare eligibility, and these coverage intersections. If these individuals were to abruptly lose their qualified health plan (QHP) solely as a result of automatic data matching, they would be left without necessary coverage until they could actively enroll in Medicare Part B. For those without access to a Special Enrollment Period or equitable relief, this could mean going without coverage for up to a year, until the next General Enrollment Period begins.

Instead of terminating QHP coverage for dual enrollees and creating these hardships, we recommend that CMS better prepare these individuals to transition to Medicare. Based on experience assisting people with Medicare and their families, dual Medicare-Marketplace enrollment is generally a symptom of a larger problem— inadequate CMS and Marketplace outreach to Marketplace enrollees who are or will soon be eligible for Medicare. Though we applaud CMS’s recent efforts to improve its materials and process, we continue to hear from individuals who are confused or misinformed about how Medicare and the Marketplaces interact and who face significant coverage and financial challenges as a result.

For many consumers, we agree with CMS that dual Medicare-Marketplace enrollment “does not represent an informed decision”.³ However, we do not agree that the solution is to remove them from this decision-making process. Rather than automatically terminate their marketplace coverage, CMS must support Marketplace enrollees in choosing the best coverage for their unique needs, which may include retaining QHP coverage while Medicare enrollment is secured. Empowering these consumers must be the first step, not stripping them of their agency and their QHP.

³ 83 Fed. Reg. at 56019, <https://www.govinfo.gov/content/pkg/FR-2018-11-09/pdf/2018-24504.pdf>.

To that end, we agree that CMS should continue to engage in the Periodic Data Matching (PDM) process as a way to identify and notify those who are dually enrolled. However, we caution that this transition should be managed by a fully-informed beneficiary, not by the Marketplace. Automatically ending an enrollee's QHP coverage because they are eligible for Medicare would be a mistake. Instead, we again encourage CMS to educate and equip individuals to manage this transition themselves.

We also note that the PDM notification process, as it currently exists, is inadequate to reach all Marketplace enrollees who are or will be eligible for Medicare. We encourage CMS to develop methods to reach all who may need to navigate the Marketplace-to-Medicare transition. Specifically, CMS should work with the Social Security Administration (SSA) to identify Marketplace enrollees who are approaching Medicare eligibility. CMS should send PDM notices during the first month of an individual's Initial Enrollment Period. This more timely receipt of information would help Marketplace enrollees meaningfully plan for their Medicare effective date and avoid a gap, or overlap, in coverage. This notice must clearly explain the steps the consumer must take to enroll in Medicare, the timeline for doing so, the consequences of inaction, and where to go for help.

Troublingly, the absence of front-end beneficiary education is not unique to Marketplace enrollees. We continue to urge CMS and SSA to work together to notify those who are approaching Medicare eligibility about enrollment rules and their responsibilities, including that they may need to actively enroll in Part B.

We are also concerned that CMS appears to be portraying the proposed Exchange application question as voluntary. It is our understanding that the current Federally Facilitated Exchange (FFE) application question is mandatory, and that people can select between having their Marketplace plan or their financial assistance terminated if they are found to be eligible for other qualifying coverage. We ask that CMS clarify whether the existing FFE and outlined question will be required. If applicants may leave it blank, we also ask the agency to clarify the consequences of doing so. If these questions are to be a part of either application, we ask that CMS engage in rigorous beneficiary testing of the revised application, to ensure the question is maximally visible and understandable.

While we recognize that dually enrolled individuals may be subject to tax consequences if they maintain dual enrollment, we are also very concerned that this proposed rule could have significant, adverse consequences for people with Medicare. Currently, people who are dually enrolled in Medicare and the Marketplace can voluntarily choose to terminate their QHP coverage and enroll in Medicare. Rather than circumventing this

process, we encourage CMS to improve it by giving enrollees more control over their health coverage and costs—not less. Accordingly, instead of finalizing the rule as written, we urge CMS to pursue an approach with necessary safeguards to maximize beneficiary choice and minimize gaps in coverage.

Section 155.1200 – Reporting of information to HHS

We oppose proposed subsection (b)(2) as both overly vague and inconsistent with the goals of the ACA. The proposals are at best administratively cumbersome and at worst, could be used in a punitive way against states. The proposal effectively cedes all authority to HHS to determine what would be included in the scope of a programmatic audit.

The proposal leaves Exchanges subject to federal overreach, creates substantial administrative burdens, possibly limits access to eligibility and enrollment information, and potentially subjects consumers to inappropriate sharing of personal information. Contrary to statements made in the NPRM that “the Federalism implications are substantially mitigated because the proposed changes . . . add specificity to the existing requirements,” the open-ended nature of the new provision removes specificity altogether.⁴

Current language in federal regulations requires annual reporting that is narrowly prescribed and fully consistent with the purpose of the ACA: a financial statement presented in accordance with GAAP; eligibility and enrollment reports; performance monitoring data; and certain reporting limited to the small number of exchanges that collect premiums on behalf of enrollees.⁵

In contrast, the proposed changes have no clearly stated purpose. They would eliminate the specific requirement of eligibility and enrollment reports and would allow CMS to require annual reporting on any or all establishment standards and other related standards under the ACA. With no specifics provided as to reporting requirements, state exchanges would be unable to plan and budget appropriately, resulting in greater costs that could negatively impact consumers or undermine the exchange’s functioning and financial health. We are also concerned about the potential scope of requests and how those might affect privacy of consumer information.

⁴ See Patient Protection and Affordable Care Act; Exchange Program Integrity, 83 Fed. Reg. 56015 (Nov. 9, 2018), <https://www.federalregister.gov/d/2018-24504/p-134>.

⁵ 45 C.F.R. 155.1200 (b)(2)-(4).

We believe CMS should continue to require that all states report on eligibility and enrollment figures and that national figures remain available. We believe that this public information is essential to local and national efforts to improve access to coverage.

Section 156.280 – Segregation of funds for abortion services

We strongly oppose the proposed changes to § 156.280 because they threaten to undermine access to quality health care, including essential reproductive health services. The ACA provided the ability to purchase and enroll in health insurance to millions of individuals who did not previously have health insurance coverage. In an effort to allow as much coverage as possible, Congress permitted states as well as qualified health plans (QHPs) to offer comprehensive reproductive health services, including abortion, through the individual market exchanges. The proposed changes to § 156.280 conflict with the intent of the Affordable Care Act. These changes will burden as well as harm consumers, insurers, and the Marketplaces, and will put access to health care services out of further reach.

A. The proposed changes to the implementing regulations of § 1303 contravene the ACA’s intent to allow abortion coverage in the exchanges.

Although § 1303 of the ACA unfairly segregates abortion from other health care coverage and imposes additional burdens on issuers that offer QHPs covering abortion services, Congress always intended § 1303 to retain availability of abortion coverage, including allowing states to require abortion coverage.⁶ Congress rejected amendments aimed at more stringent restrictions or prohibitions of abortion coverage during the health care reform debate and negotiations. The Senate refused to adopt the Stupak-Pitts Amendment, which would have banned coverage of abortion in the exchanges, as well as barred federal subsidies for any QHP that covered abortion in cases other than rape, incest, or risk to the pregnant individual’s life.⁷ In addition, the Senate rejected the Nelson-Hatch Amendment by a vote of 54 to 45, which had a similar goal to ban coverage of abortion services in the marketplaces.⁸ Congress finally adopted the

⁶ See The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (collectively the “Affordable Care Act (ACA)”).

⁷ See Amendment to H.R. 3962, 111th Cong. (2009) (offered by Rep. Stupak and Rep. Pitts), 155 CONG. REC. H12,921 (Nov. 7, 2009), available at <http://documents.nytimes.com/the-stupak-amendment>.

⁸ See e.g., 155 CONG. REC. S12,665 (2009) (statement of Sen. Patty Murray): “All Americans should be allowed to choose a plan that allows for coverage of any legal health care service, no matter their income, and that, by the way, includes women. But if this amendment were to pass, it would be the first time that Federal law would restrict what individual private dollars can pay

Nelson Amendment to replace all other proposed amendments, and allowed insurers to cover abortions so long as they comply with the provisions of § 1303.⁹ The proposed rule undermines the intent of the ACA by creating onerous administrative burdens for issuers that cover abortions in their QHPs.

Section 1303 explicitly requires issuers to segregate funds and accounts for abortion coverage.¹⁰ The issuer is responsible for segregating the premium. When Congress considered the ACA's provision on abortion coverage, the National Association of Insurance Commissioners (NAIC) - the standard-setting and regulatory support organization created and governed by the chief insurance regulators in all U.S. jurisdictions - drafted guidance on § 1303 compliance and the segregation of payments. NAIC recommended using an itemized bill and single transfer process to comply with the "special rules" on abortion where a QHP can issue:

an itemized bill that separates the costs of abortion coverage from the costs of all coverage, collects the required separate payments through a single transfer of funds in response to the itemized bill and maintains "allocation accounts" in line with current industry practice.¹¹

A 2014 Government Accountability Office report indicated that issuers that itemize non-excepted abortions indicate in their bills that there is a \$1 charge for "coverage of services for which member subsidies may not be used."¹² These findings show that issuers are following industry practice in including a line-item for non-excepted abortion, in alignment with the NAIC recommendations. The proposed changes conflict with statutory intent and, as discussed in more detail below, industry practice.

for in the private health insurance marketplace." <https://www.congress.gov/congressional-record/2009/12/08#daily-digest-senate>; *id.* at S, 12,666 (statement of Sen. Ben Cardin): "The Nelson-Hatch amendment would go beyond that. It would restrict a woman's ability to use her own funds for coverage to pay for abortions. It blocks a woman from using her personal funds to purchase insurance plans with abortion coverage. If enacted, for the first time in Federal law, this amendment would restrict what individual private dollars can pay for in the private insurance marketplace."

⁹ ACA § 1303(b)(2)(A), 42 U.S.C. § 18023(b)(2)(A).

¹⁰ ACA § 1303(a)(2)(B), 42 U.S.C. § 18023(b)(2)(C).

¹¹ See NAIC Form Review White Paper, Adopted by the NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012, https://www.naic.org/documents/committees_b_related_wp_form_review.pdf.

¹² See Govt' Accountability Office, *Health Insurance Exchanges: Coverage of Non-excepted Abortion Services by Qualified Health Plans* (2014), <https://www.gao.gov/assets/670/665800.pdf>.

B. The proposed changes will create additional confusion, burdens, and costs for all consumers buying plans on the marketplaces.

The proposed changes will add more complexity to accessing health care by causing confusion and anxiety for all consumers buying plans in the marketplaces as they try to understand the proposed billing changes. If implemented, these changes will lessen consumers' ability to make informed decisions about which plans will meet their needs. Worse, individuals may experience delays in coverage as they try to understand how to make their premium payments, or lose coverage.

The proposed changes could create unnecessary confusion for consumers who are enrolled in QHPs in the marketplaces. Consumers are accustomed to receiving one itemized bill for their insurance premiums. If the proposed rules are implemented, consumers will be confused when receiving two separate bills by the same plan, and by having to make two separate payments using two separate envelopes and stamps. It is quite likely that consumers will not have the resources or time to follow up with their plans to understand this process. Many consumers will struggle trying to navigate this process, and it is highly likely that some will not make both premium payments.

CMS contemplates consumer confusion if these proposed changes are implemented, and they propose that electronic billing may lessen this confusion.¹³ However, CMS does not recognize that many communities in this country, particularly in rural areas, are still without consistent access to the internet. According to the Pew Research Center, people of color, older adults, rural residents, and those with lower levels of education and income are less likely to have broadband service at home; and one-in-five adults in the United States only access the internet through their smartphones and do not have traditional home broadband service.¹⁴ In addition, those living with visual disabilities/and or impairments may experience difficulties in receiving information in electronic formats. Because of the disparity in accessing the internet, for some consumers, electronic billing is not a viable option. For others, even if they receive electronic bills, there will be confusion.

While CMS claims that the proposed provisions ensure that implementation is aligned with Congressional intent, the preamble indicates that CMS anticipates that people will lose coverage, showing they intend that these rules will force individuals out of coverage. The proposed regulation only establishes that consumers will not lose

¹³ *Id.*

¹⁴ Pew Research Ctr., Internet/Broadband Fact Sheet, <http://www.pewinternet.org/fact-sheet/internet-broadband/> (last visited Dec. 20, 2018).

coverage if they make one payment for their entire premium in a single transaction instead of two separate transactions.¹⁵ It is quite likely that individuals who forgo paying their smaller premium amount for non-excepted abortion services will lose coverage as the proposed language contains no protections for individuals in these circumstances. Moreover, CMS envisions that some individuals will lose coverage if they accidentally miss the second bill in the mail: “[C]onsumers may inadvertently miss or discard a second paper bill included in a single envelope, increasing terminations of coverage for failure to pay premiums.”¹⁶

The confusion and anxiety that will be caused if these changes are implemented will be greater for individuals who already face barriers in navigating health insurance, particularly for communities of color and Limited English Proficient (LEP) speakers. According to an Accenture report, more than half of U.S. consumers have low health care system literacy, with only 16 percent of surveyed consumers qualifying as experts.¹⁷ Forty-eight percent of those who qualified as having low levels of health care literacy had completed college or held a graduate degree.¹⁸ Even when accounting for education, racial disparities exist in health insurance literacy. In one study of consumers who had enrolled in a QHP in Connecticut, Blacks and Hispanic individuals with the same education level as Whites scored lower on a survey asking enrollees to identify the meaning of health insurance terms or how to best use their insurance. Blacks and Hispanic individuals with a Bachelor’s degree answered 43 percent of the questions correctly while Whites with the same degree answered 75 percent of these questions correctly.¹⁹

LEP speakers also face challenges in understanding health insurance. In the same study mentioned above, enrollees who chose to take the survey in English scored higher than individuals who chose to take the survey in Spanish.²⁰ The proposed regulation does not address how LEP individuals may experience barriers in complying with the proposed changes. This is particularly concerning for LEP individuals as they already experience hardships in navigating and accessing health care. Moreover, CMS

¹⁵ 83 Fed. Reg. 56023.

¹⁶ *Id.*

¹⁷ Accenture, *The Hidden Cost of Healthcare System Complexity* 3 (2018), https://www.accenture.com/t20180906T134048Z_w_us-en/acnmedia/Accenture/Conversion-Assets/DotCom/Documents/Local/en/Accenture-health-hidden-cost-of-healthcare-system-complexity.pdf.

¹⁸ *Id.* at 4.

¹⁹ Health Disparities Inst., UConn Health, *Health Insurance Literacy Survey Report 2* (2017), https://health.uconn.edu/health-disparities/wp-content/uploads/sites/53/2017/04/HIL-Brief-4_2017.pdf.

²⁰ *Id.*

does not propose any requirements or guidelines for how issuers should educate, inform, and conduct outreach to consumers regarding these changes in billing and payment if the proposed regulation is implemented as proposed. The harmful impact of this proposed regulation will affect not only LEP individuals, but also immigrants, individuals with low literacy and educational levels, and those living with visual disabilities and/or impairments.

Consumers will also face additional financial costs to comply with the proposed changes. CMS estimates that the cost burden on consumers will be \$30.8 million, excluding the costs that consumers will incur for learning how to comply with these proposed requirements.²¹ CMS fails to account for the costs insurers will likely pass onto consumers as a result of implementing these burdensome requirements. As multiple issuers have indicated, such requirements are likely to confuse consumers as well as impose unnecessary burdens on QHP issuers that are likely to be “passed on to beneficiaries in the form of higher plan premiums.”²² The proposed changes to the regulatory requirements of § 1303 will lead to higher costs for consumers, undermining one of the goals of the ACA, to reduce coverage costs for individuals.

Finally, the proposed changes are contrary to the current administration’s purported efforts to lessen regulatory burdens for consumers. In 2017, President Donald Trump issued Executive Order 13813 calling for government rules and guidelines that “improve access to and the quality of information that Americans need to make informed healthcare decisions.”²³ Recently, the head of the Centers for Medicare and Medicaid Services established the “Patients Over Paperwork” initiative.²⁴ The intended goal of the initiative is “to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience.”²⁵ The proposed regulations will do the opposite – increase unnecessary burdens, decrease efficiencies, and make it more difficult for individuals to enroll in and maintain coverage.

²¹ 83 Fed. Reg. 56028.

²² See AHIP, Comment Letter on HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P) (Dec. 22, 2014); Anthem, Comment Letter on HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P) (Dec. 22, 2014).

²³ Exec. Order No. 13813, 82 Fed. Reg. 48385, 48385-86 (Oct. 12, 2017), <https://www.govinfo.gov/content/pkg/FR-2017-10-17/pdf/2017-22677.pdf>.

²⁴ CMS, Patients Over Paperwork, <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html> (last visited Dec. 20, 2018).

²⁵ *Id.*

C. *The proposed changes will create onerous and unnecessary burdens to QHP issuers, go against industry practice, and will force issuers to drop enrollees from their QHPs.*

Issuers have expressed their opposition to similar requirements in prior rulemaking. America's Health Insurance Plans (AHIP) maintained that it does "not support any requirements to itemize the cost of, or separately bill for specific benefits that are incorporated in a comprehensive benefit plan."²⁶ Accepted insurance practices already allow payments for different types of coverage within the same instrument and transaction. To illustrate, insurance plans that offer bundled coverage (e.g., life and disability insurance; home and car insurance) allow enrollees to pay for their multiple policies in one transaction with the same instrument (check, automatic withdrawal, credit card payment, etc.). If distinct policies can be paid for through the same instrument or transaction, it only makes sense that payment for a covered health service would operate similarly in a single billing statement. No practical reason supports why certain abortions should be singled out from other health care services.

Setting aside long-standing industry practices, the extent to which abortion coverage is actually available depends on what issuers perceive to be practical, efficient, and in their business interests. Current requirements are already cumbersome, and adding more burdens - like issuing and processing payments from multiple instruments for each enrollee, adjusting for systems changes, notifying enrollees, and modifying appeals processes - will increase administrative complexity and costs for those issuers that cover comprehensive reproductive health services. The proposed regulatory changes will force QHPs to allocate additional resources, needlessly raising the administrative and personnel costs for these plans. While the proposed rule estimates that insurers will only incur \$1.6 million, CMS fails to take into account other costs associated with increasing customer service and addressing consumer confusion.²⁷

With additional burdens, confusion, and standards out of place from industry practice, we expect issuers will drop the abortion coverage they currently provide and/or pass the costs to consumers in the form of higher premiums. As argued earlier, consumers will lose insurance coverage when they fail to pay the premiums attributed to non-excepted abortion services. With so many enrollees dropping out of health plans because they fail to make the payment for these premiums, issuers will no longer continue to cover

²⁶ America's Health Insurance Plans (AHIP), *Comment Letter on HHS Notice of Benefit and Payment Parameters for 2016* (CMS-9944-P) (Dec. 22, 2014).

²⁷ See Patient Protection and Affordable Care Act; Exchange Program Integrity, 83 Fed. Reg. 56015 (Nov. 9, 2018).

abortions in their QHPs and include abortion providers in their networks. There could also be a ripple effect in private plans since issuers offer similar coverage in their plans off- and on- the exchanges.

D. The proposed changes diminish state flexibility, conflict with current state mandates on abortion coverage, and place issuers in those states in an untenable position.

Section 1303(c)(1) states that the ACA “does not preempt or have any other effect on state laws regarding the requirement of (or prohibition of), any coverage, funding, or procedural requirements on abortions.”²⁸ Hence, no federal rules should interfere with states’ decisions and mechanisms regarding coverage of reproductive health services. Abortion is a common and safe medical procedure, as one out of four women in the United States will have an abortion by age 45.²⁹ Recognizing that reproductive health care is a critical part of a person’s wellbeing, some states require abortion coverage in most of their plans, just like any other health service. For example, California’s Constitution and its Knox-Keene Health Care Service Plan Act of 1975 require that abortions must not be treated differently from other health care services. As a result, most health plans in the state, including QHPs, must cover abortion services.³⁰

The proposed changes to the already onerous regulatory requirements of §1303 conflict with the state’s goal to offer abortion coverage in their plans. Marketplace consumers in California who do not pay the premium apportioned to abortion services will lose coverage. This is a significant portion of the Covered California enrollee population. Further, the proposed changes establish that CMS will enforce these new provisions if states opt not to follow these requirements. The proposal seriously overrides states’ authority over issuers that operate in their states. The proposed changes will disrupt the nature of collaboration and partnership that the Affordable Care Act meant to create between the states and the federal government. At best, this new relationship will be confusing, and at worse, it will be detrimental.

²⁸ ACA § 1303; 42 U.S.C. 18023; 45 CFR 156.280.

²⁹ See Rachel K. Jones and Jenna Jerman, *Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014*, AM. JOURNAL OF PUBLIC HEALTH (2017). See also Nat’l Acad. of Sci., Eng’g and Med., *The Safety and Quality of Abortion Care in the United States*, <http://www.nationalacademies.org/hmd/Reports/2018/the-safety-and-quality-of-abortion-care-in-the-united-states.aspx> (Mar. 16, 2018) (finding that abortion in all forms is a safe and effective form of health care); *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, Am. J. Public Health 107(12): 1904-1909 (Dec. 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678377/>.

³⁰ See *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981); Cal. Health & Safety Code § 1340. .

E. By eliminating abortion coverage in many parts of the country, the proposed changes would threaten the health and economic security of consumers.

Abortion is legal and constitutionally protected form of medical care in the United States. Yet existing federal restrictions on insurance coverage, coupled with increasing federal and state attacks on access to abortion care, often render the constitutional right meaningless. Already, too many are denied abortion coverage because of how much they earn, where they live, or how they are insured. For many, coverage for abortion care means the difference between getting the health care they need when they need it and being denied that care.

Without insurance coverage, lower income women in particular have to raise the funds to pay out of pocket for an abortion. The time that it takes to raise funds for abortion care often results in delays, which in turn increase the cost of care. In a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1,874 for second-trimester abortion care.³¹

These delays can result in complete denial of abortion care as some states have imposed gestational age restrictions on abortion services. The impact of such a denial can have long-term, devastating effects on a woman and her family's economic future. Many women who seek an abortion are experiencing economic hardships when they seek this care. In one study, half of women seeking an abortion had incomes below the Federal Poverty Level ("FPL").³² When denied an abortion and forced to carry a pregnancy to term, a woman had almost a four-fold increase in the likelihood of living below the FPL and a higher chance of lacking the financial resources to pay for necessities.³³ Additionally, women who were denied abortion care were more likely to be the sole caretakers of their children in comparison to women who were able to receive the abortion care they needed.³⁴ This further demonstrates that women are making health care decisions that are best for themselves and their families. The

³¹ See All Above All & Ibis Repro. Health, *The Impact of Out-of-Pocket Costs on Abortion Care Access* (2016), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Brief%20OutOfPocket%20Impact.pdf>.

³² ANSIRH, *Issue Brief: Socioeconomic Outcomes of the Women Who Receive and Women Who are Denied Wanted Abortions 1* (2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf.

³³ *Id.* at 2.

³⁴ *Id.*

proposed changes could very well expose many individuals and families to untenable economic circumstances. This is particularly true for women of color and LGBTQ individuals of color who disproportionately struggle with poverty.³⁵

Additionally, women who are denied access to an abortion have been found to suffer adverse physical and mental health consequences. For example, according to a longitudinal study that is frequently cited in peer-reviewed journals, women denied abortions are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy, more likely to remain in relationships where interpersonal violence is present, and more likely to suffer anxiety in the short term after being denied an abortion.³⁶ The proposed changes to abortion coverage will harm the health and economic well-being of consumers.

F. The proposed regulatory changes further the administration's political agenda to undercut meaningful access to health care.

The administration continues to use its administrative powers to gut access to the full range of health care services. Earlier this year, HHS proposed regulations that would expand current religious refusal laws by granting unprecedented license to any one engaged in the health care system to refuse services or care on the basis of religious, moral, or personal beliefs. Recently, the agency finalized regulations that expand exemptions from the ACA's contraceptive coverage requirement and has proposed regulations that will gut the Title X program, the only federal program in the country dedicated solely to providing family planning and related preventive services. Combined, these efforts will threaten the health and well-being of low-income women, people of color, LGBTQ individuals, people living with disabilities, and other individuals who already face barriers seeking health care, particularly, reproductive health care, and rampant discrimination in health care settings.

³⁵ In 2016, women in all racial and ethnic groups were more likely than their white, non-Hispanic male peers to live in poverty. Kayla Patrick, Nat'l Women's Law Ctr., *Nat'l Snapshot: Poverty Among Women & Families, 2016* 1 (2017), <https://nwlc-ciw49tixqw5lbab.stackpathdns.com/wp-content/uploads/2017/09/Poverty-Snapshot-Factsheet-2017.pdf>; LGBTQ people of color, particularly transgender and gender nonconforming persons of color experience high rates of poverty. Movement Advancement Project, *Paying and Unfair Price: The Financial Penalty for Being LGBT in America* 6-8 (2014), <http://www.lgbtmap.org/file/paying-an-unfair-price-condensed-report.pdf>.

³⁶ Univ. of California-San Francisco, Turnaway Study, <https://www.ansirh.org/research/turnaway-study> (last visited Jan. 4, 2019).

We recommend that the proposed changes to §156.280 be withdrawn in their entirety. The proposed language goes far beyond the underlying statute, imposing onerous and unnecessary burdens on both issuers and consumers that will result in the loss of insurance coverage and reduced access to comprehensive health care, including reproductive and sexual health services.

Conclusion

Thank you for the opportunity to provide comments on the proposed rule. If you have any questions about our comments, please contact Mara Youdelman (youdelman@healthlaw.org) or Candace Gibson (gibson@healthlaw.org) at 202-289-7661 or Fabiola Carrión (carrion@healthlaw.org) at 310-204-6010.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor
Executive Director