STATE OF CALIFORNIA *Dave Jones, Insurance Commissioner*

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

RE: Comments in Response to Proposed Rulemaking:
Patient Protection and Affordable Care Act; Exchange Program Integrity, CMS-9922-P

To Whom It May Concern:

As California's Insurance Commissioner I am responsible for regulating the nation's largest insurance market and lead the largest consumer protection agency in the state, the California Department of Insurance (CDI). CDI implements and enforces consumer protections such as basic health coverage requirements, anti-discrimination protections, and laws pertaining to access to health care. As Insurance Commissioner I am tasked with protecting consumers as well as safeguarding their access to affordable and meaningful health insurance coverage, including abortion services. Californians have an inalienable right to privacy secured by the California Constitution, and that right includes the right to choose whether to bear a child or choose to obtain an abortion.[1] The State of California is forbidden from denying or interfering with someone exercising that right.[2]

The amendments to the *Segregation of Funds for Abortion Services* federal rule are inappropriate, unnecessary, costly, confusing and will harm consumers

I urge you to withdraw the amendments to the *Segregation of Funds for Abortion Services* federal rule (45 CFR § 156.280) found in the *Patient Protection and Affordable Care Act; Exchange Program Integrity* proposed rule. The proposed amendments to 45 CFR § 156.280 serve no purpose other than interfering with access to abortion, and have the potential to create substantial consumer confusion, which could result in cancelation of health coverage generally for some individuals. In California alone this ill-conceived proposed regulation would affect more than 1.3 million consumers enrolled in qualified health plans (QHPs) through California's Exchange, Covered California.

[1] *See* Cal. Const. art I, § 1; *Committee to Defend Reproductive Rights v. Myers*, 29 Cal. 3d 252 (1981); The Reproductive Privacy Act (Cal. Health & Saf. Code § 123460, *et seq*.).
[2] Cal. Health & Saf. Code §§ 123462 & 123466.

Abortion funds are currently inflated and segregated

The proposed amendment to the *Segregation of Funds for Abortion Services* rule found in the *Exchange Program Integrity* proposed rule is unnecessary and extraordinarily burdensome to consumers and health insurers. As the preamble to the proposed rule notes, section 1303(b)(2)(B) of the Patient Protection and Affordable Care Act, codified as 42 USC § 18023, already requires QHP issuers to collect a "separate payment" from each enrollee for a minimum of $1 per month, or an amount equal to the actuarial value of coverage for abortion services described in 42 USC § 18023(b)(1)(B)(i). This separate payment must be deposited into separate allocation accounts to be used exclusively for payments for abortion services, as described in 42 USC § 18023(b)(2)(C).

42 USC § 18023(b)(2)(D) goes on to detail that the "separate payment" need not have any relation to the real actuarial value of abortion services, and Congress set the minimum separate payment at $1, a figure known at the time to be significantly higher than the actual cost of abortion services. The real per month cost of abortion services, when included in the overall monthly premium, is between $0.11 and $0.33.[3] In California alone, this absurdly inflated "separate payment" has resulted in an estimated $53 million of consumers' premium dollars sitting in segregated allocation accounts, and those premium dollars can only be used to pay for abortion services per section 18023(b)(2)(C)(ii)(II).[4] This punitive and unwieldy governmental intrusion into the mechanics of private health insurance companies' billing and business practices has resulted in the effective waste of tens of millions of consumer dollars. Instead of forcing consumers to pay an inflated premium, CDI suggests that the Department of Health and Human Services (HHS) and Congress allow insurers to include in their premiums the actuarially based costs of abortion services.

Separate billing is inconsistent with the plain language of 42 USC § 18023

HHS stated in the preamble that the current language of 45 CFR § 156.280 does not "adequately reflect what we see as Congressional intent" that QHP issuers bill separately for the $1 of premium intended to cover abortion services. CDI strongly disagrees with this statement. The Administration may have changed since the passage of 42 USC § 18023, but the intent and the plain language of the statute have not. The statute at 42 USC § 18023(b)(3)(A) explicitly provides that a QHP that provides these services shall provide notice to enrollees "*only* as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage." (*Emphasis* added.) In addition, 42 USC § 18023(b)(3)(B) expressly states under the heading 'Rules relating to payments' that all advertising used by issuers, any information provided by the Exchange, and "any other information specified by the Secretary" shall only provide information with respect to the total amount of the combined payments for all services. The statutory

[3] Magda Schaler-Haynes, et al., *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 Univ. Pa. J. Law Soc. Change 323, 385 (2012).
[4] Alina Salganicoff, et al., *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans, Kaiser Family Foundation* (Jan. 2016), combined with Covered California enrollment data from 2014-2017.

language explicitly limits what information the Secretary can require when it comes to abortion coverage. The Secretary can only require separate notification of abortion coverage at the time of enrollment. The Secretary and the Exchange can only require payment notice information in the form of combined payments for all services. Thus, Congress intended that that advertising and noticing of payments should remain simple and uncomplicated for consumers, and only include information on combined payments for all services. The present proposal defies the statute, and is complex and extraordinarily burdensome to both consumers and issuers.

At best separate billing will lead to consumer confusion, at worst it will lead to cancelation of coverage

Consumers are accustomed to receiving and paying bills in total amounts, even when the bill includes charges for a variety of items. Examples of a single payment instrument used for multiple distinct payments include insurance premiums (when a single issuer or association provides coverage for home, auto, life, disability, etc.), telecommunications (mobile phones, internet, and cable television service bundles), and homeowner escrow accounts (mortgage principal, interest, taxes, and insurance). These examples are entirely analogous to the present situation. There is no rational reason why the current mechanism of health issuers billing for the whole premium and, upon receipt of payment, separating and segregating a dollar into a separate account, is not functional and exactly what Congress established in 42 USC § 18023. The only reason to require separate billing is punitive: to create an unduly burdensome administrative hurdle for issuers and consumers. The consequences of changing the current mechanism of "single bill, separate payments" are dire.

The preamble to the proposed rule acknowledges that consumer confusion is almost certain to follow these billing changes. It acknowledges that the prohibition on sending two separate bills in a single envelope will cause detrimental confusion, errors, and loss of vital coverage, noting that "consumers may inadvertently miss or discard a second paper bill included in a single envelope, increasing termination of coverage for failure to pay premiums." HHS also acknowledges that it is much easier and more economical for consumers to send their premium payment as a single check or credit card transaction. In fact, this proposed rule requires that issuers accept these single payment instruments and apply the funds to each separate premium account, without penalty or threat of termination of coverage. HHS does not address the very likely scenario of consumers paying what they think is their entire premium but missing the separate bill for a single dollar, or believing that they have been billed for the extra dollar in error. Failure to pay the dollar may result in cancelation of coverage due to non-payment of premium, and these consumers will not be eligible to re-enroll in any health plan until the following open enrollment period, since state and federal laws do not allow a special enrollment period for nonpayment of premium.[5] CDI strongly opposes requiring an unnecessary separate bill that will result in consumer confusion and that will lead to the extreme and unjust result of insurers canceling coverage in a way that bars consumers from obtaining other insurance for the rest of the year, and all because of nonpayment of a few dollars hidden on a separate bill. The

[5] 45 CFR §§ 147.104 & 155.420; Cal. Ins. Code § 10965.3(d).

cost to consumers in both time spent understanding this byzantine system of payment, and in potential termination of coverage due to nonpayment of de minimis amounts of premium, is unacceptably high. It is both absurd and punitive to single out this one medical service and require a separate bill and separate payment be made for this coverage. In addition to inappropriately interfering with a woman's right to abortion coverage, this rule will likely result in the cancellation of the health insurance policies of consumers who fail to understand these burdensome rules.

Separate billing is burdensome, costly, and without any benefit

Finally, the cost of the proposed rule is unacceptably large. HHS acknowledges that the doubling of billing and payment processing will create a new regulatory burden on QHP issuers and plans, stating "[t]his rules could significantly increase the administrative burden for QHP issuers covering non-Hyde abortion services in developing, sending, and processing the separate invoices under this proposal." However, HHS also underestimates the number of enrollees in QHPs offering abortion coverage. Section B of the Regulatory impact statement estimates that there are 1.3 million enrollees in QHPs offering abortion services across the nation. In fact, there are over 1.3 million enrollees in QHPs offering abortion coverage in California alone, with 11 QHP issuers across the state.[6] The costs to issuers, both in one-time investments and ongoing transaction costs, as well as customer service costs, will far exceed the estimates in this proposed rule. This significant, costly regulatory burden on issuers could result in increases in premium leading to less affordable coverage.

Conclusion

The proposed changes to 45 CFR § 156.280 are entirely arbitrary and capricious, inconsistent with statute, and come with unacceptable costs to both consumers and QHP issuers. CDI strongly opposes the proposed changes to the existing language of § 156.280, because these changes will harm consumers, issuers, and health insurance markets. This proposed regulation, a burdensome federal government intrusion, serves no legitimate purpose and should be withdrawn.

Sincerely,

DAVE JONES
Insurance Commissioner

[6]Covered California Press release, "Covered California Releases 2019 Individual Market Rates: Average Rate Change Will Be 8.7 Percent, With Federal Policies Raising Costs" (Jul. 19, 2018), *available at* https://www.coveredca.com/newsroom/news-releases/2018/07/19/Covered-California-Releases-2019-Individual-Market-Rates-Average-Rate-Change-Will-Be-8-7-Percent-With-Federal-Policies-Raising-Costs//.