No. 20-2006

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

PLANNED PARENTHOOD OF MARYLAND, INC., et al.,

Plaintiffs-Appellees,

v.

ALEX M. AZAR, II, in his official capacity as Secretary of Health and Human Services, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Maryland

BRIEF FOR APPELLANTS

JEFFREY BOSSERT CLARK
Acting Assistant Attorney General

ROBERT K. HUR
United States Attorney

ALISA B. KLEIN
AMANDA L. MUNDELL
Attorneys, Appellate Staff
Civil Division, Room 7236
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 514-3469

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STATEMENT OF JURISDICTION

Plaintiffs challenged a federal regulation and invoked the district court's jurisdiction under 28 U.S.C. §§ 1331, 1346, and 5 U.S.C. §§ 701-706. JA57. On cross motions for summary judgment, the district court invalidated the federal regulation. JA149. The court entered final judgment on July 10, 2020. JA150-51. Defendants timely filed a notice of appeal on September 18, 2020. JA152. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

Section 1303 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303, 124 Stat. 119, 168 (2010) (ACA), codified at 42 U.S.C. § 18023, requires that insurers offering qualified health plans that provide coverage of abortion services for which federal funding is prohibited "collect from each enrollee. . . a separate payment" for the portion of a premium that covers such abortion services. ACA § 1303(b)(2)(B)(i). The implementing regulation at issue here provides that, to comply with this statutory directive, the insurer must send a policy holder a separate bill and instruct the policy holder to pay the amount through a separate transaction. *See* 45 C.F.R. § 156.280(e)(2)(ii)(A), (B). The questions presented are:

1. Whether the regulation is arbitrary and capricious.

2. Whether the regulation violates Section 1554 of the ACA, which provides that HHS shall not promulgate any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."

STATEMENT OF THE CASE

I. Statutory and Regulatory Background

A. Section 1303 of the ACA

The ACA is generally designed to expand health coverage. *See King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). However, section 1303 of the ACA establishes "[s]pecial rules" regarding abortion coverage. Paragraph (a) allows a state to prohibit abortion coverage in qualified health plans offered through an Exchange and to repeal such a prohibition. Paragraph (b)(1) provides that nothing in Title I of the ACA shall be construed to require a qualified health plan to provide coverage for abortion services and that each plan issuer shall determine (subject to state law) whether or not to provide such coverage.

Paragraph (b)(2)(A) prohibits the use of the ACA's subsidies (tax credits and cost-sharing reduction payments) for abortion services that are not excepted by the Hyde Amendment, which is a longstanding proviso in the Department of Health and Human Services' (HHS) annual appropriations acts that bars the use of federal funds to pay for abortion services except in a case of rape, incest, or where the life of the mother is at risk. *See Harris v. McRae*, 448 U.S. 297, 300-04 (1980).

Paragraph (b)(2)(B)—which is directly at issue here—establishes two procedural requirements for plans that cover abortion services for which the use of federal funding is prohibited (sometimes described as "non-excepted abortion services" or "non-Hyde abortion services"). First, it requires insurers to "collect from

each enrollee . . . a separate payment" equal to the actuarial value of the coverage of non-excepted abortion services. ACA § 1303(b)(2)(B)(i). Second, it requires insurers to "deposit all such separate payments into separate allocation accounts" to segregate funds collected and used to pay for coverage of non-excepted abortion services from funds collected and used to pay for coverage of other services. ACA § 1303(b)(2)(B)(ii)-(C). The statute provides that the separate payment shall be no less than $1 per enrollee per month. ACA § 1303(b)(2)(D)(ii)(III).

B. Implementing Regulations And Agency Guidance

1. In 2012, HHS issued regulations that implemented the substantive requirements of section 1303. As relevant here, the regulatory text required insurers to "[c]ollect from each enrollee . . . a separate payment" for the portion of the premium that covers abortion services for which federal funding is prohibited, and "[d]eposit all such separate payments into separate allocation accounts." 77 Fed. Reg. 18,310, 18,472 (Mar. 27, 2012) (adding 45 C.F.R. § 156.280).

The regulatory text thus tracked the language of the statute by requiring insurers to collect a "separate payment" for non-excepted abortion services. In a later preamble to other regulations, however, HHS stated that there are several ways of satisfying the separate payment requirement, including "[s]ending the enrollee a single monthly invoice or bill that separately itemizes the premium amount for non-excepted abortion services; sending a separate monthly bill for these services; or sending the enrollee a notice at or soon after the time of enrollment that the monthly invoice or

bill will include a separate charge for such services and specify the charge." 80 Fed. Reg. 10,750, 10,840 (Feb. 27, 2015). HHS further stated that "[a] consumer may pay the premium payment for non-excepted abortion services and the separate payment for all other services in a single transaction." *Id.* at 10,840-41 (describing these statements as "clarifying guidance"). HHS reiterated those options in a guidance document issued in 2017 but also noted an earlier Government Accountability Office finding that seventeen of the eighteen issuers surveyed had failed to satisfy the requirement for collecting separate payments. Ctrs. for Medicare & Medicaid Servs., HHS, *CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act* 2, 3 (Oct. 6, 2017).[1] The Bulletin indicated that HHS was considering whether to take additional steps to ensure compliance with section 1303, including reexamining the guidance in the preamble to the 2015 rule. *Id.* at 3.

2. In 2019, after notice-and-comment rulemaking, HHS amended the regulation that implements section 1303. 84 Fed. Reg. 71,674 (Dec. 27, 2019). As relevant here, the amended regulation specifies that, to satisfy the separate-payment requirement, an insurer must send a policy holder separate bills (either in paper or electronic form) for the portion of the premium that covers non-excepted abortion services and for the remainder of the premium, and instruct the policy holder to pay each of those amounts through separate transactions. *See id.* at 71,710-11 (adding

[1] https://go.usa.gov/x7V3f.

revisions to 45 C.F.R. § 156.280(e)(2)(ii)(A), (B)). To protect enrollees from coverage loss, the amended regulations provide that, "if the policy holder fails to pay each of these amounts in a separate transaction as instructed by the issuer, the issuer may not refuse the payment and initiate a grace period or terminate the policy holder's [qualified health plan] coverage on this basis." *Id.* at 71,711 (quoting 45 C.F.R. § 156.280(e)(2)(ii)(B)).[2]

In issuing the amended regulations, HHS explained that they "better align with the intent of section 1303 of the [ACA]." 84 Fed. Reg. at 71,685. HHS explained that "Congress intended that [qualified health plan (QHP)] issuers collect two distinct (that is, 'separate') payments, one for the coverage of non-excepted abortion services, and one for coverage of all other services covered under the policy, rather than simply itemizing these two components in a single bill, or notifying the enrollee that the monthly invoice or bill will include a separate charge for these services." *Id.* at 71,684.

HHS indicated that, to "mitigate issuer burden associated with added postage and mailing costs," the amended regulations allow insurers to send separate bills in a single envelope. 84 Fed. Reg. at 71,685; *see also* 45 C.F.R. § 156.280(e)(2)(ii)(A). HHS further explained that, to protect enrollees from potential coverage loss, the amended

[2] The regulation required insurers to begin implementation on or before the first billing cycle following June 27, 2020, a deadline that HHS later extended to on or before the first billing cycle following August 26, 2020, in light of the COVID-19 public health emergency. *See* 84 Fed. Reg. at 71,710 (establishing new 45 C.F.R. § 156.280(e)(2)(ii)); 85 Fed. Reg. 2888, 2888 (Jan. 17, 2020); 85 Fed. Reg. 27,550, 27,551 (May 8, 2020) (extending the deadline).

regulations prohibit insurers from terminating coverage or placing a policy holder in a grace period simply because the policy holder makes a combined payment rather than two separate payments. 84 Fed. Reg. at 71,685; *see also* 45 C.F.R. § 156.280(e)(2)(ii)(B). In addition, to address the risk that coverage could be lost due to a policy holder's inadvertent failure to pay the separately billed amount for non-excepted abortion services, HHS indicated that, although insurers ultimately have to collect such premiums, it will not take enforcement action against an insurer that adopts a uniform policy of maintaining coverage despite non-payment of the separate amount for non-excepted abortion services. 84 Fed. Reg. at 71,686. HHS also indicated, in consideration of consumers who object to purchasing coverage that includes coverage of non-excepted abortion services, that it will not take enforcement action against insurers offering qualified health plans that modify the benefits of a plan either at the time of enrollment or during a plan year to effectively allow enrollees to opt out of coverage of such services by not paying the separate bill for such services. *Id.* HHS explained that it expected insurers to take appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for coverage of non-excepted abortion services and an intentional nonpayment. *Id.* at 71,687.

HHS projected that the costs associated with implementing the amended regulation would total approximately $1.5 billion between 2020 and 2024. 84 Fed. Reg. at 71,707 (chart).

II. Factual Background and Prior Proceedings

Plaintiffs are Planned Parenthood of Maryland, Inc., and a certified class of all enrollees in individual market Exchange plans who would be affected by the 2019 regulation, exclusive of enrollees who have opted out of abortion coverage. In February 2020, plaintiffs brought this action, seeking to invalidate the 2019 regulation.

On cross motions for summary judgment, the district court vacated the 2019 regulation as arbitrary and capricious. The court concluded that HHS failed to justify its departure from its prior guidance indicating that insurers could comply with section 1303 simply by itemizing the separate charge for non-excepted abortion coverage in the monthly bill or notice provided soon after enrollment, and depositing separate payments in separate allocation accounts. The court emphasized that, in the preamble to the 2019 regulation, HHS concluded that section 1303 does not "specify the method a QHP issuer must use to comply with the separate payment requirement" and that "the previous methods of itemizing or providing advance notice about the amounts . . . arguably identifies two 'separate' amounts for two separate purposes." 84 Fed. Reg. at 71,693. The court reasoned that, because HHS itself regarded its prior approach as permissible, HHS should have explained why it changed course despite the comments arguing that the revised approach would be disruptive and burdensome for insurers and would risk coverage loss for enrollees.

The district court also ruled that the regulation contravenes section 1554 of the ACA, which prohibits HHS from issuing a regulation that "creates any unreasonable

barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services."[3]

SUMMARY OF ARGUMENT

Section 1303 of the ACA requires that an insurer "collect from each enrollee . . . a separate payment" for the portion of the premium that covers non-excepted abortion services. The implementing HHS regulations have since 2012 tracked that statutory text by requiring insurers to collect a "separate payment" from each enrollee. Subsequent preamble to a separate rulemaking, however, indicated that distinct payments are not required, and that the separate payment provision could be satisfied in a number of ways that the agency later determined do not adequately reflect Congress's intent. Thus, HHS amended the regulations to specify that an insurer must send a policy holder a separate bill for the portion of the premium that covers non-excepted abortion services and instruct the policy holder to pay that amount through a separate transaction. The agency explained that the amended regulations better align with the intent of section 1303.

Contrary to the district court's understanding, that explanation is a sufficient basis to uphold the amended regulations. Even when statutory language is ambiguous, the Supreme Court has made clear that an agency "may justify its policy

[3] The court also ruled that the regulation's June 27, 2020 implementation deadline—which HHS later extended to August 26, 2020 in light of the pandemic—was arbitrary and capricious. That ruling has been overtaken by the passage of time and is not at issue here.

choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (quoting *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158. 175 (2007)).

The district court likewise erred in ruling that the amended regulations violate section 1554 of the ACA, which prohibits regulations that create "unreasonable barriers to the ability of individuals to obtain appropriate medical care." The amended regulation concerns billing rather than access to medical care. Moreover, Congress itself mandated that an insurer "collect . . . a separate payment" under section 1303, so the requirement to send separate bills and to instruct the policy holder to pay the amount through a separate transaction cannot be deemed an unreasonable burden. *See, e.g.*, *New Process Steel, L.P. v. NLRB*, 560 U.S. 674, 680 (2010) (explaining that provisions of the same statute should be read in harmony).

STANDARD OF REVIEW

This Court reviews de novo the district court's grant of summary judgment and its conclusions that the regulation is arbitrary and capricious and contrary to law under the APA. *Casa de Maryland v. U.S. Dep't of Homeland Sec.*, 924 F.3d 684, 703 (4th Cir. 2019).

ARGUMENT

A. The Challenged Regulation Properly Implements Section 1303 Of The ACA

1. Section 1303(b)(2)(B)(i) of the ACA mandates that an insurer "collect from each enrollee . . . a separate payment" for the portion of the premium that covers non-excepted abortion services. Accordingly, the implementing HHS regulations have from the inception required insurers to "[c]ollect from each enrollee . . . a separate payment" for the portion of the premium that covers abortion services for which federal funding is prohibited. 77 Fed. Reg. at 18,472 (adding 45 C.F.R. § 156.280). The regulatory text thus tracked the language of the statute by requiring insurers to collect a "separate payment" for non-excepted abortion services.

Subsequent preamble to a separate rulemaking, however, indicated that distinct payments are not required, and that the separate payment provision could be satisfied in a number of ways that the agency later determined do not adequately reflect Congress's intent. Therefore, HHS amended its regulations in 2019. 84 Fed. Reg. 71,674. The amended regulations specify that, to satisfy the separate-payment requirement, an insurer must send a policy holder separate bills for the portion of the premium that covers non-excepted abortion services and for the remainder of the premium, and instruct the policy holder to pay each of those amounts through separate transactions. *See id.* at 71,710-11.

In issuing the amended regulations, HHS explained that they "better align with the intent of section 1303 of the [ACA]." 84 Fed. Reg. at 71,685. HHS explained that "Congress intended that QHP issuers collect two distinct (that is, 'separate') payments, one for the coverage of non-excepted abortion services, and one for coverage of all other services covered under the policy, rather than simply itemizing these two components in a single bill, or notifying the enrollee that the monthly invoice or bill will include a separate charge for these services." *Id.* at 71,684. HHS explained that it was thus amending the regulations to achieve "better alignment of the regulatory requirements for QHP issuer billing of enrollee premiums with the separate payment requirement in section 1303 of the [ACA]." *Id.* at 71,688.

Under the Supreme Court's precedents, that explanation was sufficient. Even when statutory language is ambiguous, the Supreme Court has made clear that an agency "may justify its policy choice by explaining why that policy 'is more consistent with statutory language' than alternative policies." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016) (quoting *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158. 175 (2007)).

The decision in *Long Island Care* is illustrative. That case concerned the provision of the Fair Labor Standards Act (FLSA) that exempts from the Act's minimum wage and overtime protections "any employee employed in domestic service employment to provide companionship services" for individuals who because of age or infirmity are unable to care for themselves. *Long Island Care*, 551 U.S. at 162

(quoting 29 U.S.C. § 213(a)(15)). Initially, the Department of Labor proposed a rule that would have placed outside the exemption (and thus within the minimum wage and overtime protections) individuals who were employed by certain third-party employers. *Id.* at 174. In the final rule, the Department reversed course, explaining that its revised interpretation was "more consistent" with the "statutory language" and "prior practices concerning other similarly worded exemptions." *Id.* at 175 (quoting 40 Fed. Reg. 7404, 7405 (Feb. 20, 1975)). In a unanimous decision, the Supreme Court held that this single sentence constituted "a reasonable, albeit brief, explanation." *Id.* The Court so ruled even though it concluded that "the text of the FLSA does not expressly answer the third-party-employment question," *id.* at 168.

Here, too, the agency explained that its amended regulations are more consistent with the intent of the statute itself. That explanation suffices under the controlling Supreme Court precedents.

2. The district court's reasons for declaring the amended regulations arbitrary and capricious do not withstand scrutiny.

The court first expressed doubt that the amended regulations better align with the text of section 1303, reasoning that the "Congressional intent was to make sure federal funds were not used for non-Hyde abortions, rather than to establish the particular method by which issuers should collect payments." JA143. But that reasoning conflates the two procedural requirements that section 1303 imposes on insurers. By its terms, section 1303 requires that an insurer both (1) "collect from

each enrollee . . . a separate payment" equal to the actuarial value of the coverage of non-excepted abortion services, ACA § 1303(b)(2)(B)(i), and (2) "deposit all such separate payments into separate allocation accounts," *id.* § 1303(b)(2)(B)(ii). Thus, under the plain terms of the statute, it is insufficient for an insurer simply to segregate the portion of the premiums to be used for non-excepted abortion coverage; the statute also requires the insurers to "collect" a "separate payment" for that coverage.

The court also emphasized that "the overall purpose of the ACA" is "to increase the number of Americans covered by health insurance and decrease the cost of health care." JA143 (quoting *National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012)). Yet "no legislation pursues its purposes at all costs." *CTS Corp. v. Waldburger*, 573 U.S. 1, 12 (2014) (quoting *Rodriguez v. United States*, 480 U.S. 522, 525-526 (1987)). That is especially true here, where section 1303's "special rules" for abortion coverage formed part of a legislative "compromise." 155 Cong. Rec. S14134 (daily ed. Dec. 24, 2009) (statement of Sen. Nelson). The language that became section 1303 was an amendment proposed by then-Senator Ben Nelson. Although the ACA's overall purpose was to expand health coverage, section 1303 authorized states to prohibit abortion coverage in plans offered through an Exchange. And with respect to the provision of section 1303 that is at issue here, Senator Nelson explained that if a plan "has any [non-excepted] abortion coverage, the insurance company must bill you separately, and you must pay separately." *Id.* The district court overlooked this explanation and the compromise nature of section 1303.

The district court also misunderstood the significance of the portion of the preamble to the 2019 regulation where HHS stated that section 1303 does not "specify the method a QHP issuer must use to comply with the separate payment requirement" and that "the previous methods of itemizing or providing advance notice about the amounts . . . arguably identifies two 'separate' amounts for two separate purposes." 84 Fed. Reg. at 71,693. The court reasoned that, because HHS itself regarded its prior policy as permissible, HHS should have explained why it changed course despite comments arguing that the new approach would be burdensome for insurers and risk coverage loss for enrollees. But as explained above, although HHS viewed its former policy as permissible, it did not view that policy as the best approach for ensuring compliance with the statute. The agency accordingly explained that it was changing course, amending the regulation to bring it into better alignment with the statutory requirement.

That was a reasonable and sufficient basis on which to issue the new rule, regardless of prior statutory interpretations providing for alternative processes to satisfy the separate payment requirement of section 1303. *Long Island Care*, 551 U.S. at 173-74. Courts do not apply a "heightened standard" to agency action that "changes prior policy"; the agency "need not demonstrate to a court's satisfaction that the reasons for the new policy are *better* than the reasons for the old one." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 514, 515 (2009). Indeed, the APA "makes no distinction . . . between initial agency action and subsequent agency action undoing or

revising that action." *Id.* at 515. So long as the agency "display[s] awareness that it *is* changing position," "show[s] that there are good reasons for the new policy," and "*believes* it to be better," then the agency's "new policy is permissible under the [APA]." *Id.*

Moreover, as HHS emphasized, the amended regulation includes provisions designed to mitigate the burdens on insurers and protect enrollees from coverage loss. To reduce postage and mailing costs, the amended regulation allows insurers to send separate bills in a single envelope. 45 C.F.R. § 156.280(e)(2)(ii)(A). And to protect enrollees, the amended regulation prohibits insurers from terminating an enrollee's coverage or placing the enrollee in a grace period simply because the policy holder makes a combined payment rather than two separate payments. *Id.* § 156.280(e)(2)(ii)(B). In addition, to address the risk that coverage could be lost due to a policy holder's inadvertent failure to pay the separately billed amount for non-excepted abortion services, HHS indicated that it will not take enforcement action against an insurer that adopts a uniform policy of maintaining coverage despite non-payment of the separate amount for non-excepted abortion services. 84 Fed. Reg. at 71,685. In consideration of consumers who object to purchasing coverage that includes coverage of non-excepted abortion services, HHS explained that it will not take enforcement action against insurers that modify the benefits of a plan to effectively allow enrollees to opt out of coverage of such services by not paying the separate bill for such services. *Id.* HHS also explained that it expected insurers to

take appropriate measures to distinguish between a policy holder's inadvertent non-payment of the separate bill for coverage of non-excepted abortion services and an intentional nonpayment. *Id.* at 71,687.

Review of agency action under the APA is "highly deferential, with a presumption in favor of finding the agency action valid." *Friends of Back Bay v. U.S. Army Corps of Eng'rs*, 681 F.3d 581, 587 (4th Cir. 2012) (quoting *Ohio Valley Envtl. Coal. v. Aracoma Coal Co.* 556 F.3d 177, 192 (4th Cir. 2009)). The regulation at issue here must be upheld because the agency "examined the relevant considerations and articulated a satisfactory explanation for its action." *FERC v. Electric Power Supply Ass'n*, 136 S. Ct. 760, 782 (2016) (quotation marks and alterations omitted).

B. The Challenged Regulation Does Not Violate Section 1554 Of The ACA

The district court also erred in ruling that the amended regulation creates "unreasonable barriers to the ability of individuals to obtain appropriate medical care" in violation of section 1554(1) of the ACA.

As an initial matter, the amended regulation does not implicate section 1554. Section 1554 concerns "direct interference with certain health care activities." *Becerra ex rel. California v. Azar*, 950 F.3d 1067, 1094 (9th Cir. 2020) (en banc) (explaining that section 1554 is "most natural[ly] read[] . . . to ensure that HHS, in implementing the broad authority provided by the ACA, does not improperly impose regulatory burdens on doctors and patients"). It does not apply to "measures [that] ensure that

government funds are spent for the purposes for which they were authorized." *Id.* As in *Becerra*, the regulation at issue here does not pertain to "health care activities" because it does not relate to "individuals' ability to obtain appropriate medical care or [to] doctors' ability to communicate with clients or engage in activity." *Id.* at 1095. Instead, it enforces section 1303, which operates as a statutory limit on government spending for abortion coverage.

Even assuming that the amended regulation implicates section 1554, it does not violate that provision because it implements the requirements of section 1303. The district court concluded that requiring insurers to send two separate bills and collect payment through separate transactions "is a 'barrier' because it makes it harder for consumers to pay for insurance, because they must now keep track of two separate bills," and that it is "an 'unreasonable barrier'" because it is "likely to cause enrollee confusion and may lead to some enrollees losing health insurance." JA137. The court further declared that "[e]ven if enrollees are not confused, they will still have to spend extra time reading, understanding, and paying two separate bills each month (or arranging through autopay for the two bills to be paid)," and that "enrollees may spend time correcting billing issues if the second $1 payment is flagged by a bank or credit card as potentially fraudulent." JA138. But Congress itself required that enrollees make a separate payment for the portion of the premium that covers non-excepted abortion services. Thus, Congress evidently did not regard that requirement as an unreasonable barrier to medical care. Whatever other difficulties consumers

may face in complying with a regulation that implements section 1303, they cannot properly be regarded as an unreasonable barrier to health care within the meaning of section 1554. The Supreme Court has repeatedly admonished that provisions of the same statute should be read in harmony. *See, e.g., New Process Steel, L.P. v. NLRB*, 560 U.S. 674, 680 (2010). And in the face of any ambiguity regarding whether section 1554 could apply to the amended regulation, the more specific separate-payment requirement in section 1303 would, in any event, control. *See Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992) ("[I]t is a commonplace of statutory construction that the specific governs the general.").

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

JEFFREY BOSSERT CLARK
Acting Assistant Attorney General

ROBERT K. HUR
United States Attorney

ALISA B. KLEIN

s/ Amanda L. Mundell
AMANDA L. MUNDELL
Attorneys, Appellate Staff
Civil Division, Room 7236
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 514-3469
Amanda.L.Mundell@usdoj.gov

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 4372 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

s/ Amanda L. Mundell
Amanda L. Mundell

CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2020, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Amanda L. Mundell
Amanda L. Mundell

ADDENDUM

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Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303(b)

§ 1303. Special rules

*** * ***

(b) Special rules relating to coverage of abortion services

(1) Voluntary choice of coverage of abortion services

(A) In general

Notwithstanding any other provision of this title (or any amendment made by this title)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) Abortion services

(i) Abortions for which public funding is prohibited

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) Abortions for which public funding is allowed

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(2) Prohibition on the use of Federal funds

(A) In general

If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount

attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) Establishment of allocation accounts

In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1554

§ 1554. Access to Therapies

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

45 C.F.R. § 156.280(d), (e)(1) & (2)

§ 156.280 Separate billing and segregation of funds for abortion services.

* * *

(d) *Abortion services*—

(1) ***Abortions for which public funding is prohibited.*** The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is not permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(2) ***Abortions for which public funding is allowed.*** The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(e) *Prohibition on the use of Federal funds.*

(1) If a QHP provides coverage of services described in paragraph (d)(1) of this section, the QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

(i) The credit under section 36B of the Code and the amount (if any) of the advance payment of the credit under section 1412 of the Affordable Care Act;

(ii) Any cost-sharing reduction under section 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under section 1412 of the Affordable Care Act.

(2) ***Establishment of allocation accounts.*** In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:

(i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

(ii) Beginning on or before the first billing cycle following August 26, 2020, to satisfy the obligation in paragraph (e)(2)(i) of this section—

(A) Send to each policy holder of a QHP monthly bills for each of the amounts specified in paragraphs (e)(2)(i)(A) and (B) of this section, either by sending separate paper bills which may be in the same envelope or mailing, or by sending separate bills electronically, which must be in separate emails or electronic communications; and

(B) Instruct the policy holder to pay each of the amounts specified in paragraphs (e)(2)(i)(A) and (B) of this section through separate transactions. Notwithstanding this instruction, if the policy holder fails to pay each of these amounts in a separate transaction as instructed by the issuer, the issuer may not refuse the payment and initiate a grace period or terminate the policy holder's QHP coverage on this basis.

(iii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under paragraph (e)(2)(i) of this section shall each be paid by a separate deposit.