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July 7, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5531-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-5531-IFC. Medicare and Medicaid Programs, Basic Health Program, and Exchanges: 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

Dear Administrator Verma:

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals and families. NHeLP advocates, educates, and litigates at the federal and state levels to advance health and civil rights in the United States.

As conveyed in our comments to the proposed rule, NHeLP strongly opposes the changes to 45 C.F.R. §156.280 because they threaten to undermine access to quality health care, including essential reproductive health services.[1] We implore the administration, states, and the marketplaces to redirect their attention towards expanding access to health coverage during these perilous times instead of amplifying barriers. The National Health Law Program unequivocally rejects the implementation of the “Double Billing” rule promulgated on December 27, 2019.[2]

The United States is Facing a Health Crisis and Should Respond to It

Our country is in the midst of a public health emergency, as the U.S. Department of Health Care and Human Services (HHS) declared on January 31, 2020.[3] At the time of writing these comments, almost three million people in the United States have been diagnosed with the novel COVID-19 virus and 130,000 have perished.[4] The United States is one of the few countries in the world where cases are not leveling off or decreasing, but are actually rising.[5] Our health care system is saturated and unprepared to adequately address the health needs of millions of people. In addition, more than 90 million individuals have lost their jobs and the country faces a recession.[6] People who have lost their employer-based insurance are now enrolling in Medicaid as well as marketplace plans. In states that have Special Enrollment Periods (SEP) in order to offer immediate health coverage to the newly uninsured, marketplace enrollment numbers are doubling or tripling to where they were just a year ago even before these SEPs end.[7] Our nation has to rise to the challenge and offer support to those who need health care as well as the systems that will help them obtain coverage like the marketplaces.

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[1] CMS-2018-0135.

[2] 45 C.F.R. § 156.280.

[3] HHS, *Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus* (Jan.31, 2020), https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html.

[4] *See* Harvard Global Health Inst., Online Risk Assessment Map, (last visited July 4, 2020) https://globalepidemics.org/.

[5] *See* Andrew Witherspoon & Caitlin Owens, *Coronavirus Cases Flat or Growing in 48 states*, Axios (July 2, 2020), https://www.axios.com/coronavirus-map-cases-rising-most-states-1d3ec8d8-af4c-418e-8f9b-2360b917f91a.html.

[6] *See* Patricia Cohen, *'Still Catching Up': Jobless Numbers May Not Tell Full Story*, N.Y. Times (June 4, 2020), https://www.nytimes.com/2020/05/28/business/economy/coronavirus-unemployment-claims.html.

[7] *See, e.g.*, Covered California, California Extends Special-Enrollment Deadline to Give Consumers More Time to Sign Up for Health Care Coverage During COVID-19 Pandemic (June 23, 2020), https://www.coveredca.com/newsroom/news-releases/2020/06/23/california-extends-special-enrollment-deadline-to-give-consumers-more-time-to-sign-up-for-health-care-coverage-during-covid-19-pandemic. (Before the Special Enrollment period ends, more than 175,030 people have signed up for the marketplaces in California which is more than twice the number who signed up during the same time last year).

The National Health Law Program calls on HHS to act on its commitment "to protect the health and safety of *all* Americans" during this unprecedented crisis.[8] In its announcement to initially delay the implementation of the Double Billing rule, HHS admitted that Qualified Health Plans (QHPs) are currently strained as a result of their ongoing response to the public health emergency. Moreover, HHS noted, complying with the Double Billing rule will pose an even greater obstacle than considered before.[9] It is unconscionable to further harm enrollees and distract QHPs and the marketplaces by implementing a rule that will disrupt the health care system and put access to health care services out of further reach.

This administration should focus on expanding access to health care, including abortion, which is a legal and constitutionally-protected form of medical care.[10] Yet existing federal restrictions on insurance coverage coupled with increasing federal and state attacks on access to abortion care in the midst of a pandemic often render this right meaningless.[11] The implementation of a rule that most commenters opposed during its introduction is a thumb on the nose to the millions of Americans who will now have to pay more in health insurance premiums and lose access to essential, time-sensitive health care.

NHeLP Reiterates and Augments its Arguments

The complicated Double Billing rule will confuse enrollees

Implementing the complicated Double Billing rule will lead to widespread enrollee confusion, particularly amid a moment of uncertainty produced by a deadly pandemic. The changes will confuse QHP enrollees who are used to receiving one itemized bill for their insurance premiums. Accepted insurance practices already allow payments for different types of coverage within the same instrument and transaction. For example, insurance plans that offer bundled coverage (e.g., life and disability insurance, home, and car insurance) often allow enrollees to pay for their multiple policies in one transaction with the same instrument (e.g., check, automatic withdrawal, credit card payment). If distinct policies can be paid for through the same instrument or transaction, it only makes sense that payment for a covered health

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[8] *See* HHS *supra* note 2 (emphasis added).
[9] 85 Fed. Reg. 27600 (May 8, 2020).
[10] *Roe v. Wade*, 410 U.S. 113 (1973).
[11] *See* Michelle J. Bayefsky et al., *Abortion during the Covid-19 Pandemic — Ensuring Access to an Essential Health Service*, 19 NEW ENG. J. MED. 383 (May 7, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMp2008006?articleTools=true.

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.

Enrollees will struggle trying to navigate these changes and will often not have the resources or time to follow up with QHPs to understand this new and complicated process. It is highly likely that many will not make both premium payments because of this confusion. Many may believe that a separate bill is a scam, an error by the issuer, or a charge for coverage that they did not request. Consequently, enrollees and shoppers may experience delays in coverage as they try to understand how to make sense of these new premium payments. As NHeLP explained in its comments, these changes will mostly harm those who already struggle to navigate the health care system—including people with disabilities and limited English proficiency—and who are also more likely to need health care. This rule will add anxiety and heighten barriers to health care access during a time people are already overstretched.

Enrollees will incur additional costs, heightening economic insecurity in the middle of a pandemic.

Not presented during the comment period, the final rule included an opt-out policy that allows enrollees to drop abortion coverage from their QHPs. Once some enrollees forgo paying the second premium, however, QHPs will endure heightened administrative burdens. They will inevitably pass down costs to enrollees in the form of higher premiums and cost-sharing. In fact, HHS has conceded that the rule will result in increased premium costs for enrollees.[12] HHS, however, fails to account for the financial and human costs that enrollees will incur learning how to comply with these changes as well as the additional costs. Finally, HHS cruelly dismisses how enrollees will be able to cover these costs when they are facing economic hardships, particularly in the middle of a pandemic.

[12] *See supra* note 1.

The rule further jeopardizes health and economic security through yet another unnecessary attack on abortion access

Abortion is a common and safe medical procedure, as one out of four women in the United States will have an abortion by the age of 45.[13] Half of abortion patients are low-income individuals and many are seeking this care precisely because they experience economic hardships.[14] In addition, evidence from previous pandemics show that individuals might want to avoid having children since pregnant individuals and infants might be found to be at heightened risk from COVID-19.[15] One new study conducted by the Guttmacher Institute found that more than one-third of women reported that they wanted to delay having a child or limit future births because of the pandemic.[16] Since this administration has reduced Title X's capacity to provide contraceptive services by at least 46 percent, more individuals will likely seek abortion care to meet their reproductive health needs.[17]

Individuals who are denied abortion access have been found to endure adverse physical and mental health consequences. According to a longitudinal study that is frequently cited in peer-reviewed journals, individuals 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

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[13] NHeLP recognizes that different categories of people, including cisgender women and transgender men, are able to become pregnant. We use the term "women" here in order to conform to the cited research. *See* Rachel K. Jones & Jenna Jerman, Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 12 AM. J. PUB. HEALTH 107 (Dec. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678377/; *See also*, Nat'l Acad. of Sci., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States*, http://www.nationalacademies.org/hmd/Reports/2018/the-safety-and-quality-of-abortioncare-in-the-united-states.aspx (Mar. 16, 2018) (finding that abortion in all forms is a safe and effective form of health care).

[14] *Id.*

[15] *See* Zarah Ahmed & Adam Sonfield, Guttmacher Inst., *The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights* (Mar. 11, 2020), https://www.guttmacher.org/article/2020/03/covid-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights.

[16] *See* Laura Lindberg, et al., Guttmacher Inst., *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experience* (2020), https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.

[17] *See* Zarah Ahmed & Adam Sonfield *supra* note 14.

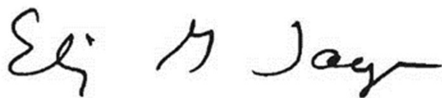
short term after being denied an abortion.[18] When denied abortions, individuals are also likely to fall deeper into poverty.[19] Harms to abortion coverage particularly harm Black, Indigenous, and other people of color as well as LGTBQ individuals who disproportionately struggle with poverty. In the midst of the current global pandemic, it is unscrupulous to worsen the health and economic wellbeing of QHP enrollees.

Conclusion

The National Health Law Program has opposed the Double Billing rule since its proposal. In the midst of a health and economic crisis, we are convinced that the rule will eviscerate essential reproductive health care in the marketplaces. The harms will disproportionately fall on people who are increasingly losing economic stability as well as women, LGBTQ, immigrants, and Black, Indigenous, and other people of color. Additionally, the rule will pose irreparable harm to the health and lives of those seeking abortion care. The National Health Law Program asks that this administration expand, not restrict health care access to adequately meet enrollees' essential health needs.

Thank you for the opportunity to comment. If you have any questions about our comments, please contact Fabiola Carrión at carrion@healthlaw.org or 310.736.1649.

Sincerely,



Elizabeth G. Taylor
Executive Director

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[18] *See* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (Feb. 2018), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247.
[19] *Id.*