EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

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

Plaintiffs,

v.

ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services, in his official capacity, *et al.*,

Defendants.

Case No. CCB-20-00361

DECLARATION OF KAREN J. NELSON
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Karen J. Nelson, declare and state as follows:

1. I am the President and Chief Executive Officer ("CEO") of Planned Parenthood of Maryland, Inc. ("PPM"), a position I have held since 2016. I am responsible for the management of PPM and therefore am familiar with our operations and finances, including the services we provide and the communities we serve.

2. Before assuming my current role, I served as President and CEO of Planned Parenthood of Central and Western New York ("PPCWNY"), a position I held beginning in 2008. Before that, I served as Finance Coordinator (1994–1998), Director of Finance and Administration (1998–2004), and Chief Operating Officer (2005–2008) for PPCWNY.

3. The facts I state here are based on my experience, my review of PPM business records, information obtained through the course of my duties at PPM, and personal knowledge that I have acquired in my over 25 years of service with affiliates of Planned Parenthood. If called and sworn as a witness, I could and would testify competently thereto.

4. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment, which seeks to enjoin a recent rule issued by the U.S. Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"). *See* Patient Protection and Affordable Care Act; Exchange Program Integrity, Final Rule, 84 Fed. Reg. 71,674 (Dec. 27, 2019); Patient Protection and Affordable Care Act; Exchange Program Integrity, Notice of Correction, 85 Fed. Reg. 2,888 (Jan. 17, 2020) ("the Final Rule" or "the Separate-Billing Rule"). I am familiar with the Separate-Billing Rule.

5. If the Final Rule takes effect, I expect that it will have a devastating effect on PPM's patients who rely on private insurance plans that they purchase through Maryland's health insurance exchange established to comply with the Patient Protection and Affordable Care Act ("ACA"). The Rule will reduce patient access to insurance coverage for abortion, impose onerous new costs on vulnerable patients, and threaten many patients with termination of their entire health insurance plans. For absolutely no benefit, it will interfere with our patients' health, well-being, and economic futures, while eroding gains that Maryland has made to ensure that health insurance is more affordable and available to its residents.

PPM's Patients and Services

6. PPM is a non-profit corporation incorporated in Maryland with headquarters in Baltimore, Maryland. PPM's mission is to provide and protect access to reproductive health care and sexuality education so that all people can make informed, voluntary choices about their reproductive and sexual health.

7. PPM operates seven health centers in Maryland. Those centers are located in Annapolis, Baltimore, Easton, Frederick, Owings Mills, Towson, and Waldorf.

8. Through its health centers, PPM provides comprehensive reproductive health care services, including birth control; testing and treatment for sexually transmitted infections; testing for HIV and the human papillomavirus ("HPV"); pregnancy testing and prenatal referrals; breast and cervical cancer screenings; and safe, legal abortion. PPM's abortion care includes medication abortions through 10 weeks after the first day of a patient's last menstrual period ("LMP") and surgical abortions through 14 weeks LMP. In 2019, PPM served more than 27,900 patients at more than 44,800 patient visits.

9. PPM provides services to individuals who are uninsured, participate in a Medicaid program, or are covered by private insurance. Commercial insurance plans reimbursed costs from approximately 35 percent of PPM's patient visits in 2019.

10. PPM performed 6,897 abortions in 2019. Approximately 18% of those patients relied on commercial insurance to pay for this service.

11. PPM provides abortions and other healthcare services to patients who rely on reimbursements through Maryland's ACA exchange.

12. Many of PPM's patients who obtain abortions have no insurance coverage for their care, and therefore are forced to pay out-of-pocket for these services.[1] Abortion services cost several hundred dollars, or more, depending on the gestational point in pregnancy.

13. When patients do not have insurance coverage or have insurance without abortion coverage, PPM does its best to defray the remaining costs for patients with the greatest need, but sometimes it is unable to do that.

[1] Federal Medicaid funding may not be used to cover abortion services except where necessary to preserve a pregnant person's life or where the pregnancy is the result of rape or incest. Maryland uses state dollars to reimburse some abortion services needed by Medicaid patients.

Interests of PPM and Its Patients in Insurance Exchange Plans

14. The ACA directed states to create health insurance exchanges to permit individual consumers to compare and directly purchase health insurance plans offered by participating private insurance companies. Since 2014, consumers in Maryland have been able to purchase health insurance plans from Maryland's Health Benefit Exchange ("MHBE"), Maryland's state-based ACA marketplace.

15. PPM has been heavily involved in advocating for increased access to health insurance throughout Maryland, including through plans offered on MHBE. In my PPM capacity, I am currently a member of the Standing Advisory Committee to the Exchange's Board of Trustees. The Committee, which is designed to provide the Exchange with consumer, provider, and carrier feedback, weighs in on a range of regulations and policies affecting the Exchange. It has, for example, provided feedback on Maryland's reinsurance program, which is widely credited with helping to reduce premiums on the Exchange; efforts to reach hard-to-reach groups in need of insurance, including the young adults who compose a significant share of PPM's patient population; and the implementation of a recent state law adding pregnancy as a basis for enrollment in an Exchange plan outside the normal enrollment window. PPM also regularly weighs in on legislation that affects the Exchange, such as a recent law adopted by the Legislature that will make it easier for consumers to enroll in Medicaid and private Exchange plans at the time they submit their Maryland income tax returns.

16. The Exchange has played a critical role in reducing the uninsured population in Maryland, particularly among Marylanders who are not eligible for employer-sponsored plans or public insurance programs like Medicaid and Medicare. In 2019, more than 156,000 individuals

in Maryland selected a marketplace plan.[2] At least half of them had earnings at or below 250 percent of the federal poverty level.[3] More than half of the marketplace participants (56 percent) were women, and nearly half (48 percent) were between the ages of 18 and 44, which are prime childbearing years.[4] Approximately 48 percent of those participants whose race was reported were non-white, and at least 9 percent were Hispanic.[5]

17. Maryland consumers who selected a marketplace plan in 2019 had an average monthly premium of $552.[6] Although most of these consumers qualified for federal assistance,[7] this assistance did not fully cover their health insurance costs. For example, even after taking into account the impact of Advance Premium Tax Credits, a form of assistance established by the ACA for households with earnings between 100 and 400 percent of the federal poverty level, the average monthly premium for participants on MHBE was $191, and even among only those participants who received a tax credit, the remaining premium was still $110 per month.[8]

18. There are currently two commercial insurance carriers (hereinafter, "issuers") that provide plans on Maryland's individual exchange: CareFirst and Kaiser Permanente, each of which offers ten plans in Maryland.

19. Under Section 1303 of ACA, absent a state law to the contrary, health insurance issuers that offer plans through the individual marketplace are permitted to determine whether their

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[2] Based on calculations released by CMS, 2019 OEP State-Level Public Use File, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.
[3] *Id.* The current federal poverty level for a single person is $12,760 and $26,200 for a family of four. HHS, Poverty Guidelines for 2020 (Jan. 8, 2020), https://aspe.hhs.gov/poverty-guidelines.
[4] CMS, 2019 OEP State-Level Public Use File, *supra* n.2.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*

plans cover abortion services, including abortion services that could not be paid for using federal ACA subsidies (i.e., abortion obtained outside of the limited instances of rape, incest, or life-endangerment). Although Maryland does not require plans to cover these federally excluded abortion services, it does not forbid such coverage, and all plans currently offered on the Exchange include this type of coverage.

The Impact of The Rule on PPM and Its Patients

20. As the Rule predicts, I expect that some issuers, in response to the Rule, will decide to stop offering abortion coverage in their plans on the individual exchange in Maryland. As HHS has recognized, the Rule will impose substantial administrative burdens on issuers, and even with outreach, is likely to result in significant consumer confusion. Issuers will have to spend money dealing with these burdens, including the costs of printing two bills each month for a single policy and handling calls and other inquiries from consumers who do not understand why they have to pay two bills—one for abortion-related coverage, and one for the remainder of the premium—each month. In addition, despite the added administrative burdens of the Rule, issuers that wish to provide coverage for abortion services will still have to comply with the ACA's Medical Loss Ratio ("MLR") provision. Under that provision, issuers must spend at least 80 percent of premiums that they receive on medical claims and quality improvement, and no more than 20 percent on administration, marketing, and profit; otherwise, they have to issue rebates to enrollees. The Rule unnecessarily drives up disfavored administrative costs, without any corresponding benefit to enrollees, further incentivizing issuers to drop abortion coverage from their plans.

21. Some PPM patients whose plans drop coverage for abortion care will be unable to afford the cost of an abortion, on top of all of their other expenses (which will still include a significant insurance premium for coverage under the exchange). Some will forgo seeking abortion

services altogether, with long-lasting, negative effects on their health, their well-being and that of their existing children, and their economic futures.

22. Other patients will struggle to pay for the cost of an abortion and delay care in an attempt to raise the necessary funds for the procedure. Based on my experience, I know that many of our patients who are forced to cover all or part of the cost of their procedure struggle to raise the necessary funds, and some resort to harmful sacrifices in an attempt to do so, including drawing on money saved for necessities like food, rent, utilities, and clothing. These tradeoffs affect not just our patients, but their families as well. Many of our abortion patients already have children.

23. Delays in accessing care due to financial barriers may prevent some patients from obtaining the abortion method they determine is best for them. Because medication abortion is only available until 10 weeks LMP, patients who cannot afford an abortion before that time will require a surgical abortion. Moreover, although abortion is a safe medical procedure, like all medical procedures, it carries risks. Those risks increase with gestational age at the time of abortion, as do costs.

24. For those patients who still manage to obtain abortion care from PPM, PPM will no longer be able to seek reimbursements from the patients' private insurance carrier to cover the abortion services. Instead, in addition to trying to scrape together a portion of the costs for care from their own funds, these patients will seek PPM financial assistance to cover the shortfall. Although PPM works to assist patients in financial need, an increase in the number of our patients seeking reduced-fee abortion services will further strain our limited resources, which are already oversubscribed from patients seeking abortions and other care who have no insurance coverage for it. An increase in patients seeking care without insurance coverage would also impede our efforts to improve the reproductive health of Marylanders. Rather than using our resources to move

forward to improve the health and lives of patients in Maryland, we will need to divert resources to pay for abortion services that would have been covered by exchange plans, but for the Final Rule.

25. Even where exchange plans nominally maintain coverage for abortion, some PPM patients may still lose access to this coverage because of the Rule's "opt out" policy. The Final Rule announced that HHS will not take enforcement action against issuers that allow policyholders to "opt out" of coverage for abortion care, even if they purchased a plan that includes such coverage. Some PPM patients are not the policyholders of their insurance plans, but are instead covered under the plans of a parent, spouse, or partner. These patients could lose access to abortion coverage without ever consenting to that loss, or even knowing about it. Patients facing domestic violence within their families are also at risk for loss of abortion coverage: an abusive policyholder may refuse abortion coverage in order to ensure that the domestic violence victim cannot access this form of care. Other patients may be confused about the effect of an "opt out," erroneously believing that they can forgo paying the abortion-related premium under an "opt out" while still maintaining abortion coverage. And other patients—already under financial strain—may deal with rising premiums or other financial stressors by opting out of abortion coverage on the assumption they will not need it, only to find themselves pregnant and seeking an abortion in the future.

26. In addition, I expect that PPM patients who rely on exchange plans that continue to cover abortion care under the Rule will ultimately pay more for the coverage they currently have, with no benefit to them whatsoever. As HHS has recognized, issuers will pass on the costs of the Separate-Billing Rule to consumers in the form of premium increases. As described above, many of PPM's patients already struggle financially. Even modest premium increases would pose a

barrier for our patients as they work to obtain sufficient food for themselves and their families, cover monthly utility and housing costs, and pay for other health-related expenses.

27. The Rule also threatens PPM patients with the loss of health care coverage altogether. As HHS acknowledged when it adopted the Rule, some consumers may not understand why they are receiving two bills—one for the abortion-related share of their premium, and the other for the remainder of the premium. They may think that the second bill is a scam, an error, or a charge for coverage that a patient has not selected or does not wish to continue. Those who do not pay the abortion-related bill are at risk of having their insurance coverage terminated completely, even for services unrelated to abortion care. Where a consumer does not pay the abortion-related premium at the time of enrollment, the inadvertent non-payment may prevent the consumer from ever obtaining coverage.

28. A consumer's loss of coverage (or failure to obtain it) will have long-lasting effects. Open enrollment in exchange plans occurs only once a year in the fall; consumers cannot enroll in exchange plans during other times of the year unless they have a specifically recognized special basis for doing so, such as a job loss. Consumers who attempt to enroll during a special or open enrollment period but are unable to do so based on inadvertent non-payment of the abortion premium could be foreclosed from obtaining health insurance for months, if not a full year. Likewise, exchange plan enrollees whose coverage is terminated due to non-payment would need to wait until another enrollment period to regain coverage. In the meantime, consumers without coverage will be forced to pay for healthcare out-of-pocket, and might need to delay, ration, or forgo altogether the healthcare they need.

29. Concerns regarding the impact of non-payment on coverage are particularly acute for certain patient populations, including our patients who have limited English proficiency, have

chronic or serious health conditions that require consistent access to healthcare services for management of those conditions, or have certain disabilities that pose a barrier to navigating the health insurance system. HHS recognized that its Final Rule could lead to the draconian outcome of full policy termination for some individuals, yet it left insurance companies free to impose it. The impact of losing insurance for these patients could be catastrophic, both in terms of their health and their financial security.

30. As with a loss of abortion coverage, where our patients' entire insurance policies are terminated, I expect that some patients will delay seeking care at PPM, ration needed care to minimize their out-of-pocket costs, or forgo care from us altogether, particularly preventive care. Even where patients who lose coverage as a result of the Rule still reach us, PPM will not be able to seek insurance reimbursement for its services. Instead, in addition to trying to raise their own funds for needed care, these patients will seek PPM financial assistance to cover the shortfall, an outcome that will further strain our limited resources to assist patients in need.

31. Even where an insurance company is able to adopt a policy that permits it *not* to terminate coverage (a possibility HHS suggested), despite an enrollee's repeated non-payment of a portion of their premium, the enrollee will continue to rack up charges for which they remain financially responsible. Our patients with modest to low incomes can ill afford yet another form of debt, including medical debt. This is precisely the kind of outcome that the ACA was intended to help prevent.

32. An expedited decision on the Rule's legality is needed to protect PPM and its patients from the Rule's harmful effects. Although issuers cannot raise premiums or change covered services during a plan year, the current deadline for them to file proposed premium rates

for the 2021 plan year with state regulators is May 1, 2020.[9] If the Separate-Billing Rule remains in effect at that time, issuers will have to factor in costs when proposing how much to charge consumers in the upcoming year and whether to continue offering abortion coverage. Issuers will begin selling exchange plans for the 2021 plan year in Fall 2020, and those plans will be in effect from January 1 through December 31, 2021.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on this 24 day of February 2020.

Karen J. Nelson

[9] Maryland Insurance Administration, Bulletin 20-01: 2021 Affordable Care Act ("ACA") Individual and Small Employer Form and Rate Filing Instructions (Jan. 7, 2020), https://insurance.maryland.gov/Insurer/Documents/bulletins/20-01-2020-ACA-Rate-and-Form-Filing.pdf.