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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENTOF HEALTH AND HUMAN SERVICES; SEEMA VERMA, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; and CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendants.

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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I. INTRODUCTION

1. A federal agency cannot preempt state law contrary to Congressional intent. As relevant here, the Patient Protection and Affordable Care Act (PPACA or the Act) contains two express non-preemption provisions that protect state consumer-protection and insurance-regulation laws against federal preemption.

2. The Trump Administration's Department of Health and Human Services (HHS) has promulgated a new regulation (the Double-Billing Rule or the Rule) that will require health insurance carriers to send two separate bills each month to enrollees in certain health care coverage plans, and instruct enrollees to pay the separate bills in two separate transactions. *Patient Protection and Affordable Care Act: Exchange Program Integrity*, 84 Fed. Reg. 71,674 (Dec. 27, 2019). One bill must cover the premium cost of coverage for all health care services except abortion, and the second bill must address only the comparatively miniscule cost of covering abortion services. Double-billing in this manner directly conflicts with Washington law.

3. The Rule's clear objective is to impede women's access to safe and legal abortion care by increasing the costs and burdens to insurers of providing coverage, and punishing states for requiring coverage parity. The Rule's immediate impacts, however, will be keenly felt by individuals who lose their health care coverage *entirely* because of the confusion and administrative burdens engendered by double-billing, and other participants in the health care system who will face dramatically increased costs with no countervailing benefits.

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4. The Double-Billing Rule is contrary to Washington law, which requires insurers to issue a single invoice per month. Furthermore, the Double-Billing Rule—a reversal of prior agency policy—serves no valid purpose. HHS admits the Rule will confuse consumers, who may assume a separate bill for a small portion (typically as little as one dollar) of their monthly premium is a scam, duplicative of a bill they already paid, or a rider or fee that does not apply to them. If consumers inadvertently fail to pay the portion of their premium reflected in the separate bill, they risk losing coverage—and 40% of enrollees in Washington could lose coverage within 30 days of missing a full payment. Widespread coverage losses will cause a cascade of harms in Washington State.

5. The Rule also is extremely costly and burdensome. HHS itself estimates the Rule will raise health care costs nationwide by well over $500 million in 2020 alone. Insurance carriers in Washington estimate the Rule will increase their costs at a minimum by $100,000 per issuer.

6. The Double-Billing Rule applies to qualified health plans (QHPs) offered on state exchanges established under the PPACA. QHPs are offered by private insurance carriers on the Washington Health Benefit Exchange (the Exchange), and are subject to oversight by Washington's Office of the Insurance Commissioner (OIC).

7. The Rule's double-billing provisions are scheduled to go into effect on June 27, 2020.

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8. The PPACA expressly permits QHPs to cover health care services beyond the "essential health services" required by the Act, consistent with applicable state law. Further, the PPACA expressly disclaims any intent to preempt state law, specifically including state insurance-regulation laws. Despite this, the Double-Billing Rule is designed to punish QHPs for offering coverage for non-federally-funded abortion services pursuant to state law. QHP issuers are already required to, and do, segregate funding to ensure that federal funds are not used to pay for such services.

9. Washington law generally requires health care plans to cover abortion services (with exemptions for certain state and federally required accommodations). The State's Reproductive Parity Act mandates that if a plan includes coverage for maternity care or services, it must also include substantially equivalent coverage for abortion services. Wash. Rev. Code § 48.43.073. In addition, another Washington statute (the Single-Invoice Statute) specifically requires insurers to send enrollees a single invoice for each billing period, consistent with industry practice and with the PPACA. Wash. Rev. Code § 48.43.074. The Double-Billing Rule directly conflicts with the Single-Invoice Statute, without directly addressing the conflict.

10. If applied in Washington, the Double-Billing Rule will impliedly preempt state law, contrary to the PPACA's express non-preemption provisions. In addition, the Double-Billing Rule is arbitrary and capricious because, *inter alia*, it is needlessly costly and burdensome, will harm the robust administration of the

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State Exchange, will inevitably confuse consumers who may overlook or otherwise inadvertently fail to pay the second monthly bill, and will introduce uncertainty into the insurance market and interfere with enrollment rates and the insurance risk pool. These effects directly undermine the PPACA's purpose of expanding affordable coverage for health care services and protecting patients. Furthermore, widespread disenrollment from QHPs will harm Washingtonians' health and well-being and increase the health care costs borne by the State. In addition, the Rule is unlawful because it was issued without adequate notice and an opportunity for public comment, and is unconstitutional.

II. PARTIES

11. Plaintiff the State of Washington is a sovereign state represented herein by its Attorney General, who is the State's chief legal adviser. The powers and duties of the Attorney General include acting in federal court on matters of public concern to the State.

12. Defendant Alex M. Azar II is the Secretary of the U.S. Department of Health and Human Services (HHS). He is sued in his official capacity.

13. Defendant HHS is the federal agency responsible for implementing the relevant portions of Title 1 of the Patient Protection and Affordable Care Act. HHS promulgated the Rule at issue in this lawsuit.

14. Defendant Seema Verma is the Administrator of the Centers for Medicare and Medicaid Services (CMS). She is sued in her official capacity.

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15. CMS is a federal agency within HHS. CMS, together with HHS, promulgated the Rule at issue in this lawsuit.

III. JURISDICTION AND VENUE

16. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 (action arising under the laws of the United States), 28 U.S.C. § 1346 (United States as a defendant), and 5 U.S.C. §§ 701–706 (judicial review of agency action under the Administrative Procedure Act (APA)). An actual controversy exists between the parties within the meaning of 28 U.S.C. § 2201(a), and this Court may grant declaratory relief, injunctive relief, and other relief pursuant to 28 U.S.C. §§ 2201–2202 and 5 U.S.C. §§ 705–706.

17. Defendants' publication of the Double-Billing Rule in the Federal Register on December 27, 2019, constitutes a final agency action and is therefore judicially reviewable within the meaning of the APA. 5 U.S.C. §§ 704, 706.

18. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(3) because this is a judicial district in which the State of Washington resides and this action seeks relief against federal agencies and their officials acting in their official capacities. *See California v. Azar*, 911 F.3d 558, 569–70 (9th Cir. 2018), *cert. denied sub nom. Little Sisters of the Poor Jeanne Jugan Residence v. California*, 139 S. Ct. 2716 (2019).

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IV. FACTS

A. Statutory and Regulatory Background

1. The PPACA and Washington's Health Benefit Exchange

19. Title 1, subtitle D of the Patient Protection and Affordable Care Act of 2010 (PPACA) provides for the establishment of state health benefit exchanges on which issuers may offer QHPs. 42 U.S.C. § 18031(b).

20. State exchanges are governmental or nonprofit insurance marketplaces established by states that facilitate the purchase of QHPs. An exchange's responsibilities include certifying health plans as QHPs, making relevant information available to consumers, and providing customer service.

21. Washington's Health Benefit Exchange is a public-private partnership created by state statute in 2011 pursuant to the PPACA. *See* Wash. Rev. Code Chapter 43.71. The Exchange operates Washington Healthplanfinder (https://www.wahealthplanfinder.org), an easily accessible online marketplace for individuals and families to find, compare, and enroll in QHPs. The Healthplanfinder also serves as Washington's enrollment portal for Medicaid, known as "Apple Health." *See* Wash. Rev. Code § 43.71.030(1)(a).

22. As of Spring 2019 (the most recent period for which data is available), Washington Healthplanfinder connected one out of every four Washingtonians to their health coverage. Five Washington counties have 40% or more of their population enrolled in either a QHP or Medicare through the State Exchange. Four of those five counties are in Eastern Washington.

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23. Section 1301 of the PPACA defines a QHP as a health care coverage plan offered on a state exchange that meets the relevant statutory criteria, including that it must offer "essential health benefits" as defined in the Act. 42 U.S.C. § 18021(a). Section 1302 specifies that "[n]othing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection." 42 U.S.C. § 18022(b)(5). Section 1311 specifies that states may require QHPs to offer benefits in addition to the "essential health benefits" required by federal law. 42 U.S.C. § 18031(d)(3)(B).

24. The PPACA provides for federal subsidies—specifically, a premium tax credit and cost-sharing subsidies—to reduce QHP enrollees' monthly premiums and out-of-pocket costs if certain requirements and qualifications are met.

25. QHPs are typically offered by private insurance carriers. In Washington, for the 2020 plan year, there are currently nine issuers offering 66 unique health plans on the State Exchange. Beginning with plan year 2021, a state-funded public option known as "Cascade Care" will be also available on the Exchange. Ch. 364, Washington Laws of 2019 (SB 5526).

26. More than 200,000 Washingtonians are covered under a QHP. About one third of Washington QHP enrollees live at or below 200% of the federal poverty level. About two thirds of Washington QHP enrollees receive federally subsidized coverage.

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2. Funding Segregation Requirements for QHP Issuers

27. Section 1303 of the PPACA establishes "special rules" regarding QHPs' coverage of certain abortion services. 42 U.S.C. § 18023. The statute makes clear that federal law does not affect QHP issuers' "voluntary choice of coverage of abortion services." *Id.* § 18023(b)(1). Unless prohibited by state law, *id.* § 18023(a), QHP issuers may include abortion coverage in their plans.

28. The U.S. Constitution protects women's freedom to choose to terminate a pregnancy. However, with limited exceptions, federal law generally prohibits the use of federal funds to pay for abortion care. Accordingly, Section 1303 provides that QHP issuers cannot use federal tax credits or cost-sharing reductions to pay for "abortions for which public funding is prohibited[.]" 42 U.S.C. § 18023(b). If a QHP covers abortion care, Section 1303 requires "segregation of funds" to ensure that federal dollars are not used to subsidize non-federally-fundable care. *Id.* § 18023(c).

29. Specifically, Section 1303(b)(2)(B) provides in full:

> In the case of a plan [that provides coverage of "abortions for which public funding is prohibited"], 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 ["abortions for which public funding is prohibited"] (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

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> (II) an amount equal to the actuarial value of the coverage of ["abortions for which public funding is prohibited"], 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.

42 U.S.C. § 18023(b)(2)(B).

30. In 2015, HHS promulgated a final rule (the "2015 Rule") explaining that Section 1303's requirement that issuers "collect . . . a separate payment," 42 U.S.C. § 18023(b)(2)(B)(i), "do[es] not specify the method an issuer must use to comply with the separate payment requirement." *Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10,750, 10,840 (Feb. 27, 2015). The 2015 Rule provided that this requirement "may be satisfied in a number of ways," including but not limited to (i) sending the enrollee a single monthly invoice that separately itemizes the premium amount for abortion services, (ii) sending a separate monthly bill for abortion services, or (iii) sending the enrollee a notice upon enrollment that the monthly invoice will include a separate, specified charge for abortion services. *Id.* The 2015 Rule further specified that the enrollee may make the separate payments for abortion services and other services in a "single transaction." *Id.* As HHS explained, these standards offered QHP issuers "several ways to comply with [Section 1303's] requirements, while minimizing burden on QHP issuers and consumers." *Id.* at 10,841.

31. The 2015 Rule is consistent with the purpose of Section 1303—namely, to provide for funding segregation to ensure federal funds are not used to pay for non-federally-fundable care. The 2015 Rule is also consistent with the standard industry practice of billing enrollees in a health care plan with a single monthly invoice, and is consistent with Washington's Single-Invoice Statute.

3. The PPACA's Non-Preemption Provisions

32. Section 1303 contains an express non-preemption provision. The relevant subsection, entitled "No preemption of state laws regarding abortion," provides in full:

> Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of abortion on a minor.

42 U.S.C. § 18023(c)(1).

33. In addition, Section 1321 of the PPACA,[1] entitled "State Flexibility in Operation and Enforcement of Exchanges and Related Requirements," contains a general non-preemption provision. That subsection, entitled "No interference with State regulatory authority," provides in full: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d). In other words, this provision establishes that state

[1] Like Section 1303, Section 1321 is found in Title 1, subtitle D of the Act.

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laws are not preempted unless they directly conflict with Title 1 of the Affordable Care Act.

4. Relevant Washington Law

34. Washington's Reproductive Parity Act requires all health plans that provide coverage for maternity care or services to also provide substantially equivalent coverage for abortion services (with exceptions for certain federally mandated accommodations). Wash. Rev. Code § 48.43.073.

35. Washington's Single-Invoice Statute codifies the State's requirement that health insurance carriers bill enrollees with a single invoice, while noting the State's compliance with Section 1303 of the PPACA. The Single-Invoice Statute provides in full as follows:

> (1) The legislature intends to codify the state's current practice of requiring health carriers to bill enrollees with a single invoice and to segregate into a separate account the premium attributable to abortion services for which federal funding is prohibited. Washington has achieved full compliance with section 1303 of the federal patient protection and affordable care act[2] by requiring health carriers to submit a single invoice to enrollees and to segregate into a separate account the premium amounts attributable to coverage of abortion services for which federal funding is prohibited. Further, section 1303 states that the act does not preempt or otherwise have any effect on state laws regarding the prohibition of, or requirement of, coverage, funding, or procedural requirements on abortions.
> (2) In accordance with RCW 48.43.073 related to requirements for coverage and funding of abortion services, an issuer offering a qualified health plan must:

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[2] 42 U.S.C. § 18023.

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> (a) Bill enrollees and collect payment through a single invoice that includes all benefits and services covered by the qualified health plan; and
>
> (b) Include in the segregation plan required under applicable federal and state law a certification that the issuer's billing and payment processes meet the requirements of this section.

Wash. Rev. Code § 48.43.074.

36. The provisions of the PPACA requiring the segregation of premium funds, and other health plan issuer requirements found in federal and state law such as the Reproductive Parity Act and the Single-Invoice Statute, are administered and enforced by Washington's Insurance Commissioner, Mike Kreidler, and the Office of the Insurance Commissioner (OIC). The Commissioner's duties include protecting consumers, the public interest, and the State's insurance markets through fair and efficient regulation of the insurance industry.

5. The Proposed Rule

37. As noted above, HHS and CMS's 2015 Rule provided that QHP issuers could comply with Section 1303 by sending enrollees a single monthly invoice that itemizes the premium amounts for federally-fundable and non-federally-fundable covered services, and accepting the monthly premium payment via a single transaction.

38. On November 9, 2018, HHS and CMS published a Notice of Proposed Rulemaking (NPRM) proposing to reverse the policy reflected in the 2015 Rule and require QHP issuers to send enrollees two separate bills for their monthly

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premium if the plan includes coverage for non-federally-fundable abortion services. 83 Fed. Reg. 56,015 (Nov. 9, 2018).

39. As set forth in the NPRM, the agencies reinterpreted Section 1303's requirement that QHP issuers "collect . . . a separate payment" for non-federally-fundable care to mean that the "separate payment" must be both separately *billed* by the issuer and separately *submitted* by the enrollee. Specifically, the proposed rule would require QHP issuers to (1) "send an entirely separate monthly bill" to each enrollee "for only the portion of the premium attributable to" non-federally-fundable abortion coverage and (2) "instruct the policy subscriber" to pay each bill in a "separate transaction." 83 Fed. Reg. 56,022 (proposed 45 C.F.R. § 156.280).

40. Under the proposed rule, if the enrollee paid the full amount in a single transaction, the issuer would not be permitted to terminate their enrollment based on the enrollee's failure to make each payment in a separate transaction. However, if the enrollee entirely failed to pay the separately billed amount (i.e., if the enrollee failed to pay the full amount of the premium—the total amount of the two separate invoices), their enrollment could be terminated. *See* 83 Fed. Reg. 56,030.

41. Under current regulations, failure to pay premiums typically results in loss of coverage after the grace period is exhausted. In addition, failure to pay the full premium for the first month of enrollment means a new enrollee will never receive the benefits of coverage, since full payment is required to initiate coverage.

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42. HHS and CMS received nearly 75,000 public comments on the NPRM. "Most commenters objected" to the double-billing proposal, whereas "a minority of commenters summarily supported the policy." 84 Fed. Reg. 71,684.

43. The Attorneys General of Washington and four other states jointly submitted a 22-page comment letter on the NPRM. The comment letter pointed out that, if adopted, the proposed rule would increase consumer confusion, lead to coverage termination when consumers inadvertently failed to make the required separate payment, increase costs to the states' fiscs due to residents' loss of insurance coverage, penalize insurance carriers for providing abortion coverage (including where required by state law), harm and unduly burden the administration of state exchanges, create unnecessary barriers to women's access to abortion care, and violate the APA, the PPACA, and the U.S. Constitution.

6. The Final Rule

44. Despite opposition from most commenters, on December 27, 2019, CMS and HHS promulgated the Double-Billing Rule, which largely finalizes the rule as proposed. 84 Fed. Reg. 71,684.

45. The relevant provisions of the Double-Billing Rule are scheduled to go into effect on June 27, 2020. *See id.* at 71,710 (future 45 C.F.R. § 156.280); *see*

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also id. at 71,686, 71,689–690.[3] That is the middle of the 2020 plan year, making implementation especially burdensome for consumers, carriers, and the State.

46. The Double-Billing Rule's key provisions are the same as the proposed rule. The Double-Billing Rule requires QHP issuers to (1) "send an entirely separate monthly bill" to each enrollee "for only the portion of premium attributable to" non-federally-fundable abortion coverage and (2) "instruct the policy holder" to pay each bill in a "separate transaction." 84 Fed. Reg. 71,684.

47. The agencies' stated rationale for the Double-Billing Rule is that "HHS now believes" the Double-Billing Rule will "better align with congressional intent regarding the separate payments provision of section 1303 of the PPACA." *Id.* at 71,684, 71,699. The agencies do not offer any support for this rationale, which is the sole and exclusive justification for requiring QHP issuers to send two monthly bills to enrollees.

48. The Double-Billing Rule's preamble contains a section entitled "Federalism." In this section, the agencies recognize that there are "Federalism implications" arising from certain provisions of the Rule not at issue here. *Id.* at

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[3] The text of the rule specifies "June 27, 2019," but this appears to be a typographical error, as the preamble repeatedly states that the double-billing provisions will go into effect "6 months after publication" of the Rule in the Federal Register—i.e., June 27, 2020.

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71,709. However, the agencies disclaim any federalism implications arising from the Rule's double-billing requirements (found in 45 C.F.R. § 156.280). *Id.*

49. The "Federalism" section of the Double-Billing Rule's preamble further states that "**[t]his final rule does not** impose substantial direct costs on state and local governments **or preempt state law**." *Id.* (emphasis added).

50. These statements are inconsistent with the text of the Rule to be published in the Code of Federal Regulations. The regulatory language requires *all* QHP issuers that provide coverage of abortion services to send separate bills and instruct enrollees to pay them in separate transactions. 84 Fed. Reg. 71,710–711 (to be codified at 45 C.F.R. § 156.280). The regulatory text does not provide an exception for issuers in states where single-invoice billing is required.

51. Further, on or about January 9, 2020, representatives of CMS stated on a conference call with state exchanges, including representatives of Washington's Exchange, that the Double-Billing Rule would preempt state law in the event of a conflict.

52. As under the proposed rule, enrollees who fail to pay the full amount of the two separate bills may lose their coverage pursuant to existing regulations governing termination for non-payment of premiums. *See id.* at 71,686 & n.12. However, the Double-Billing Rule's preamble introduces a new "enforcement discretion" concept that was not included in the proposed rule. The preamble states that HHS "will not take enforcement action against a QHP issuer that adopts and implements a policy" whereby the issuer "does not place an enrollee into a grace

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period and does not terminate QHP coverage based solely on the policy holder's failure to pay the separate payment." *Id.* at 71,686–687. However, the preamble further states that "the QHP issuer would still be required to collect the premium" and "cannot relieve the policy holder of the duty to pay" the full amount. *Id.* at 71,686.

53. The agencies' inclusion of the "enforcement discretion" concept in the preamble is a tacit acknowledgement that—as many commenters pointed out—the Double-Billing Rule is likely to result in widespread inadvertent nonpayment. If that were not the case, HHS would have no need to exercise "enforcement discretion." As discussed below, consumers are, in fact, likely to overlook a second bill entirely or otherwise inadvertently fail to pay it.

54. The new "enforcement discretion" concept is not included in the Double-Billing Rule's regulatory text. *See id.* at 71,710–711 (future 45 C.F.R. § 156.280).

7. Consumer Expectations for Health Insurance Billing

55. The Double-Billing Rule deviates from standard industry practice and does not align with consumer expectations. Many consumers receive monthly bills for a variety of services, such as health insurance, mortgage payments, and/or utilities. Most consumers do not expect to receive multiple invoices in a single month for services such as health insurance (unless they are enrolled in multiple health insurance plans, such as separate plans for medical and dental coverage). The Double-Billing Rule is unprecedented.

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56. A consumer who does not expect to receive a second monthly bill may overlook it entirely, or assume it is not a bill. If the two separate bills are mailed in the same envelope, the consumer may not realize there is a separate bill in the envelope or may assume it is not a bill.

57. Alternatively, if a consumer receives two separate invoices for their monthly health insurance premium, they may assume the second invoice is a bill for an optional coverage "rider." A rider is a limited-scope supplemental benefit policy that covers certain services not included in the standard health insurance plan. Insurers charge separate premiums for a rider and sometimes have a separate deductible for the services included in the rider. This risk of confusion may be especially high among enrollees who are unlikely to use abortion coverage benefits (such as men and individuals who are beyond their reproductive years). However, abortion coverage is not a rider. Federal law currently prohibits issuers from selling coverage riders on the individual state exchanges.

58. Another possibility is that, in this era of increased concern about financial deception, consumers may intentionally disregard a separate bill suspecting it is a scam, since they may have paid the first bill already.

59. Consumer confusion arising from the receipt of two separate bills will likely result in more enrollees entering grace periods for failure to pay QHP premiums in full. In 2018, 13% of QHP enrollees in Washington were disenrolled for nonpayment. Based on the State Exchange's experience with consumer

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behavior, additional billing results in a significantly increased likelihood of disenrollment.

60. Nearly 40% of Washington Exchange consumers are unsubsidized and would lose coverage within 30 days of failing to make a monthly payment in full, leaving little time for resolution of the confusion caused by multiple bills. Federal law requires a three-month grace period prior to termination of coverage for enrollees who receive advance payments of the premium tax credit, but does not require the grace period for other enrollees. 45 C.F.R. § 156.270. Thus, disenrollment rates are likely to be higher among unsubsidized enrollees.

61. Disenrollment rates are also likely to be significantly higher among the 80% of Exchange consumers—roughly 150,000 enrollees—who are not currently enrolled in an auto-pay program with their carriers.

62. The confusion and disruption resulting from the Double-Billing Rule will likely have a disproportionate impact on the most vulnerable populations served by the State Exchange—such as those with limited English proficiency and American Indian/Alaska Native populations—who already experience significant barriers to obtaining health care coverage and accessing care, and are at high risk of losing tax credits and the ability to maintain coverage in an affordable health plan. Disenrollment rates are likely to be higher for these enrollees.

63. The preamble to the Double-Billing Rule posits that consumer confusion can be mitigated by "notifying policy holders that they will be receiving a second, separate email or electronic communication containing a separate bill for

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the portion of their premium attributable to coverage of [non-federally-fundable] abortion services that they should pay in a separate transaction." But many consumers may not pay attention to, understand, or closely read an explanatory notice. Health insurance in the United States is already notoriously complex and paperwork-heavy, and vulnerable populations already experience barriers to accessing care.

64. Instructing consumers to pay the separate bills in two "separate transactions" each month is both unnecessary and burdensome. Consumers would have to spend time reviewing explanatory materials to understand why they are receiving two separate monthly invoices when they are only enrolled in one plan. Consumers would then be instructed to write two separate checks or complete two separate electronic transactions to pay their health insurance premiums every single month. An enrollment experience that has become reliable for consumers in Washington will, under the Double-Billing Rule, become burdensome, inconsistent, unreliable, and distrusted virtually overnight.

65. HHS estimates that it will take enrollees only "1 hour" to read and understand the separate bills and "seek help from customer service if necessary," and only "5 minutes per month" to read and understand their separate bills going forward. HHS does not explain the basis for this estimate, which is completely detached from most Americans' experience with complex health care systems and billing. Furthermore, the estimate does not purport to include the time it would take consumers to actually pay and account for the separate payment transactions made

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each month, and fails to account for disproportionate impacts on the most vulnerable populations.

66. HHS "acknowledge[d] commenters' concerns that, even with fulsome outreach and education efforts to explain the billing scheme to the policy holder, consumer confusion could still lead to inadvertent coverage losses." 84 Fed. Reg. 71,686. HHS further acknowledged that "[t]his risk may be especially acute for enrollees whose plan choices likely were not motivated by the plan's coverage of [non-federally-fundable] abortion services . . ." *Id.* Men and other individuals who are unlikely to be direct beneficiaries of abortion coverage may be particularly likely to assume the second bill is an error or related to an optional coverage rider, and thus inadvertently fail to pay their premium in full.

67. HHS stated that these risks would be "mitigated" by offering consumers plans that do not cover abortion—disregarding the fact that consumers may need covered services regardless of their "motivation" for choosing the plan, and disregarding the fact that states like Washington have parity laws requiring health plans to offer substantially equivalent coverage for reproductive health care services. The reality is that enrollees who fail to pay their premiums in full—regardless of the reason—are at risk of losing their coverage as a result of the Double-Billing Rule.

68. As another aspect of its "enforcement discretion," HHS also encourages QHP issuers to allow enrollees to "opt out" of coverage of non-federally-fundable abortion services "by not paying the separate bill for such

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services." 84 Fed. Reg. 71,686. Doing so would violate Washington law, which prohibits carriers from making changes to their plan benefits during the coverage period. Once an issuer's plan has been approved by OIC, the issuer must sell that plan during the coverage period. Unlike the remainder of the double-billing provisions, the opt-out policy goes into effect on February 25, 2020. 84 Fed. Reg. 71,687.

69. Even though it systematically underestimates the costs, HHS acknowledges that the Double-Billing Rule will be costly: it estimates that affected issuers, state exchanges, the federal exchange, and consumers will incur costs of $546.1 million in 2020 alone, and approximately $230 million per year in each subsequent year. 84 Fed. Reg. 71,700. It estimates a one percent premium increase for enrollees each year and a related reduction in enrollment, arising directly from the Rule. *Id.*

70. HHS also acknowledges that, faced with the additional costs imposed by the Double-Billing Rule, particularly in light of the midyear implementation deadline, "issuers may seek to exit the individual market in a state or incur losses." 84 Fed. Reg. 71,690. However, HHS unreasonably dismisses this risk as "small." *Id.*

71. HHS failed to consider the true costs imposed by the Double-Billing Rule on consumers, issuers, the Exchange, and the State. Its estimates of limited discrete costs are unrealistically low, and it failed to meaningfully weigh the Rule's costs against its purported benefits (which are nonexistent).

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72. Separate billing and separate payment transactions serve no discernible "program integrity" purpose, and HHS articulates none. The PPACA already requires QHP issuers to segregate separately *collected* payments into separate accounts to ensure funding segregation. Washington has achieved compliance with this requirement as to QHPs offered on its State Exchange.[4] The Double-Billing Rule is (in theory) meant to achieve the same result—i.e., funds for coverage of non-federally-fundable services would be segregated into separate accounts. But by additionally requiring separate *bills* and separate *transactions*, the Double-Billing Rule unnecessarily burdens and confuses consumers, leading to a cascade of harms within Washington State.

B. The Rule's Impact on the State of Washington

73. Washington has a sovereign interest in applying and enforcing its state laws, including the Single-Invoice Statute. Preemption of a state statute is a direct injury to Washington's sovereignty. Washington also has a sovereign interest in exercising powers traditionally reserved to the states under our system of federalism. If enforced in Washington, the Double-Billing Rule will infringe on these sovereign interests by impliedly preempting Washington's Single-Invoice Statute. Further, the Double-Billing Rule invades Washington's traditional

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[4] OIC regulations outline the accounting and auditing requirements carriers must satisfy or verify in order to demonstrate they comply with Section 1303's funding segregation requirements. WAC 284-07-540.

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authority to protect consumers, regulate the insurance industry, and exercise its police powers to protect the health, safety, and well-being of its residents—including by protecting their access to affordable health care coverage.

74. Washington also has a proprietary interest in the efficient and effective administration of its State Exchange. If enforced in Washington, the Double-Billing Rule will harm the Exchange in a number of ways. The Rule deviates from industry practice and will require significant and costly administrative and operational changes. Washington QHP issuers estimate that implementing the Double-Billing Rule will raise their costs by $100,000 to $500,000 per issuer, for a total burden of up to $3.5 million initially, not including significant ongoing monthly administrative costs. On top of that, uncertainty exacerbates issuer costs. The Rule will increase uncertainty both because it introduces inconsistency between federal and state requirements and, if carriers do double-bill their enrollees, it is uncertain how many enrollees will inadvertently fail to pay their full premiums. Uncertainty raises costs, which harms consumers by increasing their premiums. Uncertainty may also drive QHP issuers out of the Exchange's market entirely, decreasing competition and increasing premiums.

75. Higher premiums decrease enrollment and increase coverage termination for nonpayment, as some consumers will not be able to afford the higher premiums. Disenrollment harms the Exchange's operation, in part because the premium tax on each policy sold helps to maintain operations. *See* Wash. Rev. Code § 43.71.060. Disenrollment also impacts the risk pool, which raises costs. In

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addition, the Exchange will incur significant costs for increased consumer outreach, customer service, and call-center assistance necessitated by the confusion generated by the Double-Billing Rule. HHS wildly underestimated the costs of implementing the Double-Billing Rule, and failed to account for any indirect costs whatsoever.

76. Washington's proprietary interests are also impacted by increased health care costs. The cost of providing medical care to residents who lack private insurance falls largely on the State, whether through its Medicaid program (known as Apple Health) or through the provision of emergency care at State-funded hospitals. If enforced in Washington, the Double-Billing Rule is highly likely to increase the number of residents who lack private health insurance, and must rely on the State for their care. A rise in uninsured rates over the next decade could lead to a loss of federal marketplace spending and Medicaid spending, risking $4.7 billion and $38 billion, respectively. If these gains were put at risk, Washington hospitals could lose an estimated $23.3 billion and physicians could lose $7.7 billion. Uncompensated care costs in Washington would increase by $33.9 billion over this period.

77. Washington has quasi-sovereign and *parens patriae* interests in the health, safety, and well-being of its residents. If enforced in Washington, the Double-Billing Rule will compromise Washingtonians' health care coverage and impede their access to care. For example, the Rule will impose an estimated $3.5 million in costs on Washington QHP issuers, leaving less available for direct

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payment for enrollees' covered health services. Increased costs may also drive some issuers out of the Exchange market entirely and cause widespread disenrollment, as discussed above. Likewise, if a consumer inadvertently fails to pay their full premium due to confusion caused by the Double-Billing Rule, they may lose their coverage entirely. Even if the issuer chooses not to terminate coverage for nonpayment in reliance on HHS's "enforcement discretion," *see* Paragraphs 52–54 and 68, *supra*, coverage will still be compromised because the issuer will not receive full premiums—again, leaving less available for payment of covered services, driving up costs, and driving issuers out of the market.

78. The above are only some examples of the Double-Billing Rule's directly traceable impacts on Washington and injuries it will cause to Washington, all of which would be redressed by the relief requested herein.

79. Absent relief that prevents the Double-Billing Rule from going into effect as scheduled, or that declares the Double-Billing Rule inapplicable in Washington, the State and its residents will suffer irreparable harm. Consumers will inevitably be confused by receiving two bills for the same plan in the same month, leading many to inadvertently fail to pay their full premiums and thus jeopardizing their coverage. Implementing the Double-Billing Rule would also entail significant costs to the State, the Exchange, and QHP issuers, leading to the cascade of harms discussed above. Any costs incurred are non-compensable because they cannot be recovered as damages from the federal government. Likewise, the public health harms traceable to implementation of the unlawful

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Double-Billing Rule—in particular, disenrollment and reduced access to medical care—cannot be remedied after the fact. If a medical issue arises while a patient is uninsured, the financial cost of care (or the loss of access to care entirely) can have devastating short- and long-term ripple effects across families and communities.

V. CLAIMS FOR RELIEF

Count I
Violation of the Administrative Procedure Act, Section 706
Agency Action Contrary to Law: Affordable Care Act Section 1303

80. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

81. Section 1303 of the PPACA, which establishes the funding-segregation requirements that the Double-Billing Rule purports to implement, contains a non-preemption provision expressly providing that "[n]othing in this Act shall be construed to preempt or otherwise have any effect on" state laws "regarding" abortion coverage, funding, or procedural requirements. 42 U.S.C. § 18023(c)(1).

82. The Double-Billing Rule directly conflicts with Washington's Single-Invoice Statute, contrary to Congress's intent as expressed in Section 1303.

83. Federal agency rules that conflict with state law where the relevant statute includes a non-preemption provision are contrary to law and should be invalidated. *See, e.g.*, *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004), *aff'd sub nom Gonzales v. Oregon*, 546 U.S. 243 (2006) (invalidating U.S. Attorney General's reinterpretation of a provision of the Controlled Substances Act, creating

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a conflict with state law contrary to the Act's non-preemption provision). Under such circumstances, federal agency rules that create a conflict with state law "cannot be squared with" Congress's express intent not to preempt state law. *Id.*

84. In the preamble to the Double-Billing Rule, HHS and CMS claim the Rule has no preemptive effect on state law. Yet the Rule's regulatory text contains no exception for QHP issuers in states like Washington, which has a Single-Invoice Statute, nor does it include a non-preemption provision. If applied in Washington, the Double-Billing Rule would impliedly preempt Washington law because it directly conflicts with the Single-Billing Statute. Despite the preamble's language, representatives of CMS have stated that the Double-Billing Rule does preempt state laws that conflict with its requirements.

85. If applied in Washington, the Double-Billing Rule violates Section 1303's non-preemption provision and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count II
Violation of the Administrative Procedure Act, Section 706
Agency Action Contrary to Law: Affordable Care Act Section 1321

86. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

87. Section 1321 of the PPACA includes a general non-preemption provision expressly providing that "[n]othing in this title shall be construed to

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preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d).

88. The Double-Billing Rule directly conflicts with Washington's Single-Invoice Statute, contrary to Congress's intent as expressed in Section 1321.

89. For the reasons discussed above, to the extent it applies in Washington, the Double-Billing Rule is contrary to Section 1321's non-preemption provision and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count III
Violation of the Administrative Procedure Act, Section 706
Agency Action in Excess of Statutory Authority and Contrary to Law:
Affordable Care Act Section 1303

90. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

91. The Double-Billing Rule is impermissible under Section 1303 itself. The agencies' new interpretation on which the Double-Billing Rule is based contradicts the statute's plain text and is not based on a permissible construction of the statute. The Double-Billing Rule imposes requirements that exceed the agencies' authority under Section 1303.

92. Section 1303 requires QHP issuers to "collect . . . a separate payment" to ensure "segregation of funds" for coverage of non-federally-fundable abortion

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care. Contrary to the stated rationale for the Double-Billing Rule—and as HHS previously recognized in the 2015 Rule—Section 1303 does not require QHP issuers to send enrollees a separate bill or seek payment via a separate transaction.

93. Even if Section 1303 contained an ambiguity, the Double-Billing Rule would not reflect a permissible or reasonable construction of the statutory language. It cannot be reconciled with the text and purpose of the statute.

94. The Double-Billing Rule exceeds Defendants' authority under Section 1303 because it imposes expansive and onerous new requirements that are contrary to the limitations established by the statute.

95. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count IV
Violation of the Administrative Procedure Act, Section 706
Agency Action Contrary to Law: Affordable Care Act Section 1554

96. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

97. Section 1554 of the PPACA is the Act's catch-all patient-protection provision. It provides that "the Secretary of Health and Human Services shall not promulgate any regulation that," *inter alia*, "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impedes timely access to health care services," or "limits the availability of health care treatment for the full duration of a patient's medical needs." 42 U.S.C. § 18114.

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98. The Double-Billing Rule violates Section 1554's limitations on HHS's rulemaking authority because it will result in QHP enrollees inadvertently failing to pay their premiums in full. As discussed above, this will jeopardize enrollees' coverage, drive some issuers out of the Exchange market, and increase costs to the issuers that remain, increasing costs to consumers and leaving less funding available to pay for covered services. Thus, as a direct result of the Double-Billing Rule, Washington QHP enrollees will face unreasonable barriers to care, impeded access to health care services, and more limitations on the availability of health care treatment.

99. The Double-Billing Rule is contrary to Section 1554's patient-protection provisions and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count V
Violation of the Administrative Procedure Act, Section 706
Arbitrary and Capricious Agency Action

100. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

101. The Double-Billing Rule is arbitrary and capricious in numerous respects. It reverses the agencies' prior policy of permitting single-invoice billing and a single payment transaction under Section 1303 of the PPACA, with no evidentiary basis or cogent rationale. The agencies failed to adequately account for

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reliance on the prior policy, including issuers' reliance when designing their 2020 plans and setting premium amounts. The Rule ignores important aspects of the problem Congress directed the agencies to consider, most egregiously by disregarding and undermining the PPACA's overall purpose of increasing access to affordable health care coverage. Access to affordable health care will be compromised as a direct result of the Double-Billing Rule, causing significant and uncompensable harm to consumers. Though the Rule purports to implement Section 1303 of the PPACA, it is not connected to Section 1303's purpose, which is to ensure funding segregation to ensure federal funds are not used to pay for non-federally-fundable care. Section 1303 does not establish any particular procedures by which payment must be billed or submitted (which is a matter of state law). Nor is the Double-Billing Rule connected to its own stated "program integrity" purpose; there is no evidence of a lack of program integrity, and there is no evidence that the Rule would address this nonexistent problem. The Double-Billing Rule serves no valid statutory purpose. Its apparent intent is to penalize issuers for offering abortion coverage in QHPs and to punish states for requiring reproductive health care coverage parity by dramatically increasing costs and harming the robust administration of state exchanges. The agencies failed to give due weight to the harms and burdens imposed by the Double-Billing Rule, drastically underestimated its costs, and failed to meaningfully weigh the costs against the purported benefits. Overall, the Double-Billing Rule is illogical, unsupported, and unreasonable.

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102. For these and other reasons, the Double-Billing Rule is arbitrary and capricious and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count VI
Violation of the Administrative Procedure Act, Section 553
Agency Action Absent Notice and Comment

103. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

104. The Double-Billing Rule's "enforcement discretion" concept was not included in the NPRM, and the public had no opportunity to comment on it.

105. HHS's promise to exercise "enforcement discretion" is a tacit acknowledgement that, if the Double-Billing Rule is implemented, QHP enrollees are likely to inadvertently fail to pay their full premiums, implicating existing regulations regarding grace periods and termination for nonpayment of premiums. HHS addresses this problem by promising to refrain from enforcing these regulations where issuers decline to terminate coverage based on nonpayment caused by the Double-Billing Rule.

106. HHS's promise to exercise "enforcement discretion" does not solve the problem. If HHS exercised such "discretion" indefinitely, it would be an effective repeal or revision of the existing grace period and termination regulations absent compliance with procedural requirements. The scope and timeframe for the

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promised "enforcement discretion" is vague, and the concept is not included in the regulatory text, making it unreliable and unpredictable. Such uncertainty means increased costs for issuers. Furthermore, maintaining enrollees' coverage despite their failure to pay in full means issuers must undertake the cost of providing continued coverage. Rising costs to issuers will potentially drive issuers out of the Exchange market, ultimately leading to more disenrollment. Rising costs also incentivize issuers to raise premiums, which impacts enrollees. As a direct result of the Double-Billing Rule and HHS's exercise of "enforcement discretion," consumers in Washington will have less access to affordable health insurance.

107. The Double-Billing Rule was promulgated absent required notice-and-comment procedures and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

Count VII
Violation of the Tenth Amendment to the U.S. Constitution
Interference With Powers Reserved to the States

108. Washington realleges and reincorporates by reference the allegations in each of the preceding paragraphs.

109. The Tenth Amendment prohibits the federal government from commandeering state officials to implement a federal regulatory agenda, and protects against federal encroachment into areas of traditional state concern.

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Regulation of the insurance industry, and protection of residents' health, safety, and well-being, are areas of traditional state concern.

110. Consistent with the principles of federalism embodied by the Tenth Amendment, administrative agencies may not alter the constitutional balance of power between states and the federal government unless the statute makes Congress's intent to do so "unmistakably clear." *Gregory v. Ashcroft*, 501 U.S. 452 (1991).

111. The Double-Billing Rule improperly tasks states with implementing and enforcing its unlawful and unnecessary new requirements. It also improperly invades areas of traditional state concern by purporting to regulate the manner in which insurance premiums are billed and submitted (directly contrary to Washington law), and by punishing states for requiring insurance coverage parity (as Washington does). Contrary to the Tenth Amendment, the Double-Billing Rule usurps state law absent any expression of intent to do so in the PPACA.

112. The Double-Billing Rule is unconstitutional and must be invalidated and set aside. Absent declaratory and injunctive relief vacating the Rule and/or prohibiting it from going into effect, Washington and its residents will be immediately, continuously, and irreparably harmed by Defendants' illegal actions.

VI. PRAYER FOR RELIEF

Wherefore, the State of Washington prays that the Court:

a. Declare that the Double-Billing Rule is unauthorized by and contrary to the Constitution and laws of the United States;

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b. Declare that the Double-Billing Rule is invalid and without force of law, and vacate the Rule in full;

c. Issue preliminary and permanent injunctions prohibiting Defendants from implementing or enforcing the Double-Billing Rule;

d. Award the State of Washington its costs and reasonable attorneys' fees; and

e. Award such other and further relief as the interests of justice may require.

Respectfully submitted this 31st day of January, 2020.

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