No. 20-16802

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF CALIFORNIA, et al.,

Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of California

BRIEF FOR APPELLANTS

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STATEMENT OF JURISDICTION

Plaintiffs challenged federal regulations and invoked the district court's jurisdiction under 28 U.S.C. §§ 1331, 1346, and 5 U.S.C. §§ 701-706. ER-20–95. On cross motions for summary judgment, the district court invalidated the federal regulations. ER-18. The court entered final judgment on July 20, 2020. ER-3. Defendants timely filed a notice of appeal on September 17, 2020. ER-174. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUE

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 regulations at issue here provide that, to comply with this statutory directive, the insurer must send each 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 question presented is:

Whether the regulations are arbitrary and capricious.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are set forth in the addendum to this brief, pages A1-A4.

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*, 576 U.S. 473, 478-79 (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 regulations that implement section 1303. 84 Fed. Reg. 71,674 (Dec. 27, 2019). As relevant here, the amended regulations specify 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-Hyde 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 regulations 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 71,710-11 (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 71,684; *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 regulations would total approximately $1.5 billion between 2020 and 2024. 84 Fed. Reg. at 71,707 (Table 10).

II. Factual Background and Prior Proceedings

Plaintiffs are seven states and the District of Columbia. In January 2020, plaintiffs brought this action, seeking to invalidate the 2019 regulations. *See* ER-97; ER-92–93.

On cross motions for summary judgment, the district court vacated the 2019 regulations as arbitrary and capricious.[3] 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. ER-17. The court reasoned that "nothing in the administrative record shows any noncompliance with section 1303" prior to the amendment, noting that "the state Attorney Generals Multistate Comment Letters are filed every year and provide the accounting assurance that no federal funds are used for abortion services." ER-15. The court also emphasized the industry's "reliance" on the agency's prior policy and stressed the "substantial" "transactional costs to states, issuers, and enrollees," and risks of "enrollee confusion[] and . . . reduced healthcare coverage" in the absence of "any transactional benefit" identified by HHS, ER-15, 16.

[3] The parties consented to proceed before a magistrate judge. ER-19, 96. We refer to the magistrate judge's decision as the decision of the district court.

SUMMARY OF ARGUMENT

Section 1303(b)(2)(B)(i) 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 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)). And while the district court emphasized the industry's reliance interests and the potential

burdens on insurers and consumers, the agency considered those interests and costs and took steps to mitigate them.

STANDARD OF REVIEW

This Court reviews de novo the district court's grant of summary judgment and its conclusion that the regulations are arbitrary and capricious under the APA. *Alaska Oil & Gas Ass'n v. Jewell*, 815 F.3d 544, 554 (9th Cir. 2016).

ARGUMENT

A. The Challenged Regulations Properly Implement Section 1303 Of The ACA

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.

A 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-Hyde 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.

B. The District Court's Reasons For Declaring The Amended Regulations Arbitrary And Capricious Do Not Withstand Scrutiny

The district court's reasons for invalidating the amended regulations reflect a misunderstanding of section 1303. The court declared that "nothing in the administrative record shows any noncompliance with section 1303," noting that "the state Attorney Generals Multistate Comment Letters are filed every year and provide the accounting assurance that no federal funds are used for abortion services." ER-15. But as discussed above, section 1303 does not merely direct insurers to take accounting measures to assure that no federal funds are used for abortion services; section 1303 also requires insurers to "collect" a "separate payment" from policy holders for such coverage. Paragraph (b)(2)(B) establishes two distinct 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). Compliance with section 1303's *segregation* requirement is not the same thing as compliance with section 1303's *separate-payment* requirement.

The district court expressed doubt that the amended regulations better align with section 1303, stating that "the statute does not require or even suggest separate billings by issuers or separate transaction-payments by consumers." ER-15. But the absence of explicit statutory language pertaining to billing does not necessarily render the implementing regulations invalid, particularly where, as here, relevant legislative history supports the agency action. 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, who explained that if a plan "has any [non-excepted] abortion coverage, the insurance company must bill you separately, and you must pay separately." *Id.* Moreover, the district court was mistaken to conclude that section 1303 does not "even *suggest* . . . separate transaction-payments by consumers" are required, ER-15 (emphasis added), since, by its terms, section 1303 requires that an insurer "collect from each enrollee . . . a separate payment" for the coverage of non-excepted abortion services, ACA § 1303(b)(2)(B)(i).

The district court also faulted the agency for failing to explain why it departed from what the court described as a prior "rule," despite "industry reliance" and comments arguing that the new approach would be burdensome for insurers and risk coverage loss for enrollees. ER-15–17. However, the prior policy was not a "rule" but nonbinding guidance that did not alter the text of the 2012 regulations and did

not have the force of law. *See, e.g.*, 80 Fed. Reg. at 10,841 (describing the statements in the preamble as "clarifying guidance").

Furthermore, although HHS viewed its former policy as permissible, it concluded that the amended regulations better align with the intent of section 1303. The agency accordingly explained that it was changing course, amending the regulations to bring them into better alignment with the statutory requirement. As discussed above, that was a 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 "give heightened review 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." *California ex rel. Becerra v. Azar*, 950 F.3d 1067, 1096-97 (9th Cir. 2020) (quoting *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." *Fox Television Stations, Inc.*, 556 U.S. 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, contrary to the district court's understanding, *see* ER-16–17, the amended regulations include provisions designed to mitigate the burdens on insurers

and protect enrollees from coverage loss. To reduce postage and mailing costs, the amended regulations allow 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 regulations prohibit 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 71,686. 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.

The district court also mistakenly declared that that the agency had added a "new provision" that "allow[ed] enrollees to opt out of abortion coverage by choosing not to pay the premium attributable to abortion services," which the court reasoned

"supports the conclusion that HHS changed its prior policy without affording any reasoned explanation for the change." ER-17. Presumably, the district court was referring to HHS's statement in the preamble to the final rule, where HHS explained that it would not "take enforcement action" against insurers who permit enrollees to "opt out" of abortion coverage by declining to make the separate payment for such services. *See* 84 Fed. Reg. at 71,686. HHS's exercise of enforcement discretion is not a basis to invalidate the regulations' separate billing requirement, which, as discussed above, was itself adequately explained. Review of agency action under the APA is "highly deferential, presuming the agency action to be valid, and [requires] affirming the agency action if a reasonable basis exists for its decision." *Kern Cty. Farm Bureau v. Allen*, 450 F.3d 1072, 1076 (9th Cir. 2006) (quoting *Independent Acceptance Co. v. California*, 204 F.3d 1247, 1251 (9th Cir. 2000)). The regulations at issue here should 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).

CONCLUSION

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

Respectfully submitted,

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STATEMENT OF RELATED CASES

Pursuant to Ninth Circuit Rule 28-2.6, appellant identifies the following related case pending before this Court: *Washington v. Azar*, No. 20-35521. That case has been fully briefed and is currently being considered for upcoming argument in Seattle beginning in April 2021.

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 3860 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 December 28, 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.

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.